



A survey of general practitioners' knowledge, attitudes and practices regarding the prevention and management of alcohol-related problems: an update of a World Health Organisation survey ten years on

Introduction

Alcohol related problems are one of the leading causes of morbidity and premature death. Primary care is ideal for early detection and secondary prevention of alcohol-related problems and brief interventions have been shown to reduce excessive consumption in primary care patients. However, General Practitioners (GPs) exhibit low levels of formal identification, treatment and referral of patients with alcohol related problems. In a survey carried out in 1999, GPs reported receiving more alcohol-related education than in previous studies, that they were prepared to counsel patients about reducing consumption and that a perceived lack of effectiveness in helping patients change alcohol consumption could be ameliorated by more information, training and support. However, GPs were little involved in, and poorly motivated to work with, alcohol issues and identification of alcohol problems was hampered by a focus on physical symptoms. Compared to other areas of lifestyle counselling (e.g. smoking cessation, diet and physical activity), GPs reported that the largest gap between their preparedness to intervene and their sense of being a success at changing behaviour was for alcohol issues. Given that alcohol has risen higher up the public policy agenda, it is timely to assess if personal, organisational and structural factors have altered over time to promote alcohol intervention work. The aim of this study was therefore to assess the current knowledge, attitudes and practices of GPs concerning brief alcohol intervention and to examine whether these had changed over the last ten years and in light of recent health policy initiatives.

Method

The study comprised a postal questionnaire survey of 419 GP principals (one GP per practice) in the English midlands, comprising Leicester City, Leicestershire County and Rutland, Derby City, Derbyshire County, Nottingham City and Nottinghamshire County Teaching Primary Care Trusts (PCTs).

Findings

The survey achieved a 73% response rate. The average age of GPs was 47 and number of years in practice was 16; 57% were male; 50% were from urban practices; 85% were from group practices; and 50% saw 101-150 patients per week. Nearly 90% of GPs placed a 'very high' (45%) or 'somewhat high' (44%) priority



on disease prevention. Over a half (52%) had received less than 4 hours of post-graduate training, CME or clinical supervision on alcohol-related issues and 12% had received no such training. Sixty seven per cent of GPs had taken or requested a blood test because of alcohol more than 5 times in the last year and 43% had managed 1-6 patients for alcohol problems in the last year. The majority of GPs (64%) stated that physical symptoms on their own or in combination with psychological or social symptoms would elicit enquiry about alcohol. GPs' recommended drinking limits were an average of 23 units per week for men and 16 units per week for non-pregnant women.

With regard to GPs' alcohol-related practices: 88% obtained information alcohol consumption 'always' or 'as indicated'; 92% felt that moderate consumption was 'important' or 'very important' to health; 94% were 'prepared' or 'very prepared' to counsel patients; 60% felt 'effective' or 'very effective' in helping patients change alcohol consumption, with this proportion rising to 82% if GPs were given adequate information and training. Attitudes to working with drinkers were measured by the Short Alcohol and Alcohol Problems Perception Questionnaire. GPs felt that working with problem drinkers was a legitimate part of their role and that they possessed adequate knowledge but had less motivation and task-related self-esteem for this work. GPs also derived little satisfaction from this work.

The main barriers to involvement in alcohol intervention were that GPs were too busy (63%), that GPs were not trained in counselling for reducing alcohol consumption (57%) and that the current GMS contract did not encourage work with alcohol problems (48%). The main incentives for this work were if support services were more readily available (87%), if early intervention was proven to be successful (81%) and if patients requested alcohol-related advice (80%).

GPs' ratings of effectiveness for all current government policy items were low. However, the strongest endorsements were for the increased provision for treatment of alcohol problems (25%), the introduction of powers to ban anti-social drinking (24%) and the introduction of powers to ban individuals from premises/ areas following alcohol-related antisocial behaviour (22%). GPs' ratings of effectiveness for suggested policy items were relatively high, with the strongest endorsements for improved alcohol education in schools (71%), further regulation of off-sales (58%) and minimum pricing for units of alcohol (55%).



In comparison with 1999, a greater proportion of respondents in this survey were female and were younger GPs but had spent longer in practice. GPs reported working fewer hours and seeing fewer patients than 10 years ago. GPs in 2009 ordered more blood tests, treated more patients for alcohol problems and inquired about alcohol more often (if a patient did not ask) than in 1999. GPs also rated disease prevention as a higher priority in 2009, felt reducing alcohol consumption to be more important and were more prepared for this work. However, GPs in 2009 indicated that they obtained information from patients about drinking moderately less regularly than GPs in 1999, although GPs rated themselves as more effective in counselling in 2009. GPs also rated their adequacy to work with problem and dependent drinkers more highly than GPs in 1999 and were more motivated to work with dependent drinkers in 2009.

Implications

GPs see preventive medicine as a higher priority and alcohol as a more important behaviour for public health than they did ten years previously. However, GPs are not routinely asking patients about alcohol and most do so only in response to physical indicators. The provision of support to facilitate GPs in asking patients about alcohol is recommended. GPs report low numbers of patients being managed for alcohol. Levels of identification could be increased through the adoption of screening for alcohol problems into the GP contract. GPs feel more prepared to counsel for alcohol problems and more effective in doing so than they did ten years previously, though they perceive the potential to deliver more alcohol intervention if given further training. They may perceive a lack of a supportive environment for alcohol work, and might benefit from training, interventions that target practitioner attitudes and offer of broader support. Levels of postgraduate training in treating alcohol reported by GPs are low and lower than ten years previously. Further training should be made available to GPs. GPs indicate that they may often be too busy to engage in interventions for alcohol problems and report lower therapeutic commitment than role security. Inclusion of alcohol treatment in the GMS contract, and in the Quality and Outcomes Framework as an indicator, might address this. Better education about alcohol in schools, minimum unit pricing and further regulation of off-sales would be supported by GPs even though the evidence for alcohol school education is poor. Their responses suggest they would welcome being part of an approach to tackling alcohol problems, coordinated for



instance with health education campaigns. Postal surveys offer a useful means of accessing the views of GPs if carefully designed and targeted.

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