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Alcohol and brief intervention in primary health care: what do patients think?

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Excessive alcohol consumption causes major problems in the UK but is responsive to brief intervention. Excessive drinkers represent 20% of patients on practice lists and present twice as often as others. The potential of health professionals to reduce alcohol related problems contrasts sharply with current practice. Health professionals' report fears about negative reactions and losing rapport with patients. This study explored patients' attitudes to and experiences of alcohol and brief intervention in primary health care so that health professionals can provide a service which is more acceptable to patients. The study used a qualitative approach to data collection and analysis. Six focus groups, stratified by age and sex, were conducted with 31 patients from practices in northeast England. A combination of random and purposive sampling was used to recruit patients with a range of perspectives on issues emerging from ongoing data-analysis until data saturation occurred. Many patients had recently altered their lifestyle to improve their health, however, only one reported reducing alcohol consumption. Over half the patients had been advised about their lifestyle but this was not always deemed to be appropriate. Patients responded positively to advice when in an appropriate context and by a health professional with whom they had developed a relationship and rapport. Overall the general practitioner was deemed the preferred health professional to discuss alcohol issues. Brief alcohol intervention is a legitimate role of the general practitioner when carried out in an appropriate context. A National Alcohol Strategy should focus on strengthening the public health campaign in order to support general practitioners in brief alcohol intervention.

Key words: alcohol; brief intervention; patient attitudes; primary health care; qualitative research

Introduction

Alcohol is a major cause of social, health and economic problems in the UK; (Alcohol Concern, 2000; Anderson *et al.,* 1993) thus reduction in excessive drinking was one of the targets included in the Government White Paper, Saving Lives: Our Healthier Nation (Department of Health, 1999). However, alcohol problems are responsive to brief interventions (Freemantle *et al.,* 1993; Moyer *et al.,* 2002). Brief alcohol interventions are typically short in duration (5–10 minutes) and can be defined as those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it (Babor and Higgins-Biddle, 2001). General practice is a particularly valuable point of contact for the delivery of brief interventions for excessive alcohol use because of the large proportion of the population who access their general practice each year (Fraser, 1992). However, the potential of both general practitioners and practice nurses to reduce the prevalence of alcohol related problems contrasts sharply with current practice (Boulton and Williams, 1983; Deehan *et al.,* 1998; Reid *et al.,* 1986; Rydon *et al.,* 1992).

While it has been suggested, from quantitative postal surveys, that patients expect and welcome preventive lifestyle advice (Duaso and Cheung, 2002; Foss *et al.,* 1996; Richmond *et al.,* 1996; Wallace *et al.,* 1987; Wallace and Haines, 1984)

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other research, which has explored this issue in a qualitative manner, has shown that patients can resent health professionals dictating to them about lifestyle change (Miller *et al.,* 1993; Stott and Pill, 1990). In fact behaviour change experts believe that advice for those not ready to change could result in unhealthy behaviour and is potentially destructive to the patient-health professional relationship (Butler *et al.,* 1996; Kelly, 1992; Prochaska, 1995; Prochaska and DiClemente, 1982; Rollnick *et al.,* 1993; Samet *et al.,* 1996). This concern about possible negative reactions, to preventive advice, from patients may be behind the large number of opportunities for health promotion that are apparently being missed by health professionals (Lock *et al.,* 2002; Williams *et al.,* 1989). Only one study has sought to examine patients' views on the most appropriate professional to deliver preventive advice in primary health care (Eggleston *et al.,* 1995). In this study patients viewed the practice nurse and general practitioner delivered interventions as equally appropriate.

As the government strives to empower patients to become more involved in health care (Department of Health, 2001) the aim of this study was to explore patients' attitudes to and experiences of alcohol and brief interventions in primary health care so that future brief alcohol interventions are appropriate and acceptable to potential recipients thus increasing the likelihood that they will impact on patient lifestyle.

Methods

A focus group study with a random sample of patients registered with general practices supplemented with a purposive sample of patients recruited using market research methods in northeast England.

Pilot study

A small pilot study was carried out in order to test and refine the focus group semi-structured topic guide. As a result of the pilot study several changes were made to the topic guide (see Figure 1). The overall number of questions was reduced by removing some of the more general items. Other questions were removed or rephrased to avoid potential repetition of issues.

Ethical approval

The Local Research Ethics Committee granted ethical approval for the study in September 2000 and for a second recruitment strategy in November 2001.

Practice recruitment

All 75 practices within one area of northeast England were invited to be involved in the study. An invitation letter enclosing a reply slip and freepost envelope was sent to the principal general practitioner of each practice in March 2001. Examples of the patient invitation letter, information sheet, consent form and freepost envelope were also included for information and all were copied to the practice manager.

Each practice was asked if they would be willing to invite a random sample of 60 patients to attend a focus group. General practitioners were asked to exclude patients if they were under the age of 16, had learning disabilities, had severe mental health problems or were pregnant women. In total, 10 (13%) practices contacted the study centre regarding participation, eight (11%) practices went on to invite patients between March and September 2001 (see Table 1).

Patient recruitment

For ethical reasons the study centre was not made aware of each random sample of patients who received a written invitation from their practice (on University headed paper). Patients were asked to give their written consent to be contacted directly by the study centre in order to negotiate further involvement in the study. An information sheet about the study, consent form and freepost envelope were enclosed along with the invitation. Patients were told the aim of the study was to explore what they felt about being asked and advised about their lifestyle in primary health care, particularly in relation to alcohol.

Out of a total of 480 patients invited, 43 (9%)

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Figure 1: Patient Focus Group Topic Guide

Health and Health Promotion
1) What do you think are the main causes of ill health?
2) What have you done in the last 12 months to keep yourself healthy or to improve your health?

Lifestyle in Primary Health Care
3) Have you been asked about your lifestyle when you have been to the surgery?
4) How did you feel about being asked about your lifestyle?

Alcohol and Alcohol Health Promotion
5) What do you consider to be excessive drinking?
6) What are the government recommended limits?
7) What is a unit of alcohol?
8) Where have you found out this information?
9) What are the problems (if any) associated with drinking too much alcohol?
10) What are the benefits (if any) associated with drinking alcohol?

Drink-Less Brief Alcohol Intervention Programme
11) AUDIT – How would you feel about being asked these questions?
12) When would it be appropriate to ask these questions?
13) Who should raise the subject of alcohol?
14) LEAFLETS – What do you think about the materials presented?
15) How would you feel about being given advice and information about drinking?
16) CARDS – Who would be the easiest person to discuss alcohol with? (Rank cards in order from easiest to hardest?)
17) What information would you like about alcohol?
18) How would you like to receive information about alcohol?

Table 1 Study practices

Id	Number of GPs	Random sample (after exclusions)	Patient response	Response rate
A	5	60	3	5%
B	6	60	10	17%
D	4	60	4	7%
E	4	60	4	7%
F	10	60	3	5%
G	3	60	6	10%
H	3	60	5	8%
J	7	60	8	13%
	Total	480	43	9%

returned a consent form to the study centre expressing interest in attending a focus group session. Respondents were 49% (n = 21) male (age range 29–78 years) and 51% (n = 22) female (age range 18–63 years). Respondents were invited by letter to express their availability for two different dates on which they might be able to attend a focus group session. Each patient was normally given the option of one afternoon or one evening session. Patients were asked to return a reply slip detailing their availability and or preferences for the sessions in a freepost envelope provided by the study centre. The most commonly nominated date and time was selected for each focus group. All patients were then invited to a focus group by letter (enclosing a map and directions to the venue) and telephoned the day before to confirm attendance.

Due to a poor response (n = 8, 19%) from males and females under the age of 40 a second recruitment strategy was employed. Market research methods were used to recruit patients aged between 18 and 40 years from the general public. This involved approaching potential subjects, on the day of the focus group session, in the city centre. The research study was explained to them and they were given an information sheet. If they expressed an interest in participating in the study they were asked a few questions to ensure they met the recruitment criteria. If eligible, patients were asked to sign a consent form and invited to return later that day to take part in the focus group session. Once recruited these patients were treated in exactly the same manner as all other participants.

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Response rates to this method of recruitment were not recorded.

To ensure that each focus group was as homogenous as possible and had a similar number of potential participants, patients who agreed to participate in the study were stratified into six groups based on age and sex. The groups consisted of:

(a) Males aged between 18 and 29
(b) Females aged between 18 and 29
(c) Males aged between 30 and 55
(d) Females aged between 30 and 55
(e) Males aged 56+
(f) Females aged 56+

Focus groups

A total of six focus group sessions were carried out. Each session was held in a city centre community setting, easily accessible by public transport and with full access for disabled people. Each group was approximately one hour in duration and light refreshments were available throughout. Each group was moderated by an experienced researcher using a semi-structured topic guide, with a second researcher acting as an observer and taking notes to assist with the validation of data. All groups were audio tape recorded and transcribed verbatim. All six focus group sessions were carried out in November 2001.

Each participant was asked to complete a registration form on arrival at the focus group, to obtain some basic demographic and lifestyle details. Participants received compensation for travel expenses (maximum £10) as an incentive to attend.

The moderator and observer introduced themselves as researchers from the University of Newcastle upon Tyne and explained the aim of the focus group. Guidelines as to how the group would be conducted and confidentiality and data protection issues surrounding the use of audio tape recording and the information collected were also discussed. Participants had agreed to the audio tape recording of the group on the consent form and this was reconfirmed at the group itself. Participants were also given the opportunity to ask further questions about the group before it began.

The moderator guided the discussion using a semi-structured topic guide. Questions were open-ended and a 'funnel' approach was used, starting with general questions about health and lifestyle and gradually focusing upon alcohol-related issues. Participants were encouraged to discuss the questions with one another rather than with the moderator, whose role was to introduce topics and probe any issues that arose from the discussion.

During the group patients were presented with five cards each with the name of a different health professional (general practitioner, practice nurse, counsellor, lifestyle worker and alcohol worker), which they were asked to rank in order of who they would prefer to talk to about alcohol-related issues. Reasons for their decisions were also discussed.

At the end of the focus group, participants were thanked for attending and received travel expenses and a 'goody bag' of alcohol-related leaflets, a unit calculator and a pen to take home. The moderator and observer held a debriefing session immediately after the group to share initial impressions.

Data analysis

Focus group discussions were audio taped and transcribed verbatim. Tapes were listened to and each transcript checked to ensure that meaning had not been lost during transcription. Transcripts were anonymised and imported into the Nvivo (Fraser, 2000) qualitative software package for open and axial coding of data. Data collection and analysis proceeded simultaneously until saturation was reached according to the constant comparative method. Transcripts were scrutinized, emerging themes and subthemes were agreed and an initial coding frame was developed. Initial coding of data was carried out independently by the two researchers, then reviewed and revised until consensus was reached, in an attempt to reduce researcher bias. Sections of text were coded and these codes were applied to subsequent transcripts. Further codes were added as new themes emerged.

Emergent themes were analysed by age, gender and the reported lifestyle behaviour to explore any similarities or differences in patients' perceptions, attitudes and experiences on the basis of these attributes. Matrices were generated to show how many text units were coded at each given 'node' to investigate any patterns of coding.

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Participants

In total 31 people attended the focus groups, 10 recruited directly from the city centre and 21 recruited via general practice. No data was collected on the ethnic background of the participants (see Table 2).

Results

Behaviour change to improve health

Patients were asked about their experiences of changing their behaviour in order to improve their health. Most reported doing something to improve or maintain their health. Most commonly patients

Table 2 Focus group participants

Focus Group	Sex	Occupation	Age	Education[a]	Smoker	Drinking behaviour[b]	Recommended exercise[c]	Recommended diet[d]
a	M	Student	18	A Level	No	Binge	Yes	No
		Student	18	A Level	No	Sensible	Yes	No
		Student	18	A Level	No	Heavy/Binge	Yes	No
		Student	19	A Level	No	Heavy/Binge	Yes	No
		Student	18	A Level	No	Heavy/Binge	Yes	No
		Student	18	A Level	No	Sensible	Yes	No
b	F	Health Worker	24	University	Yes	Heavy/Binge	No	No
		Student	26	University	No	Heavy/Binge	Yes	No
		Administrator	24	University	No	Heavy/Binge	Yes	No
		Researcher	24	University	No	Heavy/Binge	Yes	No
c	M	Local Authority	49	A Level	Yes	Heavy/Binge	Yes	No
		Police	45	University	No	Sensible	Yes	Yes
		Co. Director	46	A Level	No	Sensible	Yes	Yes
		Manager	51	University	No	Sensible	No	Yes
d	F	Housewife	55	Missing	No	Non	No	No
		Housewife	51	Missing	Yes	Non	No	No
		Unemployed	55	GCSE	No	Sensible	No	No
e	M	Retired	58	GCSE	No	Sensible	Yes	Yes
		Retired	76	GCSE	No	Non	No	Yes
		Co. Director	57	University	No	Sensible	Yes	Yes
		Retired	75	Missing	No	Non	Yes	Yes
		Unemployed	58	Missing	No	Sensible	No	No
		Clockmaker	61	University	No	Sensible	No	No
		Retired	78	Missing	No	Sensible	No	Yes
		Retired	62	GCSE	Yes	Heavy/Binge	Yes	Yes
		Scaffolder	58	Missing	No	Heavy/Binge	Yes	No
f	F	Housewife	56	Missing	No	Sensible	No	Yes
		Retired	63	Missing	No	Sensible	No	No
		Care Worker	59	Missing	No	Non	No	No
		Housewife	72	Missing	No	Sensible	Yes	No
		Witness Service	62	University	No	Non	No	No

[a]Education relates to highest level achieved.
[b]Drinking behaviour based on British Medical Association recommendation (Non = 0 units/week, Sensible <14 units/week women <21 units/week men, Heavy >14 units/week women >21 units/week men, Binge >6 units/day.
[c]Recommended exercise based on Health Education Authority recommendation of 30 minutes of light exercise per day or 20 minutes of vigorous exercise three days per week.
[d]Recommended diet based on Health Education Authority recommendation of five portions of fruit and vegetable per day.

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reported taking up regular exercise irrespective of age or gender. For groups other than young men increasing exercise was often reported in combination with improved diet. A couple of the younger and middle aged women talked about failed attempts at giving up smoking while all the older patients who had tried to give up had succeeded. Only one patient, a young female who drank heavily and binged, described trying to reduce her alcohol consumption. Patients in the older age groups reported that this change in behaviour was due to a specific health problem (such as a heart attack, a lung condition or obesity) or for a particular reason such as the escalating cost of cigarettes or to lose weight for a special occasion. Younger patients however talked more in terms of keeping fit and preventing future health problems.

Experiences of lifestyle questions or advice

Half of the patients stated that they had been asked or advised about their lifestyle by a health professional at one time or another. This occurred in a variety of situations but most commonly happened opportunistically when patients visited primary care for a specific health problem. A couple of the patients had requested help to change a lifestyle behaviour (smoking and diet) and many attended for preventive health checks such as smears, mammograms, well-man and healthy heart clinics. Other situations in which patients had been asked about their lifestyle included occupational checks, insurance medicals, new patient registrations, attendance for repeat prescriptions for contraceptives, hospital consultations and admittance to accident and emergency.

The source of lifestyle questioning or advice giving was therefore most commonly the patients general practitioner or practice nurse but included other health professionals such as hospital doctors and occupational nurses. For patients who had sought or requested advice, information was also obtained from a helpline and written material. Many of the older patients also used newspapers as a source of information about appropriate lifestyle behaviour while a couple of middle aged and older men also used their wives for information and support.

Specific questions and advice were not always deemed to be appropriate or acceptable. Some nondrinkers said that they or their (nondrinking) relative had been advised on reducing alcohol consumption even though they did not drink, and this had left them feeling insulted and not believed. Other (female) patients spoke about the negative attitude of health professionals they had seen and the poor manner in which they had been advised. For example, where patients had wanted to be praised and encouraged by the health professional for trying to change behaviour, they instead felt that they had been ‘told off’ or treated ‘like a child’. Some female patients also said that they found it difficult to talk about their problems with their general practitioner because they felt ‘vulnerable’ or ‘intimidated’ (see Table 3a).

Patients seemed to respond more positively to general lifestyle questions and advice when this had been presented in an appropriate context, for example during the well man clinic or new patient registration, where patients expect and want to be asked or advised. The relationship between the patient and the health professional was also an important factor in the acceptability or otherwise of questions and advice. Patients who perceived they had good rapport with their health professional and had known them for a long time generally said they did not mind being asked and advised (see Table 3b).

Patients, whose lifestyle behaviour was in excess of that which is recommended by health professionals, had split views about the appropriateness of advice with some taking no notice, being insulted or lying about their behaviour while others expected questions and advice and were comfortable with this situation.

Attitudes to different health professionals regarding alcohol advice and information

Each patient was asked to rank the names of five health professionals who might be found in or attached to primary care, in order of preference of who they would want to talk to about alcohol issues. The overall order of ranking (from first to last preference) was general practitioner, practice nurse, counsellor, alcohol worker and lifestyle worker. However, many patients stated that they ranked the lifestyle worker last because they did not know what one was or what they did. There were some group differences in ranking. Young women preferred the practice nurse to the general practitioner while young men were least likely to

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Table 3 (a) Negative experiences

I know when I've been to the doctors and they've asked me if I smoked I've sort of, I haven't lied but I don't want to admit that I do smoke even though I know its really important for my health record. It makes me feel bad. I tell them the truth but I feel quite invaded sometimes, even though I know its for my own good (F 24 HD)
I feel like asking him what's your lifestyle? (M 18 SD)
In there out the other (points to ears) . . . I don't take any notice (M 58 HD)
You're like a little kid getting told off . . . you go in and you're like a little child, you become a little child. And you just take it. And then you come out and you think, I wish I hadn't bothered. Why didn't I just say? I've said to myself on my way there, but because they belittle you I've never said what I wanted to say and I think what a fool (F 51 ND)
Sometimes do you not find it awkward when you're in the doctors and they don't actually speak to you? Because they sit and fair enough they may be trained to listen, but sometimes you just need that little bit of a push. To get out what you need to. And you feel very vulnerable when they just look at you (F 55 SD)
I went to the doctors and he said 'do you drink?' And I thought he meant juice and I goes 'stacks' and he thought I was an alcoholic and I didn't drink (F 55 ND)
My husband has a belly and he went to the doctor and I've got to go with him because he's got a speech impediment. We go in and he's got a pot belly like this and the first words the doctor said to him was 'you'll have to cut out the alcohol'. Well I mean he's never had a drink in his life. He was that frustrated that he said will you tell him I don't drink, tell him. He doesn't drink doctor he doesn't drink, he's just got a weight problem. And he went well you know it doesn't help if you drink. I have never met a doctor like him in my life! (F 51 ND)
Well I've got a nurse at our practice, well I'm a diabetic and I'm an amputee, I've got no leg and I can't get the weight off. And she keeps saying to me you should lose the weight you know. If she can tell me how I can lose the weight I'll try. I've had the leg off 29 years and I just can't lose it. Well you should try and I says how do you try? I can't do it (F 55 ND)
As they said to me once, she had a go at us, as says here, what is paying your wages? I said the taxes off what I am smoking and drinking and she just laughed, she says fair comment (M 62 HD)

Table 3 (b) Positive experiences

I've got a very good doctor . . . he takes time to find out what the real problem is. He will ask, he's asked once or twice about general lifestyle when I've gone for specific things and I think that's good, and I've never been worried about that. I'd rather he did that than didn't. I think my life's very precious and if there is something, even if it's a small chance, I'll go to the doctor. I'd rather do that than take any chances. This doctor has got a fairly slow pace, he's not going to rush you out of the surgery, and he will try to get to the bottom of what the problem is. He would rather have a queue of people waiting than rush through things. I think he's really good (M 45 SD)
I don't mind, it's his job (M 19 HD)
I always used to go to the same doctor. And she knew me, she knew my family, she knew my family problems. And I could walk in and say so-and-so, so-and-so, so-and-so, and that was fine. And she would say how is this one or how is that one. And she knew the problems. And we had quite a good rapport going (F 55 SD)
I don't know how I got on to it (a well man clinic) but I wanted to get onto it because I wanted to be tested for all these things. So I was very glad to be there. Because if there's any problem I'd rather know about it sooner than later (M 51 SD)
I started drinking far too much, in the odd moments when I had the opportunity to indulge myself and my doctor asked me about it and he suggested that I should seek another form of relaxation. It was just getting away form all the stress you know. And he suggested that I should do something else . . . it was fine. I mean I knew myself that I smoke too much, I drink too much occasionally, not all the time. Just occasionally . . . so it was fine (M 49 HD)

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consult a counsellor. Some patients including most of the excessive drinkers stated that they would not consider going to see an alcohol worker, counsellor or lifestyle worker at all.

Patients were encouraged to talk about their reasons for their preferences. The main factors influencing their decisions were: their relationship with the health professional; whether or not they had time to talk to them within a consultation; perceived 'traditional' professional roles; level of training and expertise; the severity of the problem; perceived alcohol use of the health professional; and the stigma attached to certain problems and hence to specialist professional groups.

Most patients said they would prefer to go straight to their general practitioner with any alcohol concern or problem either because they had a good relationship with them and had known them for a long time or because that was traditionally who they would go to. They also thought the general practitioner would have the training and experience to deal with the problem or would refer them on if necessary. Concerns about going to the general practitioner arose from those who did not have a good relationship with their doctor or who did not want to waste the doctors limited time. A few of the (heavy drinking) patients and those patients with heavy drinking relatives questioned the drinking habits of their own general practitioner. Most believed the general practitioner to drink as much if not more than themselves and therefore deemed them unsuitable to provide advice about reducing alcohol consumption (see Table 4).

It was felt by some participants that practice nurses would have more time to discuss alcohol issues than a general practitioner, and that they were easy to talk to, approachable and understanding yet persuasive. There was an assumption amongst some younger participants that the practice nurse would be young and female and this would either make them easier to talk to because they would understand the issues themselves, or more difficult because they were perceived as not being 'serious'. Some (older) participants felt that the role of the nurse was more to do with changing dressings and giving injections than giving advice and information on alcohol. Others felt that the nurse would not have the training to give alcohol specific advice and information (see Table 5).

Some participants felt comfortable talking to a counsellor because they were trained to deal with a wide range of problems and were not alcohol specific. It was felt that they would be able to talk to them about other aspects of their lives and that they would look at the person as a whole. However many participants talked about the stigma attached to going to see a counsellor, with many young men feeling you had to be 'really messed up' if you needed to see a counsellor (see Table 6).

Alcohol workers were perceived by many participants as the person to go to when a patient had more severe alcohol problems, as they would be an expert in that field. Thus some participants stated that they would not want to see an alcohol worker because that would mean that they had a severe alcohol problem and because of the stigma attached to this. They were also concerned about seeing such a person at their doctors' practice, as they were afraid that other patients would know who they were going to see (see Table 7).

A lifestyle worker (someone who would deal with a range of lifestyle factors such as drinking, smoking, exercise and diet), came last overall in the rankings mainly because participants had never heard of one before, were not sure what their role would be and how they would differ from a counsellor. Responses to such a worker, however, were generally positive, again because they would be an expert in lifestyle behaviour but were not alcohol specific (see Table 8).

Alcohol related knowledge

Excessive drinking

Patients were asked what the term 'excessive drinking' meant to them. They defined this in a number of different ways including the quantity of alcohol consumed, the frequency of drinking, the physical effects of alcohol and the behavioural effects. Male patients and particularly the younger men talked about excessive drinking mainly in terms of the immediate and short term physical effects of alcohol. Patients also talked about the quantity and frequency of drinking, however although some talked in terms of the number of drinks consumed, no one measured excessive drinking in terms of units. (see Table 9).

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Table 4 General practitioner

Response	Respondent
Positive responses	
I think that's tradition. Just from going to the doctors, its just if you get on well with the doctor as well that helps. I think I'm just a stick in the mud, go to the doctors and that's it basically.	(M 46 SD)
If you've got a good doctor I think that would be my first choice. I suppose if it's a serious thing like alcohol maybe the doctor would have more general experience, medical training, that's why I put him first. And because I see him more often.	(M 45 SD)
GP was first because you feel that's the person who's been trained most and has the most experience. And presumably knows how to deal with whatever comes their way. So that has to be the top.	(M 51 SD)
Because I could talk to her in, without any qualms really, she's very, very nice and very charming.	(F 62 ND)
Because I know him and I feel comfortable with him.	(F 72 SD)
I've got no problems talking to my GP about alcohol, he's straightforward, gives you the facts and then lets you make up your mind.	(M 18 BD)
I've got GP number 1, because he's the bloke that knows all your problems anyway, because he's got a big file he knows what's been going on all your life anyway. He knows everything about you, he knows all the bad parts.	(M 19 HD)
I think the only good one would be the GP because you've seen them for years anyway, they all know you.	(M 18 HD)
Negative responses	
Its someone who knows you well and is responsible for your health and you might feel that its slightly oppressive. To tell all this to a doctor, you know he's going to stop you enjoying yourself so much because . . . why should you have to give him so much information when there's not a problem. That's what I'm concerned about. I wouldn't go to him with problems of alcoholism or something.	(M 28 SD)
When I first went to the doctor to talk about the problems with my family with alcohol, I thought, I'm sitting here now, and my mind was saying, he's probably as bad a boozer as our R. I was thinking that as I was talking to him. Because he seemed quite laid back about it. Not as concerned as I was. And that stayed with me. And of course, my son who says things like he's in the pub more than I'm in the pub. But you think if he's drinking and he's like, what do you want me to do about it? Because they've got a life as well. They probably do have sometimes more tension, they're stressed out. So what do they do when they go home?	(F 51 ND)
I mean they're bound to do things same as other people. My doctor drinks, my friend lives next door to him	(F 55 ND)
The biggest alcohol problems are in the medical profession. Yes they've got the worst record the doctors for drink problems. It's been in the papers. One of my own GPs who just retired early he admitted it. He admitted that the stress that they're getting basically from the NHS with all the paperwork they are getting. If they like a drink it will drive them further and further down that road. I mean give him his due he never condemned me for having a good drink	(M 62 HD)
Doctors are the biggest offenders	(M 58 HD)
They're too rushed, and you're just in and out as quickly as possible.	(F 26 HD)
I sometimes feel quite intimidated going to the doctors as well, because I feel like they're going what do you want, you're wasting my time	(F 24 HD)
I just feel quite intimidated by them, I don't think I can always say what I want to say. But I've never had a GP that I've been with for a long time that knew me, so maybe I think if I had a GP like that maybe I would talk to them.	(F 24 HD)

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Table 5 Practice nurse

Response	Respondent
Positive responses	
I can talk to her and she's more understanding	(F 55 ND)
I think they possibly have more time and they are easy to talk to and they tend to have more social skills than GPs	(M 57 SD)
Because they'll still be young and they'll understand	(M 18 HD)
Normally they seem a bit more approachable than GPs	(F 26 HD)
I feel that you can talk more openly to a nurse, I don't know maybe its like a woman on woman kind of thing. You feel you can talk better to a nurse perhaps. And I feel they've got more time as well, they're more interested in what you're saying'	(F 24 HD)
Negative responses	
I would only see the nurse if I need an injection or something like that	(M 46 SD)
I could talk to the practice nurse but I don't think I would go to her if I felt it was a real problem. You go to her if you need a boil lancing or a dressing changed	(F 55 SD)
There are many so they don't have one you go to each week . . . .so I would find if it was me I wouldn't be comfortable going to her because she's not there all the time	(F 59 ND)
I've met young nurses and they're just not really serious to be honest, as the GP. You don't know whether to listen to them or not. Like I was waiting to go into a practice room once and there was some female nurses having a laugh about what they were up to last night and you kind of think well these lot don't know what they're doing	(M 18 BD)
I wouldn't really trust a 'wifie' (woman) as much as a bloke, not in that way with my alcohol problem	(M 19 HD)

Table 6 Counsellor

Response	Respondent
Positive responses	
The counsellor deals with lots of problems and at the end of the day the counsellor has had everything	(F 50 ND)
The counsellor is more like homeopathic medicine, the whole body thing, the stresses and strains why you are drinking	(F 55 SD)
A counsellor would have had people a lot worse than having a drinking problem so they wouldn't think I was such a loser	(M 18 BD)
I think I would find the counsellor easiest to talk to because its less specific and you could perhaps talk to them about other types of things as well as drinking	(F 24 HD)
Negative responses	
I'm just going to see the counsellor – there must be something wrong with his plumbing! I'm not going to see the counsellor at the surgery. Its just that barrier I think	(M 46 SD)
I don't know about counsellor, I don't know him, so if I don't know him, personally I don't think I would feel comfortable telling him anything	(F 62 SD)
I reckon if you go to a counsellor you must be pretty messed up. I'd hate the fact that I'm messed up	(M 18 SD)
They might be patronising and you'd have to be pretty messed up. Dignity you've got your dignity	(M 18 HD)

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Table 7 Alcohol worker

Response	Respondent
Positive responses	
If the doctors surgery had some kind of special worker who could deal with these kind of things I think that would help. I know it sounds like a lot to have someone who deals with alcohol in a doctor's surgery but they're trying to do it with drugs aren't they? I know it's a lot of extra money but even if they had a session where you could go to the doctors surgery and there was someone there who knew exactly all about it and you wouldn't feel like you were talking to the doctor who was in a hurry to get the next patient in and get you out	(F 50 ND)
I feel that they know what they're talking about. They are there to help and listen to you	(F 62 ND)
I think if one had a terrible problem with alcohol you would probably accept advice from a person who knew all about it	(F 62 SD)
Negative responses	
I was thinking bloody hell, alcohol worker on the door and everyone's going to say 'he's going to the alcohol worker'	(M 46 SD)
Alcohol worker, I wouldn't like to be seen there because of what people would think	(M 51 SD)
I wouldn't like the stigma, where I think I would be ashamed, but probably if I had such a big, or maybe I would have to admit I had a problem wouldn't I?	(F 63 SD)
I wouldn't particularly like to do it because if I'm talking to these people it means I probably have got a problem. I wouldn't like to do that, I wouldn't like to actually know I've got a problem	(M 18 SD)
When you start seeing the alcohol worker you've hit rock bottom and you've got no friends so that would be the last, last resort	(M 19 HD)

Table 8 Lifestyle worker

Response	Respondent
Positive responses	
Somebody who advises on lifestyle you imagine that would be someone that is quite relaxed. You could go and perhaps just talk about things that you do or the things that you don't and how it effects your life	(M 46 SD)
To me a lifestyle worker would be to see if they could change your lifestyle	(F 59 ND)
Maybe that would be to do with diet and stuff like that, sort of general health rather than psychological. It would help that I was talking about other things with a lifestyle worker as well as if I had an alcohol problem	(F 24 HD)
Negative responses	
I've never heard of a lifestyle worker	(F 50 ND)
If its lifestyle then it means its probably going into your family and its affecting them and stuff, not just the fact that you're drinking too much its obviously affecting something else with your lifestyle	(M 18 SD)

Recommended limits and units of alcohol

All of the male patients, with one exception, were confused regarding the recommended limit for alcohol consumption and many admitted to not knowing or being unsure. Their estimates ranged from 7 to 35 units per week. However female patients were much more knowledgeable. One patient in the 56+ age group answered for the whole group with the statement '21 for a man and 14 for a woman'. In the other (female) groups, while one patient admitted to being unsure their estimates were very accurate at 2–3 units per day

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Table 9 Participants definitions of excessive drinking

Quantity	*Frequency*
More than one pint a day (M 58 SD)	Drinking more than three or four times a week (M 46 SD)
A couple of glasses of sherry (F 72 SD)	When you get drunk every night (M 46 SD)
More than two pints a day (F 24 HD)	Drinking everyday (F 26 HD)
A few pints every night (F 26 HD)	Drinking during the week (M 45 SD)
More than 10 glasses (F 72 SD)	Drinking in the afternoon (F 63 SD)
Seven to eight trebles in one night (F 59 ND)	
A bottle of wine (F 51 ND)	
A bottle of vodka a day (F 55 ND)	
More than a bottle (F 72 SD)	
A couple of bottles of sherry a night (F 56 SD)	
Effects	*Behaviour*
When you get (blind) drunk (M 18 HD)	Getting out of bed and thinking you have to have a drink (F 63 SD)
When you have to be carried home (M 19 HD)	When you drink to drown your sorrows (F 56 SD)
When you are sick (M 19 HD)	When you lie about drinking (F 63 SD)
When you feel ill the next day (m 51 SD)	When you buy a kebab (M 19 HD)
When your speech becomes slurred (PM 45 SD)	When you start to do silly things (M 19 HD)
When you have a hangover (F 55 SD)	When you run out of cash (M 18 SD)
When you can't remember the night out (M 18 SD)	
When you get in to fights (M 18 HD)	

and 12–14 units per week. Half the groups acknowledged that recommended limits differed for men and women. Most patients were aware of the unit system and what the unit equivalent was in terms of different drinks although there was some confusion over the number of units in a pint. A couple of (female) patients were also aware that the number of units in a drink could be affected by the strength of the alcohol. Patients had found out about recommended limits and units from a variety of sources including newspapers, magazines, billboards, TV news programmes, drink-driving campaigns, posters/leaflets in doctors surgeries, posters/leaflets in college and schools, personal social and religious education lessons at school, helplines, weight watchers, insurance documents, quiz nights and labels on bottles.

Problems and benefits associated with alcohol consumption

Patients were asked to describe what they thought were the problems and benefits associated with alcohol consumption (see Table 10). All patients believed alcohol consumption to have both positive and negative consequences. Most reported problems and benefits were based on personal or second hand experience. Older male patients mainly talked about relatives and friends who had experienced health consequences of alcohol consumption while older women reported more social and behavioural problems and benefits. Middle aged males talked about friends whose personalities had changed or who had become aggressive, while middle aged women had family members who drank and many had seen or directly experienced alcohol related domestic violence. Young men were more inclined to recount their personal experience of the short-term physical problems of drinking too much and seemed unaware of the long-term implications of excessive alcohol consumption. Young women reported both short and long term consequences of excessive alcohol consumption highlighting the implications for their own sexual health in terms of infertility and sexual risk taking. Many of the male patients also linked alcohol with aggression and violence at sporting events. Three male patients, (two young and one older), had direct experience of alcohol poisoning. A couple of the heavy drinking male patients felt that the 'hangover' was due to the chemicals or preservatives in the alcohol rather that the alcohol itself.

Although most participants had a fairly good grasp of the effects of alcohol a few of the older participants reported benefits which were more likely to be cultural or folklore. For example one (older, male, heavy drinker) participant believed that alcohol must help preserve the body as it is

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Table 10 Problems and benefits of alcohol consumption

Problems	*Benefits*
Dehydration	Loss of inhibitions
Sickness	Confidence
Dizziness	Sociability
Headache/hangover	Relaxation
Diarrhoea/diuretic	Nice taste
Shakes	Pleasurable experience
Red face	High/buzz
Hair loss	Reduced risk of heart disease
Weight loss/weight gain	Preserves the body
Strips enamel off teeth	Enhances the blood/good for the circulation
Blindness	Good for pregnancy
Alcohol poisoning	Soother for teething
Liver disease	Revives ill children
Kidney disease	Antidepressant
Heart disease	Adds to the enjoyment of food
Pancreatitis	Makes a good night out
Brain damage	Heightens positive emotions
Stroke	Increases sexual appetite
Death	Enhances sexual performance
Infertility	
Impotence	
Sexual risk taking/rape	
Unwanted pregnancies	
Aggression/violence	
Child abuse	
Domestic violence	
Cruelty	
Crime	
Danger for driving	
Less able to carry out job/absenteeism	
Accidents	
Poor co-ordination	
Poor judgement	
Impaired senses	
Altered personality/ altered mental state	
Depression	
Hallucination	
Sedation	
Memory loss	
Physical dependence	
Shortage of money/expense	
Divorce/separation	
Broken homes/divided families/loss of friends	

used to preserve organs. Another (older, male, heavy drinker) participant used alcohol to soothe teething pain in children (see Table 11).

Drinking culture

All patients made reference to the culture of drinking alcohol. Men over the age of 30 talked about drinking in younger generations and in the city. Patients felt it was the 'norm' for young people, both male and female, to drink, sometimes heavily. This was attributed to alcohol being freely available and affordable. Older men also talked about alcohol being associated with an area of heavy industry as well as with sporting events and personalities. Middle aged men discussed travelling on business and being expected to entertain and socialise in the evenings, events which always involved alcohol. Female patients tended to discuss the link between social events, socialising and entertainment with alcohol as well as the culture of having alcohol with a meal. Younger patients talked about drinking to keep up or in with their peers and being 'conditioned' to drink (see Table 12).

Other information about alcohol

Most patients agreed that more information about alcohol and alcohol-related problems should be made available to the general public. Suggestions included the provision of information on both the positive as well as negative effects of alcohol to provide a balanced viewpoint, the long-term negative health effects, and where to go for information, advice and help. The younger men also suggested that information on the effects of mixing alcohol with other drugs would be useful for their age group, and both younger men and women called for greater 'shock' tactics.

Other suggestions were that the labelling of alcohol content on cans and bottles should be made bigger, more visual and more visible, to have health warnings on labels and also on the shelving in supermarkets or shops where alcohol is sold, and to increase taxation on alcohol. Participants agreed that the only way to get messages about drinking across to the public was to use the mass media with advertisements, articles and stories on TV, in the newspapers and in magazines:

> People know who reads what or who listens to what, getting the message across that way would probably be more relevant then putting a sign on the doctors surgery. You look at a sign in the doctors surgery and immediately forget it when you walk away.
>
> (M 46 SD)

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Table 11 Folklore

Quote	Participant
Well that's notable in France isn't it, cirrhosis of the liver	(M 75 ND)
But how can you say that drinking, why do they preserve kidneys and livers in Gin?	(M 58 HD)
Well that's to kill things namely the bacteria that break them down	(M 61 SD)
Well that wouldn't preserve them to work in a transplant they are not preserved that much	(M 78 SD)
It can be very, very enjoyable indeed, in fact my wife was recommended to, years ago when we were having our babies, our youngsters, milk stout and also Guiness, it was all supposed to enhance the blood, you know, it was recommended for medical purposes	(M 76 ND)
I've teethed my own kids and grand kids on Whiskey. Four grandchildren. When they are teething, a drop of whiskey on their gums. Four kids and four grandchildren, none of them kids have actually ever kept me or me wife up through the night with toothache	(M 62 HD)
My mother told me, well I was there but I didn't know, I was only two or three days old and I started turning blue and we lived next door to a book-maker and he had whiskey, we didn't, and she knocked through for the women next door, the book-makers wife to come out and she says I've given him a teaspoon full of whiskey. Why I don't know that was it and my mother says that I went (smacks lips). I never looked back after that. My mother told that so it must be true	(M 78 SD)

Table 12 Drinking culture

Quote	Participant
When you travel they take you out, you can't really refuse. Japanese saki and Korean . . . . I drink a lot more when I'm travelling. Travelling isn't very good for your lifestyle, you probably eat a lot and you drink more. So you have to be very disciplined.	(M 51 SD)
I know what you're talking about, what you were saying about lifestyle. I used to work away a lot. It's easier when you're home to say I'm going home I'll not have a drink. Or I'll just have a glass of wine. When you're away and you're staying somewhere, and there's a few of the boys, or clients, it's a different kettle of fish altogether	(M 46 SD)
I think the thing about alcohol, is the way it was with smoking in the 50s and 60s, smoking was considered the norm whereas alcohol consumption, you've just got to see the town on a Friday and Saturday night	(M 57 SD)
The Newcastle United players in the 50s coming out of the Strawberry (Pub) at twenty to three in the afternoon and going onto St James Park (Newcastle United Football Club)	(M 62 HD)
It's the most difficult thing, first of all you acknowledge it, then even if you have acknowledged it, they send you to a drying out clinic, those that go in there and come out they are in the great, great, great minority. There's only two I know who have gone in, you probably know them, Malcolm MacDonald, he was the only really heavy alcoholic I knew who has really cured himself of it, you know, the other one is another footballer, Merson, he's well on the way to being cured. This is his third year I think, they are the only two people. Now George Best, he's been in and out as many times, God bless him	(M 76 ND)
Like on Sunday, we always have a bottle of wine, always . . . and it was just part of the meal and I don't think there was anything wrong with that, it was just a bottle of ordinary wine	(F 62 ND)
Sometimes you feel you have to keep up with your mates, if your mates are drinking you join them. If they drink a canny bit then you drink a canny bit	(M 19 HD)
Just the social aspect of it, going out to the pub and meeting your friends. I don't think people go out and have a coffee together as often as people go out and have a drink down the pub together. It just fits into everybody's lifestyle really. It's a big part of, its just a big part of our . . . what's the word I'm looking for?	(F 24 HD)

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Discussion

For those concerned with developing and refining health promotion programmes, prevention beliefs provide an indicator of the uptake of prevention messages and acceptance that prevention action is worthwhile. This was borne out in the fact that many of the patients in this study had amended their lifestyle behaviour to become more 'healthy'. However while over one third of the study population drank more than is recommended (see Table 2) only one patient reported attempts to reduce alcohol consumption. It was interesting to see that out of all the patients involved in these focus groups only two had asked for help to change their lifestyle. Previous studies have revealed that patients often expect their health professional to raise the issue of lifestyle rather than broaching the subject themselves (Wallace and Haines 1984).

While some research (Arborelius and Damstron Thakker, 1995; Lock *et al.* 2002) has shown that health professionals worry about losing rapport with patients if they discuss sensitive issues such as alcohol consumption conversely patients in this study felt more comfortable being questioned and advised by a health professional with whom they had already developed a good relationship and rapport. While the general practitioner was ranked overall as the most approachable it is interesting to note that females tended to prefer the practice nurse. Although there was a lack of understanding regarding the function of a lifestyle worker this concept received positive feedback. Perhaps future research should focus on evaluating the role of a lifestyle worker in general practice.

In contrast to other lifestyle behaviour, such as smoking, drinking alcohol has many perceived positive aspects which were identified by patients in this study and which can act as a barrier to behaviour change. However patients also identified many negative consequences of alcohol. In fact patients in this study held strong views about the effects of alcohol and what they considered to be excessive drinking. Health professionals may have their work cut out convincing some patients to follow guidelines regarding sensible drinking.

It was not surprising to find that many of the young patients in this study felt that alcohol was inextricably linked to social and entertainment activities and that many drink excessively to keep up or in with their peers. This was deemed to be the norm and something they had been conditioned to do. Similar findings have resulted from both quantitative and qualitative studies and in other countries (Cooke and Eadie, 2001; Kloep *et al.,* 2001). Young patients also had little concept of the risk of alcohol and defined excessive consumption in physical terms or in relation to the consequences of such behaviour. Participants had a minimal knowledge of units. When asked about risks the participants described only immediate consequences. Female participants were more aware and concerned about risks. These findings replicate those of other focus groups carried out with young people (Cooke and Eadie, 2001).

These findings are something to consider as we wait for the government to produce the national alcohol strategy for England (Alcohol Concern, 1999). Perhaps more emphasis should be placed on public education campaigns to promote responsible drinking with particular focus on strengthening alcohol education for young people rather than expecting primary health care and the health care professional to take on the bulk of this work.

Limitations of the study

Although every effort was made to recruit patients from both general practice and via market research methods there remained a lack of representation from patients aged between 27 and 44. While the groups were not intended to be representative of the general public it must be noted that a section of the population were not available to provide their views which could limit the generalisability of the results. Saturation of views was ensured as far as possible by utilizing alternative recruitment strategies. This shortfall and the difficulties in recruiting patients may reflect the subject matter of the study. In addition the northeast of England has a strong culture of heavy drinking which may also have influenced the findings.

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