IMPLEMENTING SCREENING AND BRIEF ALCOHOL INTERVENTIONS IN PRIMARY HEALTH CARE IN ENGLAND

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1. INTRODUCTION

The research described in this report forms part (Strand 1) of the English arm of Phase IV of the long-standing *WHO Collaborative Project on Identification and Management of Alcohol-related Problems in Primary Health Care*. The history of the overall WHO Collaborative Project and the specific aims and contents of Phase IV of the project will be described in more detail below, following a more general review of the literature on screening and brief intervention (SBI) for alcohol-related problems in the primary health care (PHC) setting.

1.1. Effectiveness of brief interventions

As part of a meta-analytic review of brief interventions for alcohol problems, Moyer *et al.* (2002) considered 34 investigations comparing brief interventions with control conditions in non-treatment-seeking samples. Brief interventions were defined in this review as consisting of no more than four sessions, with the exception of one important but slightly longer study (Kristenson *et al.*, 1983). The non-treatment-seeking population was defined as consisting of individuals who were identified opportunistically as showing an alcohol-related problem, or at risk of such a problem, when being treated for other problems in health-care settings. Moyer and colleagues examined multiple drinking-related outcomes at multiple follow-up points. The main conclusion was a finding of small to medium aggregate effect sizes in favour of brief interventions across different follow-up points. However, for follow-up points greater than six months, the effect for brief interventions compared to control groups was significantly larger when individuals with more severe alcohol problems were excluded, suggesting that opportunistic brief interventions in health-care settings, consisting typically of a single session of advice accompanied by feedback, are useful mainly for patients with less severe drinking problems.

The work of Moyer *et al.* (2002) has provided further strong support to the conclusions of previous reviews (Bien *et al.*, 1993; Effective Health Care Team, 1993; Heather, 1995; Wilk *et al.*, 1997) that have found positive evidence for the effectiveness of brief interventions in health-care settings. However, these reviews covered a variety of different types of investigation of different types of brief intervention delivered among different sorts of problem drinker in a variety of health-care settings. As Moyer and colleagues themselves warn, generalisations based on

these studies should take into account the particular intervention contexts and populations they represent. Two other meta-analytic reviews have focussed on a more restricted segment of the brief intervention literature.

Kahan *et al.* (1995) examined 11 trials of interventions by physicians aimed at reducing alcohol consumption among problem drinkers attending health-care facilities. These facilities were mainly general medical practices and other primary care clinics but some specialist hospital wards were included, as well as results from community health surveys in Scandinavian countries. Trials with the highest scores on a measure of validity showed that men in intervention groups reduced weekly alcohol consumption by five to seven standard drinks more than men in control groups; results for women were inconsistent across studies. The authors concluded that their review supported the use of brief interventions by physicians for patients with drinking problems. They also concluded that, although further research was needed to determine which patients were best suited to brief interventions and what type of interventions were most effective, the public health impact of brief interventions was potentially enormous.

Poikolainen (1999) carried out a meta-analytic review specifically of randomised trials of brief interventions in PHC settings. He also made an initial distinction between very brief (5-20 minutes) and extended (several visits) brief interventions. A literature search identified seven publications, comprising 14 data sets, meeting criteria for inclusion in the meta-analysis. Findings indicated that very brief interventions showed significant effect sizes compared to control conditions for alcohol consumption and gamma-GT levels but estimates of these effects were not homogeneous. For extended brief interventions, there were significant effect sizes for consumption but, again, these effects lacked statistical homogeneity. The sole significant and homogeneous effect to emerge pertained to reduced consumption from extended brief interventions among women but this effect was based on only two studies. The statistical heterogeneity observed by Poikolainen (1999) may have been the consequence of his using a fixed effects rather than a random effects model; even within the small collection of PHC studies he examined, brief interventions differed in type and style of delivery and were delivered to somewhat different groups of patients

by different professional groups in different settings. It is therefore not surprising that the effects of intervention in these studies should show variability.

When attention is confined to the largest and most rigorously-designed studies of brief intervention in primary care (Anderson & Scott, 1992; Fleming *et al.*, 1997; Israel *et al.*, 1996; Wallace *et al.*, 1988), including the larger studies included in the WHO Phase II collaborative project on brief interventions (Babor & Grant, 1992), the results are uniformly favourable to the effectiveness of brief interventions. Inspection of individual studies may also help to clarify an apparent inconsistency in the findings of brief intervention trials - the discrepancy in results among men and women. While Poikolainen (1999) reported evidence for the effectiveness of extended brief interventions among women but not among men, several other studies have reported significant effects among men but not women (Anderson & Scott, 1992; Scott & Anderson, 1991; Babor & Grant, 1992) or, at least, lesser effects among men than women (Wallace *et al.*, 1988). This gender difference appears to result from the fact that, unlike the trends among male patients, female patients in non-intervention control groups reduce their alcohol consumption to a similar degree to those in active intervention groups. Thus a plausible hypothesis is that problem drinking women in control conditions have their attention drawn to alcohol-related issues in the assessment process and become sensitised to the discrepancy between their current behaviour and their ideal self-concept (Miller & Brown, 1991; Brown, 1998) Assuming that an assessment focussing on alcohol consumption and its consequences can act as a form of behaviour-change intervention, this suggests that women are *more* responsive to brief interventions than men. When Fleming *et al.* (1997) "masked" alcohol-related issues in their assessment (i.e., it was not obvious to participants that the assessment or the research study it preceded was focussed on alcohol), women in the intervention group showed a larger relative decrease in consumption than did men.

Another issue relevant to an evaluation of the effectiveness of brief interventions is evidence of longer-term effects, i.e., beyond the six- or 12-month follow-up points employed in most trials. One of the earliest studies in the literature (Kristenson *et al.*, 1983) formed part of a community health survey among all male residents of Malmö, Sweden aged between 45 and 50. Compared to controls, patients given 3-monthly

appointments with a physician and monthly feedback on initially elevated gamma-GT readings plus counselling by a nurse showed significantly lower gamma-GT levels, together with fewer days of sickness abstenteeism and hospital days, with effects detectable up to five years following intervention. It is doubtful, however, whether the intervention studied in this trial could reasonably be considered “brief”. More recently, Fleming and colleagues from Wisconsin, USA, reported that reduced drinking after brief intervention was maintained at a four-year follow-up (Fleming *et al.*, 2001). In the longest follow-up yet reported, Wutzke *et al.* (2002) contacted participants in the Australian arm of the WHO Phase II collaborative trial of brief interventions after 10 years, including those who had initially been recruited in six general practices in Sydney. The analysis revealed trends suggestive of reduced alcohol consumption and reduced mortality for intervention groups versus control but these trends were not statistically significant. The authors suggest that follow-up counselling and other means of reinforcing behaviour change may be necessary to sustain reductions in drinking over a 10-year period. Nevertheless, what little evidence exists on this topic suggests that reductions in drinking and concomitant benefits from brief interventions without additional contact can last for at least four or five years following intervention.

A final issue to do with the effectiveness of brief interventions that must be considered concerns the distinction between "efficacy trials" and "effectiveness trials" (Flay, 1986; Holder *et al.* 1999). Efficacy trials are those in which researchers aim at rigorous control of experimental conditions to allow valid causal inferences to be made (i.e., to maximise internal validity), while in effectiveness trials the attempt is made to represent "real world" conditions of clinical practice and generalisability to situations in which the intervention under study, if effective, would be applied (i.e., to increase external validity). Most brief intervention trials reported in the literature to date have been efficacy trials; for example, identification of excessive drinkers is carried out by research staff using special procedures and intervention by the clinician is offered at specially arranged appointments. Two trials, however, were unambiguously effectiveness trials, in that screening for excessive drinking was carried out in waiting rooms during normal GP surgery hours and intervention, if indicated, was offered immediately at the same time as the presenting complaint was dealt with (Heather *et al.*, 1987; Richmond *et al.*, 1995). Neither of these trials found

a significant effect of intervention on alcohol consumption. In one case (Heather *et al.*, 1987) samples were probably too small to detect an intervention effect but in the other case (Richmond *et al.*, 1995) participants given brief intervention showed a significantly lower level of alcohol-related problems in the six months before follow-up than those in the control group, which was interpreted by the authors as a genuine effect of intervention. A possible explanation for the lesser effectiveness of brief intervention in effectiveness than in efficacy trials is that individuals selected for study in the latter were more motivated to reduce drinking. It was noticeable that in the trial by Richmond and colleagues far fewer patients returned for a second consultation following the initial contact with the GP than reported in the Wallace *et al.* (1988) study in the UK, presumably because in the Australian study participants were a relatively unselected group of excessive drinkers. (A meta-analysis examining *inter alia* possible differences between trials classified on reasonable grounds as efficacy trials and those classified as effectiveness trials is being carried out by members of the present research team.)

A conclusion here is the need for more trials of brief interventions carried out in naturalistic conditions of PHC. Another conclusion, directly relevant to the research reported here, is the need to adapt the contents and delivery methods of SBIs to real-world conditions of PHC if they are to be successfully disseminated and implemented.

1.2. Potential benefits of widely-implemented brief interventions

Assuming that screening and brief alcohol intervention could be successfully disseminated in PHC in the UK and routinely delivered in practice, what would be the effect on the prevalence of alcohol-related problems? It can easily be demonstrated that the main cost to society of excessive alcohol consumption falls in the large group of people who drink harmfully but who are not seeking help for their alcohol problem, rather than in the much smaller group who are seeking treatment (Room, 1980; Moore & Gerstein, 1981). Hence the emphasis on SBIs as a public health measure in the US Institute of Medicine (1990) report.

On the basis of their findings, Wallace *et al.* (1988) calculated that, if all GPs in the UK consistently delivered the brief intervention they studied, this would result each in a reduction to "safe" levels of alcohol consumption of 250,000 men and 67,500

women. This is clearly an optimistic and perhaps unrealistic estimate and, as noted above, is based on efficacy research rather than on effectiveness research carried out in naturalistic conditions of general practice. Nevertheless, it does give some indication of the large benefits for public health that would result from the widespread implementation of SBI.

In terms of cost-effectiveness, Fleming *et al*. (2002) used data from Project TrEAT in the US managed care system. Participants were recruited from those attending their general physician for a routine appointment. Overall the costs of the intervention were outweighed by the benefits with $56,263 in benefits generated for every $10,000 in intervention costs at 1994 price levels. However, the study did not include any benefits in terms of increased quality or quantity of life for the individual drinkers enrolled in the study. Wutzke *et al*. (2001) used data from an Australian brief intervention programme to estimate that the potential cost per life saved was under A$1000.

The World Health Organisation's CHOICE project has estimated that the impact of delivering primary care-based advice to 25% of the at-risk population in the European Union would result in an estimated 408,000 years of disability and premature death avoided at an estimated cost of 740 million Euros each year (Anderson & Baumberg, 2006). Compared to other health service interventions, primary care-based brief interventions is highly cost-effective and could be combined usefully with other measures. For example, compared with no programme at all, a policy programme that included brief physician advice, random breath testing, current taxation plus 25%, restricted access and an advertising ban would cost the EU only 1.3 billion Euros but would avert 1.4 billion disability-adjusted life years (DALYs) per year, equivalent to 2.3% of all disability and premature death in the EU. The cost of this programme would represent only about 1% of the totals tangible costs of alcohol to society and only about 10% of the estimated income gained from a 10% rise in the price of alcohol due to increased taxation (Anderson & Baumberg, 2006).

1.3. Implementing SBI

Despite the clear evidence for its effectiveness reviewed above and the indications of its cost-effectiveness, and despite also considerable efforts to persuade them to do so,

most primary care health professionals have yet to incorporate screening and alcohol brief intervention in their routine practice. There is now a large literature on the reasons for the failure of this implementation and of the obstacles and incentives that may affect it (e.g., Heather, 1996; Babor & Higgins-Biddle, 2000; Roche, Hotham & Richmond, 2002; Aalto, Pekuri & Seppa, 2003; Roche & Freeman, 2004).

As an illustration of this lack of implementation, a questionnaire survey of 430 GPs in the English midlands (Kaner *et al.*, 1999a) found that GPs did not to make routine enquiries about alcohol, with 67% enquiring only "some of the time". Moreover, 65% of GPs had managed only 1-6 patients for excessive drinking in the last year. Given figures on GPs' average list size in the UK, this suggests that the majority of GPs may be missing as many as 98% of the hazardous and harmful drinkers presenting to their practices.

A nation-wide survey of GPs in England and Wales (Deehan *et al.*, 1998) found that 15% of GPs responding to the survey reported seeing no patients for drinking problems within the last month. Of those who had seen patients because of consumption over recommended guidelines, the average number of patients seen in the past month was 3.8. From the patient's perspective, a household survey in England carried out in 1995 (Malbon *et al.*, 1996) found that, of current and former drinkers who had spoken to a medical practitioner or other health professional in the last year, only 7% (men = 12%; women = 5%) reported having discussed alcohol consumption with their GP at the surgery. There is no reason to think that this situation has changed much, if at all, in the intervening period.

From their survey in the English midlands, Kaner and colleagues (1999a) identified a list of barriers to progress in implementing SBIs. In order of their percentage endorsement by GPs, these were:

- lack of time among busy health care professionals
- lack of appropriate training to carry out SBIs
- little support from government health policies
- a belief that patients will not take advice to change drinking behaviour

- lack of suitable screening and intervention materials
- lack of reimbursement from government health schemes
- health professionals may fear offending patients by raising the topic of drinking and find it difficult to do so
- negative attitudes to patients with drinking problems derived from their experience of those with more severe problems

Some of these barriers could be fairly easily overcome. Screening and intervention materials are available; appropriate training could be provided; evidence that brief interventions are effective could be better communicated to health professionals. Some of the negative attitudes to this work could be changed by emphasizing the difference between the targets for brief intervention and the management of severely dependent individuals with serious problems and by facilitating arrangements for referring the latter group to specialist treatment. Fear of offending patients could be partly assuaged by evidence that most patients expect GPs and nurses to enquire about their drinking in appropriate circumstances and see this as a legitimate part of medical practice (Wallace & Haines, 1984; Richmond *et al.*, 1996; Rush, Urbanoski & Allen, 2003).

Research by Kaner and colleagues, as part of Phase III of the *WHO Collaborative Project on Brief Interventions for Hazardous and Harmful Alcohol Use,* has shown that telemarketing is the most cost-effective means of disseminating brief intervention programmes in PHC (Lock *et al.* 1999). The same research team randomised GPs to one of three groups: (i) training and support; (ii) training and no support; (iii) a control group receiving neither training nor support (Kaner *et al.*, 1999b). Results showed that trained and supported GPs implemented a SBI programme more extensively and systematically than those who received training alone or the control group and that this was a cost-effective strategy for encouraging GPs to use the programme on a longer-term basis.

This was confirmed in a subsequent analysis by Anderson and colleagues (2003; 2004a) of data from several countries taking part in this WHO Phase III collaborative study. This showed that, when GPs and nurses are adequately trained and supported,

screening and intervention activity increases. GPs who expressed higher role security in working with alcohol problems and who reported greater therapeutic commitment to this work were more likely to manage patients with alcohol-related harm (Anderson *et al.*, 2003; 2004a). However, training and support did not improve attitudes towards working with drinkers and even worsened the attitudes of those who were already insecure and uncommitted (Anderson *et al.*, 2004a). This suggests that training and support should be tailored to the needs and attitudes of health professionals to avoid being counterproductive.

Anderson and colleagues (2004b) carried out a meta-analysis of studies testing the effectiveness of different strategies for increasing GPs' screening and advice-giving rates for hazardous and harmful alcohol consumption. Findings were that, although the paucity of studies suggested caution in interpreting the results, it was possible to increase the engagement of GPs in this activity. While more high-quality research was needed on this topic, promising programmes seemed to be those that had a specific focus on alcohol (rather than general prevention programmes) and those that were multi-component.

Part of the problem of translating research into practice in this area, as has already been pointed out above, is the fact that most trials of brief intervention have been *efficacy* rather than *effectiveness* trials (Flay, 1986); that is, they provided a test of SBI under optimum research conditions rather than under real-world conditions of routine practice. For this reason, research now needs to focus on ways in which the procedures and materials making up SBI programmes can be adapted to meet the needs of routine practice and the requirements and preferences of both practitioners and service users. This in broad terms is one of the main aims of the present project.

1.4. The WHO Collaborative Project

As stated above, the research described in this report forms part of Phase IV of the *WHO Collaborative Project on Detection and Management of Alcohol-related Problems in PHC.* Phase IV was entitled: *Development of Countrywide Strategies for Implementing Early identification and Brief Intervention in PHC*. Previous phases of the Collaborative Project were as follows:

Phase I: a reliable and valid screening instrument for detecting hazardous and harmful drinkers in PHC settings was developed (the AUDIT questionnaire: Saunders & Aasland, 1987; Babor *et al.*, 1989; Saunders *et al.,* 1993);

Phase II: a clinical trial of SBI in PHC was carried out (Babor & Grant, 1992; Babor *et al.*, 1994);

Phase III: the current practices and perceptions of general medical practitioners (GPs) were assessed (Strand 1: Saunders & Wutzke, 1998), in-depth telephone interviews with GPs and personal interviews with key informants were conducted (Strand 2:McAvoy *et al.*, 2001) and methods for encouraging the uptake and utilization of a SBI package by GPs were evaluated in a controlled trial (Strand 3: Gomel *et al.*, 1998; Hansen *et al.*, 1999; Lock *et al.*, 1999; Kaner *et al.*, 1999b, 2001; McCormick *et al.*, 1999).

The aims of Phase IV follow logically from these previous phases of the Collaborative Project. Given that (i) an effective screening method has been developed for use with brief interventions in PHC, (ii) the effectiveness of a form of brief intervention in PHC has been demonstrated in a cross-cultural randomised controlled trial, and (iii) obstacles to widespread implementation of SBI have been identified and methods for their initial dissemination and deployment in PHC have been evaluated, the question was asked, what remains to be done in this programme of research? The answer, which forms the underlying rationale for Phase IV, is that what remains is the *development and application of country-wide strategies for the widespread, routine and enduring implementation of PHC early identification and brief intervention throughout participating countries*.

It is important to note that, whereas earlier phases of the WHO Project consisted of a single study design adapted to the situation of each participating country, Phase IV is better described as a collection of similar studies. While all Phase IV investigators shared the overall objective of the study, the specific design and procedures to be used were flexible and varied among participating countries. This flexibility was necessary in order to take account of the different systems of PHC to be found among the participating countries, as well as differences in political structures, the organisation

of professional groups and other cultural and socio-economic factors influencing the process of practical implementation in PHC. However, this flexibility was contained within clearly defined parameters and that all studies making up Phase IV shared four *common components* (see below).

Phase IV was also a much more practical and policy-oriented group of studies than seen in previous phases of the WHO Project. It was in many ways an example of *action research* (Hart & Bond, 1995; Stringer, 1996) in which the central aim was to make a significant difference to the "real world" conditions under which brief interventions are disseminated in a particular country and to establish a programme of action leading to the widespread, country-wide implementation of early identification and brief intervention in PHC. A further difference from previous phases was that, in terms of research methods, qualitative approaches often assumed equal or greater importance than quantitative methods in Phase IV.

1.4.1. Broad design features of the Phase IV study

The broad design of Phase IV borrows heavily (with permission) from a report prepared by the Alcohol Research Center, University of Connecticut Health Center (Higgins-Biddle & Babor, 1996). This report described a strategy for disseminating SBI for "risky drinking" in order to contribute towards a significant reduction in alcohol-related harm in the USA. As part of this strategy, four Action Points were described, as follows:

1) Create Customized Materials and Services
2) Reframe Understandings of Alcohol Issues
3) Establish Lead Organizations and Build Strategic Alliances
4) Establish and Evaluate Demonstrations

These headings provided the structure for WHO Phase IV and were addressed in one form or another by all participating centres. In contrast to the American plan, however, Phase IV was confined to PHC and did not include other areas of service delivery. The present report describes research in the English arm of the Phase IV study *under the first three of the headings given above.* Each of these three components of the study will now be introduced in somewhat more detail.

1.4.2. Customising materials and services

The task of customising materials and services was approached using two methods - focus groups and the Delphi method. Focus groups were carried out both with health professionals and with patients or prospective patients of PHC services. Chapters 2, 3 and 4 of the report will describe detailed procedures and results for each method separately, before attempting to combine findings from each approach.

1.4.3. Reframing understandings of alcohol issues

The aim of this component of the study was to develop a Communications Strategy to promote an understanding among the target audiences of the concept of "risky drinking", i.e., drinking above medically recommended levels with an increased risk of alcohol-related harm. Three separate target groups were identified: health care professionals; the general public; stakeholders in SBI. The Communications Strategy is described in Chapter 5.

1.4.4. Building a strategic alliance

At the inception of the study, the lead organisation for the task of striving towards routine implementation of SBI in PHC in the UK was the Centre for Alcohol and Drug Studies at Newcastle, North Tyneside and Northumberland Mental Health NHS Trust in collaboration with the Department of PHC at the University of Newcastle. This lead organisation initiated efforts to build a strategic alliance in the UK to further this aim and this work will be described in Chapter 6.

1.5. Project management

Professor Heather was Principal Investigator (PI) of the project and Dr. Kaner and Professor McAvoy were Co-PIs. The grant from AERC enabled two full-time researchers to be appointed: Ms. Hutchings (Project Co-ordinator) and Ms. Dallolio (Research Assistant). The project commenced on 1/2/2000 and ended on 31/1/2002.

Management of the project was undertaken by a Project Management Team that met on a monthly basis throughout the life of the project. The Project Management Team was chaired by Professor Heather and consisted of Dr. Kaner, Professor McAvoy, Ms. Hutchings, and Ms. Dallolio, with the addition of Dr. Paul Cassidy, Dr. Eilish

Gilvarry, Ms. Katherine Lock, Dr. Martin White, Dr. Dorothy Newbury-Birch and Ms. Sue Reay.

A local Steering Group was formed to advise and co-ordinate research activities in the local area. This contained representatives of a range of local institutions and organisations, including universities, health care organisations, local government and public relations. The members of the Steering Group were influential in publicising and advancing the aims of the project on a local basis. The members of the Steering group were: Dr. Eilish Gilvarry (Chair); Dr. Paul Cassidy; Professor Errol Cocks; Professor Chris Drinkwater; Professor Jenny Firth-Cousins; Mr Tony Ford; Professor Nick Heather; Ms. Deborah Hutchings; Dr. Ray Lowry; Dr. Mitchell Ness; Dr. Dorothy Newbury-Birch; Ms. Wendy Patton; Dr. Pauline Pearson; Ms. Sue Reay; Dr. Gill Sanders; Dr. Penny Schofield; Dr. Martin White; Dr. Paula Whitty; Professor Tim van Zwannenberg.

In addition, two Working Groups were established to oversee specific aspects of the research programme. These were:

The *Communications Strategy Working Group*. Ms. Sue Reay (Chair); Dr. Paul Cassidy; Ms. Deborah Hutchings; Ms. Katherine Lock; Dr. Ray Lowry; Dr. Mitchell Ness; Dr. Dorothy Newbury-Birch.

The *Demonstration Project Working Group* – to prepare for a Demonstration Project that would take place immediately after the conclusion of the present research. Dr. Martin White (Chair); Mr. Tony Ford; Professor Nick Heather; Ms. Deborah Hutchings; Dr. Eileen Kaner; Dr. Ray Lowry; Dr. Dorothy Newbury-Birch; Ms. Wendy Patton.

2. FOCUS GROUPS WITH PRIMARY HEALTH CARE PROFESSIONALS

The aim of this part of the project was to obtain, as part of the Customisation component of the project, the perspectives of PHC professionals on the contents and delivery of an alcohol SBI programme. It was hoped that these perspectives could inform the adaptation of the programme so that it would be appropriate and acceptable for use in PHC in England. Specific objectives were:

- To provide information about the appropriate customisation of materials for SBI in PHC
- To provide information about the most effective delivery of SBI in PHC

2.1. Methods

2.1.1. Sampling and recruitment

The first round of the focus group study was conducted with a purposive sample of PHC teams within Newcastle and North Tyneside Health Authority (n=75). Practices were stratified into two groups based on their previous experience of using the 'Drink-less Programme' in Phase III of the WHO study in order to explore both user and non-user responses to the programme:

- Previous experience of the "Drink-less Programme" (n=21)
- No previous experience (n=54).

Practices were invited to participate by a letter to the Practice Manager explaining the aims of the project and inviting the team to take part in a focus group discussion, with a follow-up telephone call and visit where appropriate. Teams were also allocated to one of two focus group discussion topics:

- To explore responses to the Drink-less package
- To explore issues surrounding the achievement of widespread, routine and enduring implementation of SBI in PHC, including training and support.

Four practice teams were recruited in this round. Groups were heterogeneous in nature in that they consisted of a number of different health care professionals (practice managers, GPs, practice nurses, receptionists etc) within existing teams. This

was done to explore the team response to the SBI programme and how it might be implemented within 'real' practice situations.

The findings of the first round were used to inform a further four professionally-homogeneous groups with GPs and practice nurses. The aim of these homogeneous groups was to explore professional differences in knowledge, attitudes to and experiences of discussing alcohol issues with patients and to derive different options for screening and brief alcohol intervention work. GPs were recruited from practices in the Gateshead area (N=30) and practice nurses from practices in the South Tyneside area (N=30), again by letter or fax to the practice manager explaining the study and inviting practitioners to participate.

2.1.2. Procedures

The first four focus groups with PHC teams were conducted at each practice surgery at the most convenient time for the team (usually a monthly lunch-time team meeting). Groups were approximately one hour in duration. GPs received PGEA accreditation and all team members received a certificate of attendance.

The second round of focus groups were held in centrally-located meeting rooms in Gateshead and South Tyneside. As these groups were held in GPs' and nurses' own time (i.e. in the evening), all participants received a buffet meal and a £30 gift voucher as an incentive to attend. The GPs also received PGEA accreditation.

Groups were 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 for qualitative analysis. The moderator introduced each session, explained the aim of the focus group, gave guidelines as to how the group would be conducted, and discussed confidentiality and data protection issues surrounding the use of audio-tape recording and the information collected. 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 screening and brief alcohol intervention and gradually focusing upon the key topic areas (either the 'Drink-less Programme' materials and procedures or issues surrounding the uptake and utilisation of the programme). Participants were encouraged to discuss the questions with one another rather than with the moderator, whose role was to clarify and further explore any issues that arose from the discussion. Finally, participants were asked to summarise their thoughts on what they considered to be the most important aspect of the discussion in an attempt to clarify the main themes. The moderator and observer held a de-briefing session immediately after the group to share initial impressions.

2.1.3. Data analysis

Focus group discussions were audio-taped and transcribed verbatim. Transcripts were anonymised and imported into the NUD.IST qualitative software package for open and axial coding of data using a grounded theory approach. Initial coding of data was carried out independently by the two researchers in an attempt to reduce researcher bias.

Emergent themes were analysed by profession (GP and practice nurse) to explore any similarities or differences in participants' perceptions, attitudes and experiences. Matrices were generated to show how many text units were coded at each given 'node' to investigate any patterns of coding, e.g. use of intervention strategies by profession.

2.2. Results

2.2.1. Participant characteristics

The characteristics of the participants who attended the first round of focus groups are shown in Table 2.1. The number of participants attending each group varied by PHC team.

Difficulties were experienced in recruiting GPs for the second round, with only two attending each of the focus groups. Reasons cited for non-attendance were "not

enough free time" and Gateshead Primary Care Group arranging other meetings (e.g. National Service Framework for Coronary Heart Disease, and the Primary Care Group moving to Trust status) in the same weeks. Composition of the groups is shown in Table 2.2.

2.2.2 Knowledge and awareness of risky and problem drinking

Many of the participants began the focus group discussion by stating that they had had little or no formal training on alcohol and that their knowledge of alcohol was therefore limited. In the nurse specific groups, all nurses had received training on general lifestyle and health promotion issues but only a third had received any training at all on alcohol. "What I've learnt is just what I've picked up sort of reading the paper. There's nothing formal, I've had no training". The GPs also reported little or no alcohol-specific training. Some GPs said they were familiar with the CAGE questionnaire from medical school or elsewhere but few had ever used it or could remember the questions. Only the participants who had been involved in Phase III of the WHO study were aware of the AUDIT questionnaire.

> *"CAGE. That's what we were taught as students a long time ago in…Cut down, guilty, angry, don't know what the 'D' stands for. Dead drunk (laughter). Daily, maybe that's daily"* (GP M)

In all focus groups, both nurses and GPs talked in terms of the weekly rather than daily recommended levels of alcohol consumption. However, the 'old' weekly recommendations of 14 units for women and 21 for men have become confused with the 'new' daily benchmarks of 2-3 units for women and 3-4 for men to give an increased weekly level of 21 and 28, as this exchange between GPs illustrates:

> "Even the levels have gone up, haven't they, from 21 to 28 units in the last year or two." *(GPM 37)*
> *"Is that right?"* (GP M 49)
> "I think it used to be 14 and 21. Is it 28 and 21 now?" *(GP M 37)*
> "Now that you mention it, I'm sure that there was something about it going up to 28." *(GP M 33)*

Many of the participants revealed that they experienced difficulties in discussing alcohol with their patients because they themselves were unsure of the facts. Patients

tended to talk in terms of cans and bottles rather than in units and health care professionals stated that they often did not know how many units there were in

Table 2.1: Composition of Focus Groups with PHC Teams (Round 1)

Focus Group	Experience of Programme	Discussion Topic	Participants	Gender	Age
1	Previous Experience	Customisation	GP GP GP GP Practice Nurse Practice Nurse Practice Nurse Practice Nurse Student Nurse Student Nurse Health Visitor Practice Manager	F F M M F F F F F F F F	42 47 - - 52 51 48 - - - - 50
2	Previous Experience	Implementation	GP GP GP GP GP Registrar Practice Nurse	F M M M F F	36 49 33 37 26 42
3	No Experience	Customisation	GP Practice Nurse Receptionist Practice Manager	F F F M	39 29 53 61
4	No Experience	Implementation	GP GP GP GP Practice Nurse Health Visitor Practice Manager Assistant Manager	M M M F F F F F	46 35 38 47 59 41 56 43

bottles, cans and certain types of drinks. This meant that they had difficulty converting across and therefore in accurately assessing how much patients were really drinking.

> *"You know how many units are in a bottle of whisky or a bottle of gin, don't you?"* (GP F 42)

"I don't really know to be honest. I should do." (laughter) *"How much in wine?"* (GP M)

"Wine is 6? 12?" (GP F 42)

Table 2.2: Composition of Focus Groups with GPs and Nurses (Round 2)

Focus Group	Participants	Gender	Age	Type of Practice
1	GP	F	--	Group – 3GPs
	GP	F	62	Group - 3 GPs
2	GP	M	38	Group - 2 GPs
	GP	F	--	Group – 3 GPs
3	Practice Nurse	F	53	Group - 7 GPs
	Practice Nurse	F	37	Solo
	Practice Nurse	F	45	Group - 3 GPs
4	Practice Nurse	F	40	Group - 5 GPs
	Practice Nurse	F	53	Solo
	Practice Nurse	F	41	Group - 5 GPs
	District Nurse	F	52	Group - 5 GPs
	Practice Nurse	F	56	Solo
	Practice Nurse	F	57	Group - 6 GPs

Health care professionals also found messages about alcohol (e.g., how much is beneficial and how much is harmful) to be complex and so difficult to discuss with patients. This would appear to be complicated by the uncertainty regarding the recommended levels and what the 'correct' messages are. There was confusion amongst some of the nurses as to the difference between "alcoholics" and excessive drinkers. Amongst the GPs, there was some uncertainty as to the definition of "problem drinking": at what point excessive drinking becomes problem drinking and to whom this is a problem – "to the patient, the relative or is it to you personally as a doctor? Are you the only one that thinks it is a problem?" (GP F).

However, there was a general awareness and recognition of health and social problems related to alcohol, and of the knock-on effects these can have on families. Most participants recognised alcohol misuse as being an important part of their work in PHC, though the size of the problem was disputed, with some participants feeling that it was relatively small and others describing it as "huge".

Perceived to be a relatively large problem *"I mean a sixth of hospital admissions are related to alcohol, or something, is a figure that I carry from years ago" (GP F 42)* *"We all know that alcohol's a much bigger killer than cigarettes but it's (i.e., cigarettes) received so much better press" (Practice manager M 61)* *"It's part of the wallpaper isn't it? You almost don't see it" (GP M 35)* *"It's not the health problem but it's a big general practice issue. And that's a problem - whether you could catch some of those people before their drinking actually wrecks their family as well as wrecking their own lives" (GP F 36)*
Perceived to be a relatively small problem *"I mean the feeling I'm getting reading in between all these lines is maybe we're not convinced ourselves how bad alcohol is" (GP M 37)* *"I suspect it's probably not going to be a huge number of patients you're looking at though, is it? Who would actually come through your doors with sufficient amounts of alcohol to actually want you to intervene?" (GP M 49)*

2.2.3. Perceptions of 'risky drinkers'

Participants agreed that for many people excessive drinking is regarded as socially acceptable and perceived to be 'the norm', especially in the North-east of England.

> "There's no stigma to go out and drink six pints every day" (GP F 62)
>
> "Well I think there's a difference between normal or healthy or recommended limits. In some parts of Britain, particularly up here and some areas in the North-east, normal is 40 or 50 units a week, although that's not healthy or recommended. That's normal" (GP M 37)
>
> "They will often compare their drinking to what their mates drink and say it's hardly anything compared to my mates" (Practice nurse F 42)
>
> "In this part of the world people do drink more as the norm…they're not aware that it's a problem" (GP F 39)

However, in general, it was believed that most people did not know how many units they were drinking or how much they 'should' or 'should not' drink, i.e. the recommended levels. They felt that these patients would therefore not realise that their drinking could be at hazardous or harmful levels. They also thought that most

patients were unaware of the risks of excessive drinking and so did not make the links with ill-health, unlike smoking and cancer.

> *"Whenever I've asked people, I try and put the units in the computer and I say it out loud, you know, so that's so many units, and I have to say it a few times when they didn't realise a pint was two units"* (GP registrar F 26)

> *"I think the difficulty people's perception of how much alcohol they drink is that everyone knows that smoking is bad for you, everyone knows that and it's quite a black and white thing, you shouldn't smoke any cigarettes at all. Whereas with alcohol people are not so sure how much they should drink"* (GP M 33)

> *"We try to counsel them a bit but a lot don't realise that they drink that amount. They don't appreciate how much alcohol they're drinking and that it's well over the limit. They think that, well, 80 is excessive but 40 units I think is quite normal. We explain to them and show them the leaflets that it's well over the limit"* (Practice Nurse F 42)

Other participants noted a gap between what they and their patients considered to be excessive drinking or harmful to health. It was felt that some patients did not accept the recommended levels as being realistic which made it difficult to advise them effectively.

> *"Well they sometimes say at least I'm not smoking, as if it (i.e., drinking) doesn't really count as far as health is concerned." (Practice nurse F)*

> *"21 and 28 doesn't bear much relation to what people are actually drinking" (GP M 38)*

2.2.4. Identified 'groups' of drinkers

Both GPs and the nurses referred to different 'groups' of drinkers and how they found talking to them about alcohol. Despite the perceived social acceptability of heavy drinking, there still appears to be some stigma attached to talking about alcohol with a GP or nurse. It was believed that for some patients talking about excessive drinking with a health professional was tantamount to 'having a drinking problem' or being called an 'alcoholic'.

"I think when you point out to them, they think you are accusing them as (being) alcoholic…they don't realise that this could just be excessive drinking" (GP F 62)

Some groups of patients were perceived to be more unwilling to discuss alcohol than others or more likely to give untruthful answers when asked about their drinking habits. However, there were also groups of patients with whom health professionals said they found it easier to talk about alcohol, usually because it was 'expected' or regarded as 'the norm' that they drank excessively. The different groups that were identified are described in more detail below.

"Teenagers going out on a Friday night to get drunk"

Participants agreed that young people (both male and female) regard 'getting out of your tree' as completely normal and acceptable, and that this group of drinkers is getting younger. At one of the practices, the nurses doing new patient checks are now expected to ask all children over the age of 10 years whether they smoke and drink.

Young people are not seen as frequently in PHC, although girls are seen more often then boys, usually for contraceptive advice. It was therefore felt that as a group they would be more effectively targeted outside of general practice, e.g. in young people's services, youth centres, etc. When young people did attend primary care services, however, both GPs and nurses felt they were more likely to be seen for or asked about illicit drug use rather than alcohol use. "I probably know there's a bit of alcohol involved as well, but I probably don't address that as significantly as I address the drug problem" (GP F).

On the occasions when nurses said they had talked to young people about alcohol, it was felt that they were 'more open' than other age-groups about how much they drank, probably because they regarded it as normal and acceptable. However, they were perceived to be less receptive to being given advice because it did not seem to be of relevance to them: "They think they are invincible, that they'll never come to any harm, that it won't happen to them because they are young". This suggests that the advice offered is not specifically tailored to the needs of young people, i.e. focused on

the immediate and short-term effects of alcohol. One GP acknowledged the importance of targeting the advice given to young people:

> *"The minute you say to someone, don't do this because it's bad for you, it's like saying do it. You've got to get them at the right sort of age and you've got to know the right messages to put across at the right time. If you said to a young person, you know you may end up with liver failure, they just think that's miles ahead. Whereas if you said to them you could be looking at sexually transmitted diseases, you could be looking at pregnancy, ...you've got to focus the message on what matters to them at that time."* (GP F)

Some of the nurses simply felt that they were not equipped to deal with drug and alcohol problems if they presented in young people, revealing a need for training and support services for this professional group.

> "I had a man who came in and did want advice on how he could get his son tested for drug or alcohol abuse. He'd come in from school with glazed eyes. And I felt absolutely awful because I didn't know how to help him other than say go to the GP. And he said I want you to do it now, I've got him in the car now, and I said, well what can I do? He's 15. I didn't know and I just passed him." *(Practice Nurse F)*

"Northern men have a problem"

It was felt that many men drank excessively, as the norm, in the North-east of England in particular: "a lot of them could have 50 (units) on a Friday night, over Saturday night and Sunday lunchtime" (practice nurse). Male patients regarded this as 'social drinking' or what they were 'entitled to' after a hard day/week's work. Many did not think drinking in excess of 50 units a week was a large amount.

> *"I had one chappy. I asked him what he drank and he said not a lot. So I said what do you mean by not a lot? And he says, well two pints every lunchtime. I said, is that it? and he said no and ten pints every night as well. He didn't think that was a lot. So, when I totted up the amount of units, the doctor came back and said surely this is wrong. And I said no, it's not. But he (the patient) didn't consider that a lot and I thought it was rather excessive" (Practice Nurse F)*

However, both GPs and nurses felt that they could discuss alcohol more easily with this group, sometimes simply because it was 'expected' that they drank.

"If it's a 40 year-old man, I say, right then and we tot it up, it's all out in the open, everybody expects that he's drinking and I expect that he's drinking" (GP F)

One nurse, who had been involved in the nurse implementation trial, said she had received a positive response from men to the AUDIT screening questionnaire.

"Men seemed to quite enjoy it, doing the questionnaire. It actually showed them how much they were drinking. They were quite amazed."

"Women are harder to manage than men"

The nurses in particular talked about the difficulties of discussing alcohol with women in comparison to men. Women drinkers were described as being 'more ashamed' and 'better at hiding it', and one nurse felt that "it's ok for men to say they drink this and they drink that, not women".

"This is a lady in her 50s. It was difficult to get her to talk at first, it took 2 or 3 sessions. I think a man would have been talking before that. She was terribly ashamed." (Practice nurse F)

It therefore appeared to be difficult to detect women who were drinking excessively unless they had started to experience quite severe health or social problems. The examples given in the discussions tended to be fairly extreme and almost all included wider 'reasons' or issues surrounding their drinking, which were not given for the men participants talked about.

"It was because she'd lost her husband, had low self-esteem and couldn't sleep and she was starting to drink in the evening" (Practice nurse F)

" I remember the case of a young woman. She went out and got plastered, but she had a two-year-old with her for some reason and he was in the taxi and she forgot he was in the taxi. And just got out and passed out at home. And the taxi driver found this child in the taxi and it was all a bit of a nightmare. But she's done very well or I think is doing quite well with her drinking but it wasn't just that that ended up being an issue. It was that she couldn't see what being a parent was all about...the drinking was part of it, not the whole thing. So it was a wider issue with her." (GP F)

“Professional people don’t have these problems”

Professional people were referred to as another group with whom it was often difficult to ask about alcohol. This was attributed to an apparent or putative 'respectability' and because social drinking either during or after work was accepted as 'part of the job'.

> *“It’s their attitude coming across to you…and professional people don’t have these problems, so it's just trying to find a way to ask them without them saying, what do you think I’m like? I’m a respectable person and I don’t do that.” (GP F)*

However, many of the nurses had found that using a 'driving the following day' strategy was successful with this group, as this was not regarded as acceptable behaviour and there was a risk that they could lose their licence.

> *“And the thing that knocked her sideways was when I actually said, so you’re driving. I think she was driving to Durham every day. So I said, do you realise just how over the top you are when you’re driving to work at 8am the next morning, and it really pulled her up short. She’s a professional lady and that helped tremendously.” (Practice nurse)*

> *“I think it would be difficult for business men to change but it's more acceptable. They understand the risks more. You can usually go down the path, ‘you’re drinking, do you realise you’re going to be driving the following day?' Especially people like reps.” (Practice Nurse F 45)*

“They are very prim, proper and precise”

Older people were also identified as being hard to discuss alcohol with, although to a lesser extent than other groups. It was felt that some older people, particularly women or 'little old ladies' might find it hard to 'admit' to drinking and would sometimes completely deny drinking at all even if they were 'smelling of alcohol'.

> *“I think it's often the older generation as well. They’re less inclined to admit it or they feel that they’re ashamed, there’s a stigma.” (Practice Nurse F)*

> *“I’ve had two people, middle-aged verging on elderly women who didn’t quite appreciate to what extent alcohol is contributing to their problem. I’ve got lots where I know it is, even if they don’t admit it.” (GP F 47)*

> *“The older ladies have had to hide it for a long time, so they are very good at doing it.” (GP F 39)*

"Unless they want help, it's a waste of time"

Participants also distinguished between different groups of excessive drinkers by separating them into those that they thought they would or would not be able to help. Some of the GPs and nurses talked about how the patient's level of motivation would affect their decision on whether they would intervene, implying that they would either implicitly or explicitly assess what 'stage of change' the patient was in (relating to the model by Prochaska and DiClemente, 1992). The nurses, in particular, talked about the 'change model' (or 'cycle of change' as it was more commonly known) which they knew of mainly in relation to smoking cessation programmes. However, although they talked about assessing a patient's motivation to change, none had actually applied the model to alcohol intervention and further discussion revealed that even with smoking cessation some of them 'forget about it actually'.

In general, participants felt they would be able to help those patients who were just over the recommended limits and who were not aware of this or had not thought about it, and those who were concerned about their drinking and willing to approach the GP or nurse to discuss it, i.e., patients in the contemplation stage and ready to change drinking. On the other hand, it was felt that they would not be able to help those who did not perceive their drinking to be a problem or simply did not wish to discuss it (pre-contemplators). Participants also talked about patients who were drinking at higher levels and those more severely dependent, with whom they (rightly) did not feel that a brief intervention would be effective. However, most participants did not go on to say that they would refer these patients to the specialist alcohol services.

Feel more able to help

"And I suppose where this comes in very well are those people where awareness raising is something where it can have an effect in the sense of reducing moderate drinkers to lower risk. Because it's often about units of alcohol, awareness of units. 'Oh, I didn't realise I was taking so much by having 3 pints or 4 pints. I didn't realise 4 pints had so much in'." (Health visitor F 41)

"I'm sure there are other people, and these make up the largest number, who drink too much and think it's probably not a good idea but don't really know why it's not such a good idea, sometimes have a bit of a hangover and get to work late. And also in that group there'll be people who probably genuinely think that they are drinking too much" (GP M 33)

"For the people who are not problem drinkers at the moment but, you know, perhaps might be heading that way, they may be at a stage where you can intervene…but it's only if they're at that sort of stage where they're still receptive to what you're saying. And once they go past that, then they have to come to you and say they want some help" *(GP F)*

"My gut feeling is that there are probably two groups of people who drink. Those who drink heavily and recognise that they probably should drink less and you'd probably have some effect by turning round to them and saying, look this is really not doing you any good. These are the potential issues and if you actually follow that up with written information, then they may well cut back on their drinking. So they have to see that there is a gain from that." (GP M 49)

"I've got quite a few people and I think persistence does pay off with some people. You know, they're sort of pre-contemplators, bordering on contemplative for like 2 or 3 years sometimes. And then suddenly they start to cut down a bit." (GP F 47)

Feel less able to help

"But then there's the other group who actually are already in trouble and I'm a bit more cynical about how much you can actually help them unless they perceive that they've got a problem." (GP M 49)

"But I suppose our focus and our minds immediately switch to those, and it is quite a significant number where…"
"…a hundred units a week is not a problem"
"and it's not even on the borderlines of hazardous, heavy drinking, it's way off the Richter scale. And it's those where you arrive thinking there's no way brief intervention is effective with that group. It can't work" (Health visitor F 41)

2.2.5. Responses to the AUDIT screening tool

Health professionals involved in Phase III of the WHO study found that the AUDIT was generally accepted by their patients in that specific context, i.e. introduced to all patients as part of a 'health survey' by receptionists in the waiting area. "My recollection is that I had a couple of people refuse and that was it" (GP F 42). However, problems were sometimes experienced by patients being unable to fill it in themselves because they found it too complicated. This meant that the health professional or even the receptionist was often asked to help fill it in.

> *"There were a few that couldn't understand it. Some of our patients just couldn't understand it, they could not fill it in without help."* (GP F 42)

"I have to say that I think it's too complicated for most of our patients and it would be off- putting because they see all those boxes. I think it could be simplified a lot." (GP F 47)

"I wouldn't think you could hand it out. I think it's something that you've got to sit and go through with the patient." (Practice nurse F 48)

"They actually confide and discuss with the receptionist quite a lot, ...I have a suspicion that they actually helped a lot of people fill in the questionnaire." (GP F 42)

The form itself was perceived by most professionals to be non-threatening, though some talked about the 'shock' patients had when they realised how much they were drinking. It was felt that it would be most useful for those patients drinking just over the recommended levels and not aware of how much they were drinking or what the recommended levels were.

"They often got quite a shock and that was the shock of the person who thought their drinking was fine but it was actually a wee bit over the top, which was useful" (GP F 42)

"I think the people who it was useful for were the people it just pulled up, they were around the 13, 14, 15 (score) and it just sort of pulled them up to sort of, hey, I need to think about this, it is creeping up" (GP F 42)

However, others were concerned that it would upset those 'borderline' patients who might feel uncomfortable answering the questions, especially if they thought they might have a problem, and that these patients would therefore not answer the questions truthfully.

"I think it's a case if the person is worried or thinks they are on too much, then I think they are going to be a bit put off about answering a questionnaire, aren't they? And those who have blameless social lives will feel quite happy filling it in, will feel quite pleased with themselves that they don't smoke or drink. I'm sure you're going to end up upsetting the borderline people who don't quite want to admit to their problem, but how else can you help them?" (GP M)

"I don't know if you've read some of the Inspector Morse books but you know that's part and parcel of the plot. Every time he goes into hospital with a drink problem he divides his consumption by four and tells the consultant I only have one pint a night when in fact he has four or five. And it's exactly the same sort of thing here" (Practice Manager M 61)

A number of adaptations to the AUDIT were suggested to make it more acceptable for patients to fill in. One was to have it 'disguised' in a generalised health questionnaire which was thought would make it less threatening "because then you're targeting everybody and if they thought it was in a general health questionnaire, they wouldn't take it as personally" (Receptionist F 53). Another was to put it onto some kind of health promotion computer for patients to fill in anonymously whilst in the waiting room. They would then be able to print out their result and discuss it with the doctor or nurse if they wished. This would access the people who were concerned about their consumption and willing to talk to someone, but only those who used the computer in the first place.

The NHS Plan (2000) aimed to modernise the use of information technology and electronic patient records in primary care by 2005. Participants were asked about the use of information technology in their practice and if this would be an opportunity to help detect and monitor patients. Practices differed considerably in their access to and use of IT and there was wide variation in the use of electronic patient records. Most GPs and nurses still used manual records rather than, or as well as, computer records. Some GPs used the computer only for drugs and prescriptions and felt that "we haven't had the time yet to really bring it into the consultation". It was felt that manual records were more helpful in monitoring changes in alcohol consumption, as this information would be recorded separately. Some nurses had experienced problems with their computer systems where "the previous information is lost unless you could save it somehow". The general response was that, on the whole, primary care professionals are not yet ready for computerised screening instruments or prompts.

2.2.6. Alcohol screening: current practice, opportunities and barriers

Despite the self-stated lack of knowledge and formal training on alcohol, all participants in the focus groups seemed to have had some experience of discussing alcohol with their patients. Most participants also had some understanding of the concept of SBI for risky drinkers.

> *"Screening is about identifying for everyone…is the use of a criteria-based questionnaire saying how many units, what's the frequency, identifying the*

pattern of drinking and what they're doing, and identifying are they at high risk or moderate risk or low risk. But the brief intervention is then about awareness-raising, identifying where they are in terms of ability or desire to change behaviour." (Health visitor F 41)

Current practice and opportunities identified for alcohol screening differed between professional groups however. These will be discussed in turn below.

GPs

When the GPs asked their patients about alcohol, it tended to be very opportunistically. It was felt that there were some 'genuinely valid times' to do this - for example, when related to the presenting problem. One facilitating factor identified by the GPs was therefore to have a list of alcohol-related conditions to 'trigger' or prompt screening within the consultation. However, they did not feel they would be able to routinely ask their patients about alcohol unless it was part of a general health or blood pressure check.

The GP's main concern was that there was too little time to bring it into a general consultation (which is 7 1/2 minutes on average), even if the result turned out to be negative. They were also concerned that asking questions about alcohol was not necessarily appropriate to the presenting problem and would be viewed as 'intrusive' by patients. They were afraid of insulting patients or 'getting their backs up' if they repeatedly asked them about alcohol or to fill in the AUDIT, and were worried about the effect this would have on the doctor-patient relationship.

Opportunities for alcohol screening

"Just listening to what people are saying as well, trying to pick up on what they might be saying, we do tend to ask quite a lot about it" (GP F)

"Picking it up earlier I think is only if we end up asking people specifically because they're new patients or because we somehow get on the subject" (GP F)

"Unless they do have some kind of condition like hypertension when you do feel it's valid to raise it." (GP F)

"Someone comes in and you can sometimes say, oh and by the way how much do you drink?, it would be rather inappropriate and out of the way. Whereas other times you could just generally be chatting about what do you weigh now and what is your blood pressure. I think as soon as you've done blood pressure, that's an entry point into all sorts of things" (GP F 36)

"When you see the common physical effects, low energy, insomnia, mild depression, if you give all the people who had those physical symptoms a questionnaire, which were caused by or exacerbated by alcohol, if we try to remember to ask them" (GP M)

"If we can't hand it out at the desk, we should attempt to be triggered by certain more nebulous complaints and injuries and falls" (GP F 42)

"I would tend to let them approach me rather than bring it up, unless there seemed to be a real particular problem. Make sure that the information is available and then say if you want to come and discuss it, then do" (GP M)

Barriers to alcohol screening

"It reflects the fact that 7 1/2 minutes, it isn't actually time enough to do what you normally have to do in a consultation. And that's the problem that you're trying to put something else…OK, it may be in total if nothing comes out of it, it takes a minute, but that's a seventh of your consultation. 7½ minutes isn't long enough anyway. And if you actually find anything, if it's actually useful that it shows something, that takes longer again. And then you've got to deal with what the patient has come about." (GP F 42)

"I think it's a good tool but you can't fit it into general practice all the time. Because this is screening for alcohol, should we be doing it for smoking, should we be screening for other things? There's so many potential things, you can't guarantee that this is the most useful thing to add 45 seconds to our consultations with." (GP M)

"It's actually verging on the intrusive. For people that are just coming in for whatever. Maybe they've got their own problem that they're thinking about, they don't want to have this as well." (GP M)

"We can't keep handing out questionnaires to people again and again and again because we're going to insult them, we're going to upset them. They've come because they've got meningitis and they're handed an alcohol questionnaire for the sixth time, you know. They get cross with me when I ask about smoking for the sixth time when they've got a sore throat or a cough. So we've got to be realistic." (GP F 42)

"I could raise this question every time they come but I don't want to really, that would antagonise them. Do you still drink? No, I would leave it to some other time." (GP F 62)

"It's not what you're seeing your patients for and there are so many other things. And if you think you're going to alienate them, it's more important that they keep coming to you for their blood pressure or their diabetes care or whatever. It just gets pushed down the line. And also you've only got ten minutes or even less" (GP F)

Practice Nurses

All of the nurses were routinely asking patients about lifestyle issues, including some questions on alcohol consumption in new patient checks and specific clinics such as the diabetic or hypertension clinics. They felt that screening was appropriate in those instances where they already ask some questions about alcohol, but where alcohol was not the only focus. In these circumstances it was felt that patients expect to be asked about alcohol "and they don't take offence". Dedicated general health screening or well man/woman clinics, which could incorporate questions about smoking, weight, blood pressure etc., were also discussed as being appropriate. These had been provided in the past as part of the Health of the Nation targets, but the funding had since been withdrawn.

Some of the nurses already worked to specific questions or templates, e.g. for new patients or certain clinics. However, asking patients how much they drank and recording the amount did not necessarily mean that patients would be advised or if they were advised that they would be monitored. There was some concern about the extra burden this would place on nurses' time, as they are now expected to take on more work from the GPs.

Opportunities for alcohol screening

"Nearly every clinic basically. Not always about alcohol but lifestyle advice. I would say it's most clinic consultations as far as I'm concerned" (Practice nurse F 53)

"If a patient comes in that we haven't seen in a while, then we would ask how much they smoke and drink and do their general health check. So most people would get asked" (Practice nurse F 37)

"Well, in all our hypertension clinics they are asked about alcohol, total lifestyle…the new patient registration checks…and family planning clinic" (Practice nurse F 53)

Barriers to alcohol screening

"There's a time factor again. When they come in for a new patient check they'll be there for 20 minutes and you have a lot of things to go through" (Practice nurse F 42)

"I can't see us really doing it for everybody. I don't think it would be acceptable for everybody" (Practice nurse F 51)

"I'm involved in screening those at highest risk of developing a disease, hypertensives, people who already have heart disease, and it's quite a struggle to get through those, never mind the general…" (Practice nurse F 29)

Receptionists

Participants were also asked about the feasibility of receptionists handing out alcohol screening questionnaires, such as the AUDIT, to patients in the waiting room, as carried out in the Phase III trials. One practice had experienced difficulties when they tried to do this in a large and busy surgery. Other participants felt that receptionists would not have time to be doing this as well as their usual duties.

There was widespread agreement that having leaflets, booklets and posters available in the waiting room for patients to read would raise awareness of alcohol-related issues. Many participants also felt that an alcohol screening questionnaire could be successfully introduced in the waiting room as a voluntary scheme for patients, who could pick it up, fill it in and score it themselves. They felt that this would prompt people to talk about alcohol with their GP or nurse if they were concerned and enable the GPs and nurses to target those patients who were contemplating change. However, as previously discussed, some patients had found the AUDIT in its present form too complicated to fill in by themselves and had had to ask the receptionist or health professional for help.

Opportunities for alcohol screening

"I actually think that if there was some way of presenting it in the waiting room so people could use it as they wished and have a result…The only way I can see it working is perhaps a stack of these questionnaires. You know, we're interested in alcohol consumption, we recognise it is appropriate, if you're interested in looking at this questionnaire and discussing it with your doctor as a voluntary thing." (GP F 42)

"I think it could work surprisingly well as a voluntary thing if it was prominent enough in the waiting room. Because lord knows they're short of things to do in the waiting room while they're waiting for us being slow. And this could be something they could do about it at some point rather than a handout on benefits or something" (GP M)

Barriers to alcohol screening

"They (receptionists) couldn't do it when they were handling four surgeries and two nurses, the district nurses, and the chiropodist and phlebotomist. The staff would just be going dizzy. I mean even trying to hand it out…The other problem was that when you asked us to do it we were labelling the notes to say who had done it…You can't

do that in a busy surgery. You know you can't pull all the notes and then go back to six different lists and go through ticking to say these are the people of the regulation age who haven't had it" (GP F 42)

"From my point of view, or from a receptionist's point of view, if these clinics took part it would be the amount of work that would involve us, and the amount of paperwork and computer work…we're all basically working flat out at all three surgeries to get through the workload we already have" (Receptionist F 53)

2.2.7. Responses to the Drink-less Programme brief intervention materials

Participants in general responded positively to the materials presented. It was thought that the smaller handy cards in particular were very good and would be useful to give to patients. Participants also liked the fact that the booklet was anonymous-looking with a blank cover.

> *"I think these little cards are excellent, having identified someone who had a problem"* (GP F 47)
>
> *"I think these (handy cards) are quite useful for patients"* (Practice nurse F 51)
>
> *"I think this is quite good, if this is the finished product, that it's anonymous looking (holding booklet). It doesn't have a picture on it…You usually have pictures of people with glasses in their hand and I think that's really quite good"* (GP F 39)

One GP, who had used the Drink-less pack quite extensively in Phase III, felt that it contained too many items (booklet, handy card, advice card). These had been difficult to store and find in a busy surgery and she had eventually returned to using the one Health Education Authority leaflet.

> *"I mean, I thought these were really good when I was using them. What's interesting is that having then stopped doing it, about 6 months after I then reverted back to the various 'That's the Limit' booklets and such like. And I think that's partly the slow chaos. I mean we've got loads of different things we're trying to do in a consultation which have got values, and you actually want one thing you can pull out…But in fact when push came to shove what fitted in my filing cabinet, what was easy to find, easy to pull out, was a straightforward 'That's the Limit' booklet"* (GP F 42)

A few participants felt that the information presented was too 'drastic' and were concerned about 'alarming' or shocking their patients when discussing levels of consumption. Others felt that it wasn't 'shocking' enough.

> *"If I thought I was drinking too much, this would scare the living daylights out of me. Just looking at the brain damage and memory loss and things like that. It would scare me"* (Receptionist F 53)

> *"There must be some really strong health statistics you could throw at people. If you drink this much you're five times more likely to…I don't know"* (GP M 33)

2.2.8. Brief intervention: current practice, opportunities and barriers

During focus group discussions, many of the GPs and nurses said that they tried to intervene with patients if they were aware that they were drinking excessively, although the extent to which they were doing this is not clear. It also began to emerge that they were using a number of different strategies to intervene with those patients. These strategies included giving positive advice and encouragement, use of 'fright' tactics, use of GGT and liver function tests, and use of blood pressure measurements. These will be discussed in turn below.

"I can just advise people and encourage them"

Both the GPs and nurses talked about advising patients on their level of alcohol consumption and using the recommended levels as a benchmark, although due to the confusion about these levels it would seem that inconsistent advice is being given to patients. Quite often, the advice would be to reduce consumption to a 'realistic level' for the patient and not necessarily to the recommended levels mentioned, although these were deemed useful as a comparison. For one GP, use of the recommended levels also gave a feeling of back-up and support when talking to patients.

> *"You have a discussion, so OK you're not aiming at what the national guideline is, but what are you aiming for? And this is why there is a national guideline and this is why I'm worried about you, but I'm going to be realistic. What do you think you could do?" (GP F)*

> *"I think the only thing is that there is this figure out there, so it's not me making it up. It's not that I'm saying that you're drinking too much…it means that I'm not an isolated doctor picking a figure out of the air" (GP F)*

Advice would also be given about the health and social effects of alcohol. This would be given either using a positive, non-judgemental approach or by using 'fright' tactics,

usually when the GP or nurse felt frustrated. The approach used appeared to depend on their relationship with the individual patient.

> *"The sort of approach that I would try and say to people, I'm not here to dictate to you but I am genuinely concerned for you. And I would like you to be healthy and have a good family life and to be an active member of society for as long as possible. And I can see that this is going the wrong way. I'm not trying to say you're a naughty person and you shouldn't do this, you try to put to them the benefits of changing their behaviour, that you're doing it out of concern for them. That's why you became a doctor" (GP F)*

> *"I sometimes will say to people this is what I advise you to do but I can often end up saying, well you know if you don't want to listen to me or what I say, perhaps not putting it quite as bluntly as that, but sometimes saying it as bluntly as that, if you want to kill yourself with alcohol, fine, go ahead. You can just put it blankly to them that it's a free country, it's legal, they're quite at liberty to go and do that if they want (laughs). Which perhaps doesn't sound quite the right thing to say, but sometimes you get driven" (GP F)*

> *"Some people need it in their face, some people you don't do that to" (Practice nurse F 40)*

> *"It depends how well you know the patient as well. I mean if you've known them over several years you know how you can talk to them" (Practice nurse F)*

How GPs' and nurses' own drinking habits affect the advice that they give was also discussed. Three of the four GPs that attended the second round of focus groups volunteered that they did not drink at all (one for religious reasons and the others out of personal choice). One GP said that she found it helpful to say to patients that she did not drink any more and that it is possible to go out and have a good time without drinking. However, she also stated that "I would like to be able to talk to people as if I was somebody who did enjoy going out for a drink on a more realistic level." Other GPs talked about the perception that "you know you have a problem with alcohol if you drink more than your doctor". This was a perception that was attributed to the patients; however, some of the GPs appeared to agree that many doctors are themselves heavy drinkers. The implications were that these GPs might not intervene with a patient if their own alcohol consumption was at a similar or higher level, and that patients might not take any advice given by the GP seriously if they held this opinion of doctors in general.

> *"I think medics are not good role models. I mean they are good role models in terms of cigarette smoking and the vast majority have actually taken that on board. But I suspect medics are still, and nurses as well I expect, are perceived to be people who work hard and play hard as well"* (GP M 49)

> *"Do you think that's from the patients point of view? They won't know whether you or I drink but you and I will know whether you or I drink. And you might say, well you have your own drinking levels in your mind before you want to criticise a patient. You might think, well he's drinking too much but it's only really what I drink"* (GP M 37)

> *"Oh yeah, there's a standard joke isn't there about if you drink too much you're a doctor (laughter)"* (GP M 49)

All of the nurses talked about 'enjoying a drink' but some also talked about how they try to "put (your) own values aside and give them the facts". However, there were also comments such as, "you may not be as reinforcing of it", "do as I say, not as I do", and "I don't like drunken people so…" implying that despite their best intentions, their personal attitudes to alcohol were affecting the way they talked about it with patients.

"It's great if the Gamma GT is up as well"

One strategy sometimes used by GPs for intervening with heavy drinkers was the use of GGT and other liver function tests. A positive result was seen to give both the GP and the patient 'proof' of a problem, and then made it easier for them to discuss reducing consumption. Use of tests could also provide positive feedback after a patient had reduced consumption.

> *"When it's high it's useful because people get worried. And that may be a wrong use but you just show them and say well OK, but when they've cut down it's quite a bit improved." (GP F)*

A high GGT might also be detected by 'accident' when a patient had a blood test for some other reason.

> *"They happen to have a blood test and their gamma GT is high. That's often the way. Abnormal blood tests which happen to be done for some reason" (GP M 38)*

However, if the tests came back negative, even when it was known that the patient was drinking heavily, this would "often give them an opportunity to say, well this isn't affecting me. I'm the one who's not going to be caught by this". This suggests that test results on their own are not sufficient to detect and intervene with patients effectively.

> *"Sometimes the GGT is so…I'm amazed that it's normal. This person is drinking a bottle of whisky every night. Admits it. And it's normal and he just looks at me and says, that's alright then, I can drink." (GP F 62)*

> *"It's amazing though; you can have somebody on 100 units a week and have a GGT of 57. I mean it's incredible and then they're of limited value" (GP F)*

A negative result might also mean that the patient would have no need to make another appointment to see the GP, making further monitoring or intervention difficult. Repeat appointments were viewed as being an important factor in the success or otherwise of an intervention.

"His blood pressure was so high it was just one of the questions"

Both nurses and GPs found raised blood pressure to be a useful trigger to discuss alcohol and other lifestyle issues with patients. This often happened as part of a new patient or routine health check and appeared to be a useful strategy to help patients reduce their consumption, especially when the patient returned for regular check-ups.

> *"If you take somebody's blood pressure and it's raised, again go back to your lifestyle issues, are you smoking, do you drink, do you take exercise?" (Practice nurse F 45)*

> *"I usually check their blood pressure on a regular basis, and they'll come in ever so proud. I've cut out my smoking or I've cut down on my drinking. And they're really proud that they've managed to do it…Once their blood pressure starts coming down, you usually say, we'll see you on a three monthly basis. Unless it's stayed high and the doctor has put them on medication, then we still have to check their blood pressure on a regular basis. They try and get it down before they see the doctor because they don't want to take tablets for the rest of their life." (Practice nurse F)*

One nurse also used diet as a prompt to discuss reducing alcohol consumption.

> *"I usually tell them that it's high in calories and if they drink more than the limit, they're not going to lose weight. It's got more calories in than certain foods and things. And I get round to that, try and cut down on your drinking." (Practice nurse F)*

2.2.9. Brief intervention: perceptions of GP and practice nurse roles

Participants were asked about the respective roles of GPs and practice nurses in delivering brief interventions. The nurses felt that they should be playing "quite an active role" and thought of themselves as "the first line" in assessment and giving general advice on alcohol and other lifestyle issues. However, without specific training, some nurses said they would refer any 'high risk' patients to the CPN or the GP. Patients were also passed to the GP "to do their bloods for their liver function and to see if those levels are raised".

Many of the GPs in the focus groups felt they had a role in terms of opportunistic intervention when prompted by the presenting problem.

> *"We have a responsibility to point out to patients, if they are drinking heavily, that it's hazardous to their health, not just in terms that it's addictive, just physically damaging"* (GP M 49)

> *"I always see my role as telling somebody what the risks are and letting them decide"* (GP M 37)

> *"And I think as part of the primary care team, we should be able to identify if the problem is there and if it is, how we can help them." (GP F 62)*

However, as previously discussed, there was concern that there were groups of patients with whom they would never have any success or that the success rate would be very low. This again suggests that the GPs would be more likely to intervene with those patients that are contemplating or ready to change their behaviour. They also talked about the lack of time they had to intervene with a patient in a normal consultation and the possibility of asking people to come back for another appointment instead.

"Suppose it was just bad luck and you actually got 2 or 3 of these in your surgery. I mean I don't know how many we would be expecting to get. But if you're already running late, which is something that I tend to do, then I think it would be an issue of whether you can actually deal with it there and then. Or whether you need to say, well look it looks like there's a potential here that you may be at risk from your drinking, would you like to come back and see us? I can see it working like that, but I can also see a lot of people not coming back" (GP M 49)

"I think that the 'come back and see me' is quite a test as to whether they'll actually want to address the issue and whether they are likely to be willing to make the changes that are necessary. I mean I would find it a bit depressing if nobody ever comes back and I suspect that's the issue" (GP M)

Most of the GPs and nurses felt that in general patients would find it easier to discuss alcohol issues with a practice nurse, who was regarded more as a 'friend' or a 'people's person', than with a GP, who was referred to as 'authoritarian'. Both groups talked about this perceived distinction and how they thought it influenced patients' attitudes and behaviour. Some felt that patients seemed to view an appointment with the nurse as being less 'formal' or even less 'important' than with the GP. One nurse felt that this enabled the GP, as the 'authority' figure, to get patients to stop smoking or drinking, whereas the nurse could only persuade them to cut down.

The nurses also had more time to spend with patients than the GPs, and it was felt that some patients would go and talk to the nurse because they thought the doctor was 'too busy' to listen to them. Despite this impression that nurses have lots of time to spend 'chatting' to patients, most of the nurses were feeling 'overloaded' with new work, such as smoking cessation programmes, national service frameworks and minor ailment clinics. It was felt that this would make it more difficult for nurses to take on alcohol intervention work and was a view shared by some of the GPs.

"I just think that we have more time to spend with them and they class you as a friend. The doctor's the doctor and he's the man, isn't he? They listen to him. But they're more pally-pally with the nurse. In some ways it's a good thing, but I don't think you can say that we have the authority. We've got to be one or the other, haven't we? And the doctor's the authority." (Practice nurse F 53)

"Because they're (nurses) not regarded as so authoritarian and people will often open up to them and generally go in for a chit-chat." (GP F)

" If the doctor says stop smoking a lot of people do, because the doctor's said so. It's almost as if it's written in stone. But the nurse has to do a lot more drawing out, to find ...I would suggest from my experience that the nurse doesn't have the impact. You can encourage them to reduce and I think that's successful in getting them to reduce. I think a nurse can often get people to reduce the amount of alcohol, but in my experience I don't think you can get people to stop using alcohol" (Practice nurse F 53)

"I think in a lot of cases it's the blue frock…They want to get something done. Some people want something done but they feel that the doctor's too busy. And they can come and talk to the nurse" (Practice nurse F)

"Also they have this preconceived idea, not just that the nurse is an angel of mercy and that she's more approachable, but also that the nurse has loads of time" (Practice nurse F)

"Even when I go to the doctors I always feel as if I've got to say what I've got to say and go. And I feel rushed. I hate to take their time up" (Practice nurse F 40)

"It's a general thing that patients do think, oh we're only going to see the nurse, she's got plenty of time. I get patients turning up a half-hour late, no excuses, and they still think you can see them. You've got loads of other patients, they don't think you've got loads of other patients" (Practice nurse F)

"A lot of the work has been shifted onto nurses and it's competing with everything else for time" (GP M 38)

"With the best will in the world, you start to wear thin sometimes" (Practice nurse F)

2.2.10. Support

The need for support to enable PHC professionals to carry out brief intervention work was highlighted by both GPs and nurses. However, there were differing opinions as to what form this support should take. Some GPs said they were prepared to intervene themselves, with backup from the local drug and alcohol service as appropriate. Others would like to be able to refer to a specially trained professional (nurse or other) to provide either alcohol-specific or general lifestyle intervention.

> *"I would be happy to deal with most of it as part and parcel of you taking primary care of that patient. It's part of your remit. And then when it's identified, that it really is something beyond which you can deal with, then you would want your backup services" (GP F)*
>
> *"In terms of skill mix, it would be appropriate to have a person, whether that be a nurse or whoever, trained to do lifestyle education advice, then when one*

picked up a problem through opportunistic screening methods it would be great to have somebody to refer them to" (GP F)

Smoking cessation programmes were viewed as being a useful model in this sense, because they provide a co-ordinated strategy between primary and secondary services using a 'stepped care' approach. GPs ask patients about their smoking habits, assess their motivation to change and refer them to the smoking cessation clinic as appropriate. Practice nurses are trained to provide the clinics but there are also two or three district-wide 'advisors' who can be contacted for support or referral when having problems with particular patients. Many of the nurses said they were prepared to carry out brief interventions if they were given the additional time, training and support in a similar way to the smoking cessation programme.

"*Someone to refer on to if we're stuck" (Practice nurse F 42)*

"Having someone you can ring to get advice from" (Practice nurse F 46)
"Somebody who's done training in alcohol misuse. Not necessarily a CPN but somebody who's done training" (Practice nurse F)

"If you look at the way things are going now, there are a lot of practice nurses now trained for smoking cessation, you know we're counsellors for that. I've just done the training for that. So I could imagine in a few years to come there might be something for alcohol as well" (Practice nurse F)

However, concerns were expressed by some of the GPs that this model of care can result in waiting times for patients and in the de-skilling of practice team staff:

"I now only talk very briefly to people about their smoking. I know there is the smoking cessation clinic which by definition does it much better than I do. As a result, people are waiting weeks and weeks to go to the smoking cessation clinic. And I think there is a real danger if you skill somebody up in a practice, that it then becomes, she or he becomes, 'the person' and de-skills everyone else. And I think that's something personally one has to be extremely careful about. These are all generic skills, which as doctors we should be capable of using up to a point. We may then need help. But if we are encouraged to use somebody else, I think that very much detracts and takes away our own ability to deal with it" (GP F)

Other GPs felt that they had neither the time nor the training to carry out brief interventions and suggested having a specifically trained person to intervene with patients. Participants had differing views, firstly, as to whether this should be a

practice nurse or a specialist worker attached to the primary care group and, secondly, whether they should be offering alcohol-specific or general lifestyle intervention. Some participants felt that it would be too stigmatising for patients to see an 'alcohol worker' and that many would not make/attend an appointment. They suggested that a general 'lifestyle counsellor', incorporating alcohol with smoking, diet, weight etc. would be perceived as less threatening and more acceptable to patients. They also felt that this would take some of the workload, including smoking cessation, off the practice nurses.

Alcohol-specific worker

"If you really wanted to do it on everybody, you would have to have a separate person doing it rather than us. Like the alcohol nurse who did the questionnaire and then came in and gave them the counselling. That's the only way you could really do everybody, because we obviously couldn't take it all on. And if that was a genuine goal, to screen every patient between certain ages, that's what it would take" (GP M)

"This is actually quite a complex area. It's not something which we've been, either as doctors, nurses or health visitors, have been used to doing…It actually does fit in very nicely with the clinical psychologist's role and you can't suddenly make a nurse into a clinical psychologist or even a doctor into a clinical psychologist. Which comes back to this idea of actually having someone there who is trained in this sort of work" (GP M 38)

"What would encourage us most working in the situation, as it is at present and applying it to our patients, would be having the tool and having someone who was going to apply the tool if you like or the responses from the tool in another setting. So that I would be happy to introduce this to a patient and they would then be referred on to someone else within the team. And that may be an external person who is offering a session for people" (GP M 46)

"I think we should have some sort of way to find out and maybe we could have a backup to help, like the drug and alcohol worker" (GP F 62)

"That's another problem isn't it, there's always people like NECA (i.e., North-east Council on Addictions), the NECA counsellor, there'll be a waiting list for the NECA counsellor, it's the resources again" (Assistant Manager F 43)

"I have a patient who says her husband won't come and see the counsellor, the general counsellor, because the other patients in the waiting room know that the counsellor is in that room. And when he comes out of there they know he's a 'nutter' because he's seen the counsellor. And it doesn't take long for the word to get around that this person deals with this problem" (GP F 39)

Health/lifestyle worker

"I think that if there was a parallel service set up which is easily accessible where you could transfer the patient sideways slightly. We're dealing with the physical effects of their immediate concern and then they saw a health visitor type or a health advisor type of person who can then go into more detail about the drinking side. But not with much delay, I think it has to be fairly immediate, because the advantage of having the person in front of you is that they are, and the evidence shows that people will listen more while they're actually in some sort of pain" (GP M 38)

"It's about the gain in health, you know that's what you're hoping to sell and this is called a health centre and you should be promoting health. I think we could become enthusiastic in support of somebody adopting the role" (GP M 46)

"At the moment you've got your nurses who are doing their work and increasingly taking on more comprehensive follow-up of people and now they've taken on smoking cessation which is very time-consuming. If they could think of a way where we could set up a service of lifestyle advisors who were there for the locality, not each individual practice, where they knew there was a clinic, like the GU clinic has a telephone number where you phone up and make an appointment…you could envisage that a lifestyle advisor could spend 20 minutes on patients and we could just hand them a card. You know, of course we'll give brief advice, but for those who want to go the next stage in education, in understanding and addressing their problems" (GP F)

"We need a lifestyle counsellor…tobacco, alcohol, weight, exercise and someone with an understanding of psychology. Set in the context of ischaemic heart disease, diabetes, lung cancers and other cancers. You need a resource. We could employ that person five days a week from the time we opened to the time we shut" (GP M 46)

"If it's not just focused on alcohol, people might actually be prepared to go to a lifestyle counsellor rather than an alcohol counsellor" (Practice Manager F 56)

2.2.11. Training and communication issues

There were also differences in views about the importance and necessity of training. As previously discussed, few of the GPs or nurses had received any alcohol-specific training, although all had stated that they were carrying out some level of alcohol-related work.

Not all the GPs thought training was necessary, and for these participants time was generally considered to be more important. Most of them seemed comfortable with the general training they had already received, feeling that it was more an issue of communication and building up a relationship with the patient "and that should be the

basic training for a GP". It was acknowledged, however, that "a few simple facts" and "having information (that) can help the communication process" would be useful, particularly in terms of the effects of alcohol and strategies that patients can use to help cut down. Many participants also wanted evidence of the effectiveness of SBIs, facts and figures about the size of the problem in their patient population and relative risks to health.

"I don't think I need a lot more training. I think we've done all these things before in different ways. And I'm always being told that doctors aren't paying enough attention to it but it's a time issue. I think we're all doing it to a certain extent as it is" (GP F 47)

"That's where I struggle. I don't think anybody particularly has a problem picking people up who are drinking too much but I think the patient and I both sit there. I feel I should tell them to stop and they know I'm going to tell them to cut down and we both sort of look at each other and carry on. I don't really know what's the best way to intervene and stop people" (GP Registrar F 26)

"It would be nice to have some hard figures to quote at people…If you drink so much you are x number of times more likely to have this that and the other" (GP M 33)

"Not so much training in the intervention but having been trained in the intervention and using it, does it make a difference? Give us the evidence" (GP M 49)

"What sort of interventions are you discussing, you know, let's look at the man who drinks 10 pints four times a week and what are you going to say to him?" (GP F 36)

"I'd like more information about how effective it is and how effective it is on different sorts of patients" (GP M 35)

"I think it's having the time to put into effect any training strategies that you might give us" (GP M 49)

The nurses, however, identified training as being the main incentive for them to carry out brief intervention work. They had already received quite a lot of general health promotion and lifestyle training, but little or none specifically on alcohol. Expressed training needs included the effects of alcohol, hazardous and harmful levels, different strategies to use with different patients, and ways of reducing consumption.

> *"I think we should first of all have more training. I don't think there's much training on alcohol for practice nurses. There's smoking cessation groups, there's diet, there's the cardio-vascular, even though alcohol comes into*

cardio-vascular. I don't know of any training. There's definitely a training issue" (Practice nurse F)

"If you do a brief intervention and can't follow it through, you could possibly do more harm than good. It sometimes worries me that just sort of saying in passing, well you know you could possibly be drinking too much, and leave it at that and haven't got the time or training to continue on through, you might actually do more harm than good" (Practice Nurse F 59)

The nurses also specified that practice team-based training would be preferable to individual nurse training. There were several reasons for this. It was felt that some nurses would not be released for training unless alcohol became a bigger priority for their practice and their practice received a financial incentive for the training and subsequent cover. Many practice nurses have to fund their own training at present and so the provision of funding is an important issue.

"A lot more people would like support and help but it isn't available. And I don't think, unless it's forced through the National Service Framework, and the PCGs will have to start to address it. The PCGs will actually, if it's going to be on an individual basis like the smoking cessation, then the PCG will address it. And then the nurses would go off to train, they would then reimburse the practice. It would be all down to that. When push comes to shove, if the doctors get money we could do it; if they don't, forget it" (Practice nurse F 53)

Secondly, it was felt that it would be difficult to find a suitable time for nurses from different practices to attend a joint training session unless it was in their own time. However, training sessions could be arranged with individual practices in their own designated time and held at the practice itself with all members of the team attending. This was also suggested in the primary care team and GP focus groups, implying that the whole team - GPs, practice nurses, health visitors, etc. - would be involved in SBI training and delivery to some extent. However, one GP noted that there needs to be sufficient 'marketing' to the practice beforehand to encourage uptake of any training package offered.

"I think that one incentive is knowing that what we would be learning is going to be useful. Almost you need to give us that information in the first place, that this is a useful strategy and then we say, OK we can sign up to that and then move on from there" (GP M 49)

Although practice team-based sessions were identified as being the preferred format for training in the delivery of SBI, both the nurses and GPs said that they heard about new services, ways of working and interventions via individual professional group meetings. For the nurses in South Tyneside, there was a PCG practice nurse training group and also a practice nurses' forum, where speakers were invited to attend. However, not all the nurses attended these groups which were usually held after work in the evenings. The GPs in Gateshead similarly attended local accredited education meetings (held in a local restaurant) on a regular basis, where speakers such as local consultants or service managers talked about their services and answered questions. It was felt that a number of dates could be offered to access more GPs, although it should be noted that the GPs attending the focus groups were more likely to be representative of those who attend these meetings anyway. Information sent via the post was not recommended. "The problem is sending us another piece of paper, as much as we'd love to read everything, it's an absolute nightmare" (GP F)

2.2.12. Wider implementation issues

Participants felt that the issue of alcohol misuse and alcohol-related harm was much wider than PHC. It was suggested that a campaign could be implemented in other settings, particularly to target young people and others who do not traditionally access primary care services.

> *"I think if it's going to be a nationwide campaign you can target different people in different places. It doesn't have to be in the primary care setting. Things like young people's clinics…and family planning clinics, you'll usually find a poster or two on the wall about alcohol"* (GP F 39)

Participants pointed out that the success of the smoking cessation programmes relied on a concerted effort by the government and media as well as PHC professionals to get the message across, and that a similar effort would have to be made for alcohol intervention to be effective. It was agreed that the issues of alcohol use and misuse needed a higher profile nationally and that both the health and the wider social effects of alcohol should be included in the message communicated.

It was strongly felt that there should be more publicity on alcohol and its effects via media campaigns, including TV programmes, 'soaps' and adverts. The use of celebrities was highlighted as having been a successful factor in the recent 'flu campaigns. Media campaigns were also recommended as a means of reaching the majority of the population, regardless of whether they accessed primary care services. Other suggestions for reaching the public included leaflets in waiting rooms, warnings on alcoholic drinks "like they do on a cigarette packet", and help-line numbers.

> *"If you're going to splurge money into education, a TV campaign with information on where to go for education or advertisements on billboards, a national campaign does have an effect. You know people watch telly" (GP F)*
>
> *"Should the spotlight be on us or should it be on the billboard or television?" (GP F)*
>
> *"Should we be saying all the time, like the smoking, that drinking can be harmful to your health? Like on cigarettes it says but on alcohol it doesn't" (GP F 62)*
>
> *"Get something on Eastenders or get Alan Shearer doing some adverts on television. That would be more effective" (GP M 37)*

For SBI to be successfully implemented in primary care, it was felt that government support and resources would be needed. Most participants were not aware of Government plans for a National Alcohol Strategy.

> *"If you're going to start a programme I think there has to be a general recognition of the size of the problem. I think there has to be a will to deal with the problem nationally and to resource it properly within the NHS if that's the vehicle which is going to be used"* (Practice Manager M 61)

Lack of resources and incentives to carry out the work were discussed as being a main barrier to implementation. There were differences in opinion, however, with some GPs valuing evidence of effectiveness above financial incentives.

Resources and financial incentives

"If you took us a normal reaction you certainly wouldn't get very far. It would just be looked upon as yet another job to do without any real incentive for the people carrying out the work or for the people coming" (Practice Manager M 61)

"Primary care is carried out by a whole host of professionals with various backgrounds, various training and mix of skills. And already we're trying to fulfil certain roles in an under-resourced environment…So it's actually quite complex, lots going on and unless you actually understand that complexity and understand the pressures on everybody's time in primary care, I think you're always going to make the mistake of thinking that you can lump on an extra service and expect it to do well. It won't do well. It won't work unless time and provision is made for it" (GP M 38)

"If somebody wants to change or modify or do something about it, it's actually monitoring that change as well. And that often doesn't get built into the resourcing programmes…it's seen as a one-off brief intervention but in fact unless you're supporting people, rewarding them or doing something about recognising the change…it's coming back and reviewing what's gone on is another often missed element. Again it's another resource" (Health Visitor F 41)

Evidence of effectiveness

"I'd like more information about how effective it is and how effective it is on different sorts of patients" (GP M 35)

"If I thought it was going to make any difference to the patient's alcohol consumption. Yes quick, easy and effective" (GP M 33)

"At the end of the day it does come down to feeling as if you're going to make a difference. Because, you know, even if you started chucking money at it, I don't know that any of us would be financially orientated. It would be nice to have a sense if you achieved a target in how many people stopping drinking and you were able to add something to improve your services and the practice. That would be very nice. But I think most people here…would do it anyway providing they felt it was going to be effective" (GP M 49)

2.3. Summary and comment: focus groups with health professionals

In the first round of focus groups, the use of health professionals from different professional backgrounds might be criticised because the conventional recommendation (e.g., Kitzinger, 1995; Morgan & Kruegar, 1997) is that groups should be convened with homogeneous membership. There is a danger, for example, that in mixed groups of the kind used here, GPs might dominate the discussion because of their higher status in the primary care setting. However, texts on focus groups methodology also recognise advantages of bringing together "a diverse group

(for example from a range of professions) to maximise exploration of different perspectives within a group setting" (Kitzinger, 1995). The reason we used this kind of group in the first round was that we wished to explore a primary care team response to the issues involved and thereby get closer to the real situation in which SBI would be implemented. The findings from the groups suggest that this aim was successful.

Professionally homogeneous groups were used in the second round of focus groups with health workers and we took the opportunity to feed in to these groups themes emerging from the first round. However, a limitation of these groups was the small number of GPs who could be persuaded to take part. This may itself be a reflection of one of the main obstacles to progress in implementing SBI in PHC – the lack of involvement of medical professionals, for whatever reasons, in this work. Despite the different composition of the two types of group and their slightly different remits, it will be convenient to describe findings, and to summarise them here, for the two kinds of group together.

One of the clearest initial findings from the groups, and something that has been noted many times in previous work (e.g., Cooper, 1994; Bowler & Gooding, 1995; Roche, 1996; McAvoy, 1997, 2000; Albery *et al.*, 1997; Deehan *et al.*, 1998; Kaner *et al.*, 1999b; Johansson, Bendtsen & Akerlind, 2002), is the lack of training in alcohol-related matters that health professionals had received. The majority of both nurses and GPs said that they had received little or no specific training on alcohol and what little information had been imparted had mostly come through more general training on health promotion and lifestyle issues. Despite the fact that it is in worldwide use and has received a great deal of attention in the literature, the only GPs who had heard of the AUDIT questionnaire were those who had been involved in one of our previous brief intervention studies (Kaner *et al.*, 1999a; Lock *et al.*, 1999).

This low level of training was presumably responsible for the considerable confusion that was evident regarding recommended levels for low-risk alcohol consumption, a finding that has also been reported recently elsewhere (Webster-Harrison *et al.*, 2001). The confusion applied to whether levels were daily or weekly, what the specific number of drinks described by the levels were and what amount of alcohol constituted

a “units”. This degree of confusion was obviously felt to be unhelpful when attempting to speak to patients about their drinking. There was also disappointing uncertainty about definitions of “alcoholic”, “problem drinker” and “excessive drinker” and this also seemed to act as a deterrent to raising the issue of drinking with patients. Of particular concern is the possibility that, if health professionals are unclear about the difference, patients who are “excessive drinkers” with little or no experience of alcohol dependence may conclude that they are being diagnosed as “alcoholics”, with the consequent resistance and resentment this may lead to.

On a more positive note, there seemed on the whole to be sufficient awareness of the gravity and extent of alcohol problems in the population and a recognition that this was, or should be, an important part of the health professional’s work. Other considerations aside, this suggests that attempts at education might in principle be aimed at a receptive audience.

There was general agreement that, in the North-east of England particularly, heavy drinking was “the norm” and was generally socially acceptable. It was also felt, however, that contributing to this acceptance of heavy drinking was an ignorance among patients of the risks of excessive consumption and the level of drinking at which such risks arise. The perceived difference between what patients and health professionals considered excessive represented another disincentive to intervention. The implication was that education for patients about alcohol, as well as for health professionals, would be necessary for SBI to work.

Both GPs and nurses were conscious of the stigma attached to talking to a health professional – a stigma that was likely to be felt by most patients to some degree. However, they were able to distinguish between particular groups of patients who differed in their willingness to talk candidly about their drinking. These were: young people; Northern men; women in general; older people; professional people; and unmotivated patients.

Young people of both sexes were seen as especially difficult targets for intervention, mainly because intoxication was viewed among them as perfectly normal behaviour. Although young women were more likely to be seen in PHC than young men, it was

felt that young people would be more effectively targeted outside general practice. Even if they were targeted in general practice, illicit drug use would probably be given a higher priority than excessive drinking. Although young people might be more open about their drinking than their elders, advice on the topic was likely to be ignored. Some nurses said they were especially needful of training and support in dealing with the drinking problems of young people.

The problem of a social acceptance of heavy consumption was perceived to be especially relevant to the drinking habits of men in the North-east of England. Paradoxically, some health professionals felt that this made it easier to talk to local men about their drinking because there was a mutual expectation that quantities reported would be large. On the other hand, nurses said there were special difficulties in raising the issue of drinking with women, mainly because of the shame and tendency to deception that the topic aroused in female patients (cf. Chang, 1997). It was difficult to detect drinking problems among women unless these problems were severe and obvious, and the consequences of such problems were seen as wider in nature than those among men. Older patients too, especially older women, were found to present special problems for identification and brief intervention. This again suggests the need for training to focus on the special problems presented by different genders and ages.

People in professional occupations were another group with whom participants found it difficult to talk about drinking. There is indeed evidence that health professionals tend to avoid implementing brief interventions among patients from higher socio-economic backgrounds (Kaner *et al.,* 2001). The present results from focus groups tend to support this earlier observation based on a study of the use of the AUDIT questionnaire in PHC. A novel suggestion for advising patients in professional occupations was the use of warnings about "driving the following day" after heavy drinking.

An interesting and potentially useful grouping made by participants was the distinction between patients whom they felt they might be able to help and those they felt they could not. It seemed that the excessive drinking of those in the latter category might well be simply ignored. Much of what was said on this topic was consistent

with the "stages of change" model developed by Prochaska and DiClemente (1992). Indeed, such is the popularity of this model that many participants, especially nurses, were familiar with it and mentioned it by name. It was, however, disappointing and perhaps surprising that nurses had learned about the model through work on smoking cessation and that none had applied it to drinking problems. But even if the model had not been explicitly applied to alcohol-related issues, it is likely that participants had implicitly used the model in responding to drinkers encountered in their work.

Among "precontemplators", a sub-group was described of patients drinking slightly over recommended level for whom only correct information about risks was needed to instigate a change in drinking behaviour. Also likely to be helped by intervention were those "contemplators" who had already been thinking and perhaps worrying about their drinking. On the other hand, a separate group of precontemplators was identified who were resistant to change and for whom intervention was unlikely to be successful. Finally, patients with more severe levels of dependence were thought unlikely to benefit from intervention, although it was disappointing that participants did not mention referral to specialist addiction services for such patients.

Previous brief intervention packages have employed the stages of change model in their advice to practitioners (see Heather, 1989, 1995; UK Alcohol Forum, 2001). The findings from focus groups presented here suggest that this approach fits naturally with the existing practice of health professionals but could make it more structured and consistent in operation. Guidance on when to refer patients to specialist service would be an essential addition to an algorithm based on the model.

When respondents were asked to comment on the AUDIT questionnaire, there was a range of responses. Those participants who had used the instrument before were generally favourable in their views of it but some said that certain patients found it too complicated to complete without help. Shorter and simplified versions of the AUDIT have been developed (Bush *et al.*, 1998; Seepa, Lepisto & Sillanaukee, 1999; Gordon *et al.*, 2001; Gual *et al.*, 2002; Hodgson *et al.*, 2001) and one of these might be used to solve this difficulty. Given that these shorter versions are reported as having nearly as good sensitivity and specificity as the full AUDIT, any saving of time in the busy general practice setting they would produced would be valuable.

A positive aspect of the AUDIT was that it was seen as non-threatening to patients drinking just over recommended levels. On the other hand, heavier drinkers might find it threatening and it was recommended by some participants that questions about drinking should be included in a more general "Health Questionnaire" asking about a range of health behaviours. This screening method has, of course, been used in previous work (e.g., Wallace *et al.* 1988; Anderson & Scott, 1992; Richmond *et al.*, 1995; Heather *et al.,* 1995) and might be used again as an alternative to the AUDIT, at least as a first step in the identification process.

Another suggestion was the used of computerised versions of AUDIT or some other screening instrument in surgery waiting rooms where patients who wished to would be able to enter their personal data. However, participants varied considerably in their reported access to and familiarity with information technology, and their views as to its possibilities in general practice. The most prevalent view was that, despite the Government's intentions in the NHS Plan, health professionals were not yet ready for innovations of the kind suggested.

Although all participants seemed to have had some experience of discussing drinking with patients and most understood the concept of SBI, ideas about screening differed between professional groups. GPs tended to screen opportunistically, particularly when drinking appeared related to the patient's presenting complaint. It was therefore suggested that a list of conditions to which excessive drinking was empirically linked would facilitate SBI. Importantly for present purposes, GPs were opposed to routine screening for excessive drinking unless it was part of a general health or blood pressure check. GPs' concerns about SBI were the familiar ones of having too little time during the consultation (e.g., Heather, 1995; Wutzke, Gomel & Donovan, 1998; Kaner *et al.* 1999b), fear of questioning that would be perceived as intrusive by the patient (e.g., Thom & Tellez, 1986) and, in more general terms, fear of damaging the patient-doctor relationship (e.g., Durand, 1994).

All practice nurses participating in the groups asked patients questions about their drinking as part of interviews on general life-style, which they felt was the only appropriate context in which alcohol enquiries could be made. Some nurses had

developed specific procedures for this purpose. New patient checks, diabetic or hypertension clinics, well man/woman clinics and general health screening were all mentioned as being appropriate circumstances in which to ask about drinking. It is important to note, however, that, even if the result of screening was positive, this did not mean that the patient would necessarily receive a brief intervention or even brief advice, mainly because of limited resources. It is highly relevant to this that the funding previously provided to address alcohol issues in the Health of the Nation targets had since been withdrawn.

There was a lack of support among participants for the idea of receptionists handing out screening questionnaires to all patients. However, making questionnaires easily available in waiting rooms for the benefit of those patients who wished to complete them was widely endorsed. The only problem here was the observation mentioned above that some patients needed assistance to complete the AUDIT.

With regard to the Drink-less brief intervention materials themselves, there was a generally positive response from participants, especially to the "handy cards." One doctor felt that the items making up the pack were too many and difficult to store. There was disagreement about whether the contents were too or insufficiently "shocking".

Although many participants said that they currently offered brief interventions to excessive drinking patients, the extent of this activity was not clear. There were also a range of strategies and methods that were seen as brief intervention.

One source of variation concerned the level of alcohol consumption patients were advised to aim for. Levels recommended by medical authorities (e.g. Royal College of Physicians, 1986) were often used, although the uncertainty about what these levels were may well have made advice inconsistent. Other participants spoke of recommending "realistic levels". Information about the adverse health and social effects of heavy drinking was also frequently given, although again the manner in which this information was imparted seemed to vary considerably. It is clear that not

all health professionals used the "motivational interviewing" techniques that are favoured in the literature (e.g. Rollnick, Butler & Hodgson, 1997) as a way of instigating behaviour change. There was also a clear recognition among participants that their own drinking habits could affect the advice they gave in a number of ways.

Feedback of the liver enzyme, gamma-glutamyl transferase has been used in previous studies of brief interventions for excessive drinking (Kristenson et al., 1983; Heather et al., 1987). The present findings indicate mixed feeling about the use of liver function tests (LFTs) in this context. Some GPs found it valuable as a means of reinforcing advice to cut down and legitimising the discussion of drinking. However, when the results of the test were negative, which can sometimes be the case even if the patient is drinking heavily, this was thought to have unhelpful consequences, mainly in terms of enabling patients to be unconcerned about their alcohol consumption and discouraging them from attending follow-up consultations. Certainly, the use of LFTs alone could not be considered sufficient as an intervention against excessive drinking. Participants regarded the measurement of blood pressure as perhaps more useful as an incentive and reinforcement for cutting down drinking, especially as part of new patient or routine health checks. The examination of diet to assist brief alcohol interventions was also mentioned.

There was general agreement, among both GPs and nurses, that patients would normally find it easier to talk to a practice nurse about their drinking than to a doctor. While the greater "authority" of the GP might sometimes lead to the patient heeding advice, the more informal and friendlier nature of interactions with a nurse made it easier to discuss drinking. Indeed, nurses themselves felt they should be taking the lead role in assessing and advising patients about alcohol consumption, even though their lack of proper training might lead them to refer some cases (e.g. those at higher risk or who needed an LFT) to the doctor. CPNs were another possible point of onward referral. Unfortunately, despite the perception that practice nurses would have more time to discuss drinking with patients, it was felt that their increasing workload and other demands on their time would make it difficult for them to take on alcohol work.

GPs also saw themselves as having a role in delivering opportunistic brief interventions, especially when drinking was related to the presenting complaint. It emerged, however, that such intervention would be mainly limited to patients who were seen as likely to change their drinking habits and not to all those drinking over recommended levels. The familiar problem of lack of time in the normal consultation imposed further constraints on what it was felt GPs could reasonably offer.

The literature on brief alcohol interventions in primary care has long emphasised the need for support to health professionals care if widespread implementation is to be achieved (Shaw et al., 1978; Anderson, 1985; Kaner et al., 1999b). The present results are no exception to this, although there were different opinions as to what form this support should take – back-up for GP brief interventions from a local specialist service, or onward referral for specialist alcohol or general lifestyle intervention. A useful model for a "stepped-care" approach involving generalist and specialist services was provided by current smoking cessation strategies, although there was a minority concern that this model could lead to a de-skilling of primary care staff. Another model proposed was a specialist worker employed in the PHC setting. Again, however, there was disagreement as to what kind of person this should be, and whether they should offer alcohol-specific or general lifestyle counselling.

The paucity of training that health professionals had received has already been referred to above. Later in discussion, however, different views were evident about the need for training and what kind of training would be most beneficial. Those GPs who thought that training was unnecessary felt that the skills to carry out brief interventions had been provided by their basic training. Even here, though, it was conceded that simple information about the risks and effects of alcohol and tips on brief intervention method would be useful. The desire many participants expressed to see the evidence on the effectiveness of brief alcohol interventions once more points to a failure to communicate effectively this positive body of evidence to health professionals.

The importance of training in alcohol issues was more clearly endorsed by nurses. Here, however, the need for such training to be practice-based in situ was highlighted by participants for a number of reasons, including as a means of obtaining release for training and financial cover, and as more logistically feasible. Practice-based training

would also involve the whole practice team in the delivery of brief interventions, although it was pointed out that this form of training would have to be well "marketed" to succeed. Other suggestions were made regarding the best way of arranging training at a local level.

Finally, participants were aware that the effort to reduce alcohol-related harm was much wider that intervention at the level of primary care. Mass media campaigns were strongly supported as a way of preparing the ground for brief interventions to be effective and it was clearly recognised that alcohol issues required a higher national profile, a number of specific suggestion being made in this regard. The recent national strategy on smoking cessation was again held up as a model that the alcohol field might borrow. As perhaps might be expected, most participants were unaware of Government plans for a National Alcohol Strategy. More generally, the familiar issues of lack of resources and incentives for carrying out alcohol work in PHC and lack of government support were identified by focus groups participants as the main obstacles to progress in implementing SBI.

3. FOCUS GROUPS WITH PATIENTS

As part of the Customisation component, the aim of this part of the study was to obtain patients' perspectives on the contents and delivery of an alcohol screening and brief intervention programme. This was intended to inform the adaptation of the programme so that it is appropriate and acceptable to potential recipients. Specific objectives were:

- To provide information about the customisation of materials and services for SBI in primary health care

- To provide information about the delivery of SBI in primary health care

3.1. Pilot Study

A small pilot study was carried out in order to test and refine the semi-structured topic guide, which had been informed by the findings of focus groups held with primary health care professionals. Two focus groups (one for male and one for female participants) were conducted with volunteers from Gateshead Primary Care Group (PCG) User Forum. Several changes were made to the topic guide as a result of these groups. The overall number of questions was reduced by removing some of the more general questions on health and health promotion at the beginning of the discussion. Other questions were removed or rephrased to avoid potential repetition of issues

3.2. Methods

3.2.1. Sampling and recruitment

The focus group study was conducted with a purposive sample of patients registered with practices within Newcastle and North Tyneside Health Authority. Ethical approval for the study was obtained from Newcastle and North Tyneside Joint Local Research Ethics Committee.

All practices within the study area (n=75) were invited to participate. A letter explaining the study, a copy of the patient information sheet, a reply slip (stating that the practice was willing to participate in the project) and a freepost envelope were sent to one GP per practice and a copy sent to the practice manager. Ten practices contacted the study centre regarding participation.

Participating practices were asked to select a random sample of 60 patients from their records, stratified by age (16-18, 19-25, 26-45 and 46+) and gender (male and female), to be invited to attend a focus group. Patients with learning disabilities, severe mental health problems or under the age of 16 years were excluded from the study. Pregnant women were also excluded as the alcohol health promotion they receive is specifically tailored to their condition. Eight practices sent out invitation letters to 60 randomly sampled patients (after exclusions) giving a total sample of 480 patients.

Sampled patients were invited to participate in the study by letter, patient information sheet and consent form, which were sent via their practices. Patients interested in taking part in the study were asked to complete, sign and return the consent form in the freepost envelope provided. Patients were offered payment of travel expenses (£10 maximum) as an incentive to attend. A total of 43 patients (21 male and 22 female) returned their consent forms agreeing to take part in the study. Of these, 35 (81%) were over 40 years of age.

Due to the low response from patients aged under 40 years, a second recruitment strategy was developed and ethical approval again obtained from the Newcastle and North Tyneside Joint Local Research Ethics Committee. Market research methods were used to recruit participants aged between 18 and 30 years from the general public. Subjects were approached in Newcastle city centre, the research 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 quota criteria and were residents of Newcastle and North Tyneside. If eligible, they were asked to sign a consent form and invited to attend a focus group. Again, participants were offered payment of travel expenses (£10 maximum) as an incentive to attend.

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 placed into groups determined by their age and gender. This gave a total of six groups with the following characteristics: female 18-30; male 18-30; female 40-55; male 40-

55; female 56+ and male 56+. (No patients aged between 30 and 40 years had agreed to participate).

Potential participants in each group were sent a follow-up letter and a reply slip detailing a choice of two dates and times (afternoon or early evening) and the venue for the focus group. They were asked to mark their availability and/or preference on the reply slip and return to the study centre in the freepost envelope provided. Focus groups were arranged for the date and time suitable for the majority of participants in each age/gender stratum. Letters were sent to participants confirming the details of the focus group and enclosing a map and directions for the venue. They also received a reminder telephone call 1-2 days before the group took place.

3.2.2. Procedures

The focus groups were held in a city centre community setting, easily accessible by public transport and with full disabled access. Each group was approximately one hour in duration and light refreshments were available throughout. Participants were asked to fill in a registration form upon arrival to obtain some background information on participant characteristics and current health behaviour, including alcohol consumption. Groups were 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 for qualitative analysis.

The moderator introduced each session 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. Participants agreed to the audio-tape recording of the group on the consent form and this was re-confirmed 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 and the

'Drink-less Programme' screening and brief intervention materials. Participants were encouraged to discuss the questions with one another rather than with the moderator, whose role was to clarify and further explore any issues that arose from the discussion. During the group, participants were presented with the AUDIT screening questionnaire and the 'Drink-less Programme' booklet and 'handy card' to comment on. They were also presented with five cards on which was written the name of a different health professional (GP, practice nurse, counsellor, lifestyle worker and alcohol worker) and which they were asked to rank in order of whom they would prefer to talk to about alcohol-related issues. Reasons for their decisions were also discussed. Finally, participants were asked to summarise their thoughts on what they considered to be the most important aspect of the discussion in an attempt to clarify the main themes.

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 'Drink-less' pen to take home. The moderator and observer held a de-briefing session immediately after the group to share initial impressions.

3.2.3. Data analysis

Focus group discussions were audio-taped and transcribed verbatim. Transcripts were anonymised and imported into the NUD.IST qualitative software package for open and axial coding of data using a grounded theory approach. Initial coding of data was carried out independently by the two researchers in an attempt to reduce researcher bias.

Emergent themes were analysed by age, gender and the reported drinking status of participants (categorised into non-drinker, sensible drinker, excessive drinker and binge drinker) to explore any similarities or differences in patients' perceptions, attitudes and experiences. Matrices were generated to show how many text units were coded at each given 'node' to investigate any patterns of coding, e.g. attitudes/AUDIT/context by patient drinking status.

3.3. Results

3.3.1. Participant characteristics

The characteristics of the participants who attended each of the focus groups are shown in Table 3.1. Drinking status was determined by participants' responses to the registration form questions: 'How many days per week do you have an alcoholic drink?' and 'On a typical day when you are drinking how many units of alcohol do you have?' A 'sensible drinker' was defined as drinking less than or up to the medically recommended weekly levels of 14 units for women and 21 units for men (Faculty of Public Health Medicine/ Royal College of Physicians, 1991). An 'excessive drinker' was defined as regularly drinking above those levels. A 'binge drinker' was defined as regularly drinking 6 or more units on a single drinking occasion.

3.3.2. Experiences of lifestyle questions or advice in primary care

Half the participants stated that they had been asked or advised about their lifestyle at one time or another when visiting the GP surgery. The reasons for these visits varied from going to see the GP for specific health- or stress-related problems to attending certain clinics, patient registration and general check-ups. Participants said they had been asked either general or specific lifestyle questions depending on the reason for their visit.

Specific questions and advice were not always deemed to be appropriate or acceptable. Some non-drinkers said that they or their (non-drinking) 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) participants spoke about the negative attitude of the health professional 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 a behaviour, they instead felt that they had been 'told off' or treated 'like a child'. Some female participants also said that they had found it difficult to talk about their problems with the GP because they felt 'vulnerable' or 'intimidated'.

Table 3.1: Focus Group Participant Characteristics

Focus Group	Gender	Age	Occupation	Drinking Status
1	Female	24	administrator	Binge drinker
		26	student	Binge drinker
		24	researcher	Binge drinker
		24	community health worker	Binge drinker
2	Male	18	Student	Binge drinker
		18	student	Sensible drinker
		18	student	Binge drinker
		19	student	Binge drinker
		18	student	Binge drinker
		18	student	Binge drinker
3	Female	55	Housewife	Non-drinker
		55	unemployed	Sensible drinker
		50	housewife	Non-drinker
4	Male	51	business manager	Sensible drinker
		45	civilian supervisor (police)	Sensible drinker
		46	company director	Sensible drinker
		49	local authority worker	Excessive drinker
5	Female	63	Retired	Sensible drinker
		57	housewife	Sensible drinker
		59	care worker	Non-drinker
		62	housewife	Sensible drinker
		62	court witness service worker	Non-drinker
6	Male	75	retired	Non-drinker
		58	scaffolder	Excessive drinker
		58	retired	Sensible drinker
		61	clockmaker	Sensible drinker
		57	company director	Sensible drinker
		58	unemployed	Sensible drinker
		62	retired	Excessive drinker
		76	retired	Non-drinker
		77	retired	Sensible drinker

Participants seemed to respond more positively to general lifestyle questions and advice (on smoking, alcohol consumption, diet etc.) when this had been presented in an appropriate context - for example the well man/woman clinics 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 a good rapport with their GP and had known them for a long time generally said they did not mind being asked and advised.

Positive experiences

"And my doctor asked me about it. And he suggested that I should seek another form of relaxation. It was just getting away from all the stress, you know. And he suggested that I should do something else…It was fine, I mean I know myself that I smoke too much, I drink too much occasionally" (M 49 ED)

"I wanted to get on to it (well man clinic) because I wanted to be tested for all these things. So I was very glad to be there…because if there's a problem I'd rather know about it sooner than later. It's good yes" (M 51 SD)

"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" (F 55 SD)

"I've had a full check-up not so long ago and I was asked whether you smoke, drink all the bits and pieces" (M 46 SD)

"When you go in, depending on what's the matter with you, they nearly always say do you smoke, do you drink, and if you say yes they say how much" (M 77 SD)

"Don't mind, it's his job" (M 19 BD)

"This doctor has got a fairly slow pace, he's not going to rush you out of the surgery and he will try and 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)

Negative experiences

"We go in and he's (husband) 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 50 ND)

"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)

"Sometimes do you not find it awkward when you're in the doctor's 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)

"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 50 ND)

"In there, out the other (points to ears)…I don't take any notice" (M 58 ED)

"I feel like asking him what's your lifestyle?" (M 18 BD)

"I know when I've been to the doctor's 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 it's 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 it's for my own good" (F 24 BD)

3.3.3. Health improvement and behaviour change

Participants were also asked about their experiences of changing their behaviour and improving their own health. Most participants reported doing something to improve or maintain their health. For younger and middle age groups this tended mostly to be taking up regular exercise, whereas for older participants it often meant changing to a healthier diet. Some women also talked about trying to give up smoking. A small number of participants in the middle and older age groups reported that this change in behaviour was due to a specific health problem, such as a heart attack or diabetes. Men in the middle age group, however, talked more in terms of keeping fit and preventing future health problems. Only one participant (F 24 BD) mentioned that she had tried to reduce her alcohol consumption.

3.3.4. Perceptions of excessive drinking

Participants 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 situations or context in which drinking took place and the physical effects of alcohol. Male participants, and particularly the younger men who were also binge drinkers, talked about excessive drinking mainly in terms of the immediate and short-term physical effects of alcohol:

> *"When you feel ill the next day you've obviously had too much" (M 51 SD)*
>
> *"If my speech is getting slurred or something like that" (M 45 SD)*
>
> *"When you start to try and fight with everybody, I don't really fight people, I just start to get more aggressive and sort of rowdy and that's when you have had too much" (M 18 BD)*
>
> *"One of my mates only remembers two nights out since we've been here and we go out two or three nights a week, so I would say that was quite excessive" (M 18 SD)*

Participants 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. Non-drinkers and sensible drinkers in the middle and older age groups tended to define excessive drinking more in terms of the context of that drinking, i.e., the situations or times when drinking was deemed to be a potential problem:

> *"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" (M 51 SD)*
>
> *"I have friends ...get them into a pub, then you can't get them out. That's a big problem I think" (F 55 SD)*
>
> *"I would think that anyone who is dependent and getting out of bed and thinking they would have a drink" (F 63 SD)*

A few participants, mostly older and non-drinkers, talked about excessive drinking in terms of 'alcoholics'. Other participants mentioned that it depended on the person and how much you were used to drinking.

3.3.5. Perceptions of recommended levels and units

Most participants had a reasonably accurate idea of the recommended weekly or daily levels of alcohol consumption and that these levels differed for men and women. The men in the younger age group, however, were both uncertain and incorrect in their estimates, as this exchange illustrates:

> *"12.5 units" (M 18 BD)*
>
> *"I don't pay any attention" (M 18 BD)*
>
> *"25 units a week, isn't it?" (M 18 BD)*
>
> *"7 or something?" (M 18 SD)*

However, although they were not aware of the recommended levels of consumption, both the younger male and female groups were aware of the unit system and what the equivalent was in terms of different drinks. In general, the older men and women were not as sure how many units a drink contained:

> *"How many people know what a drink is? (Agreement). If you went into a pub, you know, like as a Chronicle reporter or Tyne Tees (TV) and said, 'excuse me, do you know how many units are in that glass?' How many people would know?" (F 57 SD)*

Participants had found out about recommended levels and units from a variety of sources, including newspapers, women's magazines, TV news programmes, drink-driving campaigns, posters in doctors' surgeries, posters in college, school, 'personal, social and religious education' lessons, weight watchers and labels on bottles.

3.3.6. Perceptions of the benefits of alcohol

All participants believed alcohol to be beneficial in one respect or another. Female participants in particular discussed the positive social aspects of drinking in terms of meeting friends, drinking at special occasions and drinking with a meal. Older participants talked more in terms of the benefits of alcohol to health.

> *"Just the social aspect of it, going out to the pub and meeting your friends" (F 24 BD)*

"I think it's just a big part of everyday life, if you're going to a wedding you drink, you know it's a common factor that everyone's drinking. If you go to a funeral then perhaps people drink afterwards, christenings" (F 24 BD)

"My wife was recommended to years ago when we were having our babies, our youngsters, milk stout and also Guinness. It was all supposed to enhance the blood, you know, it was recommended for medical purposes" (M 76 ND)

"It's good for your circulation" (F 57 SD)

All groups thought that alcohol had positive psychological and behavioural effects in that it helped them to relax, reduced stress and increased confidence in social situations:

"In some ways losing inhibition is a good thing. If you are a bit shy like I am, if you go for a drink, have a few drinks, you come out of yourself a lot more" (M 45 SD)

"I mean it relaxes you, it can help your stress" (F 55 SD)

"Confident yeah, if you're a bit nervous it relaxes you a bit, you've got guts to do stuff you would never normally do" (M 19 BD)

3.3.7. Perceptions of alcohol-related problems

When asked what problems were associated with excessive drinking, sensible drinkers and non-drinkers in the middle and older age groups talked mainly in terms of social and behavioural problems, such as crime, aggression, violence and family problems. Some had experienced these at first hand:

"It's a loss of self-control that leads to crime…when they've had a drink there could be violence, there could be domestic violence, child abuse, anything like that. Obviously you have to have to have some sort of capacity to want to do these things anyway or criminal intent but a lot of these things come out more when you've had a drink" (M 45 SD)

"The first 7 months of my marriage I was battered by him because of the drink, alcohol" (F 55 ND)

"Shortage of money, wife beating, people coming in and wrecking homes. I mean these are all related to drink and they are pushed under the counter. People don't want to see them, don't want to hear about it" (M 75 ND)

The younger male binge drinkers, however, were more inclined to discuss the short-term physical problems of drinking too much, such as feeling sick and dizzy or having accidents. Two of these participants also mentioned that they had had alcohol poisoning as a result of a binge drinking episode and one had needed emergency hospital treatment. They did not seem aware, however, of the longer-term physical problems related to excessive drinking.

> *"Cotton mouth in the morning, your mouth is totally dry and you're gasping for a drink in the middle of the night, a mouth like sandpaper, you feel dizzy, sickness, dizziness" (M 19 BD)*
>
> *"What I find as well is if I've drank way too much I find that I cannot walk, I can't function. I know what I'm doing in my head, I think to myself I know what I'm doing here but I can't do it" (M 19 BD)*
>
> *"You totally become immune to pain when you've had a drink. Wake up in the morning, bruises all over your face and cuts" (M 18 BD)*

3.3.8. Responses to the AUDIT screening questionnaire

None of the participants had seen the AUDIT questionnaire before the focus group. Some of the younger binge drinkers found it difficult to answer the questions about a 'typical' day's drinking, which to them depended on whether they were drinking socially or 'to get drunk'. There was also confusion about the use of the term 'standard drink' in the questions rather than 'unit', even though this is explained and illustrated on the questionnaire. The main criticisms of the questionnaire itself were that it was too 'cramped' or 'busy' in its present format and that it was too specific/focused on alcohol. Many participants agreed that it would be more acceptable to include questions about alcohol with other lifestyle questions, such as about smoking and diet, and that this would give the GP/nurse better overall information about the patient. One participant suggested that the questionnaire should be layered to avoid 'insulting' non- or sensible drinkers who would then only need to answer the first few questions.

Participants were also asked when it would be acceptable to be given the AUDIT questionnaire. Most agreed that it would be acceptable either at a patient registration, as part of a general health survey or when related to the presenting problem. They also

thought it could be completed in the waiting room as a way of passing the time, although there were concerns about small or busy waiting rooms and lack of privacy.

Positive responses to the AUDIT

"I think your average person would love it as just a general query about every aspect of health - portray it like that, I would think that's probably better" (M 46 SD)

"These questions make sense" (F 50 ND)

"It's quite quick to do as well…i'ts quite good that you can just tick the boxes" (F 24 BD)

"If you mixed it with dietary questions and smoking questions and then of course you would get a better opinion of somebody's whole lifestyle" (F 55 SD)

"If somebody had a problem with alcohol and they didn't have a problem with diet or a problem with cigarettes, they might feel better filling this in because they've got something positive to say" (F 55 SD)

Negative responses to the AUDIT

"It's very specific about drinking" (M 45 SD)

"It's too targeted" (F 55 SD)

"Do you not think the questionnaire is trying to cover too much? I think you're going from people and what your levels of drinking are to the guy who has to have a drink first thing in the morning. Now to have a drink first thing in the morning I would suggest that you are fairly dependent on alcohol, as opposed to the social drinkers" (M 57 SD)

"The questions aren't the best, the typical day drinking. It's not like your aiming to get drunk or just a normal…. I mean I go down to the pub most nights but odd nights I just get leathered. I mean it depends what a typical day is, whether it's a typical day getting wasted or a typical day just going down to the pub" (M 18 BD)

"I find some of these questions medically irrelevant" (M 18 BD)

"Also on question 2, it says how many drinks containing alcohol, it should go into units, 'cos it says 5 or 6, you could have 5 or 6 pints or 5 or 6 glasses of wine, it's a totally different volume" (M 18 BD)

Acceptable *"If there's an option of a separate area if you wanted to go there, I think most people would be happy to just fill it out. I'd be happy to fill it out in the waiting room" (M 45 SD)* *"I think if the problem is so very, very obvious that the doctor feels the need to ask, that's fair enough" (F 55 SD)* *"I wouldn't mind filling it in but once I found out if it was just the norm thing or was it with women over a certain age or because they have had heart trouble or a heart attack and then that would be fine" (F 63 SD)* *"I think I would expect to fill it in at a registration unless I'd been going to the doctors and having some sort of continual trouble where it might be an issue" (F 24 BD)* *"I think it depends how they put it. If they put it as we're just doing this survey of all people and every time someone's come in we've asked them to fill out the forms, that would be OK if they explained it like that" (F 26 BD)*
Not Acceptable *"But I don't think, come in Mrs so-and-so, by the way how much do you drink a week?" (F 55 SD)* *"If you'd gone in with a broken arm or something and you got handed something about alcohol, I don't think it would be relevant so I wouldn't bother filling it in" (M 18 BD)* *"If you'd just been given this, you would think that they thought that you had an alcohol problem. I think if you went somewhere and they said, just fill this in, you'd just be like, why do you want me to fill this in?" (F 26 BD)* *"I think it would be inappropriate to be bugging you when you're in a lot of pain; the last thing you want is for someone to be giving you a form to fill in " (F 26 BD)* *"I wouldn't want to be given it in the waiting room because I've been given forms to fill in in the waiting room before and I don't like that. Just because you feel that someone might see what you're putting" (F 24 BD)*

The general response to the AUDIT was that it would be acceptable to those patients drinking sensible amounts or perhaps just over those amounts. However, many thought that heavy drinkers would either not want to fill in the questionnaire at all or would not answer the questions truthfully. The only excessive (heavy) drinker who commented upon this aspect of the discussion felt that patients should fill in the AUDIT as truthfully as possible to help the doctor provide the best treatment possible, as long as it was not for insurance purposes. The younger binge drinkers also responded positively to the AUDIT and stated that they would have no problems with answering the questions.

Positive response

"A lot of people would respond to this fairly genuinely. It would give you good information I would imagine" (M 46 SD)

"I think people who drink socially and drink small amounts would be prepared to fill it in" (F 55 SD)

"I think people would answer a questionnaire like this better than they would answer someone asking the questions straight to them. If they've got a piece of paper they can tick it and go away before it's read, so they'd have a bit more confidence" (F 55 SD)

"I wouldn't have a problem filling it in I think its pretty straightforward. And you get things to fill in all the time when you go to the doctors, so I wouldn't have a problem with that myself" (F 24 BD)

"I wouldn't mind filling it in - it's quite easy. I wouldn't mind, you know, I wouldn't object because of the content or anything like that" (F 26 BD)

Negative response

"I think you'd get a mixed response to this…the difficulty I perceive is that there will be some people who think, I'm not going to put that, I'm going to put this" (M 46 SD)

"Other people who drank more than they should might have a guilt complex, so they wouldn't fill it in truthfully or say no, I don't want to fill one in" (F 55 SD)

"How many people to their GPs would actually admit that they have quite a lot, because the next time they go for an illness they will say, well it would help you maybe if you cut down on your drinking and they probably wouldn't go back" (F 57 SD)

"If I was embarrassed, if I was an alcoholic, I wouldn't want to fill it in" (M 18 BD)

3.3.9. Responses to the 'Drink-less Programme' brief intervention materials

In general, responses to the materials themselves were positive, with participants commenting upon the easy-to-read layout and useful, interesting information. There was again some confusion about the use of the terms 'standard drink' and 'unit' and it was suggested that a consistent approach be used throughout the materials. The main criticisms, however, came from the young male group who thought that the materials were not appealing to younger people and should be made more colourful and possibly more explicit, with photographs showing the negative health effects of excessive drinking. They also thought that the handy card should include both the daily and weekly recommended levels, information about drinking and driving, and

information about drinking and illicit drug use. This suggests that the materials need to be customised separately for young adults.

Positive response to the BI materials

"It's good (booklet) in the sense it's broken up with cartoons, bullet points are good, easier to read, it's handy to have" (M 51 SD)

"I think the booklet's better really, about drinking goals and drinks consumed, that's the practical self-help thing you can use over the course of the month. It's got six different stages. If anyone is serious about, if they have a problem trying to overcome it, it's an excellent book" (M 45 SD)

"Things like high blood pressure and that, I bet they don't realise that, you know. I bet they don't think about the money bit" (F 62 ND)

" I think the physical and emotional effect, I think people would perhaps look at it and go, oh, I didn't know that and that's maybe why I'm not feeling so happy. You know, it says here, depression, stress and perhaps not being able to sleep. I think it would be good for people that don't realise the effects of drinking too much" (F 24 BD)

Content: Negative response to the BI materials

"This stuff is mainly aimed at younger people than older people, so if you put something on the front it would appeal more. I think that just looks appalling" (M 19 BD)

"Students and that would just ignore it, whereas if it had some description on what it was, they might pick it up and have a little flick" (M 19 BD)

"It (card) mentions units at the top and standard drinks lower down, which is slightly confusing. Some people might not think that a drink is the same as a unit" (M 45 SD)

"I think they should probably make these weekly because most people just drink on Fridays and Saturdays, weekly rather than daily. I mean 6 pints a day?" (M 18 BD)

"Does it means drinks or units, when it says 6 drinks a day, that's only 3 pints" (M 18 SD)

"The safe amount for drinking and driving, because I think that's quite ambiguous. Some people might say, oh, a couple of pints, some might say its four pints." (F 24 BD)

Many participants thought that the small 'handy card' was appropriate for people drinking a little too much or generally to raise awareness of alcohol-related problems. The booklet was seen by some as being more appropriate for those who were experiencing problems and needed practical help.

"If you were advised that perhaps you were drinking too much, you would look at this (card), maybe recognise one or two symptoms and think, well, I have been going at it a little too heavy, and you think where do I go from here? OK, well here's some practical ways of reducing your intake. The other booklet, it's two parts of the same story…I certainly think that this (card) would be the way to make yourself aware of a problem or potentially of a problem" (M 46 SD)

However, some participants in the middle and older age-groups felt that patients might be offended if given something like this about alcohol, and that heavy drinkers would not take any notice of the advice and information given. Younger participants, however, found the materials to be of great interest, particularly the information about longer-term health effects; they would not mind being given advice and information.

Positive response

"I think it's good for the young ones because it's a little bit of information, it's there for them to look at" (F 50 ND)

"As a support mechanism, I think that's good, but I think it's got to come with something else" (F 55 SD)

"That can be given to you to go away, read in your own time and you should also be given the opportunity to go back once you've digested this" (F 55 SD)

"I'd be fine about it, perfectly fine. I'd take their information on board because obviously they know best, within reason" (M 19 BD)

"Why shouldn't it be talked about, it's just like anything else, like sex education is talked about, so why shouldn't they talk about alcoholism? It's just a general thing everybody does" (M 18 SD)

Negative response

"I would probably take it away with the good intention of reading it and forget about it" (M 49 ED)

"Some of them would think it's a bit off" (F 50 ND)

"I think it would be an age thing as well. I think older people would take it as, my mum would be disgusted if the doctor handed her something like this. She really would. She wouldn't want to go back" (F 55 SD)

"I would think, why are you giving it to me? If they handed me something like this, I would think, why are you giving it to me, do you think I've got a problem?" (F 55 SD)

"I think he would look at them and just not bother" (F 59 ND)

"A drinker too far gone would never really take any notice" (F 62 SD)

3.3.10. Attitudes to different health professionals regarding alcohol advice and information

Participants were asked to rank in order of preference five types of health professional who might be found in or attached to primary care and whom they would want to talk to about alcohol issues. Means and other statistics of these ranks are shown for all respondents in Table 4.1, by male or female gender of patient in Table 4.2, and by age group of patients in Table 4.3.

Table 3.1: Preferences regarding different health professionals: all respondents

	N	Mean Rank	SD	Median	Interquartile Range	Min	Max
GP	27	1.667	1.144	1.0	1	1	5
Practice Nurse	27	2.593	1.217	2.0	1	1	5
Counsellor	27	3.481	1.424	4.0	3	1	5
Alcohol Worker	27	3.667	1.271	4.0	2	1	5
Lifestyle Worker	27	3.741	0.944	4.0	1	2	5

Table 3.2: Preferences regarding different health professionals: by gender

l	N	Mean rank	SD	Median	Interquartile Range	Min	Max
Male:							
GP	15	1.400	1.056	1.0	0	1	5
Practice Nurse	15	2.800	1.082	3.0	2	1	5
Counsellor	15	3.733	1.387	4.0	3	1	5
Alcohol Worker	15	3.667	1.291	4.0	2	1	5
Lifestyle Worker	15	3.600	0.910	4.0	1	2	5
Female:							
GP	12	2.000	1.206	1.5	2	1	4
Practice Nurse	12	2.333	1.371	2.0	1.5	1	5
Counsellor	12	3.167	1.467	3.0	2.75	1	5
Alcohol Worker	12	3.667	1.303	4.0	2	1	5
Lifestyle Worker	12	3.917	0.996	4.0	2	2	5

Table 3.3: Preferences regarding different health professionals: by age group

	N	Mean	SD	Median	Interquartile Range	Min	Max
Younger (18-30):							
GP	10	2.200	1.398	2.0	2.25	1	5
Practice Nurse	10	2.500	1.080	2.5	1.5	1	4
Counsellor	10	3.500	1.780	4.0	4	1	5
Alcohol Worker	10	3.500	1.509	3.5	3	1	5
Lifestyle Worker	10	3.400	0.966	3.5	1.25	2	5
Middle (40-55):							
GP	7	1.714	1.254	1.0	2	1	4
Practice Nurse	7	2.714	1.380	2.0	2	1	5
Counsellor	7	3.429	1.512	3.0	3	2	5
Alcohol Worker	7	3.714	1.496	4.0	2	1	5
Lifestyle Worker	7	3.429	0.787	4.0	1	2	4
Older (56+):							
GP	10	1.100	0.316	1.0	0	1	2
Practice Nurse	10	2.600	1.350	2.0	1.5	1	5
Counsellor	10	3.500	1.080	3.5	1.5	2	5
Alcohol Worker	10	3.800	0.919	4.0	1.25	2	5
Lifestyle Worker	10	4.300	0.823	4.5	1.25	3	5

As will be seen from Table 3.1, the overall order of ranking (from first to last preference) among all respondents was GP, practice nurse, counsellor, alcohol worker and lifestyle worker. Although there were clear preferences for, first, the GP and then the practice nurse, the median ranks show that there was little difference between counsellors, alcohol workers and lifestyle workers. However, many participants stated

that they ranked the lifestyle worker last because did not know what one was or what they did.

Table 3.2 shows that there were few differences between male and female patients in their preferences and that these closely resembled the overall order of preference among all respondents. It is noticeable, however, that, compared to women, men tended to rank the GP more highly relative to the practice nurse and other health professionals. Counsellors appeared somewhat more acceptable to women than to men.

Table 3.3 suggests trends in preference related to the age of the participant. Notably, preference for seeing the GP increases as age increases. At the same time, the lifestyle worker was less popular among older than among younger participants. There were also some group differences in ranking when the interaction of gender and age was considered (not shown). Younger women overall ranked the practice nurse before either the GP or the counsellor. Younger men on the whole ranked the counsellor below the alcohol or lifestyle worker.

Some participants, including all the excessive drinkers, stated that they would not consider going to see an alcohol worker, counsellor or lifestyle worker at all:

> *(M 58 ED) acts throwing the alcohol worker, lifestyle worker and counsellor away, over his shoulder.*
>
> *"And the other three are only in there because you asked us to put them in order. I wouldn't use those at all" (M 49 ED)*

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

Most participants said they would prefer to go straight to their GP 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 whom they would go to. They also thought that the GP would have the training and experience to deal with the problem or would be able to refer them on to somebody else if necessary. Concerns about going to the GP arose from those who did not have a good relationship with their doctor or who did not want to 'waste' the doctor's limited time. Two of the excessive drinkers thought that doctors themselves have "the worst record…for drink problems" but preferred the GP to any other health professional*: "I mean, give him his due, he never condemned me for having a good drink" (M 62 ED).*

GP: Positive response

"I think that's tradition. Just from going to the doctors, 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" (M 45 SD)

"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" (M 51 SD)

"Because I know him and I feel comfortable with him" (F 62 SD)

"Got no problems talking to the GP, he's straightforward, gives you the facts and then lets you make up your mind" (M 18 BD)

"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 BD)

GP: Negative response

"It sounds horrible doesn't it? 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" (F 50 ND)

"If you believe everything the doctors tell us, two-thirds of us wouldn't be bloody breathing, 'cos the biggest alcohol problems are in the medical profession" (M 62 ED)

"The GP would just tell you how much of a nasty person you'd been" (M 18 BD)

"They're too rushed and you're just in and out as quickly as possible" (F 26 BD)

"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 BD)

"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 if I had a GP like that I would talk to them" (F 24 BD)

It was felt by some participants that practice nurses would have more time to discuss alcohol issues than a GP, and that they were easy to talk to, approachable and understanding. 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 as 'serious'. Some (older) participants felt that the role of the nurse had 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.

Some participants felt that they would prefer to talk to a counsellor after the GP and practice nurse because they dealt with a wide range of general 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, other participants, in particular younger men, talked about the stigma attached to going to see a counsellor, whom they associated with patients who must be really 'messed up'.

Practice nurse: Positive response

"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 BD)

"Normally they seem a bit more approachable than GPs" (F 26 BD)

"I feel that you can talk more openly to a nurse, I don't know, maybe it's 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 BD)

Practice nurse: Negative response

"I would only see the nurse if I needed 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 BD)

Counsellor: Positive response

"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 it's less specific and you could perhaps talk to them about other types of things as well as drinking" (F 24 BD)

Counsellor: Negative response

"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. It's 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 BD)

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 the experts in dealing with them. 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 doctor's practice, as they were afraid that other patients would know whom they were going to see.

Alcohol worker: Positive response

"If the doctor's 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 doctor's 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)

Alcohol worker: Negative response

"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 BD)

A lifestyle worker (someone who would deal with a range of lifestyle factors, such as drinking, smoking 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 not be alcohol specific.

Lifestyle worker: Positive response

"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 affects 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 BD)

Lifestyle worker: Negative response

"I've never heard of a lifestyle worker" (F 50 ND)

"If it's lifestyle, then it means it's probably going into your family and it's affecting them and stuff, not just the fact that you're drinking too much, it's obviously affecting something else with your lifestyle" (M 18 SD)

3.3.11. Attitudes to general alcohol information

Participants 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 illicit drugs would be useful for their age group, and both younger men and women called for greater 'shock' tactics:

> *"Facts about people's deaths, the death tally of mixing drink and drugs" (M 18 BD)*
>
> *"I think the more gruesome the better" (M 18 BD)*
>
> *"It's a totally lethal drug, it's a fact, more people die of alcohol than any other drug in the world, that's a fact, so there should be warnings on it" (M 18 BD)*
>
> *"They're not the shock tactics like on the telly, the lung cancer ones…the ones on the radio are just…if you drink, don't get drunk. I don't think they're that shocking if you don't know what it can do, what drinking too much can do to you" (F 26 BD)*
>
> *"I just don't think people are aware of the effects it has on the body. I think people could be made more aware of that. They do the adverts for drink driving and stuff like that but they don't actually do adverts about the physical effects. They've got adverts for smoking and it's going to lead to cancer, but if you're a heavy drinker I suppose it's just as important that you're aware of the effects it's going to have in later life. And then people can start making the decision" (F 24 BD)*

Other suggestions were that the labelling of alcohol content on cans and bottles should be made bigger and more visible, and to have health warnings on labels and also on the shelving in supermarkets or shops where alcohol is sold. 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 doctor's surgery. You look at a sign in the doctor's surgery and immediately forget it when you walk away" (M 46 SD)*

It was also suggested that alcohol information should be made specifically available in schools and universities as well as GP surgeries.

3.4. Summary and comment: focus groups with patients

In general, participants did not resent being asked or advised about lifestyle issues, particularly if these issues were raised at certain clinics (e.g., patient registration, general check-ups, well-man/-woman clinics) where they expected them to be raised. It seems, however, a positive response would be more likely if discussions of alcohol consumption were incorporated in advice about general lifestyle concerns, including smoking, diet and exercise. The quality of the patient's relationship with the health professional was also important in determining the acceptability or otherwise of lifestyle advice. It seemed, too, that most participants had already attempted to change health-related behaviours, although only one specifically mentioned drinking in this connection.

When asked what "excessive drinking" meant to them, participants gave a variety of replies but none appeared to use the concept of alcohol units to measure drinking level and define what was excessive. As with health professionals, it is clear that the attempt to persuade the general public to think about drinking in these terms has mainly been unsuccessful; people may be aware of the idea of a unit of alcohol, particularly since units began to appear on the labels of beverage alcohol containers, but this does not seem to have encouraged the monitoring of consumption in these terms, as was intended. Nevertheless, with the main exception of young men, most participants were able to estimate recommended levels of alcohol consumption with reasonable accuracy. This suggests that further attempts at educating the public should focus on the meaning of a standard unit of alcohol, rather than how many of these units were seen as acceptable.

As might perhaps be expected, all participants subscribed to the benefits of drinking alcohol, including health, psychological and social benefits. It is interesting, however, that the main problems associated with excessive drinking, however defined, were seen as behavioural in nature, i.e., crime, violence, damage to family relationships etc.; longer-term health problems were virtually ignored. Younger male participants focussed almost exclusively on the short-term consequences of drunkenness.

It is perhaps surprising, given the popularity of the instrument, that participants reported they would have difficulties in completing the AUDIT questionnaire. The problems in thinking about "typical" or "average" drinking are well known (e.g., Gregson & Stacey, 1982) but other difficulties identified concerned the concept of the "standard drink", the too cramped layout and the over-emphasis on alcohol. In relation to the last point, participants again preferred widening the focus of question to cover general lifestyle issues. Most participants agreed that being asked to complete the AUDIT would be acceptable as part of general health screening, new patients registrations or while waiting to see a health professional, provided in the lat instance that privacy could be ensured.

The suggestion that screening alcohol consumption should be "layered" to avoid giving offence to patients could be met by the use of the FAST version of the AUDIT questions (Hodgson *et al.*, 2002). This procedure involves initially asking one question relating to how often the respondent drinks above a certain level. If the response to this question is low, this is regarded as a negative case and if it is high, this is taken as a positive identification of excessive drinking; only in a middle range of responses to the initial question are a further three questions put. Research has shown that this procedure works nearly as efficiently as the full AUDIT in busy practice setting (Hodgson *et al.*, 2002). It is obviously for more economical of time and less likely to give offence to both light and heavy drinkers.

Apart from some small degree of confusion over the contents, the Drink-less intervention package was regarded positively be participants. It did emerge, however, that the materials should probably be specially adapted to suit the needs and concerns of younger drinkers.

When participants were asked to rank-order five types of health professional in terms of their preference for discussion alcohol issues with, the resulting order was: GP, practice nurse, counsellor, alcohol worker and lifestyle worker. However, there is a range of factors that affect the interpretation of this order and these will be commented on by taking each professional role separately.

General practitioner: The overall preference for the GP seemed to be based on a perception of their "traditional" role in primary health care and their greater degree of training and expertise than other professions. The main exception to this general rule concerned those participants who felt they had a poor relationship with the GP or who feared wasting the doctor's time. Older participants and men had a somewhat more positive view of alcohol discussions with the GP than younger or female participants.

Practice nurse: The same perception of the relative roles of GP and practice nurse as emerged from the focus groups with health professional was also apparent here: nurses were seen as having more time and being more approachable, understanding and easy to talk to. These perceptions applied more particularly to younger participants; some of the older members of the groups had a more limited and conservative view of the nurse's role in lifestyle matters. Young women tended to say that they would prefer to talk to a nurse than to a GP about drinking, although this probably arose from the assumption that the nurse would be female and the doctor male.

Counsellor: On the whole, intervention by a counsellor was favourably regarded by participants because they could take a broader, more holistic view of the patient's problems. A special role for the counsellor that was described was as someone to see after the problem had first been identified by a doctor or nurse. Against this, the image of the counsellor among younger male participants was poor, apparently because of possible associations with treating mental illness. It is noteworthy that none of excessive drinkers taking part in the focus groups said they would be willing to see a counsellor.

Alcohol worker: As might be expected, participants' main objections to being seen by an alcohol worker concerned the possibility of stigma. For most, this type of worker was associated with more severe alcohol problems, probably what they perceived to be "alcoholism". None of the excessive drinkers said they would be prepared to see a specialist alcohol worker.

Lifestyle worker: The last place in the rank order for the lifestyle worker may well be misleading because few participants thought they knew what such a person would do. It is true that, once more, all the excessive drinkers were averse to seeing a lifestyle worker but among other participants the wider remit of this person was seen in positive terms.

Finally, there was general agreement among participants about the need for more information to the general public on alcohol and its associated problems. A number of suggestions were made as to how this information could best be conveyed.

3.5. Combined findings from health professionals' and patients' focus groups

There will now be an attempt to integrate the two sets of findings from focus groups with PHC professionals, described in Chapter 2, and with patients or members of the general public, described in the current chapter.

The most obvious conclusion is that there was widespread agreement among both patients and PHC professionals alike that screening for hazardous or harmful drinking and brief intervention to reduce alcohol-related harm were acceptable in contexts where patients expected such lifestyle-focused activity - for example, in new patient registration or chronic disease management) or where it was linked to presenting health problems. Integrating questions about alcohol with other lifestyle behaviour was also seen as a useful way of avoiding the potential sensitivity of asking questions about alcohol consumption. Thus *targeted* approaches to the detection of alcohol-related risk (i.e., neither universal screening of all patients nor restriction to those seeking treatment for alcohol problems) appears to be feasible and acceptable to both patients and health professionals.

This conclusion may also help to resolve a debate in the research community (Rollnick *et al., 1997;* Beich *et al.*, 2002, 2003; Kelly, 2002) about the value of screening in PHC, since most of the criticisms of screening have assumed that it is universal screening that it is intended to implement. Targeted screening avoids the most prominent of these criticisms. The targeted approach has also been recommended in the Alcohol Harm Reduction Strategy (Prime Minister's Strategy Unit, 2004). However, since most brief intervention trials have been efficacy studies

utilising universal screening, pragmatic trials are needed to provide evidence for the effectiveness of such an approach in routine primary care.

PHC professionals' uncertainty about the evidence relating to brief interventions clearly shows the need for more active dissemination of the massively positive body of research evidence relating to SBI. Despite this, however, both health professionals and patients felt brief interventions would be useful for patients drinking slightly over recommended levels, for whom only simple information about risk-reduction was needed, and also for those who were already thinking and perhaps worrying about their drinking.

In common with previous findings (Anderson, 1985; Kaner *et al.*, 1999a), the present focus groups showed that professionals highlighted the need for additional support to carry out brief interventions if widespread implementation were to be achieved. It is important to note that most patients felt that there would be a stigma associated with seeing an alcohol-specific worker in general practice. Patients also felt that the quality of their ongoing relationship with PHC professionals was fundamental to the acceptability of advice about alcohol. Nevertheless, the concept of a generic 'lifestyle worker' in practices was positively received by many participants. This approach would be in line with recommendations in the recent White Paper 'Choosing Health' to provide NHS health trainers to advise and support lifestyle change (Department of Health, 2004). The introduction of such trainers could provide an opportunity for more widespread delivery of brief alcohol interventions in primary care in the future.

In summary, the combined findings from the two sets of focus groups suggest the following:

a) a targeted approach to alcohol screening and intervention is more acceptable to patients and professionals in primary care than universal screening and would fit naturally with existing practice.

b) uncertainty about the evidence of effectiveness and a lack of resources for brief alcohol intervention remain key barriers to its implementation.

c) Both health professionals and patients believe that raising and discussing alcohol-related risk is acceptable in primary care when combined with other lifestyle issues or linked to relevant health conditions.

d) There was uncertainty among health professionals about the effectiveness of brief alcohol interventions and some disagreement with patients concerning who was best placed to deliver them. Health professionals felt that nurses were best placed for such work whilst patients reported that they would initially raise the subject with GPs.

e) There was broad acceptance of brief intervention approaches but a lack of support and specific incentives for this work may impede their delivery in routine practice.

4. DELPHI SURVEY

4.1. The Delphi technique

The Delphi technique takes its name from the Greek god Apollo who, as master of Delphi, was renowned for his ability to predict the future. The technique was developed in the early 1950s by the RAND Co-operation as a forecasting tool to predict the effects of atomic warfare in the USA. Although relatively new to health services research, there has been a significant increase in the technique's popularity in this field in recent years. Studies have now been conducted addressing issues such as training and education (Crotty, 1993; Stewart *et al.*, 1999), information and priorities in health care (Oranga & Nordberg, 1993) and nursing and clinical practice (Duffield, 1998; Moscovince *et al.*, 1988) and several others.

4.1.1. The Delphi method

The Delphi "is a method for the systematic collection and aggregation of informed judgements from a group of experts on specific questions or issues" (Reid, 1998, p.231). Several types of Delphi have been developed over the years and the technique has been characterised in different ways by different researchers. However, it is generally recognised that there are three main types of Delphi: the classical, policy and decision Delphis (Woudenberg, 1991). The type used in the present study is the classical Delphi. This involves a large panel of experts who use facts to come to a consensus regarding a specific set of related issues (Crisp *et al.*, 1999). Features of this method include anonymity for the respondents and iteration with controlled feedback (Duffield, 1998). Feedback often takes the form of a statistical group response, usually a measure of central tendency. This method can also include comments provided by individual panel members. The normal practise is to feed back the full range of opinions or statements produced, with some indication of the strength of support for each, and to invite the panel to reconsider their responses on the basis of this information (Reid, 1998).

Thus, in a typical Delphi study, questionnaires are sent to the "expert panel" in a series of rounds. The first questionnaire gathers qualitative data and enables panel members freely to express their opinions on the topic. The responses to the first questionnaire are then gathered into statements and grouped under headings, and this forms the basis of the second questionnaire. This second questionnaire asks respondents to use a Likert scale

to indicate how much they agree or disagree with the items generated by the panel as a whole. The third questionnaire contains the same statements as the second but also includes descriptive statistics showing the individual respondent's initial response and the average group rating. Respondents then have the opportunity to re-rank their agreement with each statement in the light of the group response. This process is repeated until consensus is achieved. Usually no more than three rounds are required since additional rounds tend to show little further change in opinion (Duffield, 1998). Useful descriptions and discussions of the method will be found in Jones and Hunter (1995) and Campbell *et al.* (2000).

There are several advantages to the Delphi technique. One is that it allows respondents to remain anonymous and enables them to respond without any form of coercion or influence from other participants. This anonymity diminishes the likelihood of socially desirable response sets and encourages refinement of opinion on critical topics. It thus provides a consensus of expert opinion without the bias that can occur in other techniques, such as group discussions (Williams & Webb, 1994). Each panel member has equal status within the group and strong personalities cannot dominate. Moreover, discourse that might otherwise be logistically impossible due to the large geographical distances between respondents can occur in this method of study (Jenkins & Smith, 1994). It is therefore a relatively cost-effective way of collecting data from a group without the difficulties of organising acceptable times and venues.

The Delphi technique is also a powerful educational tool since panel members are presented with information they may not have considered previously (Duffield, 1998). Due to its iterative nature, the technique allows the panel members to alter or add to their views with the benefit of considered thought. Each participant is given time to consider his or her responses in ways that might not have been possible in other research methodologies (Jenkins & Smith, 1994). The technique also provides the panel members with motivational feedback, thus enabling the panel to feel fully involved in the study.

Although it clearly has many advantages, the Delphi technique has been criticised on methodological grounds and it has been argued that technique fails to meet standards that are normally set for scientific research. The most frequently cited criticism concerns the researcher's role in the decision process, as there is considerable potential for the results

to be influenced by the researcher. For example, poor sampling and particular interpretations of the findings may introduce bias into the results. It is therefore believed that every attempt should be made to elicit a representative sample and for researchers to be rigorous in declaring how decisions were made (Scott & Balck, 1991; McKee *et al.*, 1991).

The Delphi is also open to the same criticisms as the postal questionnaire, in that the researcher cannot be assured that it is the nominated expert who completes the questionnaire (Beretta, 1996). The method can also be an extremely time-consuming exercise and there is a risk that panel members may lose motivation (Duffield, 1988). However, it is possible that many criticisms apply only to poor quality studies rather than the method itself (Jones & Hunter, 1995; Reid, 1998; McKenna, 1994). Jenkins and Smith (1994) argue that "Delphi results are only as good as their methodology" (p. x). All these considerations were borne in mind when designing the present study.

4.2. Aim of the study

The aim was to obtain a consensus of views on how best to implement screening and brief intervention (SBI) for excessive drinkers in a routine and enduring fashion in primary health care throughout England.

4.3. Method

4.3.1. Sampling and recruitment

In the absence of databases containing lists of "experts" in the field of SBI in primary health care (PHC), extensive searches were made during April/May 2000. Searches of internet sites such as the National Research Register, Alcohol Concern, Medline etc. were carried out. Names were also taken from relevant research papers and project lists. At the beginning of June a letter was sent to all individuals (n=59) who were identified in this way. The letter explained the process of the Delphi study and issued an invitation to participate in it. As participants' motivation is vital for success, all letters were personalised and clear explanations were given in an attempt to increase motivation (Duffield, 1988). As the intention was to gather a larger sample than first obtained, it was decided to use a "snowball" sampling technique (Babbie, 1998), i.e., a section was included in the letter asking people to suggest others who might be interested in SBI in PHC. A two-week deadline was given. Various names were suggested and letters were

sent to the new contacts, and so on. Overall, invitation letters were sent to a total of 113 individuals. Of those 113, 79 (70%) agreed to participate in the study, 13 (12%) declined the invitation and there were 21 (19%) who did not reply. Refusals and non-responders were followed up with telephone calls. However, many of the non-responders were on annual leave at the time and contact could not be made. Those who refused tended to stress lack of time (n=15), no incentives (n=4) and leave (n=3) as reasons for not wanting to participate. Of those who agreed to take part, 45 (57%) were male and 34 (43%) female, and the sample was broadly geographically representative of the UK. The composition of the sample and response rates for each round of the study can be inspected in Table 4.1.

Table 5.1: Composition of sample for Delphi study

Subgroup	Recruitment	Round One	Round Two	Round Three
Academic	26	20	18	11
Researcher	28	21	24	12
G.P.	14	11	9	7
Nurse	15	7	7	6
Alcohol Service Worker	39	28	25	17
Director/Chief Exec. of Alcohol Service	5	5	5	5
Other	7	7	7	6

* Numbers do not sum to totals in text as some individuals fall into more than one category.

4.3.2. Prior to Round One

After several meetings of the Project Management Team, it was decided that the first questionnaire would consist of the following seven open-ended questions:

1. What is the best way to identify risky drinkers in primary health care?
2. How could screening for 'risky drinking' be carried out without offending patients and how can patients best be encouraged to talk about their drinking?
3. What are the most effective and cost-effective types of brief intervention for risky drinkers in primary health-care?

4. Which primary health care professionals should be involved in screening and brief interventions for risky drinking and what should their respective roles be?
5. How can primary health care professionals be encouraged to routinely deliver screening and brief interventions?
6. How can the concept of 'risky drinking' best be communicated to primary health care professionals and to the general public?
7. What do you consider to be the most important issues concerning screening and brief intervention in primary health-care?

The first six questions ask for respondents' views on general issues surrounding SBI in PHC. The last question was included to provide respondents with the opportunity to raise any additional issues that may not have been covered in the first six questions. A section was also included at the back of the questionnaire to allow respondents to provide additional comments or raise further issues if they so wished. Contact details of the main researcher (ED) were given for further information. The length of the questionnaire was limited to fit one side of A4 paper in the attempt to optimise response rates.

4.3.3. Pilot study

The questionnaire was piloted with a small number of health professionals working within the field of alcohol problems treatment at the Newcastle and North Tyneside Drug and Alcohol Service in Newcastle upon Tyne. There were no major concerns with the questions and it was felt that the questionnaire would pose no problems.

4.3.4. Round One

During August 2000, a questionnaire was sent with an accompanying letter and guidelines for completing the Delphi study to all individuals (n=79) who had agreed to take part. A floppy disk with copies of the questionnaire saved in two different formats was also included for convenience. All respondents were allocated a reference number, thus allowing the tracking of responses. Respondents were given the options of returning the questionnaire via post, fax or e-mail and were reminded to include their reference number when replying. It was felt that if the respondents were able to use a variety of means to return the questionnaire, there might be an increase in the number of responses. Once again, a coded SAE was included to aid responses. The respondents were given a two-week deadline in which to comply.

4.3.5. Round Two

Preparation of the second questionnaire began shortly after Round One questionnaires had been received. The majority of participants had provided carefully thought-out detail in their responses and several meetings of the Project Management Team took place to decide items for inclusion in the second questionnaire. A total of 264 items were listed by respondents and a content analysis was conducted to establish the main themes and corresponding items. As a result of the content analysis the number of items was reduced to 242 items. This number was culled further to 157 after removing similar and redundant answers. In addition, there was considerable overlap in the responses given to the first two questions and these were therefore merged. There were still some similarities between items but it was decided not to distil them further. To give the questionnaire more structure, question 6 above was divided into two separate sections, one addressing the general public and the other health care professionals. Therefore, the second questionnaire consisted of eight sections:

- The best way to identify risky drinkers in primary health care without offending patients is by … (17 items)
- Patients can be encouraged to talk about their drinking by … (20 items).
- The most effective types of brief intervention for risky drinkers in primary health are … (18 items)
- Which PHC professionals should be involved in screening and brief interventions for excessive drinking and what should their respective roles be? (13 items)
- Primary health care professionals can be encouraged to routinely deliver screening and brief intervention by … (26 items)
- The concept of risky drinking can best be communicated to the general public via … (23 items)
- The concept of risky drinking can best be communicated to PHC professionals via … (13 items)
- The most important issues concerning screening and brief intervention in PHC are … (27 items)

Respondents were asked to agree or disagree with each item using a five-point Likert scale (cf. Fiander & Burns, 1998). The response categories ranged from '1' (Strongly Disagree)

to ‘5’ (Strongly Agree). After piloting, at the beginning of February the second questionnaire was again sent to all individuals (n=79) who had initially agreed to participate.

4.3.6. Round Three

The responses to the second questionnaire were then entered into SPSS. It was evident from the additional comments that some of items needed to be clarified. Amendments were made to the third and final questionnaire which consisted of the same overall set of items as the second. During May 2001 this was sent to all individuals (n=68) who had completed the second round of the study. Using a mail merge facility, the median response and the individual’s responses to each item were included on each questionnaire and the panel was asked to re-rate each item in light of the group’s response. If new ratings differed by more than one point from the median, respondents were encouraged to comment on their reasons for this at the end of the questionnaire.

4.3.7. Analysis of Round Three

Using SPSS, the median and the inter-quartile range were calculated for the panel as a whole. The same statistics were also calculated separately for three sub-groups of the panel (see below).

In analysing findings from Round Three, consensus was defined in terms of the inter-quartile range. Items with an inter-quartile range of =<1 were defined as having achieved group *consensus*; an inter-quartile range of 0 was taken to indicate *high consensus* (Jenkins & Smith, 1994; Fiander & Burns, 1998; Jeffrey *et al.*, 2000).

4.4. Results

4.4.1. Response rates - Round One

Sixty-two out of 79 (78%) respondents replied to the first questionnaire. Half completed the questionnaire using the disk provided and returned the questionnaire via fax or e-mail. The remaining questionnaires were returned by post in the SAE’s provided. Non-responders (n=17) were followed up by telephone calls and e-mails. Contact could not be made with small number (n=4) who did not return their questionnaires. Others stressed

annual leave (n=3) and lack of time (n=8) as reasons for not returning the questionnaire. The remaining non-responders (n=2) felt that they did not have the relevant knowledge to complete the questionnaire.

4.4.2. Response rates - Round Two

In Round Two, 68 out of 79 (86%) questionnaires were returned but only seven by e-mail. Once again, non-responders (n=11) were followed up. Contact could be made with only a small number of non-responders (n=5), all of whom stressed lack of time as a reason for not replying.

4.4.3. Response rates - Round Three

A total of 53 out of 68 (78%) respondents returned questionnaires in Round Three, representing 67% of the eligible sample of 79. Of these 32 (60%) were male and 21 (40%) female. During this round only 9% (n=5) returned their questionnaire via e-mail or fax. Once again, lack of time (n=11) and annual leave (n=4) were given as reasons for not completing and returning the questionnaire.

4.4.4. Characteristics of final sample

The final sample of 53 respondents to Round 3 were classified in the following occupations: Academic = 5; Researcher = 8; GP = 2; Nurse = 5; Alcohol Service Worker = 15; Director/ Chief Executive, Alcohol Service = 4; Academic & GP = 3; Nurse & Researcher = 1; Academic, Researcher & Alcohol Service Worker = 2; Academic, Researcher & GP = 1; Chief Executive of Alcohol Service & GP = 1; Other (Primary Care Trainer, Consultant in Public Health, 2 Trust Board Directors) = 4; Alcohol Specialist = 2.

4.4.5. Ratings for Round Three (whole panel)

Inter-quartile ranges, medians, standard deviations, and minimum and maximum ratings of the whole panel for 157 items are shown in Table 5.2. For all sections of the Table except Section D, the shaded area shows those items that achieved a consensus as defined above, with those showing a high consensus listed first. Given the same inter-quartile range, items are listed in order of their median values. For Section D on the roles of different healthcare professions, items are listed in the order in which they appeared on the Delphi questionnaire for ease of comprehension.

4.4.6. Interpretation

In view of the large number of items reaching consensus as defined, in interpreting the ratings attention is mainly directed to those with a consensus around "Strong Agreement" or "Strong Disagreement". More specifically, where an item obtained *high consensus* (inter-quartile range = 0), this item is included in the interpretation irrespective of the amount of agreement-disagreement; however, for those items obtaining only *consensus* (inter-quartile range > 0, <= 1), those items with consensus around "Strong Agreement" (i.e., median = 5) or "Strong Disagreement" (i.e., median = 1) are mainly considered. Items with less than strong disagreement are sometimes included for illustrative purposes, as are some items that failed to reach consensus.

In the text to follow, when an item is mentioned in the discussion it will be followed by parentheses containing two numbers (e.g. 1/5). The first of these numbers is the inter-quartile range obtained by the item and the second is the median value. In this way the degree of consensus and the degree of agreement-disagreement with the item can be discerned.

SECTION A: The best way to identify risky drinkers in PHC without offending patients

There was a high consensus about providing a computer-based assessment for patients in the waiting area (0/3). However, this strong consensus was around the median value of 3, which is best characterised as "Neither Agree Nor Disagree" and it would therefore seems that this suggestion was neither supported nor rejected by the panel.

Table 4.2: INTER-QUARTILE RANGES, MEDIAN VALUES ETC. FOR THE WHOLE PANEL ON ALL ITEMS

A. The best way to identify risky drinkers in primary health care without offending patients is by	**Interquartile range**	**Median**	**SD**	**Min**	**Max**
1. Providing a computer-based questionnaire for patients in the waiting area.	**0**	**3**	**.74**	**2**	**5**
2. Screening during New Patient registrations and general health and lifestyle reviews	**1**	**5**	**.54**	3	5
3. Being generally aware of underlying alcohol-related issues in physical/ psychological presentations, e.g., depression, anxiety, insomnia	**1**	**5**	**.60**	3	5
4. Screening during special clinics or medical check-ups, e.g., well-man, well-woman, diabetes, antenatal, insurance medical examinations, etc.	**1**	**5**	**.71**	1	5
5. Training PHC professionals to recognise risk factors or signs of excessive drinking	**1**	**5**	**.75**	2	5
6. Health promotion drives similar to Smoking Awareness campaigns	**1**	**3**	**1.11**	1	5
7. Gathering information from partners and other family members	**1**	**2**	**.91**	1	5
8. Liver function tests via blood samples	**1**	**2**	**1.00**	1	5
9. Detecting alcohol on patients' breath	**1**	**2**	**1.02**	1	5
10. Conducting screening within an established relationship between patient and health professional	**1.5**	**4**	**1.19**	1	5
11. Routinely using an appropriate screening tool/questionnaire (e.g. AUDIT,FAST,CAGE,PAT etc.)	**1.5**	**4**	**.88**	1	5
12. Making self-assessment materials available	**2**	**4**	**1.12**	1	5
13. Taking and maintaining a history of alcohol intake for all patients	**2**	**4**	**.85**	1	5
14. Opportunistically screening all patients attending the surgery	**2**	**4**	**1.06**	1	5
15. Asking patients to keep a drinking diary	**2**	**3**	**1.21**	1	5
16. Using health promotion evenings	**2**	**3**	**1.08**	1	5
17. Assigning specialist alcohol workers	**2**	**3**	**1.18**	1	5
18. Using an established referral process	**2**	**3**	**1.21**	1	5
19. Paying GPs on the percentage of cases identified	**2**	**2**	**1.21**	1	5
20. Screening at specific primary care alcohol and drug clinics	**2**	**2**	**1.21**	1	5
B. Patients can be encouraged to talk about their drinking by	**Interquartile range**	**Median**	**SD**	**Min**	**Max**
21. Avoiding labelling drinking as "bad", i.e., adopting non-judgemental language and attitudes at all times	**0.5**	**5**	**.49**	3	5
22. Providing training to all PHC staff to enable them to be more confident about raising alcohol issues	**1**	**5**	**.58**	**3**	**5**
23. Discussing the positive and negative aspects of drinking	**1**	**5**	**.64**	3	5
24. Giving patients enough time to discuss their problems	**1**	**5**	**.64**	3	5
25. Ensuring clear and concise factual information on alcohol is available at surgeries	**1**	**5**	**.64**	3	5

26. Starting with the patient's own concerns	**1**	**5**	**.67**	2	5
27. Keeping alcohol on the GP's agenda	**1**	**4**	**.60**	3	5
28. Explaining the relationship between alcohol and the patient's health problems	**1**	**4**	**.70**	2	5
29. Using motivational interviewing techniques	**1**	**4**	**.74**	2	5
30. Talking about the part alcohol plays in the patient's life rather than concentrating on quantity consumed	**1**	**4**	**.76**	2	5
31. Stressing confidentiality	**1**	**4**	**.77**	2	5
32. Asking open questions	**1**	**4**	**.82**	2	5
33. Finding questions that patients would be willing to answer	**1**	**4**	**.84**	2	5
34. Stressing that many people in the UK are risky drinkers	**1**	**3**	**.96**	1	5
35. Using prominent publicity stating that health checks will include questions on alcohol	**1**	**3**	**.97**	1	5
36. Asking patients' views on drinking and exploring using a joking style	**1**	**2**	**1.01**	1	5
37. Stressing that the aim is preventative and that the focus is on health and fitness	**1.5**	**4**	**.88**	1	5
38. Starting conversations with non-sensitive topics until patients are at ease	**2**	**4**	**1.04**	1	5
C. The most effective types of brief intervention for risky drinkers in primary health care are	**Interquartile range**	**Median**	**SD**	**Min**	**Max**
39. Intervention during special clinics or medical check-ups, e.g., well-man, well-woman, diabetes, antenatal, insurance medical examinations, etc.	**0**	**4**	**.82**	**1**	**5**
40. A long-term package based on community care by primary health care teams	**0.5**	**3**	**1.00**	1	5
41. Interventions tailored to individual patients	**1**	**5**	**.84**	2	5
42. Drinking guidelines and use of drinking diaries (enough to enable informed choices to be made)	**1**	**4**	**.71**	1	5
43. Provision of a self-help booklet/ manual with information both factual and related to methods that can be adopted to assist behaviour change	**1**	**4**	**.73**	2	5
44. Opportunity for "checking in" at intervals to monitor success	**1**	**4**	**.78**	1	5
45. Motivational interviewing techniques	**1**	**4**	**.80**	2	5
46. Brief advice (between 5-30 minutes) aided by provision of a self-help book with useful tips and ideas, then follow-up to see if suggested action has been taken	**1**	**4**	**.93**	1	5
47. Brief simple advice following routine use of an appropriate screening tool/ questionnaire (e.g. AUDIT, FAST, CAGE, PAT, etc.)	**1**	**4**	**1.02**	1	5
48. Providing a summary of evidence showing negative outcomes at levels patients are drinking at, with time for patient to reflect on the information and discuss thoughts about change	**1**	**3**	**.82**	1	5
49. Cognitive-behavioural therapy	**1**	**3**	**.82**	2	5
50. Goal negotiation consisting of three 10-minute sessions	**1**	**3**	**.84**	1	5
51. Feedback of liver function tests via blood samples	**1**	**3**	**.98**	1	5
52. Variations on Motivational Enhancement Therapy	**1.5**	**4**	**.85**	2	5
53. A referral to a specialist alcohol worker based in the surgery	**1.5**	**4**	**.98**	2	5
54. The provision of factual information	**2**	**4**	**.78**	2	5
55. Opportunistic intervention during routine consultations	**2**	**4**	**.83**	2	5

D. Which PHC professionals should be involved in screening and brief interventions for excessive drinking and what should their respective roles be?	**Interquartile range**	**Median**	**SD**	**Min**	**Max**
56. **GP**:	**0.25**	**5**	**.86**	**1**	**5**
Screening	**1**	**5**	**.86**	1	5
Brief intervention	**1**	**4**	**1.00**	1	5
Support and monitoring	**2**	**4**	**1.01**	1	5
Referrals	**1**	**5**	**.59**	2	3
57. **Practice Nurse**:	**1**	**5**	**.72**	1	5
Screening	**1**	**5**	**.77**	1	5
Brief intervention	**1**	**5**	**.81**	1	5
Support and monitoring	**1**	**5**	**1.03**	1	5
Referrals	**1**	**5**	**1.23**	1	5
58. **District Nurse**	**1**	**4**	**.98**	1	5
Screening	**1**	**5**	**1.05**	1	5
Brief intervention	**2**	**4**	**1.22**	1	5
Support and monitoring	**2**	**4**	**1.16**	1	5
Referrals	**2**	**4**	**1.29**	1	5
59. **Health Visitor**:	**2**	**4**	**1.09**	1	5
Screening	**2**	**4**	**1.07**	1	5
Brief intervention	**1**	**4**	**1.16**	1	5
Support and monitoring	**1**	**4**	**1.14**	1	5
Referrals	**2**	**4**	**1.29**	1	5
60. **Midwife**	**2**	**4**	**1.09**	1	5
Screening	**2**	**4**	**1.05**	1	5
Brief intervention	**1**	**3**	**1.11**	1	5
Support and monitoring	**1**	**3**	**1.05**	1	5
Referrals	**1**	**3**	**1.25**	1	5
61. **Dietician**	**1**	**5**	**1.08**	1	5
Screening	**2**	**4**	**1.13**	1	5
Brief intervention	**1**	**5**	**1.16**	1	5
Support and monitoring	**1**	**5**	**1.06**	1	5
Referrals	**1**	**5**	**1.24**	1	5
62. **Counsellor**	**0**	**5**	**.95**	1	5
Screening	**1**	**5**	**1.25**	1	5
Brief intervention	**1**	**5**	**1.13**	1	5
Support and monitoring	**1**	**5**	**.97**	1	5
Referrals	**1**	**5**	**1.05**	1	5
63. **CPN:**	**0**	**5**	**.80**	1	5
Screening	**1**	**5**	**.90**	1	5
Brief intervention	**1**	**5**	**1.04**	1	5
Support and monitoring	**1**	**5**	**.89**	1	5
Referrals	1	5	.88	1	5
64. **Family Planning staff:**	2	4	1.25	1	5
Screening	2	4	1.15	1	5
Brief intervention	2	3	1.13	1	5
Support and monitoring	2	2	.95	1	5
Referrals	2	3	1.35	1	5
65. **Receptionist:**	1.75	3	1.27	1	5
Distribute self-assessment screening tools	2	3	1.25	1	5

66. **All PHC professionals**:	1	5	.92	1	5
Screening and brief intervention, while also being aware of referral protocols to specialist agency	1	5	.88	1	5
67. **Specialist Alcohol Worker who is a member of the PHC team:**	1	5	.80	1	5
Screening	1	5	1.14	1	5
Brief intervention	0	5	.57	3	5
Support and monitoring	0	5	.46	3	5
Referrals	0	5	.47	3	5
68. **The role will depend on circumstances**	2	4.5	1.18	1	5
E. Primary health care professionals can be encouraged to routinely deliver screening and brief intervention by	**Interquartile range**	**Median**	**SD**	**Min**	**Max**
69. Designating PHC alcohol specialists to work alongside practices to provide supervision and support	**1**	**5**	**.58**	**3**	**5**
70. Developing a clear referral protocol so that staff don't feel they have to deal with alcohol issues alone	**1**	**5**	**.60**	3	5
71. Creating a solid and well-advertised support system	**1**	**5**	**.61**	3	5
72. Including questions on alcohol consumption as part of general health and lifestyle reviews	**1**	**5**	**.63**	3	5
73. Establishing closer liaisons with specialist alcohol agencies to assist with referrals and provide ongoing training and support	**1**	**5**	**.64**	2	5
74. Training them in risk factors/signs and brief intervention skills	**1**	**5**	**.73**	2	5
75. Bringing about a general change in attitudes towards alcohol	**1**	**5**	**.73**	2	5
76. Providing evidence of the effectiveness of screening and brief intervention	**1**	**5**	**.80**	1	5
77. Providing accredited postgraduate training courses and workshops	**1**	**5**	**.85**	1	5
78. Providing evidence of the cost-effectiveness of screening and brief intervention	**1**	**5**	**.85**	1	5
79. Teaching alcohol intervention work in medical schools	**1**	**5**	**.89**	2	5
80. The development of the new National Alcohol Strategy by the Government	**1**	**5**	**.95**	2	5
81. Providing easy-to-use screening tools	**1**	**4**	**.68**	3	5
82. Convincing them of the value of their work	**1**	**4**	**.77**	2	5
83. Allocating more time resources	**1**	**4**	**.86**	2	5
84. Developing a computer-based screening protocol	**1**	**4**	**.98**	1	5
85. Placing information in the surgery to tell patients that the health care professionals will routinely ask about alcohol consumption	**1**	**3**	**1.00**	1	5
86. Developing fixed period campaigns on alcohol issues with GP practices	**1**	**3**	**1.01**	1	5
87. They should not be encouraged to routinely screen patients	**1**	**1**	**1.11**	1	5
88. Emphasising their role in the prevention of physical and psychological health problems	**1.75**	**4**	**.84**	2	5
89. Evidence informing them that screening and brief intervention will lead to a reduction in their overall workload	**2**	**4**	**1.01**	2	5
90. Acknowledging that this a team effort	**2**	**4**	**1.01**	1	5

91. Constantly raising the issue until it is embedded in routine clinical practice	**2**	**4**	**1.05**	1	5
92. Adding alcohol to the GP contract	**2**	**4**	**1.08**	1	5
93. Weekly alcohol clinics	**2**	**3**	**1.15**	1	5
94. Financial incentives	**2**	**3**	**1.21**	1	5
F. The concept of risky drinking can best be communicated to the general public via	**Interquartile range**	**Median**	**SD**	**Min**	**Max**
95. Controlled drinking packages via the internet	**0**	**3**	**.86**	**1**	**5**
96. Consistent risk messages, not just at Christmas	**1**	**5**	**.54**	3	5
97. A National Alcohol Strategy sending a clear message	**1**	**5**	**.75**	2	5
98. Using different information for different groups, e.g. young, pregnant etc.	**1**	**5**	**.77**	2	5
99. Work in schools linked to smoking and sex education	**1**	**5**	**.91**	2	5
100. A new language away from 'alcoholic'	**1**	**5**	**1.09**	1	5
101. Identifying and conveying the risks of drinking at different levels	**1**	**4**	**.71**	3	5
102. Media coverage	**1**	**4**	**.74**	2	5
103. Clear consistent information on government recommendations	**1**	**4**	**.75**	3	5
104. Clear factual information (posters, leaflets) in practices	**1**	**4**	**.89**	2	5
105. Inclusion in Health Improvement Programmes (HiMPs)	**1**	**4**	**.91**	2	5
106. Free telephone information lines	**1**	**4**	**.95**	2	5
107. Strong images and information on alcohol-related consequences	**1**	**4**	**.95**	1	5
108. Members of primary health care teams to take responsibility for dissemination of information	**1**	**4**	**1.00**	1	5
109. Public debates/meetings	**1**	**3**	**.95**	1	5
110. Using case studies as examples	**1**	**3**	**1.09**	1	5
111. Road shows	**1**	**3**	**1.13**	1	5
112. Using celebrities	**1.75**	**4**	**1.16**	1	5
113. Public awareness campaigns	**2**	**4**	**.86**	2	5
114. Warnings on alcohol advertising	**2**	**4**	**.86**	2	5
115. Leaflets in libraries, sports centres, etc.	**2**	**4**	**.88**	2	5
116. Involving local community leaders and agencies	**2**	**4**	**.90**	2	5
117. Using pints, bottles etc. as measures rather than units	**2**	**3**	**1.90**	1	5
G. The concept of risky drinking can best be communicated to PHC professionals via	**Interquartile range**	**Median**	**SD**	**Min**	**Max**
118. Improved training and education	**1**	**5**	**.64**	**3**	**5**
119. A National Alcohol Strategy sending a clear message	**1**	**5**	**.72**	3	5
120. Clear consistent information on the government recommendations	**1**	**5**	**.72**	3	5

121. Ensuring that the local service providers are sufficiently well-resourced to enable them to develop direct relationships with primary care	**1**	**5**	**.77**	2	5
122. Utilising PCGs/PCTs	**1**	**4**	**.77**	2	5
123. Articles in health journals	**1**	**4**	**.79**	2	5
124. Stressing the relevance to their work	**1**	**4**	**.79**	2	5
125. Training packages – videos, books CD–ROMs	**1**	**4**	**.91**	2	5
126. Direct communication between PHC professionals ensuring that alcohol features as an element in all priorities and discussions	**1**	**4**	**.93**	1	5
127. Conferences, meetings, workshops and training sessions	**1.5**	**4**	**.90**	1	5
128. Providing statistics on hospital admissions, street crime, domestic violence etc.	**1.5**	**4**	**.93**	2	5
129. Using pints, bottles etc. as measures rather than units	**1.5**	**3**	**1.07**	1	5
130. Circulars	**2**	**3**	**1.10**	1	5
H. The most important issues concerning screening and brief intervention in PHC are	**Interquartile range**	**Median**	**SD**	**Min**	**Max**
131. The need for realism all round	**1**	**5**	**.87**	**1**	**5**
132. The need for training in risk factors and SBI	**1**	**5**	**.96**	1	5
133. The National Alcohol Strategy making SBI a priority	**1**	**5**	**.94**	1	5
134. A change in overall attitudes towards drinking	**1**	**4.5**	**1.01**	1	5
135. The need for a well-developed pathway to alcohol advice and services	**1**	**4**	**.59**	3	5
136. Lack of resources – time and money	**1**	**4**	**.72**	2	5
137. Showing PHC professionals the value of their work	**1**	**4**	**.72**	2	5
138. Accessible screening tools and materials	**1**	**4**	**.73**	2	5
139. The provision of evidence of effectiveness	**1**	**4**	**.75**	1	5
140. Clear consistent information on government recommendations	**1**	**4**	**.76**	2	5
141. Working with and helping families	**1**	**4**	**.77**	2	5
142. Role adequacy and legitimacy	**1**	**4**	**.78**	2	5
143. Ongoing recording, supervision and monitoring to measure the impact of SBI	**1**	**4**	**.80**	2	5
144. Empowering patients by developing and using self-screening tools	**1**	**4**	**.82**	2	5
145. The need for ongoing support for PHC professionals	**1**	**4**	**.83**	1	5
146. The misuse of brief intervention as a panacea, i.e., should not be used as a complete response to people who have other mental health or social problems.	**1**	**4**	**.87**	1	5
147. Training in motivational interviewing skills	**1**	**4**	**.92**	1	5
148. The need to make SBI routine practice	**1**	**4**	**1.01**	1	5
149. The use of 7-day retrospective drinking diaries	**1**	**3**	**.84**	1	5
150. The fact that clients don't like alcohol misuse entered in their records	**1**	**3**	**.97**	1	5

151. The need for PHC professionals to address their own drinking	**1**	**3**	**1.01**	1	5
152. The need to make blood testing equipment available	**1**	**3**	**1.06**	1	5
153. The challenge from the drinks industry	**1**	**3**	**1.09**	1	5
154. The importance of reaching binge drinkers	**2**	**4**	**.78**	2	5
155. The essential need for a broader approach	**2**	**4**	**1.00**	1	5
156. Prevalence of the medical model in medical settings	**2**	**4**	**1.19**	1	5
157. Not using brief intervention with patients who are alcohol dependent	**2**	**3**	**1.13**	1	5

The following four items showed a consensus around strong agreement (1/5):

Screening during New Patient registrations and general health and lifestyle reviews.
Being generally aware of underlying alcohol-related issues in physical/ psychological presentation, e.g., depression, anxiety, insomnia.
Screening during special clinics or medical check-ups, e.g. well-man, well-woman, diabetes, antenatal, insurance medical examinations, etc..
Training PHC professionals to recognise risk factors or signs of excessive drinking.

These four statements can be divided into two groups: A. 2 statements endorse screening in special circumstances, including New Patient registrations, health and lifestyle reviews and special clinics where excessive drinkers are likely to be found; B. the other 2 statements endorse training and increased awareness of presentational factors associated with excessive drinking.

In contrast to A. above, statements endorsing routine screening of all patients (i.e., "Routinely using an appropriate screening tool/ questionnaire" (1.5/4) and "Opportunistically screening all patients attending the surgery" (2/4) showed less agreement and no consensus. There was a consensus that use of LFTs via blood tests, detecting alcohol on patients' breath and gathering information from partners and other family members were not to be recommended as methods of identification (1/2).

SECTION B: Patients can be encouraged to talk about their drinking by:

The following items reached consensus around strong agreement:

Avoiding labelling drinking as "bad", i.e., adopting non-judgemental language and attitudes at all times (0.5/5).
Providing training to all PHC staff to enable them to be more confident about raising alcohol issues (1/5).
Discussing the positive and negative aspects of drinking (1/5).

Giving patients enough time to discuss their problems (1/5).
Ensuring clear and concise factual information on alcohol is available at surgeries (1/5).
Starting with the patient's own concerns (1/5).

Three of the above statements (non-judgemental language and attitudes, positive and negative aspects of drinking and starting with patient's own agenda) reflect a wide acceptance of motivational interviewing principles or the negotiation rather than attempted prescription of behaviour change. Curiously, however, there is consensus but somewhat less agreement with "using motivational interviewing techniques" (1/4) which may arise from less enthusiasm for motivational interviewing as a specific method of counselling. The other three consensual statements above endorse the value of training, providing clear and concise information at the PHC level and giving patients enough time to discuss their concerns.

SECTION C: The most effective types of brief intervention for risky drinkers in primary health care.

Only one item here received both consensus and strong agreement: “Interventions tailored to individual patients”(1/5). Another item had high consensus around agreement (but not strong agreement): “Intervention during special clinics or medical check-ups, e.g. well-man, well-woman etc.” (0/4).

Thus there was support for the idea that brief interventions should be tailored to individual patients and that they should be given during medical check-ups and specials clinics. Although several types and characteristics of brief intervention (self-help booklets and manuals, drinking diaries and guidelines, brief advice, motivational interviewing techniques) received some support, there was no clear consensus among respondents as to the most effective types of brief intervention or their essential ingredients. In particular, there seemed to be no clear preference for either brief advice or more extended forms of brief intervention.

SECTION D: Which PHC professionals should be involved in SBI and what should their respective roles be?

There was a high consensus around strong agreement that counsellors (0/5), CPNs (0/5) and GPs (0.25/5) should be involved in SBI and also consensus and strong agreement that practice nurses should be involved (1/5). Interestingly there was strong support for a role for dieticians in SBI (1/5). There was also strong support for the role of a specialist alcohol worker who is a member of the PHC team (1/5) but no stronger support than for the role of

the specific professions listed above. Finally, there was strong support for the idea that all PHC professions should be involved (1/5).

There was a consensus but less importance attached to the role of the district nurse (1/4). However, there was agreement but no consensus that the role would depend on circumstances (2/4.5) and this verdict also applied to health visitors, midwives and family planning staff (all 2/4). It is of some interest that there was neither consensus nor agreement regarding the role of the receptionist (1.75/3).

With regard to the specific contributions of the various professions to SBI, the most obvious conclusion from these data is that there was very strong support (0/5) for the role of a specialist alcohol worker in carrying out brief intervention, support and monitoring and onward referrals. Also strongly supported but with slightly less consensus (1/5) was the specialist worker's role in screening for excessive drinking. This last observation should be compared with the lack of support for "assigning specialist alcohol workers" (2/3) in views on the best way to identify risky drinkers from Section A.

Another obvious conclusion is that there was strong support (1/5) for the roles of practice nurses, CPNs and counsellors in all aspects of SBI - screening, brief intervention, support and monitoring, and referral. However, while there was strong support for the idea that GPs should be involved in screening and referrals (1/5) there was somewhat less agreement (1/4) regarding their role in brief intervention itself (1/4) and no consensus about their involvement in support and monitoring (2/4).

There was consensus and strong agreement that district nurses should be involved in screening (1/5) but no consensus regarding their role in other aspects of SBI (2/4). Conversely, there was strong support for the role of dieticians in brief intervention, support and monitoring, and referral (all 1/5) but no consensus regarding their role in screening for excessive drinking (2/4).

Although there was nominal support for the idea that all PHC professionals should be involved in SBI (1/5), there was in fact little support in general for the roles of health visitors, midwives and family planning staff. There was very little enthusiasm for the role of receptionists in distributing screening instruments (2/3).

SECTION E: Primary health care professionals can be encouraged to routinely deliver screening and brief intervention by ……

There was a consensus around strong agreement (1/5) for 12 items:

Designating PHC alcohol specialists to work alongside practices to provide supervision and support.
Developing a clear referral protocol so that staff don't feel they have to deal with alcohol issues alone.
Creating a solid and well-advertised support system.
Including questions on alcohol consumption as part of general health and lifestyle reviews.
Establishing closer liaisons with specialist alcohol agencies to assist with referrals and provide ongoing training and support.
Training them in risk factors/signs and brief intervention skills
Bringing about a general change in attitudes towards alcohol
Providing evidence of the effectiveness of screening and brief intervention
Providing accredited postgraduate training courses and workshops
Providing evidence of the cost-effectiveness of screening and brief intervention
Teaching alcohol intervention work in medical schools
The development of the new National Alcohol Strategy by the Government

There was also a consensus around strong *disagreement* for the following item:

"They should not be encouraged to routinely screen patients" (1/1).

There is thus a range of measures that are supported as means to encourage PHC professionals to routinely deliver SBI, without any of these clearly being singled out as more effective in this respect than the rest. The development of a National Alcohol Strategy was included in these strongly supported measures.

The strong disagreement with the statement that PHC professionals should not be encouraged to routinely screen patients seems at first sight inconsistent with the lack of support for routine screening in Section A. However, these latter statements are concerned with opportunistic screening using standard questionnaires of all patients attending the surgery, not with routine screening as such. Thus the consensus view could be interpreted as meaning that routine screening should be carried out for new patient registrations and at special clinics.

It is interesting that there appears to be little consensual support for two measures that are sometimes proposed - adding alcohol to the GP contract and offering financial incentives for this work.

SECTION F: The concept of risky drinking can best be communicated to the general public via …

There were five statements that gained high consensus and strong agreement (1/5):

Consistent risk messages, not just at Christmas.
A National Alcohol Strategy sending a clear message.
Using different information for different groups, e.g. young, pregnant etc.
Work in schools linked to smoking and sex education
A new language away from 'alcoholic'

It seems there are a number of measures that are strongly supported as ways of communicating the concept of "risky drinking" to the general public. Using a National Alcohol Strategy to send a clear message about risk drinking was again strongly endorsed. The appeal to "a new language away from 'alcoholic' is consistent with the aim of the Reframing component in the WHO Phase IV study. Surprisingly perhaps, measures for which there was roughly equal consensus but less agreement included "inclusion in Health Improvement Programmes" and free telephone information (both ¼).

Measures that failed to reach consensus included some that are frequently proposed as ways of educating the general public about the risks of drinking, e.g., using celebrities, public awareness campaigns, warnings on alcohol advertising, involving local community leaders and agencies and using pints, bottles etc. as measures of alcohol consumption rather than standard units.

SECTION G: The concept of risky drinking can best be communicated to PHC professionals via …

There were four statements that gaining consensus and strong agreement (1/5):

Improved training and education.
A National Alcohol Strategy sending a clear message.
Clear consistent information on the government recommendations.
Ensuring that the local service providers are sufficiently well-resourced to enable them to develop direct relationships with primary care.

Thus, a few measures were strongly supported as ways in which the concept of risky drinking could be communicated to PHC professionals, including improved training and education, clear and consistent information on government recommendations, and ensuring that specialist services are sufficiently well-resourced to enable them to develop direct

relationships with primary care. Once more, there was strong support for a National Alcohol Strategy in this context.

It is perhaps surprising that utilising PCGs/PCTs, articles in health journals and training packages were seen as less important than the measures listed above. It should be emphasised, however, that these measures were consensually supported around agreement rather than strong agreement (1/4).

It is also interesting that there was either no consensus, disagreement or both with respect to conferences, meetings, workshops and training sessions as ways of communicating the concept of risky drinking. In view of data from Section H below, this could be interpreted as meaning, not that training in SBI is unnecessary, but that the concept of risky drinking is already familiar to health professionals.

SECTION H: The most important issues concerning screening and brief intervention in PHC are …

Three measures gained consensus and strong agreement(1/5):

The need for realism all round.
The need for training in risk factors and SBI.
The National Alcohol Strategy making SBI a priority

There was also a measure with high consensus and level of agreement between "agreement" and "strong agreement": *"A change in overall attitudes towards drinking" (1/4.5).*

The call for training and for emphasis on SBI in a National Alcohol Strategy are perhaps not surprising. However, the endorsement of "the need for realism all around" suggests that the panel is well aware that implementing SBI in PHC presents great difficulties and that expectations should not be set too high.

It should also be pointed out that there were a large number of measures (n=14) in Section H that obtained consensus but only agreement (rather than strong agreement) (1/4) (Table 5.2, q.v.). It is perhaps surprising that some of these measures did not obtain greater agreement but it should be emphasised that they *were* supported. There was a consensus but neither agreement nor disagreement (1/3) about the need for PHC professionals to address their own drinking, the fact that patients don't like alcohol misuse entered in their records and the

challenge from the drinking industry. Surprisingly again, there was no consensus about the importance of reaching binge drinkers (2/4) and of not using brief interventions with patients who are alcohol dependent (2/3).

4.4.7. Sub-group analysis

To explore whether there were any differences in views between groups of panel members with different professional orientations to SBI, separate sub-group analyses were undertaken. For this purpose, the whole panel was divided into mutually exclusive sub-groups, as follows: (i) PHC professionals, including all those who described themselves as GPs or nurses, irrespective of other self-reported designations or affiliations (n=13); (ii) alcohol specialists, including all those who described themselves of alcohol service workers, Directors/ Chief Executives of alcohol services or "alcohol specialists", irrespective of whether they also described themselves as academics or researchers (n=23); (iii) those who described themselves as academics or researchers without any other designation (n-13). Four panel members who described themselves variously as primary care trainers, consultants in public health and Trust Board Directors were not included in this classification.

To examine possible differences between these groups, Round 3 ratings on all Delphi items were subjected to a one-way analysis of variance. Because of the large number of tests of significance this entailed (= 199), only probability levels beyond 0.01 were considered for further examination. Items meeting this level of significance were then subjected to 2-way post hoc comparisons using a Bonferroni correction. Only four items met these stringent criteria, as follows:

Item 10. *(The best way to identify risky drinkers in primary health care without offending patients is by) conducting screening within an established relationship between patient and health professional.* PHC professionals were more in agreement with this item (median = 4) than either alcohol specialists or academic and researchers (median = 3).

Item 37. *(Patients can be encouraged to talk about their drinking by) stressing that the aim is preventative and that the focus is on health and fitness.* Although the panel as a whole neither agreed nor disagreed with this item, alcohol specialists were more in agreement with it (median = 3) than academics and researchers (median = 2).

Item 77. *(Primary health care professionals can be encouraged to routinely deliver screening and brief intervention by) providing accredited postgraduate training courses and workshops.* Academics and researchers were less in agreement with this item (median = 3) than either PHC professionals and alcohol specialists (median = 4).

Item 127. (*The concept of risky drinking can best be communicated to PHC professionals via) conferences, meetings, workshops and training sessions.* Although the panel as a whole agreed with this item, alcohol specialists agreed more strongly with it (median = 5) than academics and researchers (median = 4), with PHC professionals occupying an intermediate (but not significantly different) position (median = 5)

4.5. Conclusions from the Delphi survey

There was on the whole a high level of consensus among the experts who took part in this survey, as well as agreement or strong agreement with a majority of items. It could be that, in this particular use of it, the Delphi method was unable to show much discrimination among current views on SBI. Despite the anonymity of the survey, it is conceivable that participants tended to give responses that were "socially desirable" in the context of the current climate of scientific and professional opinion on SBI and expressed views they assumed would concur with the opinions of the researchers. On the other hand, it may simply be that, owing to frequent discussions and the large literature on the topic, there is relatively little disagreement among experts in the UK on the best ways to encourage implementation of SBI in PHC.

In extrapolation from the findings of randomised controlled trials of SBI, it has been assumed that practical delivery of SBI in PHC settings should follow a procedure in which all patients attending the PHC facility are screened, typically by a receptionist handing out the AUDIT questionnaire (Saunders *et al.,* 1993) to patients on arrival, and that the GP or other health professional should then offer a brief intervention to all patients scoring positive for hazardous or harmful drinking. Rollnick *et al.* (1997) have questioned this model of delivery of SBI and Beich *et al.* (2002), on the basis of focus groups with GPs in Denmark, concluded that such blanket screening causes more problems than it solves and should therefore be abandoned. A clear conclusion from the present survey is that UK experts recommend a way of delivering SBI that is intermediate between these extremes; they were opposed to opportunistic screening of all patients, especially if involving receptionists handing out questionnaires, but were equally agreed that *routine* SBI should be carried out in special

circumstances, i.e., new patient registrations, general health check-ups and special clinics where excessive drinkers were likely to be found. This fully confirms the findings from focus groups with both PHC professionals and patients that were summarised in Chapter 3.

It might be objected that restricting the delivery of SBI in this way might lose much of the public health impact that has been predicted from widespread implementation (e.g. Wallace *et al.*, 1988). However, given the very low level of delivery of SBI at present (Deehan *et al.,* 1998; Kaner *et al.*, 1999a), it would be preferable to make SBI more acceptable to PHC staff than to recommend a mode of delivery they are unlikely to find acceptable. Once routine delivery of SBI has been incorporated in a limited form, an expansion of range could then be envisaged.

Another clear conclusion from the survey is strong support for the employment of a specialist alcohol worker to carry the main load of work created by the delivery of SBI. In this view, the specialist worker should be an integral member of the PHC team. In this respect, the conclusion from the Delphi study is at odds with that from the focus groups, in which both PHC professionals and patients were unenthusiastic about the employment of an alcohol specialist worker, mostly for fear of the stigma that visiting such a person might give rise to.

However, the Delphi findings suggest a model involving screening by other PHC staff, possibly in addition to screening by the specialist, followed by brief intervention, support and monitoring and onward referral to alcohol or addictions agencies where appropriate by the specialist worker. This suggests a model of inter-professional co-operation in the delivery of SBI. Views of the expert panel regarding the respective roles of the various professions can be interpreted as follows: (i) screening for excessive drinking is carried out in appropriate circumstances by the GP, practice nurse, district nurse and counsellor; (ii) referral of positive cases for brief intervention is made to the practice nurse, the counsellor or the dietician, with additional involvement by the GP or the health visitor given time and interest; (iii) support and monitoring of the patient is carried out by the PHC staff member who gave the brief intervention; (iv) onward referral is made by the same staff member, perhaps in consultation with the GP. A model of this kind could be incorporated into clinical guidelines for the delivery of SBI.

In common with many other recommendations regarding the implementation of SBI (e.g., Adams *et al.,* 1997; Kaner *et al.,* 1999, 2001; McAvoy *et al.,* 1999; Aalto *et al.,* 2001; Johansson *et al.* 2002), the expert panel stressed the need for increased and improved training and education of health care professionals in skills related to SBI, particularly with regard to the recognition of risk and presentational factors, how to encourage patients to talk about their drinking and other brief intervention skills. The panel also agreed that such training should emphasise the clear evidence that exists for the effectiveness and cost-effectiveness of SBI. However, there was no consensus in this survey as to the best methods for effecting training and education (cf. Albery *et al.,* 1997; Deehan *et al.,* 2002).

Experts showed broad agreement on the importance of principles bearing on the interaction between helper and patient derived from the motivational interviewing perspective (Miller & Rollnick, 2002) and the idea that behaviour change should be negotiated with the patient rather than prescribed or imposed (Rollnick *et al.* 1993). Beyond that, however, there was no clear consensus regarding the form brief interventions should take. This leaves open the possibility of recommending several options, differing perhaps in duration and the degree of training and skills needed, for the delivery of brief intervention.

Regarding communications with the general public, the panel stressed the importance of the government providing clear, consistent and relevant information on risks and developing different messages for different groups at risk, and of the need for a reframing of understandings of alcohol issues away from an exclusive preoccupation with "alcoholism" and towards the concept of "risky drinking". A range of media was suggested for these purposes, including education in schools linked to smoking and sex education, mass media coverage, posters and leaflets in PHC practices, and free telephone information lines. PHC teams should take responsibility, in collaboration with health promotion specialists and others, for the local dissemination of the required information.

For communications with PHC professionals, besides improved training and education, the panel recommended that the government should provide clear and consistent information to professionals, stress the relevance of alcohol SBI to the PHC professionals' work, ensure that specialist services are sufficiently well-resourced to enable them to develop direct relationships with primary care and utilise Primary Care Trusts for these purposes.

Despite recognising the difficulties of implementing SBI in PHC and "the need for realism all round", the panel saw a national alcohol strategy in which SBI played a prominent part as a crucial element of successful implementation.

5. REFRAMING UNDERSTANDINGS OF ALCOHOL ISSUES

The aim of this component of the project was to develop a Communications Strategy to promote an understanding among the target audiences of the concept of "risky drinking", i.e., drinking above medically recommended levels with an increased risk of alcohol-related harm. The basic assumption of the strategy was that this should be seen as primarily a lifestyle issue and needs therefore to be distanced from concepts of "alcoholism" or severe dependence. Positive messages in relation to moderate drinking and healthy lifestyles were also be communicated in the strategy. It was further assumed that, without such an improved understanding of the rationale behind screening and alcohol intervention, no attempt at widespread dissemination can be expected to succeed in the long term.

5.1. Communications Strategy Working Group

The development of the strategy was undertaken by a Communications Strategy Working Group, the composition of which was given in Chapter 1 of this report.

5.1.1. Remit

The remit of the group was to advise and produce recommendations for a Communications Strategy on two levels:

a) on a national level for widespread dissemination throughout England;

b) on a local level for inclusion on the Demonstration Project component of this study.

5.2. Marketing Strategy

As part of its output, the Working Group produced a document entitled, *Marketing Strategy for Screening and Brief Intervention in Primary Health Care*. This was intended to meet the objective producing recommendations for promoting implementation of SBI throughout England. The document contained within in a Communications Strategy concerned specifically with the task of reframing understandings of alcohol-related issues among target groups.

The Marketing Strategy document has been posted on the project web site www.alcohol-phaseivproject.co.uk. It has also been sent to the Cabinet Office Strategy Unit concerned with developing a *National Alcohol Harm Reduction Strategy.* An approach to *Alcohol Concern* has been made regarding the possibility of publishing the document and distributing it widely among relevant organisations and individuals in England.

The full Marketing Strategy can be inspected on the web site. In this report, only an abridged version is presented, leaving out material that is redundant with other sections of the report.

5.2.1. Health market environment: PEST analysis

The implementation of health and social programmes is affected by changes in the wider political, economic, social and technological environments (Kotler & Roberto, 1989). An effective strategy for implementing screening and brief interventions must therefore attempt to map out the health market environment, assess the impact of external factors upon the strategy and identify relevant opportunities and threats accordingly.

5.2.1.2. Political environment

NHS reforms in primary care: 'The New NHS' (Secretary of State for Health, 1997) set out the Labour Government's 10-year programme for the modernisation of the health service. One of the key objectives was the establishment of Primary Care Groups and Trusts to commission and provide services for local patients based on their need. 'The NHS Plan' (Secretary of State for Health, 2000) took this one stage further with the planned future development of 'Care Trusts' to bring primary care and social services together to commission and provide health and social services within a single organisation. This means that GPs will be working in teams alongside nurses, pharmacists, dentists, therapists, opticians, midwives and social care staff. Nurses may take on new responsibilities and some GPs may specialise in treating specific conditions. The plan also aims to recruit 2,000 more GPs, 20,000 nurses and 6,500 extra therapists.

Since 1998, a number of GPs have been working to a Personal Medical Services (PMS) contract rather than a standard national contract. PMS pays GPs on the basis of meeting

set quality standards and the particular needs of their local population. For example, if an area had a particularly high level of heart disease the PMS contract could set targets for ensuring that local people at risk were identified and prescribed appropriate treatment. It was expected that nearly one-third of GPs will be working to PMS contracts by 2002.

Opportunities

- Funding is being moved to primary care to commission and provide services based on local need. Local health needs assessment could be carried out for excessive drinking.
- New care trusts provide opportunities for a wider range of (integrated) services, including those for alcohol.
- There will be opportunities for the development of specialist-generalist GPs and nurses for excessive drinking.
- PMS contracts could include targets for identifying people at risk from excessive drinking and providing appropriate interventions.

Threats

- There is currently a GP and nurse recruitment and retention crisis, putting pressure on the provision of existing primary care services to the detriment of new service development.
- GPs and nurses are overloaded with the demands of the National Service Frameworks.
- Excessive drinking is not a high priority compared with smoking cessation and illicit drug use.

Public health policy: 'Our Healthier Nation' (1998) set out proposals for a public health strategy which were published in 'Saving Lives' (1999). The strategy aims to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness, to improve the health of the worst off in society and narrow the health gap. The priority is to concentrate on lifestyle factors such as diet, physical activity, sexual behaviour, drugs, smoking and alcohol as a cause of ill health. The strategy focuses on the four areas of cancer, coronary heart disease and stroke, accidents and mental health with specified targets to be achieved by 2010.

Proposals for wider action on public health include the development and implementation of a National Alcohol Harm Reduction Strategy by 2004. This will aim to "encourage people who drink to do so sensibly in line with guidance so as to avoid alcohol-related problems, protect individuals and communities from anti-social and criminal behaviour related to excessive drinking, and provide services of proven effectiveness that enable people to overcome their excessive drinking problems". The targets set out in 'Saving Lives' and the National Service Frameworks (together with locally agreed targets) are to be translated into action via Health Improvement Programmes.

Opportunities

- A focus on lifestyle factors includes excessive drinking as a major cause of ill health.
- Excessive drinking is a risk factor in the four national priority areas of cancer, coronary heart disease and stroke, accidents, and mental health.
- The Government intends to implement a National Alcohol Harm Reduction Strategy by 2004.
- Excessive drinking can be identified in Health Improvement Programmes and the links between excessive drinking and the national priorities explicitly made.

Threats

- Excessive drinking is a low priority compared with other lifestyle factors such as smoking and illicit drug use.
- There are currently no national targets for excessive drinking.
- The majority of Health Improvement Programmes include little about excessive drinking with no local targets set.

5.2.1.3. Economic environment

Expenditure on alcohol: The total household expenditure on alcohol in the UK in 2000 was £33 billion (ONS, 2000a). The Family Expenditure Survey (ONS, 2000b) reported an average weekly expenditure on alcohol of £15.30 representing 4.3% of the total weekly expenditure.

Tax revenue: UK tax revenue from alcoholic drinks was £11 billion in 1999, representing 3.5% of total tax revenue.

Cost of excessive drinking: The financial cost of excessive drinking in England has been estimated as at least £10.8 billion a year (Alcohol Concern, 1999). Of this, the inpatient costs to the NHS alone have been estimated at £3 billion (Royal College of Physicians, 2001). Societal costs including sickness and absenteeism from work, accidents, premature deaths and alcohol-related crime have been estimated to be a further £3 billion (Godfrey & Hardman, 1994).

Government spending on alcohol prevention and treatment was £1.1 million in 2000/2001 compared with £91.45 million on illicit drugs. In comparison, the drinks industry spends £227 million a year on advertisements for its products (Alcohol Concern, 2001).

Opportunities

- £15.5 million has been made available in a new joint Drug, Alcohol and Tobacco Prevention Grant (Alcohol Concern 2001). At least a third of these funds could be earmarked specifically for alcohol.
- The implementation of the Government alcohol strategy would raise the profile of alcohol-related problems and set national priorities for alcohol, which would encourage local health and social care commissioners to commit funds to provide alcohol services.

Threats

- There is a dominance of Government spending on illicit drugs to the detriment of investment in alcohol services.
- Health and social care commissioners are reluctant to commit funds to alcohol services in the absence of a national strategy and specific alcohol targets.

5.2.1.4. Social trends

Although the proportion of men drinking more than the medically recommended levels has remained fairly stable over the last ten years, the number of women exceeding these levels has increased by almost 50%. This increase has been attributed to a combination of

factors such as increased purchasing power, acceptability of drinking by women and availability of alcohol for home consumption (Alcohol Concern, 1999).

The proportion of 16- to 24-year olds who regularly exceed the safe limits has also increased to 36% of men and 25% of women. Young men and women are drinking more heavily than before and, for many, binge drinking (regularly drinking more than 6 units on a single occasion) has become the usual pattern of consumption. This trend has not only been associated with increased purchasing power and access to alcohol, but also with the increased advertising and availability of 'new' designer drinks with higher alcohol content, and the proliferation of drinks promotions and 'happy hours'.

Teenagers are also consuming larger quantities of alcohol. The European School Survey Project on Alcohol and other Drugs (ESPAD) (Hibell *et al.*, 2000**)** found that nearly 40% of young people in the UK had been drunk by the time they were 13 years old and almost a third reported binge drinking at least three times in the last 30 days.

Opportunities

- Primary health care professionals could specifically target young adults for alcohol screening and brief intervention with tailored health information and advice on the effects of binge drinking.
- Alcohol screening and brief intervention could be implemented in other locations accessible to young people, such as young people's services, clinics, youth centres, schools and colleges.

Threats

- Primary health care professionals have to 'compete' with the power and resources of the drinks industry and the enormous amounts of money spent on alcohol advertising targeted specifically at young people.
- Young people traditionally do not access primary health care as much as other age groups.

5.2.1.5. Technological trends

Screening tools: A number of methods can be used to detect hazardous and harmful drinkers, including physical examinations, quantity/frequency questions relating to alcohol consumption, laboratory markers such as GGT tests and the use of drinking diaries. The past ten years, however, have seen an increase in the development and use of screening tools to detect hazardous drinking and/or alcohol dependence. These have been developed for use in a variety of settings, including in-patient, A&E and primary health care and have varying levels of sensitivity and specificity.

- The Alcohol Use Disorders Identification Test (AUDIT), AUDIT-PC and Five Shot have been developed to detect hazardous and harmful drinking in primary health care settings.
- The Michigan Alcoholism Screening Test (MAST) and CAGE can be used to detect more severe alcohol dependence.
- The Paddington Alcohol Test (PAT) and FAST have been developed to detect hazardous and harmful drinking in A&E departments.

Information technology: The NHS Plan (Secretary of State for Health, 2000) aims to modernise the use of information technology and electronic patient records in primary care by 2005. All GP practices have been connected to the NHSnet by 2002 giving patients improved diagnosis, information and referral. NHS Direct aims to provide a one-stop gateway to health care for patients and will be providing health information via digital TV as well as via telephone and the internet by 2004. 500 NHS Direct information-points providing touch screen information and advice about health and the health service are also planned for places such as shopping centres and railway stations.

Opportunities

- There are a number of suitable screening tools developed specifically to detect hazardous and harmful drinkers in primary health care.
- Screening tools with patient specific advice and information could be provided in CD-ROM version for GP practices with modernised IT systems.

- Screening tools with patient specific advice and information could be accessed directly by patients via NHS Direct and internet sites.

Threats

- Alcohol specific screening tools may be regarded as too focused and threatening for patients.
- Practices differ considerably in their access to, training and use of IT.

5.2.2. Marketing 'mix'

5.2.2.1. Product/service development

The WHO Collaborative Project on Identification and Management of Alcohol-related Problems in Primary Health Care began in 1982. The three previous phases of the project were described above (Chapter 1). The Collaborative Project has resulted in two products that can be used in screening and brief interventions for excessive drinking in primary health care settings – the AUDIT questionnaire and the Drink-less brief intervention package.

5.2.2.2. Price/cost

The direct cost of delivering one SBI has been estimated as less than £20 (Effective Health Care Team, 1993). Direct cost refers to the time of professionals (GP or practice nurse) administering the screening tool and the intervention, and the cost of the materials used in the intervention. Costs will depend upon who delivers the SBI, the method of delivery (e.g. opportunistic or in specified clinics), the screening tool used and the length of the intervention. Associated costs will include the costs of training health professionals, any mechanisms to encourage them to intervene with patients, any support services provided, and any increase in referral to the specialist services.

5.2.2.3. Place/location

Primary health care is an ideal location to deliver SBI. Depending on the preferred method of delivery, this could take place within GP consultations, specified clinics or new patient registrations etc..

5.2.2.4. Promotion: Communications Strategy

The key messages to link all aspects of the Communications Strategy include:

a) How much is too much? What the recommended sensible/'healthy' levels of drinking are;
b) What is 'risky' drinking? How drinking too much puts us at risk of a wide range of health and social problems;
c) How many of us drink too much? Why this is an important public health /primary care issue;
d) What can be done to help? How GPs and practice nurses can advise patients on healthy lifestyles and effectively reduce risky levels of drinking.

The objectives of the Communications Strategy are as follows:

1. Identify and segment the target audiences;
2. Identify information to be provided for each target audience and message content;
3. Identify the best means of delivering this information e.g. words, graphics, video, multi-media;
4. Identify the most appropriate communication vehicles for each e.g. mail, telephone, web site, TV, radio, billboards, posters in waiting rooms, workshops, seminars, presentations, conferences, etc..

5.2.3. Communications Strategy

5.2.3.1. Target audiences

There are three broad target audiences for the strategy:

Primary Health Care Professionals: In this report, the term primary health care professionals refers to those based at or attached to general practice settings, e.g., GPs, practice nurses, health visitors etc..

Stakeholders: The term stakeholders refers to any individual or organisation that has a vested interest in the implementation of SBI in primary health care, the reduction of alcohol-related health and social problems, the improvement of public health and safety, and the associated cost savings to the NHS.

The General Public: The wider general public refers to all individuals in England, including targeted sectors such as young people, older adults, parents, professional and non-professional groups, ethnic minorities etc., where appropriate.

5.2.3.2. Primary Health Care Professionals

The main aims of the strategy for primary health care professionals are as follows:

- to raise initial awareness of 'risky' or excessive drinking and alcohol-related problems;
- to develop widespread interest in screening and brief intervention (SBI) for excessive drinkers in primary health care;
- to encourage the uptake of SBI and related training programmes in primary health care;
- to promote the implementation of SBI in practice.

Information needs: Barriers and facilitators to the implementation of screening and brief interventions in primary health care have previously been identified (Kaner, 1999; Kaner et al., 1999b). These have a number of implications for the sort of information that needs to be communicated to primary health care professionals to encourage and enable them to carry out SBI in practice.

Barriers to alcohol intervention work include:

- health professionals' confusion over the recommended (weekly and daily) levels;
- difficulties converting drinks, bottles and cans etc to units;
- the complexity of discussing alcohol with patients (how much alcohol is beneficial and how much is harmful);
- uncertainty as to the differences between excessive drinkers, problem drinkers and 'alcoholics';
- the need for clarification on the size of alcohol-related problems (nationally and locally);

Incentives for brief alcohol intervention work include:

- readily available information on support services to refer patients to;
- dissemination of evidence of the effectiveness of SBI;
- suitable screening tools and materials relating to alcohol intervention;
- clarification of the impact of alcohol on health;
- clarification of the official recommendations regarding sensible drinking;
- suitable leaflets, posters etc for patients to read in the waiting room;
- identifying related physical and psychological conditions to "trigger" or prompt SBI;
- information on the risks to health with facts and figures made available.

The findings of the Delphi Survey described in Chapter 4 of this report show that, in terms of *content*, there was consensus and agreement that 'clear consistent information on the government recommendations' and 'stressing the relevance to their (PHC professionals') work' should be provided.

Recommendations

The findings indicate that clear information is needed for primary health care professionals in the following areas:

1) A *consistent* message regarding the medically recommended (daily/weekly) levels and information on units;
2) Up-to-date information on the conversion of drinks (bottles, cans etc.) to units, e.g. using a "ready reckoner" unit calculator;
3) The positive as well as negative effects of alcohol, with definitions of "risky" or hazardous and harmful levels;
4) The links between alcohol and health/social problems, including links to the national priority areas identified by the Government in 'Saving Lives: Our Healthier Nation';
5) Statistics on the extent of alcohol-related problems both nationally and locally;
6) Information on common alcohol-related problems/conditions likely to present in primary health care;

7) Facts and figures on relative risks;
8) Evidence of the effectiveness of SBI in primary care;
9) The availability of local support services, clear referral procedures and guidelines (developed by the primary care team and local alcohol services);
10) Provision of appropriate leaflets and posters for patients in the waiting room (targeting identified patient groups).

Communication channels: This information should to be communicated to primary health care professionals via appropriate and effective channels. These will differ according to the purpose of the information, i.e., whether it is to raise initial awareness, to disseminate SBI and training packages, or to educate/train professionals in carrying out SBI.

a) Raising awareness of alcohol-related problems and SBI. In focus group discussions (see Section 3 above), both GPs and practice nurses identified 'presentations' or discussions at existing meetings (i.e., from invited speaker) as being the most effective method of initial awareness-raising. The speaker should be a key identified person (opinion leader) for each particular audience, e.g. an appropriate local consultant or prominent GP for GP meetings. Several dates/times should be offered to access most professionals.

GP postgraduate education meetings (accredited where possible) were identified as a useful channel of communication, particularly as Primary Care Group/Trust (PCG/T) education and training strategies are linked closely to service development. PCG/T training and committee groups for practice nurses were also suggested as being appropriate and effective channels where these exist.

Participants who attended the focus groups however, are more likely to be representative of those professionals who attend meetings generally. For those professionals who are not able or willing to attend such meetings, practices should be offered the option of having a speaker attend one of their scheduled practice team meetings. These meetings could also be accredited by the PGEA and attendance certified for other members of the team.

The Delphi study expert panel agreed that 'improved training and education', 'utilising PCGs/PCTs', 'direct communication between PHC professionals ensuring that alcohol

features as an element in all priorities and discussions', 'training packages – videos, books CD–ROMs', 'articles in health journals', and 'a National Alcohol Strategy sending a clear message' were the most useful ways of communicating to PHC professionals.

b) Dissemination of SBI package and training programme. Phase III (Strand III) of the WHO Collaborative Project was a randomised controlled trial to evaluate the effectiveness and cost-effectiveness of different marketing, training and support strategies in the dissemination of SBI in primary health care. This was described in Section 1.xxx. The study found personal marketing to be the most effective overall dissemination strategy but telemarketing to be the most cost-effective (Lock *et al*., 1999).

A review of the Cochrane Effective Practice and Organisation of Care Group (EPOC) literature on what is and what is not effective in changing professional practice and promoting effective innovations found:

- Consistently effective methods include educational outreach visits (academic detailing), reminders or prompts (manual or computerised) at the time of consultation, multifaceted interventions (combination of two or more methods) and interactive educational meetings;
- Sometimes effective methods include audit and feedback, local opinion leaders, and patient mediated interventions (information leaflets or patient held prompts);
- Little or no effect was found in didactic educational meetings or the distribution of printed guidelines.

c) Training primary care professionals in SBI. In the WHO Phase III study, it was found that practice-based training with telephone support was the most effective and cost-effective strategy for encouraging implementation (Kaner *et al*., 1999a).

Similarly, in focus group discussions in this study (see Chapter 2), most GPs, practice nurses and primary health care teams preferred practice team-based rather than individual professional training when considering practical training in SBI.

Recommendations

1) Raising awareness of alcohol-related problems and creating interest in SBI via interactive professional group (education and training) meetings and/or in-house practice team meetings;

2) Dissemination of SBI package and training programme to practices via (follow-up) telemarketing;

3) Provision of interactive practice team-based training with ongoing telephone support.

The Communications Strategy for PHC professionals is summarised in Table 5.2 below.

5.2.3.3. Stakeholders

The aims of the strategy for identified stakeholders are:

- to promote ownership of and active involvement in a SBI implementation strategy for primary health care;
- to promote ownership of and active involvement in a general public awareness campaign.

Key stakeholders to target for ownership of /involvement in a SBI implementation strategy include:

National	Local

Top Down Approach
 	
▪ Department of Health
▪ BMA
▪ Royal College of Physicians
▪ Royal College of General Practitioners
▪ Royal College of Psychiatrists
▪ Royal College of Nursing
▪ Medical Council on Alcoholism
▪ Nursing Council on Alcohol
▪ Alcohol Concern
▪ Health Promotion England
▪ Health Development Agency
▪ The Portman Group
	Bottom Up Approach
	
	▪ PCT managers/commissioners
	▪ NHS trusts
	▪ A&E departments
	▪ Health improvement groups (linked to HImPs) and HAZ operational groups
	  ▪ CHD and stroke
	  ▪ Cancer
	  ▪ Mental health
	  ▪ Older people
	  ▪ Child health
	  ▪ Alcohol and drugs
	  ▪ Accident prevention
	▪ Health partnerships (locality based)
	▪ Alcohol services (including voluntary agencies) and DATs

TABLE 5.2
Communications Strategy for Primary Health Care Professionals

Objective	Channel	Content	Format
Raising awareness	▪ Professional (GP/Practice Nurse) education/training group meetings ▪ Individual practice team meetings	▪ Alcohol-related problems (health and social) ▪ Size of problems (nationally and locally) ▪ Public health/primary care issue ▪ Recommended levels ▪ 'Risky' drinking vs alcoholism ▪ What is SBI ▪ Evidence of effectiveness of SBI	▪ Presentation and discussion ▪ Overhead slides ▪ Handouts ▪ Printed SBI materials for demonstration ▪ Web site
Dissemination	▪ Telemarketing by GP or nurse ▪ Follow-up from awareness-raising meetings	▪ 'Risky' drinking and primary care ▪ SBI programme details ▪ Training programme details	▪ Telephone call and 'script'
Provision of SBI tools / materials	▪ Published screening tools ▪ Intervention materials ▪ Clinical guidelines	▪ Clinical guidelines for SBI and appropriate referrals ▪ Screening questions and scoring ▪ Information on units, sensible, hazardous and harmful levels, benefits of cutting down, strategies for cutting down etc for patients ▪ Available support services	▪ Written guidelines and decision making diagram/flow chart ▪ Screening tool and scoring template ▪ Unit calculator ▪ BI materials (advice card, handy card, booklet) ▪ CD ROM version ▪ Posters and leaflets for waiting room ▪ Directory of support services ▪ Web site
Training	▪ Practice team based training sessions (accredited)	▪ Recap of session for raising awareness (see above) ▪ Use of screening tools ▪ Stages of change (Helping people change) ▪ Brief interventions ▪ Motivational interviewing ▪ Diagnosis and treatment of dependence ▪ Available support services and referrals ▪ Audit and feedback mechanisms	▪ Overhead slides ▪ Handouts ▪ SBI Materials ▪ Interactive exercises ▪ Video ▪ Role play

Links should be made with existing strategies, programmes and campaigns where possible e.g. via HAZ groups, HIMPS etc..

Information needs: The key messages that need to be communicated include:

- the 'safe' and 'risky' levels of drinking;
- the health and social problems associated with excessive drinking;
- the estimated costs of alcohol-related problems to the NHS and industry;
- the links to existing health and social policies, priorities and programmes;
- evidence of effectiveness/cost-effectiveness of SBI.

Communication channels: Effective communication channels will differ between stakeholders and need to be carefully researched for specific organisations. Options include attending relevant meetings, presentations at local and national conferences, written articles in existing stakeholder publications, and providing local seminars and workshops. Utilising an enthusiastic PCG/T, finding a local 'champion' to push things forward and setting up an Alcohol Health Improvement Group linked to the health improvement programme would also help to raise the profile of alcohol-related problems.

Recommendations

1) Utilisation of the Phase IV National Strategic Alliance to work together to promote the widespread implementation of SBI
2) Further building of a Local Strategic Alliance to promote the implementation of SBI in the local area and link with existing strategies and campaigns
3) Staging of a national conference to bring together members of the Alliance and key stakeholders, with interactive workshops to further the development of the implementation strategy and encourage ownership
4) Dissemination of SBI research and an implementation programme via stakeholder meetings, conferences, publications and the internet.

5.2.3.4. The general public

The aims of the strategy for members of the general public are to:

- Raise awareness of 'safe' and 'risky' levels of drinking;
- Raise awareness of alcohol-related problems (including longer-term health problems);
- Highlight the benefits of drinking sensibly;
- Encourage people to ask their GP or practice nurse for alcohol-related information and advice.

An effective Communications Strategy for the general public cannot be 'one size fits all'. Segmentation into defined target groups (e.g. by age, sex, drinking pattern and associated risk) is necessary to tailor message content, format and communication channels. Options for segmentation include:

- Young people (aged 16-24) - binge drinkers, concerned with the short-term and physical effects of excessive drinking, e.g. risky sex, teenage pregnancy and STDs, accidents, mixing alcohol and other drugs etc.;
- Parents - their influence on children's awareness of the effects alcohol and drinking behaviour, parental drinking and problems of arguments, violence and abuse;
- Professional and non-professional groups - absenteeism and poor performance at work as a result of drinking, driving the morning after a 'heavy' drinking session when still over the limit;
- Older adults - drinking with medication, risk of accidents and falls;
- Ethnic minority groups - access to culturally appropriate information in different languages.

Information: The panel in the Delphi Survey (see Section 5) were asked how the concept of risky drinking could best be communicated to the general public. There was consensus and agreement that the *content* of such messages should include 'using different information for different groups, e.g., young, pregnant', 'a new language away from 'alcoholic', 'identifying and conveying the risks of drinking at different levels', 'clear consistent information on

government recommendations', 'consistent risk messages, not just at Christmas' and 'strong images and information on alcohol-related consequences'.

In focus group discussions (see Section 3), primary health care professionals generally thought that patients did not know how much they should or should not be drinking (i.e., the recommended levels), or how many units were in certain drinks (e.g., thinking that a standard pint of beer is one unit rather than two). This was especially felt to be the case in relation to new drinks, such as alco-pops, and stronger wines and lagers (n.b., many of the professionals in the focus groups were unsure of the number of units in these too). It was also felt that drinking 40 units a week, for example, is considered by many people to be normal and acceptable, and is not thought of as excessive. Professionals believed that patients do not generally make the link between excessive drinking and ill health (unlike for smoking).

A recent MORI survey of the general public reported that:

- 50% think they are fairly well-informed about alcohol-associated risks;
- 27% would like more information;
- 66% had heard of units;
- 58% say they had heard of weekly limits and say they know what these mean;
- 67% have never heard of daily benchmarks;
- 45% agree that they do not take much notice of health promotion campaigns on alcohol;
- 44% would like more information on associated risks.

In focus groups with patients (see Section 4), many participants had a reasonably accurate idea of the recommended weekly or daily levels of alcohol consumption, and that these levels differed for men and women. The men in the younger age-group (aged 18-19), however, were both uncertain and incorrect in their estimates, although they were aware of the unit system and what the equivalent was in terms of different drinks. In general, older men and women were not as sure of how many units a drink contained.

Participants were aware of a number of different problems associated with excessive drinking. Examples given included social, behavioural and health problems, such as crime, aggression, violence, family problems, road accidents, liver damage and stroke. Young male binge drinkers were more inclined to discuss the short-term physical problems of drinking

too much, such as feeling sick and dizzy or having accidents, and did not seem aware of the longer-term physical problems related to excessive drinking. Information about alcohol units and alcohol-related problems had been obtained from various sources, including reading about it in newspapers and magazines, seeing TV coverage, drinking and driving adverts, and seeing posters in a GP surgery.

All participants 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 health effects of excessive drinking, and where to go for information, advice and help. The younger men also suggested that information on the effects of mixing alcohol with illicit drugs would be useful for their age-group, and both younger men and women called for greater 'shock' tactics.

A Tyne and Wear Health Action Zone focus group study on binge drinking and young people (aged 16-20) found that participants had a minimal knowledge of units and generally felt that the units system was not relevant to them and that they would not use it. Most had never made any attempt to monitor their drinking and had no intention of doing so in the future. The majority were unfamiliar with the term 'binge drinking' but defined excessive drinking in physical terms or in relation to the consequences of their behaviour. These were immediate consequences such as hangovers, being sick, losing your friends, having your drink spiked and street violence. Long-term risks were rarely considered and often dismissed as being irrelevant.

In terms of attitudes to health messages, participants claimed that they would not pick up health education leaflets on alcohol in public, despite seeming interested in their contents when shown copies. Many took leaflets away with them following the focus group. However, it is reported that some of the statements in the leaflets were met with "hysteria and ridicule" in the younger unemployed groups, and the authors suggest that "care needs to be taken to pitch information at appropriate levels of maturity and understanding". The report suggests that "a harm minimisation approach has the potential to improve young people's existing personal safety strategies".

Recommendations

1) A consistent message regarding the medically recommended (daily/weekly) levels and up-to-date information on unit content in drinks.
2) The increasing risks of hazard and harm associated with drinking at increasing levels including the long-term health effects.
3) Excessive drinking is a lifestyle issue and needs to be distanced from concepts of "alcoholism" or severe dependence.
4) Positive messages in relation to moderate drinking and healthy lifestyles should be communicated e.g. promoting good health, safety and enjoyment.
5) Information on where to go for information and advice i.e. local GP or practice nurse should be provided.
6) Identified messages need to be targeted at the corresponding groups using the right wording, images and formats.

Communication/dissemination channels: Appropriate and effective communication channels also need to be tailored to the specific target sub-groups. In focus group discussions, primary health care professionals identified having leaflets, posters and displays for patients to read in the waiting room or in community areas, such as libraries, sports facilities, shopping centres etc., as a facilitating factor in implementing SBI. It was suggested that these could also include the AUDIT questionnaire, with details about contacting the local GP or practice nurse for more information. Health promotion computers for people to access voluntarily were also suggested.

Both GPs and nurses said that they do not tend to see young people, particularly young men, as much as other groups in primary care. Young women tend be seen mainly in relation to contraception advice. It was felt that this group would be more effectively targeted outside of general practice, e.g., in young people's services, clinics, youth centres, colleges, etc.. Details of appropriate web sites such as "Wrecked", a web-site about excessive drinking aimed at young people developed by Health Promotion England, could be included in targeted information.

Media campaigns were considered to be essential to raise the public's awareness of excessive drinking and related problems, and to make it easier to discuss alcohol issues in

primary care. The 'flu vaccine campaign was viewed to have been so successful because celebrities (Bobby Robson, Henry Cooper) were used in the adverts. Government health warnings on labels and alcohol advertising (similar to cigarette advertising) were also suggested.

Suggestions from focus groups with patients included increasing the size of labelling of alcohol content and units on cans and bottles to make it more visible, and to have health warnings on labels and also on the shelving in supermarkets or shops where alcohol is sold. Participants agreed that the only way to get messages about drinking across to the public was to use the mass media and either advertise or place articles and stories on TV, in the newspapers and in magazines. It was also suggested that alcohol information should be made specifically available in schools and universities as well as GP surgeries.

In the Delphi survey, there was consensus and agreement that the concept of risky drinking could best be communicated to the general public via the following: 'work in schools linked to smoking and sex education', 'media coverage', 'clear factual information (posters, leaflets) in practices', 'free telephone information lines', 'members of primary health care teams to take responsibility for dissemination of information', and 'a National Alcohol Strategy sending a clear message'.

Nationally, the NHS Plan (Secretary of State for Health, 2000) has outlined a number of initiatives to provide patients with more information about how they can look after their own health. These include NHS Direct health information via digital TV as well as telephone and internet, and 500 NHS Direct information points providing touch screen information and advice about health in places such as shopping centres and railway stations.

Recommendations

1) Appropriate (and targeted) leaflets, posters, and displays should be made available in general practice waiting rooms and other identified health, community, educational and workplace settings. Health Promotion England provides support and resources to professionals in the field (free to NHS organisations), and run media campaigns. They promote sensible drinking with resources such as Drinkline (a free alcohol helpline), posters and leaflets. Links with stakeholders

would enable leaflets, posters and displays to be made available in the targeted settings.

2) A national media campaign (TV, radio, newspapers etc.) should be launched with the support of the Department of Health and Health Promotion England.

3) Alcohol information should be included in NHS Direct initiatives.

4) Working with initiatives such as “Healthy Cities”, “Healthy Workplaces”, “Healthy Schools”, “Arts in Health”, etc. to encourage ownership, active participation and creative work by local communities.

6. STRATEGIC ALLIANCE

As stated in Chapter 1, the lead organisation of this project was the Centre for Alcohol and Drug Studies at Newcastle, North Tyneside and Northumberland Mental Health NHS Trust in collaboration with the Department of Primary Health Care at the University of Newcastle. As also stated, a Project Management Team was formed to run the Phase IV study and this met regularly on a monthly basis throughout the study.

6.1.1. Local alliance

A local Steering Group was formed to advise and co-ordinate research activities in the local area. This contained representatives of a range of local institutions and organisations, including universities, health care organisations, local government and public relations. The members of the Steering Group were influential in publicising and advancing the aims of the project on a local basis.

6.1.2. National strategic alliance

To develop a Strategic Alliance on a nation-wide basis, a meeting was held at the Department of Health in London in May, 2000 which was attended by representatives of leading national organisations with a potential interest in promoting the implementation of SBI in England, including Alcohol Concern, the Royal College of General Practitioners, the Royal College of Nursing and the All-Party Parliamentary Group on Alcohol of the House of Commons.

Using contacts established at this meeting, publicity in various media and, following completion of the survey, the panel formed in the Delphi survey, a national Strategic Alliance was formed of organisations and individuals interested in promoting the widespread and routine implementation of SBI in PHC in England. Those joining the alliance were asked to sign a statement endorsing the aims of the Phase IV project. The membership of the Strategic Alliance contained 47 organisations and 92 individuals, including several Members of Parliament or Members of the European Parliament. The organisations in the Strategic Alliance are listed Table 6.1.

TABLE 6.1.

Membership of the Strategic Alliance (Organisations)

Addiction Prevention in Primary Health Care, London	National Association of Primary Care
ADS (North West), Manchester	Newcastle & North Tyneside Drugs & Alcohol Service
Alcohol Concern	Newcastle & North Tyneside Health Promotions Department
Alcohol Counselling and Prevention Services, London	NORCAS
Alcohol Education and Research Council	North Lambeth Primary Care Group, London
Alcohol Problems Advisory Service, Nottingham	North Wales Drug & Alcohol Forum
Alcohol Recovery Project, London	Northumberland CSMT
Alcohol Services for the Community	Nursing Council on Alcohol
Appleby Solutions Ltd	Options
C.A.I.S. Ltd	Royal College of General Practitioners
City and Hackney Alcohol Service, London	Royal College of Nursing Practice Nurses Association
Clapham Family Practice, London	South Tyneside Drug & Alcohol Service, Tyne & Wear
Community Alcohol & Drugs Service, Kings Lynn	South Tyneside PCT
Community Mentors Ltd	Specialist Community Alcohol Team, Crewe
Department of Nursing & Community Health, Glasgow	Sunderland Community Health Council
Department of Pubic Health & Family Health APU, Chelmsford	Swanswell Charitable Trust : Coventry Community Alcohol Service
Drinksense	Leamington Community Alcohol Service
Health Development Agency	Nuneaton Community Alcohol Service
Heath Promotional Research Group University of Newcastle	Rugby Community Alcohol Service
Hereford and Worcester Advisory Service on Alcohol	The Albert Centre
Leeds Addiction Unit	The Department of Nursing & Community Health, Glasgow Caledonian University
Manchester Community Alcohol Team	Trafford Alcohol Service, Manchester
Medical Council on Alcoholism	Trafford SMS, Manchester

6.2. National one-day conference

As part of the activities of the Strategic Alliance, a national one-day conference was held at the *International Centre for Life* in Newcastle upon Tyne in June 2002. The conference was organised by a local public relations company, *Benchmark Communications Ltd* and sponsored by the Alcohol Education & Research Council, the NHS Health Development

Agency, the Newcastle/ Gateshead Initiative and Pfizer UK Ltd. The conference was titled, *Action on Alcohol: the Role of Primary Care* and was attended by over 300 delegates. Invited keynote addresses in the morning sessions were by Professor Sir Liam Donaldson, the Chief Medical Officer and Professors Griffith Edwards, Paul Wallace, Hazel Watson and Mike Kelly. In the afternoon there was a presentation of the latest findings from the Phase IV study by the project team, followed by another keynote address by Dr. Stephen Rollnick. The meeting concluded with a discussion among the members of the Phase IV Strategic Alliance of the best ways to take forward the alliance and the aims of the project. The conference programme is shown in Table 6.2.

6.3. Summary

The Strategic Alliance formed during the project helped to bring to the attention of interested organisations and individuals the need to achieve a full implementation of alcohol SBI in PHC in England and provided the basis on which this objective can be furthered in future work.

TABLE 6.2.

ACTION ON ALCOHOL:
THE ROLE OF PRIMARY HEALTH CARE
A One-day Conference to be held at the Centre for Life, Newcastle upon Tyne, Friday 28th June 2002

PROGRAMME

9.30am	Registration & Coffee
10.00am	Welcome to the conference - Professor Nick Heather
10.10am	Morning Session (Chair: Professor Tim van Zwanenberg)
10.10am	"The Burden of Alcohol-related Harm in the UK" Professor Sir Liam Donaldson
10.40am	"On the Drink" Professor Griffith Edwards
11.10am	Refreshments
11.30am	"Is General Practice the Right Place for the Detection and Management of Excessive Alcohol Consumption?" Professor Paul Wallace
12.00pm	"Screening for Alcohol Problems and Delivery of Interventions: A Role for Nurses?" Professor Hazel Watson
12.30pm	"Alcohol and Evidence Base" Professor Mike Kelly
1.00pm	LUNCH
2.00pm	Symposium: WHO Phase III & IV projects (Chair: Dr. Noel Olsen)
2.00pm	"Overview of the WHO programme of research on Identification and Management of Alcohol-related Problems in Primary Health Care" Professor Nick Heather
2.10pm	"Results from the WHO Phase III project and related research" Dr. Eileen Kaner
2.30pm	"Results from the WHO Phase IV project: focus groups with health professionals and patients" Ms. Deborah Hutchings
2.45pm	"Results from the WHO Phase IV study: Delphi study of expert opinion" Ms. Emma Dallolio
3.00pm	Refreshments
3.20pm	Meeting of *Strategic Alliance* for the Routine Implementation of Screening and Brief Alcohol Interventions in Primary Health Care in England (Chair: Professor Nick Heather)
3.20pm	"Behaviour change in primary care: variations on a theme" Dr. Stephen Rollnick
4.00pm	"Where do we go from here?" General discussion on ways to take forward the Strategic Alliance (Facilitator: Dr. Paul Cassidy)
5.00pm	Close

7. FUTURE DIRECTIONS, CONCLUSIONS AND RECOMMENDATIONS

7.1. Demonstration Project

The original intention of the WHO Phase IV study, including the English arm of the study, was to use the information and experience gained in the first three components of the study described in this report (Customisation, Reframing, Strategic Alliance) to feed into a fourth component, the Demonstration Project. The intention was that customised materials and procedures making up an SBI pack, indications of how the relevant understanding of alcohol issues could be reframed and the support of an alliance of committed organisations and individuals would be used to *demonstrate* that widespread and routine implementation of SBI in PHC in a circumscribed area could be achieved. This demonstration could then serve as a model for similar attempts at implementation throughout the country.

Unfortunately for this plan, it proved impossible to obtain the necessary funding to conduct the Demonstration Project. Three applications for funding to various bodies were made but all proved unsuccessful. Reasons for this failure to attract funding are unclear since the logic of the proposed study seemed sound and the importance of its aims self-evident. It may be that funding organisations still favour conventional forms of research, like RCTs and randomised surveys, at the expense of action research and qualitative methods, which may be seen as "unscientific". At the same time, funders may not sufficiently appreciate the need for "translational research" (Babor, 2005), i.e., research aimed at translating research evidence into routine practice. If true, it is to be hoped that these attitudes among funding bodies will change in future.

The main consequence of this failure to attract essential funding was a lack of continuity in research and implementation activity. Staff who had been trained in SBI research and had become skilled and knowledgeable in this area were lost to other fields of study. Moreover, the impetus for widespread implementation of SBI that had been built up by the formation of the Strategic Alliance and strengthened by the national conference in Newcastle in 2002 was to a large extent dissipated.

On a more positive note, the hiatus caused by the delay in carrying out a Demonstration Project may have had unintended benefits for the effort to

implement SBI in England. This is because the delay allowed time for several important developments to occur that have now provided a unique opportunity to make progress in the Phase IV study's central aim. These developments are:

- the Government's Alcohol Harm Reduction Strategy for England (AHRSE: Prime Minister's Strategy Unit, 2004), implemented in March 2004. The AHRSE document includes reference to alcohol SBI in general and SBI in PHC in particular in Chapter 5 on Treatment and Identification and summarises the Government's intentions with regard to SBI in England. While there are flaws in the discussion of SBI in the AHRSE, in particular its neglect of the hazardous drinkers as opposed to patients with established alcohol problems, the prominence given to SBI in the document, especially in PHC, gives grounds for optimism that the Government now recognises its potential in the effort to reduce alcohol-related harm in England;

- the New General Medical Services Contract (nGMS) which came into effect at the beginning of April 2004. A specification for the treatment of "Patients who are alcohol misusers" is provided in the Contract as a National Enhanced Service (NES) and this includes SBI for hazardous and harmful drinkers. It is clear that the nGMS needs reform if it is to assist the widespread implementation of SBI but the opportunity to effect such reforms does exist.

- a White Paper published by the Department of Health in November 2004 entitled Choosing Health: Making Healthy Choices Easier (Department of Health, 2004). This includes alcohol consumption among the other health behaviours it addresses and proposes a new profession of "Health Trainers" to work in PHC to give advice to patients showing health-related risk behaviours.

In addition, in November 2003, the Tyne and Wear Health Action Zone (HAZ) invited tenders for a one-year project entitled, *Implementing Screening and Brief Alcohol Interventions into Pilot GP Practices*. Some of the authors of this report (Heather, Kaner), together with other colleagues, were successful in bidding for

this grant. The application for funding specifically mentioned the opportunity to build on the research conducted in the WHO Phase III and Phase IV studies and the HAZ project can therefore be regarded as a form of Demonstration Project fitting the requirements of the Phase IV protocol. The project was described as an example of action research in which the participants in the project were invited to join researchers in meeting the project aims and an iterative process is used to make progress towards those aims. The project began in August 2004 and data collection has now been completed.

The aims of the project were:

i) To pilot the routine implementation of alcohol SBI in at least one general medical practice in each of the five areas of the Tyne & Wear HAZ (Sunderland, Newcastle, South Tyneside, Gateshead, North Tyneside);
ii) On that basis, to develop Clinical Guidelines to assist primary health care professionals to deliver SBI in their everyday practices;
iii) At the same time, to develop a Training Programme for the routine delivery of SBI in primary health care;
iv) To roll out tried and tested Clinical Guidelines and a Training Programme to general practices across the HAZ and beyond.

The findings of the HAZ SBI pilot implementation project will be described in due course elsewhere. However, in the light of the developments just mentioned, the research described in this report is clearly still of obvious relevance to implementing SBI routinely in PHC and is possibly more in line now with declared national priorities and government thinking than when the study began. More specifically, as promised in the AHRSE, in May 2005 the government invited tenders for research to carry out a number of pilot schemes to test how best to use a variety of models of targeted screening and brief intervention in primary and secondary healthcare settings, focusing particularly on value for money and mainstreaming. The main questions that were to be addressed were:

a) Can it be demonstrated within the UK context and in a real-life environment that screening and brief intervention are clinically effective and cost effective in changing individual drinking behaviour?

b) What forms of screening and intervention for alcohol misuse are acceptable and reasonable to be implemented GPs, primary care staff, healthcare staff in other settings (A&E, outpatient clinics, inpatient wards) as well as staff in other settings such as criminal justice settings?

Our Newcastle team is part of a consortium that was successful in bidding for this research grant and will take particular responsibility for a cluster randomised trial in the PHC segment of the project. While some answers to the questions above have been provided, at least in PHC, by the Tyne and Wear HAZ project (see above), the new project will investigate these questions on a much wider scale and in a more formal, quantitative fashion.

7.2. Conclusions regarding customisation of SBI materials and procedures

There are numerous conclusions that could be drawn from the detailed findings described in this report. However, the following seem to be the most prominent in the current national context.

a) Focus groups with PHC professionals and with patients showed that discussions about alcohol are acceptable within specific contexts in primary care.

b) A targeted rather than universal approach to alcohol screening and intervention would be more acceptable to patients and professionals and fits naturally with existing practice.

c) There is still uncertainty among professionals as to the effectiveness of brief interventions and disagreement between professionals and patients as to who should carry them out.

d) Lack of resources and incentives remains a barrier to implementation. General practices that take on alcohol as an enhanced service through the nGMS contract will receive additional training and resources; however, the nGMS contract could become a disincentive if PCTs are financially unable to commission the work.

e) In a Delphi survey, there was strong support for the employment of a specialist alcohol worker to carry the main load of work created by the delivery of SBI. The specialist worker should be an integral member of the PHC team. By contrast, the idea of employing a specialist alcohol worker in PHC was unpopular among professionals and patients in focus groups, mainly because of the stigma that might be created by visiting such a person. The concept of a "lifestyle counsellor" was more acceptable to patients and professionals.

f) UK experts recommended a way of delivering SBI that is intermediate between universal screening for all patients attending a PHC facility and the abandonment of screening. They were agreed that routine SBI should be carried out in special circumstances, i.e., new patient registrations, general health check-ups and special clinics where excessive drinkers were likely to be found. These views were consistent with those of patients and professionals in focus groups.

g) In practices where a specialist worker is considered suitable, findings suggested a model involving screening by other PHC staff, possibly in addition to screening by the specialist, followed by brief intervention, support and monitoring and onward referral to alcohol or addictions agencies where appropriate by the specialist worker.

h) In circumstances where the employment of a specialist worker is not feasible, the findings suggested a model of inter-professional co-operation in the delivery of SBI: (i) screening for excessive drinking is carried out in appropriate circumstances by the GP, practice nurse, district nurse and counsellor; (ii) referral of positive cases for brief intervention is made to the practice nurse, the counsellor or the dietician, with additional involvement by the GP or the health visitor given time and interest; (iii) support and monitoring of the patient is carried out by the PHC staff member who gave the brief intervention; (iv) onward referral is made by the same staff member, perhaps in consultation with the GP.

i) The Delphi expert panel stressed the need for increased and improved training and education of health care professionals in skills related to SBI, particularly with regard to the recognition of risk and presentational factors, how to encourage patients to talk about their drinking and other brief intervention skills.

j) Experts showed broad agreement on the importance of principles bearing on the interaction between helper and patient derived from the motivational interviewing perspective and the idea that behaviour change should be negotiated with the patient rather than prescribed or imposed.

7.3. Recommendations regarding reframing of understandings of alcohol issues

7.3.1. Primary health care professionals

The Marketing Strategy developed during the project indicates that clear information is needed for PHC professionals in the following areas:

a) A consistent message regarding the medically recommended (daily/weekly) levels and information on units;

b) Up-to-date information on the conversion of drinks (bottles, cans etc.) to units, e.g. using a "ready reckoner" unit calculator;

c) The positive as well as negative effects of alcohol, with clear definitions of "risky" or hazardous and harmful levels;

d) The links between alcohol and health/social problems, including links to the national priority areas identified by the Government in 'Saving Lives: Our Healthier Nation';

e) Statistics on the extent of alcohol-related problems both nationally and locally;

f) Information on common alcohol-related problems/conditions likely to present in primary health care;

g) Facts and figures on relative risks;

h) Evidence of the effectiveness of SBI in primary care;

i) The availability of local support services, clear referral procedures and guidelines (developed by the primary care team and local alcohol services);

j) Provision of appropriate leaflets and posters for patients in the waiting room (targeting identified patient groups).

7.3.2. Communications channels

Channels for communicating information about SBI to health professionals should include:

a) Raising awareness of alcohol-related problems and creating interest in SBI via interactive professional group (education and training) meetings and/or in-house practice team meetings;

b) Dissemination of SBI package and training programme to practices via (follow-up) telemarketing;

c) Provision of interactive practice team-based training with ongoing telephone support.

7.3.3. Stakeholders

Reframing understandings of alcohol issues among relevant stakeholders should include:

a) Utilisation of the Phase IV National Strategic Alliance to work together to promote the widespread implementation of SBI;

b) Further building of a Local Strategic Alliance to promote the implementation of SBI in the local area and link with existing strategies and campaigns;

c) Staging of a national conference to bring together members of the Alliance and key stakeholders, with interactive workshops to further the development of the implementation strategy and encourage ownership;

d) Dissemination of SBI research and an implementation programme via stakeholder meetings, conferences, publications and the internet.

7.3.4. The general public

Reframing understanding of alcohol issues among the general public should be based on the following principles:

a) A consistent message regarding the medically recommended (daily/weekly) levels and up-to-date information on unit content in drinks;

b) Information on the increasing risks and harm associated with drinking at increasing levels including the long-term health effects;

c) Stressing that excessive drinking is a lifestyle issue and needs to be distanced from concepts of "alcoholism" or severe dependence;

d) Positive messages in relation to moderate drinking and healthy lifestyles should be communicated, e.g. promoting good health, safety and enjoyment;

e) Information on where to go for information and advice, e.g. local GP or practice nurse, should be provided;

f) Identified messages need to be targeted at the corresponding groups using the right wording, images and formats.

7.3.5. Communication/ dissemination channels

Channels for communicating information about the need for alcohol SBI to the general public should be based on the following:

a) Appropriate (and targeted) leaflets, posters, and displays should be made available in general practice waiting rooms and other identified health, community, educational and workplace settings. *Health Promotion England* provides support and resources to professionals in the field (free to NHS organisations), and run media campaigns. They promote sensible drinking with resources such as Drinkline (a free alcohol helpline), posters and leaflets. Links with stakeholders would enable leaflets, posters and displays to be made available in the targeted settings.

b) A national media campaign (TV, radio, newspapers etc.) should be launched with the support of the Department of Health and Health Promotion England.

c) Alcohol information should be included in *NHS Direct* initiatives.

d) Working with initiatives such as "Healthy Cities", "Healthy Workplaces", "Healthy Schools", "Arts in Health", etc. to encourage ownership, active participation and creative work by local communities.

7.4. National Strategic Alliance

The national Strategic Alliance formed during the project could be revived and used to help the widespread and routine implementation of SBI in PHC in future attempts to do so.

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