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

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Summary

Background

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

Method

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

Results

The survey achieved a 73% response rate. The average age of GPs was 47 and number of years in practice was 16; 57% were male; 50% were from urban practices; 85% were from group practices; and 50% saw 101-150 patients per week. Nearly 90% of GPs placed a 'very high' (45%) or 'somewhat high' (44%) priority on disease prevention. Over a half (52%) had received less than 4 hours of post-graduate training, CME or clinical supervision on alcohol-related issues and 12% had received no such training. Sixty seven per cent of GPs had taken or requested a blood test because of alcohol more than 5 times in the last year and 43% had managed 1-6 patients for alcohol problems in the last year. The majority of GPs (64%) stated that physical symptoms on their own or in combination with psychological or social symptoms would elicit enquiry about alcohol. GPs' recommended drinking limits were an average of 23 units per week for men and 16 units per week for non-pregnant women.

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

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

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

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

Conclusion

GPs see preventive medicine as a higher priority and alcohol as a more important behaviour for public health than they did ten years previously. However, GPs are not routinely asking patients about alcohol and most do so only in response to physical indicators. The provision of support to facilitate GPs in asking patients about alcohol is recommended. GPs report low numbers of patients being managed for alcohol. Levels of identification could be increased through the adoption of screening for

alcohol problems into the GP contract. GPs feel more prepared to counsel for alcohol problems and more effective in doing so than they did ten years previously, though they perceive the potential to deliver more alcohol intervention if given further training. They may perceive a lack of a supportive environment for alcohol work, and might benefit from training, interventions that target practitioner attitudes and offer of broader support. Levels of postgraduate training in treating alcohol reported by GPs are low and lower than ten years previously. Further training should be made available to GPs. GPs indicate that they may often be too busy to engage in interventions for alcohol problems and report lower therapeutic commitment than role security. Inclusion of alcohol treatment in the GMS contract, and in the Quality and Outcomes Framework as an indicator, might address this. Better education about alcohol in schools, minimum unit pricing and further regulation of off-sales would be supported by GPs even though the evidence for alcohol school education is poor. Their responses suggest they would welcome being part of an approach to tackling alcohol problems, coordinated for instance with health education campaigns. Postal surveys offer a useful means of accessing the views of GPs if carefully designed and targeted.

Background

Alcohol-related problems are most prominent in developed countries, accounting for 9.2% of the disease burden [1] and ranking third after tobacco and blood pressure as the lead causes of morbidity and premature death. Worldwide, alcohol contributes 4% to the total disease burden, 3.2% of all deaths and is the 5th largest risk factor for injury [2]. In England 38% of men and 16% of women have an alcohol use disorder which is equivalent to 8.2 million people [3]. There has been a dramatic increase in deaths in the UK from liver cirrhosis and alcohol disorders over the last 50 years compared to heart disease [4].

In primary health care, one-fifth of patients are likely to be excessive drinkers, presenting at twice the rate as average patients and with a wide range of alcohol-related problems [5]. Primary care is ideal for early detection and secondary prevention of alcohol-related problems due to its high contact-exposure to the population [6]. Moreover, brief interventions have been shown to reduce excessive consumption in primary care patients [7, 8]. Yet GPs exhibit low levels of formal identification, treatment and referral of patients with alcohol use disorders [3]. It has been reported that GPs may be missing as many as 98% of the excessive drinkers presenting to primary health care [5].

In a survey carried out in the English midlands in 1999, GPs reported receiving more alcohol-related education than in previous studies, that they were prepared to counsel patients about reducing consumption and that a perceived lack of effectiveness in helping patients change alcohol consumption could be ameliorated by more information, training and support. However, GPs were little involved in, and poorly motivated to work with, alcohol issues and identification of alcohol problems was hampered by a focus on physical symptoms [5, 9]. Compared to other areas of lifestyle counselling (e.g. smoking cessation, diet and physical activity) GPs reported that the largest gap between their preparedness to intervene and their sense of being a success at changing behaviour was for alcohol issues. These findings have proved important to both researchers and policy makers alike and are highly cited within the academic community (ISI Web of Knowledge, Web of Science, citation search). It is reassuring to note that another survey, published at this time, reached essentially the same conclusions [10, 11].

Prior to 1999, work published in the UK concerning GPs' attitudes to working with alcohol-related problems reported that GPs possessed high 'role legitimacy' in working with such patients. However, GPs lacked 'role adequacy' and 'role support' in this work and were poorly motivated to address alcohol-related problems. These studies took place in a context where GPs reported receiving little post-graduate education about alcohol-related issues [12, 13]. Qualitative research, at this time [14] and more recently [15], reported patient resentment and GP awkwardness as important factors in discouraging GPs from enquiring about alcohol consumption.

At the time of the 1999 survey the Government was working towards the aim of a reduction in the proportion of individuals drinking more than recommended limits,

set out in the 1992 White Paper 'The Health of the Nation: A Strategy for Health in England' [16]. Since the original survey took place there have been significant policy changes. A review of 'The Health of the Nation' concluded that it had failed to realize its full potential [17]. As a consequence the 1998 Green Paper, Our Healthier Nation: A Contract for Health [18] and the 1999 White Paper, Saving Lives: Our Healthier Nation [19] restated the Government's aims as improving the health of the population by combating the key killers in the UK - cancer, heart disease and stroke, accidents and mental illness. Excessive alcohol consumption was named as a risk factor in these four national priority areas but new targets were not set.

In 2004, the Government in England published the first National Alcohol Harm Reduction Strategy [20] which aimed to identify and, where possible, prevent the harmful consequences of alcohol misuse; to help those who suffer the consequences of alcohol misuse; and to manage the consequences. An early interim report had provided an evidence base for the National Strategy and quantified the scale of the problem related to excessive drinking in England [21]. At the same time the Academy of Medical Sciences [22] called on the Government to take immediate measures, not only to stop the rise in alcohol consumption but also to cut drinking to 1970 levels, a reduction of 33%. The 2004 White Paper, Choosing Health [23] emphasised and built on the recommendations in the National Alcohol Strategy with an information campaign to tackle problems of binge drinking, and by piloting screening and brief interventions in primary and secondary health care settings and similar initiatives in criminal justice settings. In 2007 the Government renewed its alcohol strategy in 'Safe. Sensible. Social. The next steps in the National Alcohol Strategy' [24] and recent information campaigns are keeping alcohol high on the agenda (http://units.nhs.uk/). Despite all this policy-level activity, a recent review of 'Choosing Health' reported, not only lack of real progress on alcohol but also that the cost of this public health problem had more than doubled to over £50 billion per annum [25].

As noted above, primary care has been identified as a key location to tackle alcohol problems. Eighty six per cent of all the health needs of the British population are managed in primary care, with over 15% of the entire population seeing a GP in any two week period and 78% of people consulting their GP at least once during each year [6]. In 1999, GPs identified a range of barriers and facilitating factors that influenced their ability to carry out alcohol interventions. The main barriers to brief alcohol intervention were given as insufficient time and training, and lack of help from government policy; the main incentives related to availability of appropriate support services and proven efficacy of brief interventions. Given that alcohol has risen higher up the public policy agenda, it seems timely to assess if these personal, organisational and structural factors have altered over time to promote alcohol intervention work. The proposed study provides an ideal opportunity to determine the extent of GP education related to alcohol in 2009 (another 10 years on) and to establish if changes in GPs' attitudes to working with drinkers have occurred in the last decade in light of policy changes.

Aim

The aim of the study was to assess the current knowledge, attitudes and practices of GPs concerning brief alcohol intervention and to examine whether these have changed over the last ten years and in light of recent health policy initiatives.

Objectives

- To administer a survey to a representative sample of GPs;
- To maximise response rate to ensure generalisability;
- To describe current knowledge, attitudes and practices regarding alcohol issues;
- To compare the above with similar data collected in 1999.

Method

Participants

General Practitioners (GPs) in the English midlands, comprising Leicester City, Leicestershire County and Rutland, Derby City, Derbyshire County, Nottingham City and Nottinghamshire County Teaching Primary Care Trusts. This was roughly the same geographical area as the previous survey. The sample consisted of 419 GP principals (one GP per practice). Details of general practices were provided either directly by the PCT (Leicester City, Nottinghamshire County) or via the NHS Choices website (Derby City, Nottingham City) or a combination of the two (Leicestershire County, Derbyshire County). At the time of data collection (February 2009) the NHS Choices website (http://www.nhs.uk) displayed the date the page was last updated and in many cases this was over 2 years old. Some surgeries also had their own website listed on NHS Choices, so this was checked to verify details if it had a more recent update. The study team was also made aware that other alcohol intervention activity was ongoing with GPs in the Leicestershire area.

Questionnaire

The questionnaire used in this survey (see Appendix 5) was a slightly modified version of the questionnaire from the previous 1999 survey [5, 9]. Most questions were the same in order to allow for comparison across the two surveys, while a small number were altered to reflect recent changes in GP practices particularly the Quality and Outcomes Framework:
(http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/QOF)
that makes prevention care a key element of routine general practice work. As before, the Short Alcohol and Alcohol Problems Perception Questionnaire [26] was included in the questionnaire (sections #21, 22) to provide quantitative assessments of GPs' attitudes to working with 'problem drinkers' and 'alcoholics' separately. The questionnaire also included additional sections at the end (#26, 27) to gauge the influence of policy change on attitudes and behaviour. These sections were developed via a list of policy-relevant alcohol strategies and interventions available in the literature [27]. Current policies were mapped to this list and then any outstanding strategies were used as suggestions for future policies. Each questionnaire contained a unique ID number which could be matched to GP contact details in order to allow reminders to be sent to non-responders. GP contact details were stored on a secure server in a separate database from the questionnaire data.

Procedure

The procedures used were similar to those employed in the previous survey in order to replicate this work. However, based on previous experience [28], a number of techniques were utilised to ensure adequate response rates [29]. Two weeks prior to sending questionnaires, GPs were posted a pre-notification letter (see Appendix 1) informing them about the study and alerting them to the forthcoming questionnaire. Questionnaires were mailed via first class recorded delivery (envelope with full

colour university logo and “important documents enclosed” printed on the front). Enclosed with the questionnaire was an unconditional £10 Marks & Spencer voucher to compensate GPs for their time, a covering letter encouraging GPs to respond (see Appendix 2), and an addressed envelope for return of completed questionnaire. Non-responders were telephoned two weeks later to encourage them to respond. Two further reminder questionnaires were posted to non-responders at two weekly intervals, comprising revised letters (see Appendix 3 and 4) further encouraging GPs to respond and an addressed return envelope. All letters were personalised, printed on university headed paper and individually signed by the practicing study GP (PC). All envelopes were white and sent either recorded delivery or first class; addressed return envelopes had a first class stamp attached. All documents were posted between 25 June 2009 and 7 September 2009 which included a period of school holidays and occurred during the swine flu pandemic

Approval

The study received ethical approval from the Local Research Ethics Committee (North East Strategic Health Authority) and R&D approval from the 6 PCT areas surveyed (Leicester City, Leicestershire County, Derby City, Derbyshire County, Nottingham City and Nottinghamshire County). The study was also adopted by the East Midlands and South Yorkshire Primary Care Research Network and was supported by the local Drug and Alcohol Action Teams (Leicester, Leicestershire, Derby, Derbyshire, and Nottinghamshire) and Nottingham Crime and Drugs Partnership. The study also had a local collaborator at the University of Leicester (MC).

Analysis

SPSS statistical software version 17.0 [30] was used to store, code, clean and analyse the data, using paired or unpaired t-tests for continuous variables and chi-square tests for categorical data. Because of the large number of tests conducted, a p-value of 0.01 was taken to indicate statistical significance.

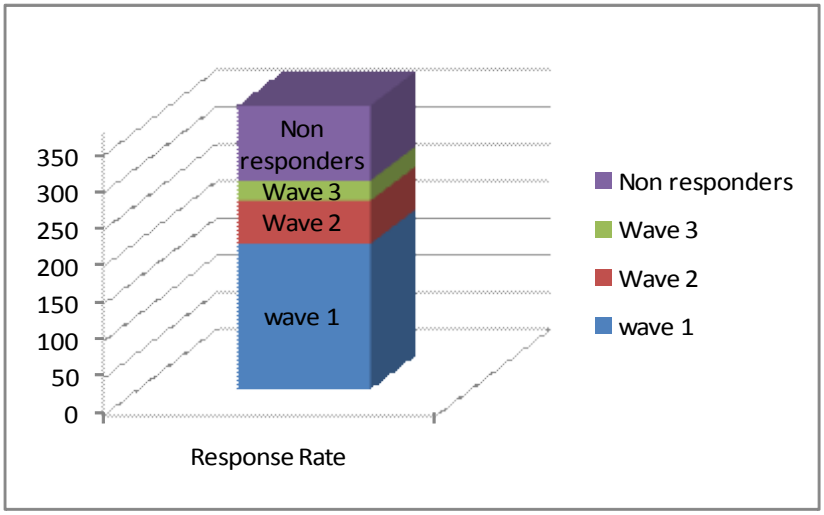
Results

Response rate

Out of an initial total sample of 419 GPs, 34(8%) were not eligible to complete the survey. Of this ineligible number, 24(71%) GPs had left practice, 7(20%) had retired, 2(6%) were on maternity leave and 1(3%) was on long-term sick leave. Thus there was a total eligible sample of 385 GPs.

In total 282(73%) GPs responded to the survey. Figure 1 shows response rate by wave (First wave – introductory letter then questionnaire 197(51%), Second wave – telephone call and/or reminder 58(15%), Third wave - second reminder - 27(7%))

Figure 1: Response rate by wave of survey



The 1999 survey achieved a response rate of 68% (279/411). There was no significant difference between response rates for the current and the previous survey ($\chi^2(1)=2.75$, $p=0.097$).

Response rate by area

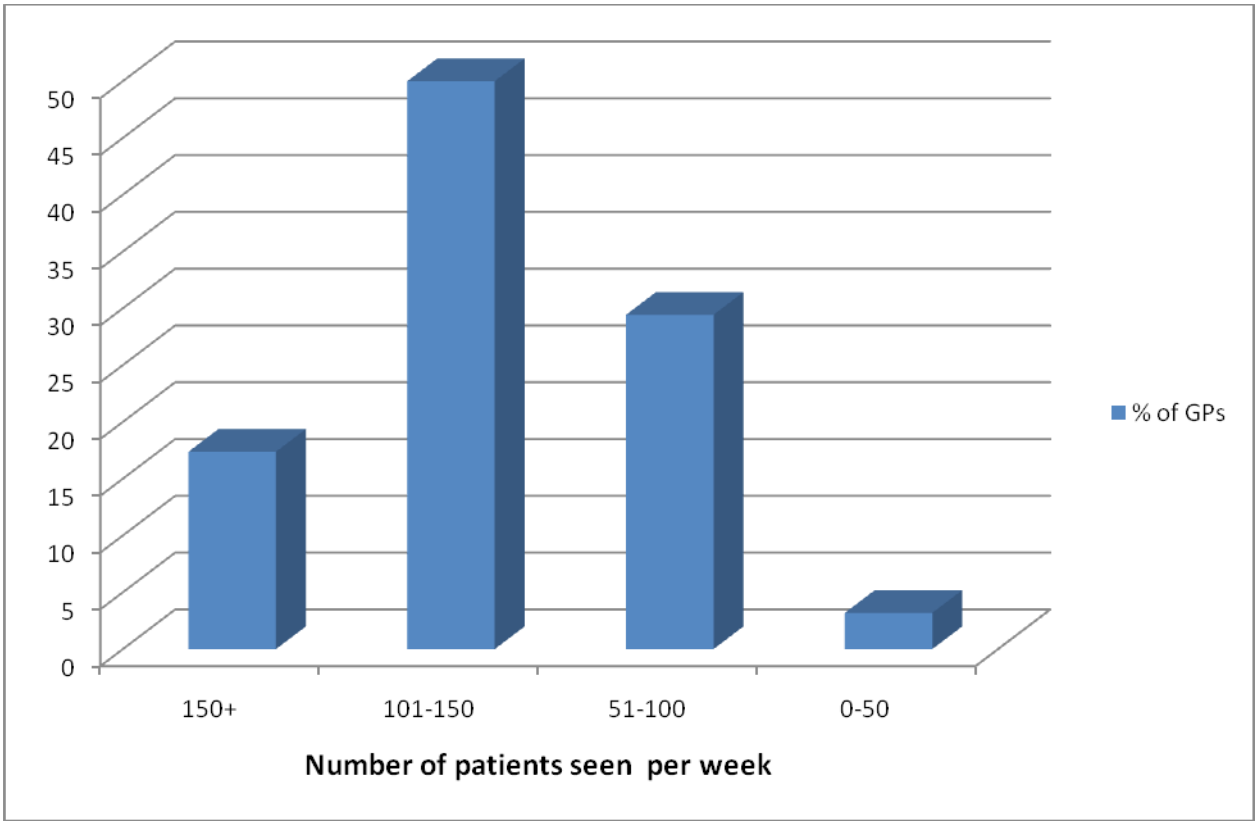
Response rates for each of the three areas were Leicester City and Leicestershire County 77% (101 responded/131 eligible, n=139), Derby City and Derbyshire County 68% (78 responded/115 eligible, n=126) and Nottingham City and Nottinghamshire County 74% (103 responded/139 eligible, n=154).

GP characteristics

The average age of GPs was 47 (s.d. 9.25) years; the majority were male (57%). They had practised for an average of 16 (s.d. 9.19) years; male GPs had significantly more years in practice (mean 18.5 yrs, s.d. 9.00) than female GPs (mean 13.1yrs, s.d. 8.52), ($t(279)=5.11$, $p<0.001$). The average number of days per week in general practice was 4.20 (s.d. 1.03); male GPs reported significantly more days per week in practice (mean 4.51 days, s.d. 0.90) than female GPs (mean 3.78 days, s.d. 1.05), ($t(277)=6.24$, $p<0.001$). The modal response for number of patients seen each week

was 101-150 (50%); 29% said they saw 51-100 (Figure 2). Number of patients seen per week differed significantly between male and female GPs ($\chi^2(3)=47.22$, $p<0.001$), with a trend for male GPs to see more patients. There was no significant difference between number of patients seen by older and younger GPs ($\chi^2(3)=0.26$, $p=0.967$).

Figure 2: Number of patients seen per week by GPs



Half the respondents described their practice as urban and 32% described it as mixed urban and rural. Type of practice did not differ significantly by age ($\chi^2(2)=8.34$, $p=0.015$) or gender ($\chi^2(2)=0.31$, $p=0.857$). The mean number of FTE GPs at the practices was 4 (s.d. 2.15), the modal number was 2. Fifteen per cent of GPs worked as sole practitioners. Number of partners in the practice did not differ significantly by gender ($\chi^2(2)=7.01$, $p=0.030$) or by age ($\chi^2(2)=8.60$, $p=0.014$). A summary of the characteristics of GPs and practices is presented in Table 1.

Table 1: Summary of GP and practice characteristics

Characteristic	Mean or %
Age	47 years
Sex	57% male
Time in practice	16 years
Time in practice/week	4 days
Patients per week	50% '101-150'
Practice location	50% 'urban'
Practice type	15% solo practice
Practice partners	3.93 partners

The sample profile is similar to that of English GPs as a whole. In 2006 60% of GPs were male; 37% were aged 40-49 and 28% were aged 50-59, compared with 36% and 28% respectively in the current sample. The proportion of solo practitioners (15%) is higher than in the national workforce in 2006, where single-handed practitioners accounted for 5% of GPs [31].

Emphasis on disease prevention

GPs were asked in an open-ended question to state what conditions typically led them to talk to a patient about alcohol. Their answers were coded into physical, psychological (e.g. depression, anxiety, stress or mood disorders), social syndromes or other conditions (e.g. health checks, medication reviews) or combinations thereof. The most frequent response was a combination of physical and psychological syndromes (33%), followed by a combination of any of physical, psychological or social syndromes plus 'other' (28%); the least frequent responses were psychological or social syndromes alone (1%, 0%) and a combination of social and psychological syndromes (1%).

89% of GPs said that they placed a 'very high' (45%) or 'somewhat high' (44%) priority on disease prevention. Less than 1% indicated a 'very low' priority for disease prevention. Sixty nine per cent said that they placed 'somewhat more' priority on disease prevention than other medical practitioners; a further 17% said that they placed 'much more' priority. There were no significant differences for gender or age of GPs in respect of own priority ($\chi^2(3)=1.66$, $p=0.646$); ($\chi^2(3)=3.30$, $p=0.347$) or comparative priority ($\chi^2(3)=5.40$, $p=0.145$); ($\chi^2(3)=2.77$, $p=0.429$).

GPs were asked how often they obtained information from their patients in relation to various aspects of health on a scale of 1-4 from 'rarely/never' to 'always'. Ninety nine per cent of GPs indicated that they obtained information about smoking; 88% gave these responses 'always' or 'as indicated' about alcohol consumption. Responses to questions on prevention and obtaining information on lifestyle behaviours are summarised in Table 2 and Figure 3. In a separate question, GPs were asked whether they enquired about alcohol if a patient did not mention it, using a scale of 1-4 ('all the time', 'most of the time', some of the time', 'rarely or never'). The largest proportion of GPs (58%) said that they enquired about alcohol 'some of the time' if the patient did not volunteer information. Frequency of inquiring about

alcohol did not differ significantly between male and female GPs ($\chi^2(3)=8.59$, $p=0.035$) but was significantly different between older and younger GPs ($\chi^2(3)=24.92$, $p<0.001$), with a trend for older GPs to ask more frequently than younger GPs.

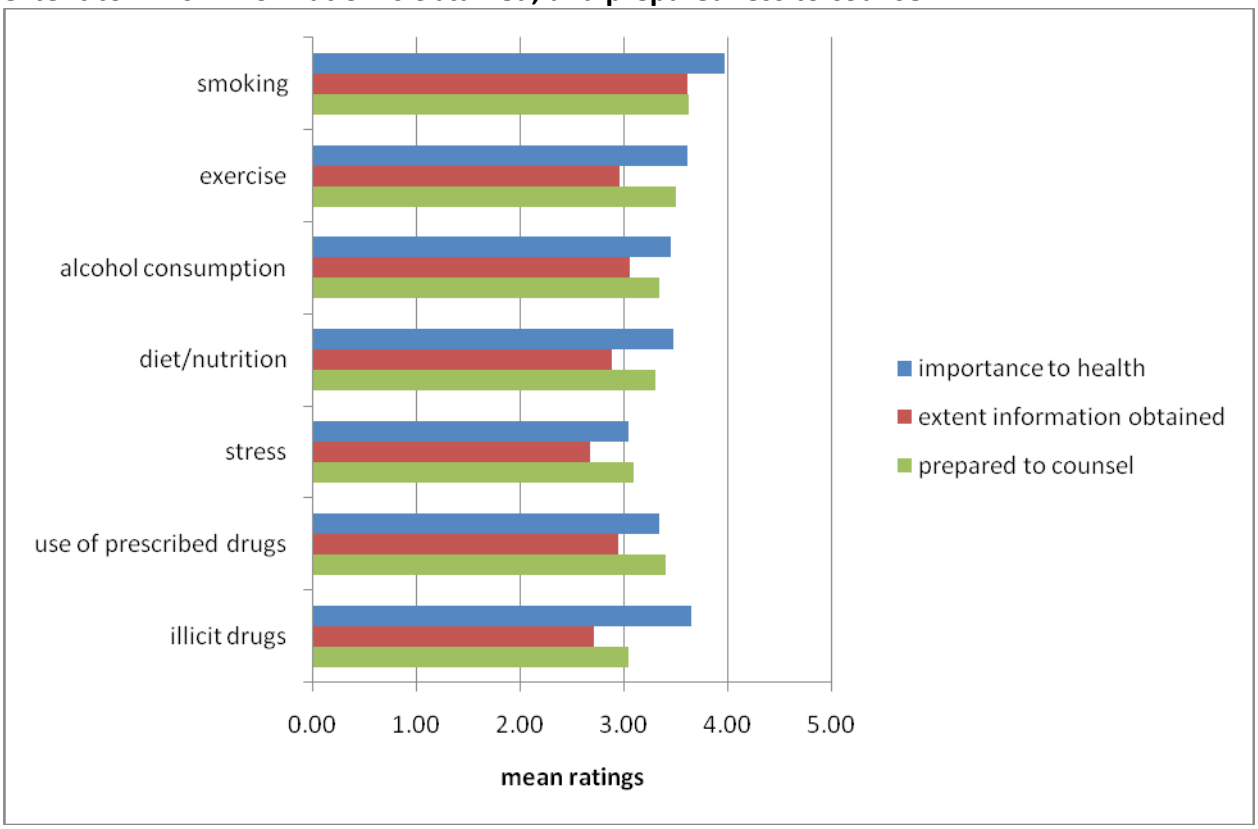
Table 2: Summary of current practices

Measure	Mean rating	% 'very' or 'somewhat high'
Priority on disease prevention (1=v high, 2= somewhat high 3=somewhat low 4=v low)	1.66	89

Perceived extent to which information is obtained
(4=always; 3=as indicated; 2=occasionally; 1=rarely/never)

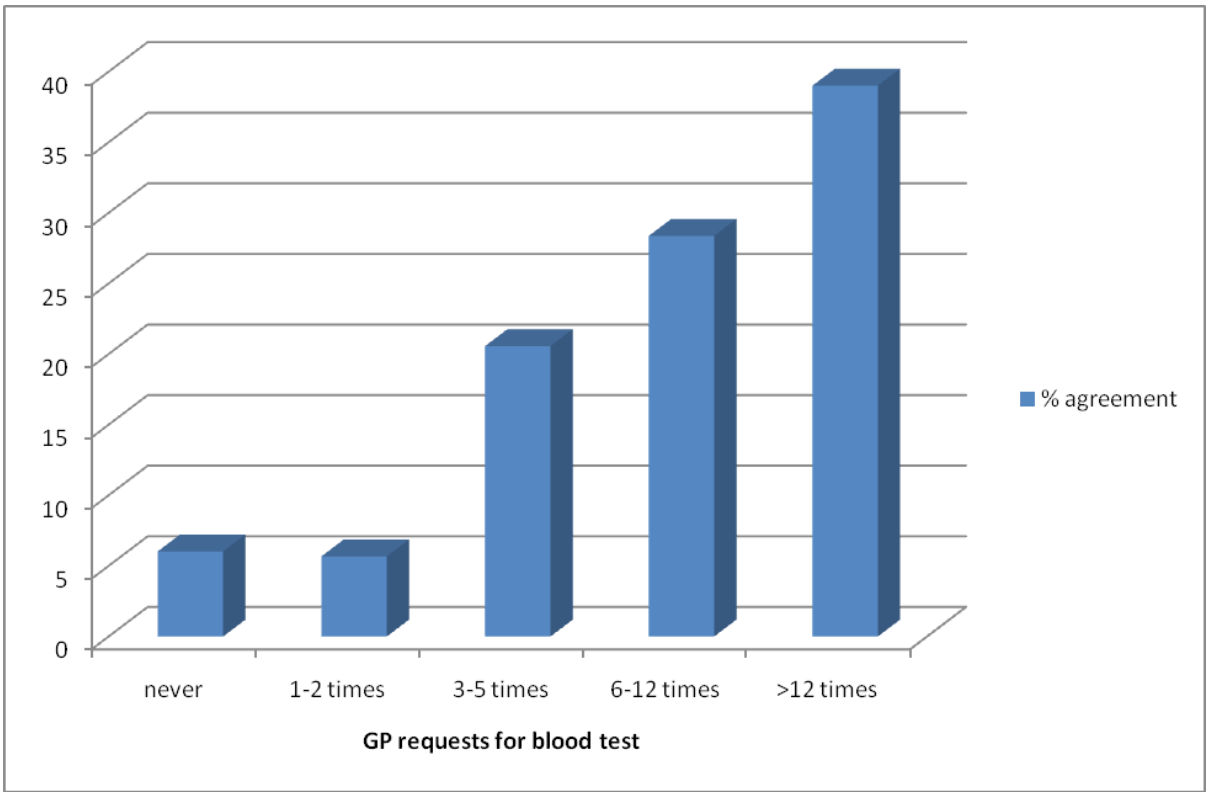
Behaviour	Mean rating	% 'always' or 'as indicated'
Not smoking	3.6	99
Alcohol consumption	3.0	88
Use of prescription drugs	2.9	78
Exercising regularly	2.9	78
Diet/nutrition	2.8	75
Illicit drug use	2.7	65
Stress level	2.6	64

Figure 3: Summary of GPs' attitudes to the importance of behaviours to health; extent to which information is obtained; and preparedness to counsel



67% of GPs indicated that they took or required a blood test because of alcohol more than 5 times in the last year. Thirty nine per cent indicated more than 12 such blood tests last year (Figure 4). There was no significant difference in number of blood tests requested between male and female doctors ($\chi^2(4)=7.61$, $p=0.107$) or between older and younger ($\chi^2(4)=11.26$, $p=0.024$). Forty three per cent of GPs reported that they managed between one and six of their patients specifically for their hazardous drinking or alcohol-related problems in the previous year (Figure 5). There were no significant differences in number of patients managed for alcohol between male and female doctors ($\chi^2(5)=2.34$, $p=0.801$) or between older and younger ($\chi^2(5)=3.75$, $p=0.585$).

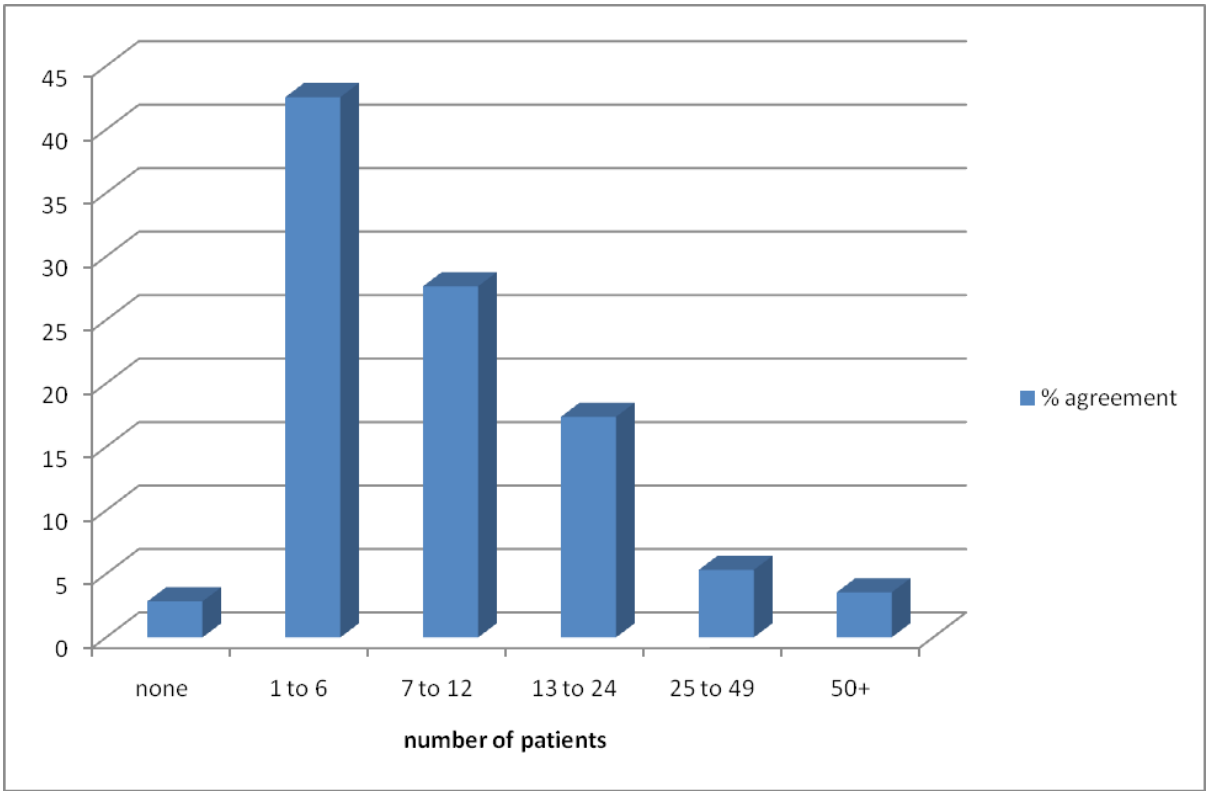
Figure 4: Number of times GPs took or requested a blood test because of alcohol



Sensible drinking limits

Most GPs reported the upper limit for alcohol consumption before advising to cut down in terms of drinks or units per week (rather than per day). The mean responses for men and non-pregnant women respectively were 23 units per week (s.d. 4.8) and 16 units per week (s.d. 4.2). Median and modal responses were both 21 for men (50% of GPs) and both 14 (52% of GPs) for women.

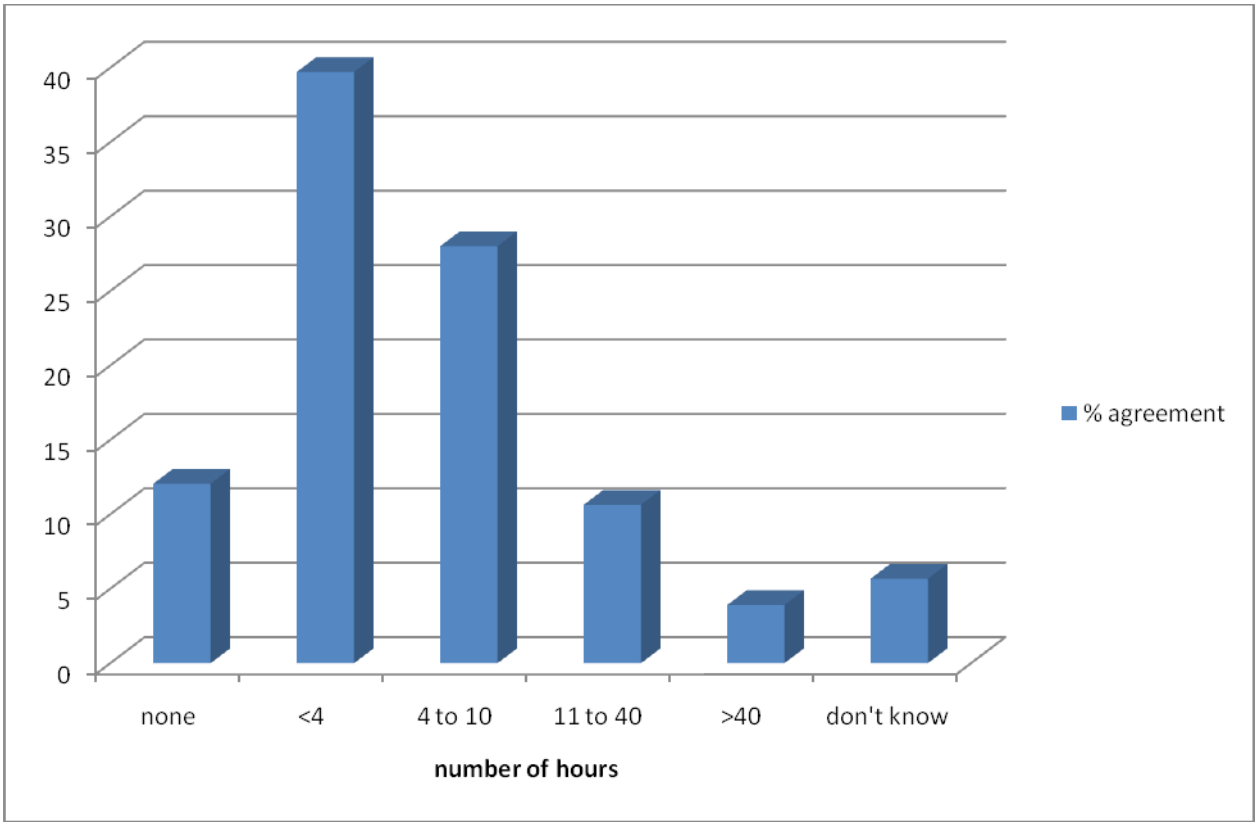
Figure 5: Number of patients managed specifically for alcohol problems per year



Medical education and training on alcohol

Most GPs (52%) indicated that they had received less than four hours of post-graduate training, continuing medical education or clinical supervision on alcohol and alcohol-related problems, including 12% who said they had received no such training (Figure 6).

Figure 6: Number of hours of postgraduate training, continuing medical education or clinical supervision on alcohol



The Short Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ)

The SAAPPQ is a 10-item Likert-type questionnaire measuring the attitudes of professionals towards the provision of care to those with alcohol use disorders [26]. The 10 items are scored from 1 (strongly disagree) to 7 (strongly agree). Five pairs of items are each summed to give measures of adequacy, self-esteem, motivation, legitimacy and satisfaction when working with drinkers. The questions were all asked in respect of both hazardous/harmful and dependent drinkers. Results are shown in Table 3 and Table 4.

Table 3: Problem (hazardous and harmful) drinkers

SAAPPQ Component	Mean score	S.D.	% agree
Adequacy	10.06	1.77	78
Self-esteem	9.03	2.26	53
Motivation	8.40	2.06	42
Legitimacy	11.14	1.75	88
Satisfaction	6.90	2.07	10

Table 4: Dependent drinkers

SAAPPQ Component	Mean score	S.D.	% agree
Adequacy	9.58	2.04	69
Self -esteem	8.84	2.37	49
Motivation	7.94	2.16	35
Legitimacy	11.13	1.88	87
Satisfaction	6.62	2.25	12

Mean scores were significantly greater for problem drinkers than for dependent drinkers for adequacy ($t(276)=6.36$, $p<0.001$), motivation ($t(277)=5.29$, $p<0.001$) and satisfaction ($t(279)=3.62$, $p<0.001$). No significant differences were observed for self-esteem ($t(271)=2.11$, $p=0.036$) or legitimacy ($t(279)=0.30$, $p=0.765$).

Alcohol in relation to other lifestyle behaviour and GPs' preparedness to counsel

The respondents rated the importance of seven health behaviours 'in promoting the health of the average person'. Ratings were on a scale of 1-4 from 'unimportant' to 'very important'. The behaviours seen as most important were not smoking (mean rank 3.94), not using illicit drugs (mean rank 3.62) and exercising regularly (mean rank 3.58), with 99%, 90% and 96% respectively indicating them as 'important or 'very important'.

GPs were also asked to rate how prepared they felt for counselling patients in these health-related areas. The four-point (1-4) scale used for rating ranged from 'very unprepared' to 'very prepared'. Respondents felt most prepared to counsel for not smoking, exercising regularly and responsible use of prescription drugs, with 98%, 97% and 94% of GPs feeling 'prepared' or 'very prepared' to counsel on these behaviours. Ninety four per cent of GPs were 'prepared' or 'very prepared' to counsel for reducing alcohol consumption. Mean values are presented in Table 5. See also Figure 3.

Table 5: Perceived importance of lifestyle behaviours to health and GPs' preparedness to counsel for these

Perceived importance of lifestyle behaviours (4=very important; 1=unimportant)		
Behaviour	Mean rating	% 'very important' or 'important'
Not smoking	3.9	99
Not using illicit drugs	3.6	90
Exercising regularly	3.6	96
Avoiding excess calories	3.4	92
Drinking alcohol moderately	3.4	92
Responsible use of prescription drugs	3.3	82
Reducing stress	3.0	73

Preparedness for counselling patients (4=very prepared; 1=very unprepared)		
Behaviour	Mean rating	% 'prepared' or 'very prepared'
Not smoking	3.6	98
Exercising regularly	3.5	97
Responsible use of prescription drugs	3.4	94
Reducing alcohol consumption	3.3	94
Avoiding excess calories	3.2	89
Reducing stress	3.0	80
Not using illicit drugs	3.0	77

Self-efficacy in relation to alcohol issues

In the questionnaire, GPs were asked to rate on a scale from 1 to 4 ('very ineffective' to 'very effective') how effective they felt in helping patients to achieve change in various health behaviours, and how effective they felt they could be given adequate information and training. Table 6 summarises their responses.

Table 6: Summary of self-efficacy measures

Perceived effectiveness when counselling patients
(4=very effective, 1=very ineffective)

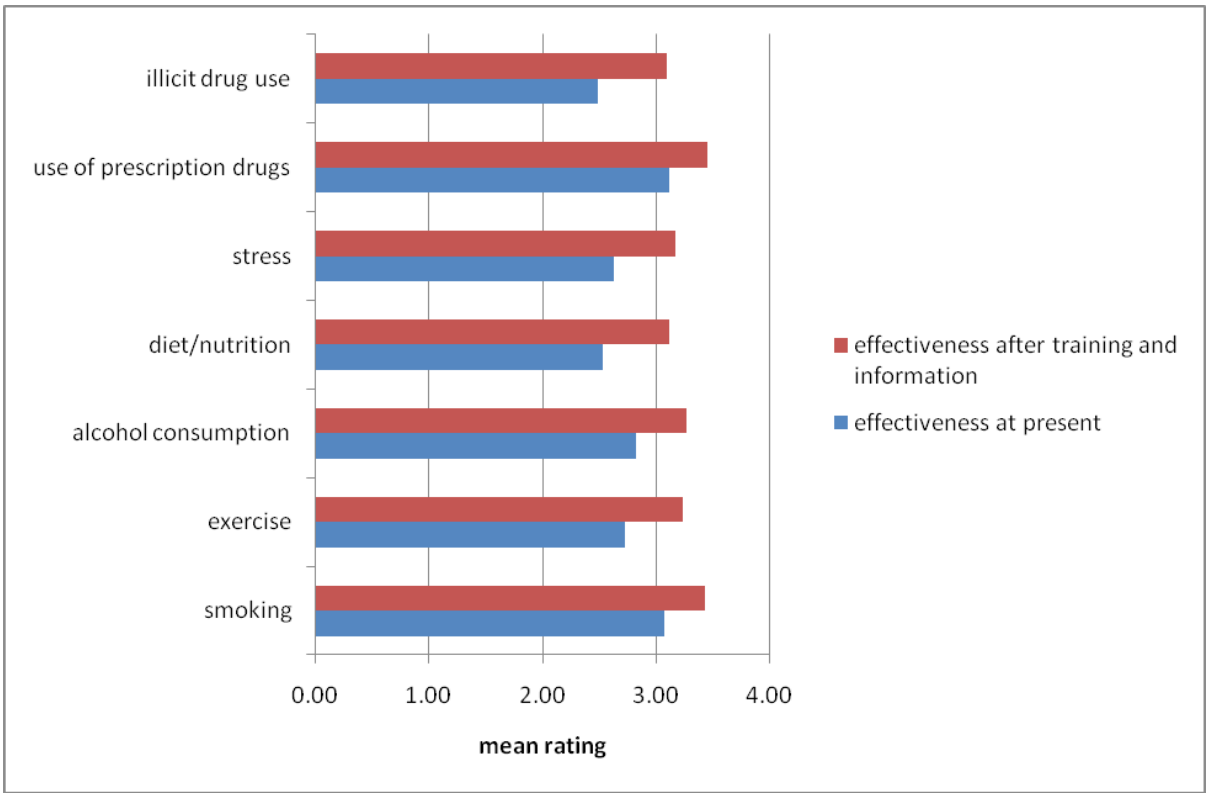
Behaviour	Mean rating	% 'effective' or 'very effective'
Not smoking	3.0	85
Responsible use of prescription drugs	3.0	84
Reducing alcohol consumption	2.6	60
Exercising regularly	2.5	50
Reducing stress	2.5	48
Avoiding excess calories	2.4	39
Not using illicit drugs	2.3	38

Perceived effectiveness given adequate training and information
(4=very effective, 1=very ineffective)

Behaviour	Mean rating (2009)	% 'effective' or 'very effective'
Not smoking	3.3	93
Responsible use of prescription drugs	3.3	90
Reducing alcohol consumption	3.1	82
Exercising regularly	3.1	79
Reducing stress	3.0	76
Not using illicit drugs	3.0	71
Avoiding excess calories	2.9	71

GPs felt most effective in helping patients not to Sixty per cent of GPs felt 'very effective' or 'effective' in helping patients to reduce alcohol consumption. Ninety three per cent felt they could be 'effective' or 'very effective' in counselling patients not to smoke given adequate training and information; 82% of GPs gave this response in respect of reducing alcohol consumption (Figure 7).

Figure 7: Self-efficacy



Perceived barriers to early alcohol intervention

To consider potential barriers to early intervention in general practice, GPs were asked to indicate their agreement on a scale of 1-4 ('not at all' to 'very much') with 15 suggested barriers, 14 replicated and one modified from the 1999 questionnaire. Table 7 presents their agreement with these items. Agreement was highest for the statements suggesting that doctors were 'just too busy' (63%); that doctors were not trained in counselling for reducing alcohol consumption (57%); and that the current GMS contract did not encourage work with alcohol problems (48%). The lowest rates of agreement were with statements that doctors have a disease model rather than preventive training (21%); that doctors believe patients would resent enquiry (17%); and that alcohol was not an issue in general practice (14%).

Table 7: GPs' agreement with suggested barriers to early alcohol intervention

Statement	agreement
Doctors are just too busy dealing with the problems people present with	63%
Doctors are not trained in counselling for reducing alcohol consumption	57%
*Doctors are not sufficiently encouraged to work with alcohol problems in the current GMS contract	48%
Doctors do not have suitable counselling materials available	46%
Doctors believe that alcohol counselling involves family and wider social effects, and is therefore too difficult	41%
Doctors do not believe that patients would take their advice and change their behaviour	39%
Doctors do not know how to identify problem drinkers who have no obvious symptoms of excess consumption.	30%
Doctors do not have a suitable screening device to identify problem drinkers who have no obvious symptoms of excess consumption	28%
Doctors themselves may have alcohol problems	28%
Doctors themselves have a liberal attitude to alcohol	27%
Doctors think that preventive health should be the patients' responsibility not theirs	23%
Doctors feel awkward about asking questions about alcohol consumption because saying someone has an alcohol problem could be seen as accusing them of being an alcoholic	22%
Doctors have a disease model training and they don't think about prevention	21%
Doctors believe that patients would resent being asked about their alcohol consumption	17%
Alcohol is not an important issue in general practice	14%

**modified from 'The government health scheme does not reimburse doctors for time spent on preventive medicine'*

Perceived incentives for early alcohol intervention

To consider potential incentives to early intervention in general practice, GPs were asked to indicate their agreement on a scale of 1-4 ('not at all' to 'very much') with 7 suggested incentives, 5 replicated and two modified from the previous questionnaire. Table 8 presents their agreement with these items. Most statements were strongly endorsed by GPs. Agreement was highest that readily available support services (87%), proving the success of early intervention (81%) and patients requesting health advice about alcohol (80%) would offer an incentive; the lowest rating was for improving salary and working conditions as an incentive (39%).

Table 8: GPs' agreement with suggested incentives to early alcohol intervention

Statement	Agreement
**General support services (self-help/counselling) were readily available to refer to	87%
Early intervention for alcohol was proven to be successful	81%
Patients requested health advice about alcohol consumption	80%
Quick and easy counselling materials were available	76%
Quick and easy screening questionnaires were available	70%
Training programs for early intervention for alcohol were available	69%
Public health education campaigns in general made society more concerned about alcohol	67%
*Providing early intervention for alcohol was included in the Quality in Outcomes Framework (QOF)	63%
Salary and working conditions were improved	39%

**modified from 'Training in early intervention for alcohol was recognised for continuing medical education credits'*

***modified from 'Support services were readily available to refer patients to'*

GPs' views on policy to reduce alcohol-related harm

GPs were asked to indicate their views on the effectiveness of 12 government measures and 11 suggested policies to tackle alcohol problems. They were asked to rate effectiveness on a scale from 1 to 5 (1=no opinion, 2=ineffective, 3=slightly effective, 4=quite effective, 5=very effective). The proportions of GPs answering 'very effective' or 'quite effective' are presented in Table 9 for the government policies and in Table 10 for the suggested policies.

Ratings of effectiveness for all government policy items were low (25% or less). The strongest endorsements were for the increased provision of treatment of alcohol problems (25%) and the introduction of powers to ban anti-social drinking (24%); the lowest was for the introduction of flexible opening hours (5% saw this as effective).

Ratings of effectiveness for most suggested policy items were relatively high. The strongest endorsements were for improved alcohol education in schools (71% saw this as effective), further regulation of off-sales (58% saw this as effective) and minimum pricing for units of alcohol (55% saw this as effective); the lowest was for a government monopoly of retail sales (27% saw this as effective).

Table 9: GPs' views on effectiveness of government policies in reducing alcohol-related harm

Policy	Very effective or quite effective
Increased provision for treatment of alcohol problems	25%
Introduction of powers to ban anti-social drinking in areas	24%
Introduction of powers to ban individuals from premises/areas following alcohol-related ASB	22%
Increased provision for brief interventions to prevent alcohol problems	20%
Promotion of recommended guidelines on drinking limits and health information	18%
Increased powers to enforce and penalise breach of licence conditions	18%
Sharpened criminal justice for drunken behaviour	18%
Introduction of local alcohol strategies	17%
Stricter rules for the content of alcohol advertisements	13%
More extensive considerations when granting licenses	13%
Promotion of a 'sensible drinking' culture	11%
Introduction of more flexible opening hours licensed premises	5%

Table 10: GPs' views on potential effectiveness of suggested policies in reducing alcohol-related harm

Policy	Effective or very effective
Improve alcohol education in schools	71%
Further regulation of alcohol off-sales (e.g. supermarkets, off-licences)	57%
Institute minimum pricing for units of alcohol	55%
Increase restrictions on TV & cinema alcohol advertising	54%
Lower BAC limit for drivers	53%
Make public health a criterion for licensing decisions	49%
Raise minimum legal age for purchasing alcohol	48%
General changes in alcohol price through taxation	48%
Statutory regulation of alcohol industry	43%
Raise minimum legal age for drinking alcohol	39%
Government monopoly of retail sales of alcohol	27%

Comparison of 1999 and 2009 surveys

The 2009 survey largely repeats a previous survey of GPs in the East Midlands from 1999. 10 respondents indicated that they thought they had filled the questionnaire in on the previous survey; the two samples are therefore substantively distinct. The results for demographic and practice characteristics and attitude items (on lifestyle behaviours, self-efficacy, SAAPPQ, barriers and incentives to early intervention) from these two surveys are compared in this section.

Table 11 presents comparative demographic characteristics and practice information for the two surveys.

Table 11: Summary of GP and practice characteristics

Measure	Means or % for total sample (2009)	Means or %s for total sample (1999)
Age	47 years	51 years
Sex	57% male	76% male
Time in practice	16 years	13 years
Time in practice/week	4.2 days	5.3 days
Patients per week	50% 100-150	48% >150
Practice location	50% urban	50% urban
Practice type	86% group	78% group
Practice partners	3.9 partners	3.4 partners

There were significantly ($\chi^2(1)=19.75$, $p<0.001$) more female doctors in the 2009 sample (43%) than in the 1999 sample (24%); the average age of respondents in 2009 was significantly lower (mean 47 years, s.d. 9.25) than in 1999 (mean 51 years, s.d. 8.51), ($t(510)=5.44$, $p<0.001$).

GPs in the 2009 sample had been in practice for significantly longer (mean 16.2 years, s.d. 9.19) than GPs in the 1999 sample (mean 13.0 years, s.d. 8.30), ($t(512)=-4.05$, $p<0.001$).

GPs in the 2009 sample spent fewer days per week in practice (mean 4.20, s.d. 1.03) than GPs in the 1999 sample (mean 5.3, s.d. 1.03), ($t(512)=12.31$, $p<0.001$).

The number of patients seen per week was significantly different between the surveys ($\chi^2(3)=64.95$, $p<0.001$), with a trend towards fewer patients seen per week in the later survey. Modal values were '101-150 patients per week' in 2009 compared with '>150 patients per week' in 1999.

The hours of specific postgraduate training in alcohol reported by GPs in the 2009 sample (mode '<4') were not significantly different from those reported by GPs in the 1999 sample (mode '4-10') ($\chi^2(5)=12.31$, $p=0.031$).

GPs in 2009 reported significantly different numbers of blood tests ordered per year in respect of alcohol problems (mode '>12') from GPs in 1999 (mode '3-5'),

($\chi^2(4)=46.24$, $p<0.001$), with a trend towards more blood tests ordered in the later year.

The number of patients reported as being treated for alcohol problems was significantly different between 2009 and 1999 ($\chi^2(5)=27.35$, $p<0.001$), with a trend for more patients being treated in the later year; the modal response of '1-6 patients' was the same for both years.

Fifty eight per cent of GPs in 2009 and 67% of GPs in 1999 indicated that they enquired 'some of the time' about alcohol if a patient did not ask. There was a significant difference in responses to this question between 2009 and 1999 ($\chi^2(3)=16.07$, $p=0.001$), with a trend towards patients being asked more of the time in the later year.

GPs' rating of their own priority on disease prevention was significantly different between 2009 and 1999 ($\chi^2(4)=41.23$, $p<0.001$), with a trend towards higher priority in 2009. Their ratings of their own priority on disease prevention in comparison with other practitioners was also significantly different between 2009 and 1999 ($\chi^2(4)=27.46$, $p<0.001$), with a trend towards perceiving relatively more priority than other practitioners in 2009.

Lifestyle behaviours and preparedness to counsel

In 2009, GPs' mean ratings of the importance of reducing alcohol consumption (3.40, s.d. 0.671), regular exercise (3.58, s.d. 0.557) and avoiding excess calories (3.44, s.d. 0.625) as lifestyle behaviours were all significantly higher ($t(506)=-6.24$, $p<0.001$); ($t(508)=-3.58$, $p<0.001$); ($t(508)=-7.99$, $p<0.001$) than the mean ratings of GPs in 1999 (3.00, s.d. 0.764; 3.39, s.d. 0.629; 2.97, s.d. 0.705). Ratings of the importance of other lifestyle behaviours were not significantly different between surveys (Table 12).

Table 12: Importance of lifestyle behaviours

Importance of:	2009 % important/very important	1999 % important/very important	t	df	*p*
Smoking	99	98	0.364	508	0.716
Exercise	96	90	-3.580	508	<0.001
Alcohol	92	75	-6.236	506	<0.001
Calories	92	74	-7.988	508	<0.001
Stress	73	71	-0.563	507	0.574
Prescription drugs	82	75	-1.969	507	0.050
Illicit drugs	90	89	0.559	507	0.577

GPs' mean ratings of their preparedness to counsel for these lifestyle behaviours were significantly higher in 2009 than in 1999 for all except the responsible use of prescription drugs (Table 13).

Table 13: Preparedness to counsel for lifestyle behaviours

Prepared to counsel for:	2009 % prepared/very prepared	1999 % prepared/very prepared	t	df	*p*
Smoking	98	88	-3.13	504	0.002
Exercise	97	85	-4.73	506	<0.001
Alcohol	94	81	-4.39	507	<0.001
Calories	89	73	-4.37	504	<0.001
Stress	80	68	-3.00	503	0.003
Prescription drugs	94	84	-1.38	506	0.169
Illicit drugs	77	49	-6.25	505	<0.001

GPs in 2009 indicated that they obtained information from patients about drinking alcohol moderately significantly less regularly (mean 3.02, s.d. 0.53) than GPs reported in 1999 (mean 3.22, s.d. 0.62), ($t(508)=4.00$, $p<0.001$); they reported asking about illicit drug use significantly more regularly in 2009 (mean 2.69, s.d. 0.80) than those in 1999 (mean 2.49, s.d. 0.81), ($t(508)=-2.70$, $p=0.007$). No significant differences were observed between the surveys in respect of obtaining information on any other lifestyle behaviours (Table 14).

Table 14: Extent of obtaining information about lifestyle behaviours

Obtain information about:	2009		1999		t	df	*p*
	% always	% as indicated	% always	% as indicated			
Smoking	57	42	52	43	-1.420	508	0.156
Exercise	11	67	16	61	1.026	507	0.306
Alcohol	14	73	32	57	4.001	508	<0.001
Calories	8	67	9	59	-1.040	505	0.299
Stress	4	60	3	64	0.895	508	0.371
Prescript. drugs	18	60	28	49	1.758	508	0.079
Illicit drugs	12	53	8	44	-2.696	508	0.007

Self-efficacy at present and given training or information

GPs in 2009 rated themselves as significantly more effective in counselling for all lifestyle behaviours than GPs in 1999, both at present and if given adequate training and information. (Table 15 and Table 16)

Table 15: Self-efficacy at present

Counselling for:	2009 % Effective/very effective	1999 % Effective/very effective	t	df	*p*
Smoking	85	39	-11.45	504	<0.001
Exercise	50	28	-6.06	500	<0.001
Alcohol consumption	60	21	-9.29	497	<0.001
Calories	39	19	-6.26	501	<0.001
Stress	48	29	-4.63	501	<0.001
Prescription drugs	84	64	-4.43	502	<0.001
Illicit drugs	38	18	-6.22	497	<0.001

Table 16: Self-efficacy given adequate training and information

Counselling for:	2009 % Effective/very effective	1999 % Effective/very effective	t	df	*p*
Smoking	93	62	-8.17	503	<0.001
Exercise	79	57	-5.97	499	<0.001
Alcohol consumption	82	56	-6.70	499	<0.001
Calories	71	49	-5.97	499	<0.001
Stress	76	55	-5.47	497	<0.001
Prescription drugs	90	75	-3.69	501	<0.001
Illicit drugs	71	43	-7.42	499	<0.001

SAAPPQ

GPs in 2009 rated their adequacy to work with both problem drinkers (mean 10.06, s.d. 1.77) and dependent drinkers (mean 9.57, s.d. 2.03) more highly than GPs in 1999 (mean 9.62, s.d. 1.75; mean 9.04, s.d. 2.10), (t(496)=-2.76, p=0.006 and t(499)=-2.88, p=0.004). The 2009 GPs also rated themselves as more motivated in working with dependent drinkers (mean 7.93, s.d. 2.16) than the 1999 GPs (mean 7.35, s.d. 1.89), (t(499)=-3.18, p=0.002).

Significant differences were not found between surveys in respect of satisfaction, self-esteem and legitimacy when working with problem drinkers (t(501)=-1.47, p=0.143); (t(495)=0.30, p=0.762); (t(501)=0.13, p=0.900) or dependent drinkers (t(500)=-2.20, p=0.028); (t(493)=-1.73, p=0.084); (t(501)=0.09, p=0.927), nor in respect of motivation when working with problem drinkers (t(497)=-2.45, p=0.015). Results are presented in Table 17 andTable 18 below.

Table 17: Problem (hazardous and harmful) drinkers – 2009-1999 comparison

SAAPPQ Component	% agree 2009	% agree 1999	t	df	*p*
Adequacy	78	72	-2.756	496	0.006
Self-esteem	53	20	0.303	495	0.762
Motivation	42	23	-2.445	497	0.015
Legitimacy	88	87	0.126	501	0.900
Satisfaction	10	13	-1.469	501	0.143

Table 18: Dependent drinkers – 2009-1999 comparison

SAAPPQ Component	% agree 2009	% agree 1999	t	df	*p*
Adequacy	69	61	-2.882	499	0.004
Self-esteem	49	28	-1.729	493	0.084
Motivation	35	24	-3.182	499	0.002
Legitimacy	87	87	0.091	501	0.927
Satisfaction	12	7	-2.198	500	0.028

Perceived barriers & incentives

GP agreement with seven of the suggested barriers to early alcohol intervention was significantly lower in 2009 than in 1999. Responses to items on perceived barriers to early intervention are compared for the two surveys in Table 19 (No comparison was made in respect of the one reworded item).

Table 19: Barriers

Perceived barrier	2009 % agreement	1999 % agreement	t	df	*p*
Alcohol not important issue in general practice	14	28	4.760	491	<0.001
Disease model training	21	40	4.443	488	<0.001
Not responsible for preventive health	23	38	4.620	489	<0.001
Lack suitable screening device	28	38	3.111	484	0.002
GPs don't believe patients take advice	41	49	2.613	485	0.009
GPs liberal re alcohol	28	40	3.996	487	<0.001
GPs have alcohol problems	30	38	3.136	485	0.002
GPs too busy	63	69	1.973	491	0.049
GPs believe patients would resent if asked	18	20	0.468	486	0.640
GPs feel awkward asking	23	23	0.135	488	0.893
GPS can't identify without	30	29	0.773	490	0.440

obvious symptoms					
GPs lack suitable counselling materials	46	47	0.760	486	0.448
GPs not trained in counselling	59	58	0.957	487	0.339
GPs believe alcohol counselling difficult	43	48	1.658	484	0.098

GPs' agreement regarding incentives to early alcohol intervention in 2009 was significantly greater than in 1999 with respect to four of the items, and significantly less in relation to a fifth (salary and working conditions) (see Table 20).

Table 20: Incentives

Perceived incentive	2009 mean agreement	1999 mean agreement	t	df	*p*
Quick easy questionnaires	70	48	-4.72	493	<0.001
Quick easy counselling materials	76	56	-4.38	492	<0.001
Training for early intervention	69	53	-3.40	492	0.001
*Early intervention provision in QOF	63	33	-6.798	493	<0.001
Salary & working conditions	39	56	4.48	492	<0.001
**General support service availability	87	80	-1.407	495	0.160
Public health education campaigns	67	61	-0.586	495	0.558
Patients requested health advice	80	72	-1.748	495	0.081
Early intervention proven successful	81	75	-0.428	495	0.669

**modified from 'Training in early intervention for alcohol was recognised for continuing medical education credits'*

***modified from 'Support services were readily available to refer patients to'*

Discussion

Response rate

The response rate of 73%, similar to that of the 1999 study, gives these findings strong external validity as representative of the views of GPs [32] and exceeds expectations derived from the literature. A recent review of postal surveys of healthcare professionals concluded that mean response rates from GPs were in decline, having fallen significantly to 58% from the 61% reported for the previous decade [33, 34]. The response from GPs in the current study is remarkable given that the questionnaire was distributed during school holidays and a national flu pandemic. A number of factors may have influenced this outcome. The design of the study incorporated many features known to have a positive impact on return rates [28, 29], including the use of pre-notification, covering and reminder letters signed by a GP, unconditional financial incentives, recorded delivery of the questionnaire and telephone follow-up. Local awareness of the study was raised through contact with organisations including the PCRN and DAATs for the area. It may also be that a growing level of concern with alcohol among GPs contributed to the high response; many respondents added further comments at the end of the questionnaire about the problems of alcohol misuse, for instance telling us how many alcohol-related deaths there had been among their patients. In the face of pessimism regarding the use of postal surveys with busy healthcare professionals, the current study suggests that an appropriately designed and distributed questionnaire about issues of relevance to the target population can still secure acceptably high response rates.

Profile

The profile of the sample of GPs participating in the current study is similar to that of English GPs overall. 57% of GPs in the sample were male compared with 60% nationally; 36% were aged 40-49 and 28% were aged 50-59, compared with national rates of 37% and 28% respectively [31]. The proportion of solo practitioners (15%) is higher than in the national workforce, where single-handed practitioners accounted for 5%-6% of GPs [31][35]. This may reflect characteristics of the local population of GPs. Some differences from 1999 were evident in the sample. A greater proportion of respondents were female GPs than in the 1999 study. GPs reported working fewer hours and seeing fewer patients than 10 years ago, probably reflecting the fact that the increasing proportion of female GPs were more likely to work part-time. The decrease in number of patients seen is also to be expected given the transfer of activity over that period from secondary to primary care of patients, the move to a greater skill mix within practices, and an increase in the proportion of patients with more complex conditions seen in primary care [36].

Attitudes to prevention

Preventive approaches in primary care have been highlighted as a key measure in tackling alcohol misuse [37]. Eighty-nine per cent of GPs in the current survey reported that they placed a high priority on preventive medicine, significantly more

than the 75% reporting a high priority in the 1999 survey. There were no significant differences in these responses for age or gender, consistent with previous findings that young or female GPs were no likelier than older or male GPs to see preventive medicine as important [9]. This increase in perceived importance among GPs may be seen as encouraging or may reflect either the prioritisation of preventive medicine in the current Quality and Outcomes Framework for general practice [38] or changes in the orientation of teaching of medicine to prevention rather than cure. In a professional context driven by targets for preventive medicine, endorsing such practice may be viewed as a socially desirable response. However, GPs may see themselves as 'out on a limb' in these views. Most rated themselves as prioritising preventive medicine to a greater extent than other medical practitioners, and to a greater extent than GPs did in 1999. While the maintenance of a positive self-image may lead GPs to view themselves more positively than others around them, the increase in their perceived prioritisation relative to other practitioners since 1999 suggests that, while GPs are embracing the ideal of preventive medicine, they do not perceive professional culture as moving towards prevention with them. Qualitative research examining how GPs evaluate their own and others' attitudes in this area would be useful in illuminating how preventive approaches are becoming embedded in medical discourse and practice.

Indications of preventive practice, screening and identification

GPs in England have been observed to report a high level of systematic screening in their practice but achieve very low rates of identification of both hazardous and dependent drinkers [39]. A heightened priority for preventive medicine might be expected to result in more extensive routine enquiries about alcohol, in turn leading to identification of, and intervention with, more of the large proportion of problematic drinkers in their caseload [5, 6, 40]. Routine enquiry about alcohol still does not appear to be a mainstream practice from the results of the current study. If a patient does not ask about alcohol, most GPs (58%) would ask them about alcohol 'some of the time', as in 1999 (67%). However 40% said they would ask most or all of the time and there is a significant trend towards asking more often now than in 1999, when 27% reported asking most or all of the time; also, older GPs asked more often about alcohol use if a patient did not mention it. One explanation may be that older GPs learn from experience that alcohol problems are common and that many symptoms are related to excessive alcohol consumption.

GPs are requesting significantly more blood tests because of alcohol; most (67%) now make six or more such requests per year, whereas in 1999 most (55%) requested 5 or fewer. The proportion ordering more than 12 tests over a year has risen by 20%. Although GPs might not always request a blood test where an alcohol problem is indicated, this statistic nevertheless suggests a low rate of identification. The 22% rise in the proportion managing seven or more patients per year for alcohol problems also represents a significant change in practice. However, as in 1999, the largest proportion of GPs managed between 1 and 6 patients for alcohol in the last year. Given that most GPs reported seeing 100 or more patients per week, levels of

identification of alcohol problems in primary care still appear low, or short of the 20% of their caseload who may be misusing alcohol. It may be that the wording of one of the questions – 'managing' patients for alcohol – led some GPs only to count patients with higher needs whose alcohol problems required specialist intervention over a period of time. A one-off brief intervention, for instance, may not be thought of as 'management'. Monthly means of 8.1 patients treated for dependence and a further 14.2 patients drinking excessively, with most GPs treating 1-5 patients for dependence, have been reported elsewhere [39]. This suggests that results for the number of patients managed for alcohol problems in the current study may represent the proportion of dependent patients being managed on an ongoing basis, rather than patients identified as drinking excessively who may have received, for example, a one-off brief intervention. The 1-6 patients most GPs' manage for alcohol out of a caseload of 100 or more is commensurate with the 3.6% rate of alcohol dependence identified in the population [39], although the responses in the current study do not indicate whether the patients were being managed for dependent or hazardous/harmful drinking.

Attitudes to working with alcohol

GPs in the survey rated moderate alcohol consumption as, on average, slightly less important to patient health than other behaviours, including not smoking and not using illicit drugs. There was nevertheless a significant increase in its perceived importance from the previous study: drinking alcohol moderately is now seen as important or very important by 92% of GPs as against 75% in 1999. This may indicate growing awareness of, or concern with, the impact of alcohol on society and public health. It may also be a consequence of the overall drive towards preventive activity. Although its treatment is not used as a clinical indicator, alcohol is now amongst those issues deemed important as shown by their discussion in the guidelines for the QOF [38]. The QOF has however privileged targeted screening rather than universal screening. GPs considered they were more likely to obtain information on patients' alcohol consumption than on the other health behaviours listed apart from smoking, but only 14% of GPs indicated that they would *always* obtain information about a patient's alcohol consumption, with 73% stating that they would enquire only if symptoms indicated this was necessary. In 1999 these proportions were 32% and 58% respectively. This significant difference suggests a trend from proactive routine enquiries about alcohol use towards gathering information once alcohol is identified as a potential problem.

If identification of alcohol problems increasingly takes place on a responsive or targeted basis, the conditions prompting inquiry about alcohol may be important in determining whether a patient is screened. GPs are still most likely to talk about alcohol to patients with a combination of physical and psychological (e.g. depression, anxiety, stress or mood disorders) syndromes. The proportion of GPs stating that psychological or social problems alone would elicit an enquiry about alcohol problems remains at 1%, as in 1999; most GPs (64%) stated that physical symptoms, on their own or in combination with psychological or social conditions, would elicit talk about alcohol. Physical indicators therefore still appear central in the process of

identifying alcohol problems in primary care; alcohol misusers with associated mental health conditions or deteriorating social or family lives might not be questioned about their drinking by many GPs.

Potential to treat alcohol problems

GPs, then, appear to see alcohol as an increasingly important health issue and increasingly endorse preventive approaches, but do not appear to be increasing their identification of alcohol through routine questioning or working with alcohol problems to reflect the extent to which they are presumed to affect the population. Respondents saw themselves as significantly more prepared to counsel for reducing alcohol consumption, with 94% of GPs indicating that they felt prepared or very prepared for this, an increase of 13% from 1999. Sixty per cent of the sample felt effective in helping patients reduce alcohol consumption, a significant increase on the 21% who felt this way in 1999. These figures indicate that the gap between GPs' perceived preparedness to tackle alcohol and perceived self-efficacy in doing so has narrowed to some extent, and no longer shows the largest disparity among the areas of lifestyle counselling examined. Eighty-two per cent now perceive potential self-efficacy if given adequate training, compared with 56% in 1999, suggesting that GPs now see even greater potential for moderating alcohol consumption in primary care that they still fall short of being able to deliver.

Attitudinal factors limiting alcohol work

Attitude theories suggest various factors that might inhibit a positive attitude to treating alcohol problems from translating into the clinical behaviours of identification and intervention [41]. GPs may be enthusiastic about preventive approaches but not perceive them as normative behaviour; their responses on preventive medicine suggest that they perceive their own priorities as distinct from those of other practitioners. They may alternatively be expressing priority for preventive medicine as a socially desirable response to the questionnaire, masking a lesser enthusiasm to tackle alcohol problems. Or, it may be that GPs still do not perceive themselves as being enabled to tackle alcohol problems.

GPs have been found to be more likely to manage patients with alcohol-related harm where they; have received more education on alcohol, feel supported in working with alcohol problems and feel secure in, and committed to, that role, with role security measured by the SAAPPQ elements for legitimacy and adequacy and therapeutic commitment by the self-esteem, satisfaction and motivation elements [42]. Despite the rise in perceived efficacy and perceived potential to be effective in treating alcohol problems, most GPs now report 4 hours or less of postgraduate training specifically on alcohol, and 12% reported none. These are similar to rates of training highlighted as a concern in 1985 [13] and suggest a decline over a decade in hours of training, since most GPs reported 4-10 hrs in 1999. A supportive working environment for intervening with alcohol problems has been measured as one that has available suitable counselling and screening materials, training in their use, and help with handling difficult associated problems [42]. Around half (41-57%) of GPs in

the present study agreed that lack of training, materials and support for counselling were barriers to early intervention for alcohol, though there was significantly less agreement (28%) than in 1999 (38%) that lack of screening materials was a barrier. Results in the current study from the SAAPPQ indicate that GPs largely perceive themselves as secure in the role of intervening for alcohol. Most indicated that they had a legitimate role in helping dependent (87%) or problem drinkers (88%) to change their drinking. Significantly more GPs agreed they had adequate training and skills to carry out work with problem drinkers (78% agreement) than with dependent drinkers (69% agreement). Agreement was markedly lower, however, for role satisfaction, motivation and task-specific self-esteem (items measuring therapeutic commitment [42]) with either problem drinkers (10%, 42%, 53%) or dependent drinkers (12%, 35%, 49%). Overall, these results are not dissimilar from the picture of GPs obtained ten years previously. GPs express high security in the role of intervening for alcohol but have lower levels of training, perceived support and therapeutic commitment. This situation might be improved with further training interventions that also addressed practitioner attitudes or provided on-site support [43].

Other barriers, incentives and beliefs

The most widely acknowledged incentives to early intervention included the availability of general support and health education campaigns to support alcohol work. GPs may find themselves facing more practical limitations than attitudinal ones, however. The primary barriers acknowledged by GPs also included their being too busy and not being supported by the GMS contract; low importance of alcohol in general practice and the potential for patient resentment were among the least agreed barriers. The chance to register an opinion about government policy on tackling alcohol may have been among the motivations for GPs to participate in the study (one GP wrote on his questionnaire to thank the research team for giving GPs the chance to express their views) and GPs may not see existing policy as incentivising alcohol work. Respondents showed little support for previous government policies to tackle alcohol, with 25% or less agreement with the items presented. Only 5% saw the introduction of flexible opening hours for licensed premises as having helped to tackle problematic drinking. The views they did endorse are close to the recommendations of the recent House of Commons Health Committee report on alcohol [44]. What GPs want to see most is better education about alcohol in schools, with substantial support for more regulation of off-sales and minimum pricing for units of alcohol. In general, evidence of effectiveness is strong for the regulation of physical availability and the use of alcohol taxes. Given the broad reach of these strategies, and the relatively low expense of implementing them, the expected impact of these measures on public health is relatively high. In contrast the expected impact is low for school-based education. Although the reach of educational programmes is thought to be excellent (because of the availability of captive audiences in schools), the population impact of these programmes is poor. Similarly, while feasibility is good, cost–effectiveness and cost–benefit are poor [27].

Research strengths and limitations

Strengths of the current research study include the substantial response rate from a large and systematically sampled population of GPs, and the broad similarity of that sample's profile to that of the national workforce, offering a valid representation of GPs' attitudes. The replication of materials and target population from the previous study, and the inclusion of the SAAPPQ as a widely used measure to enable a robust decade comparison, enhance the comparability of these findings with other studies and would support its application in other geographical areas.

Limitations of the research include the fact that this is self-reported data and therefore subject to socially desirable responding. There is also a possibility that some questions may have been worded ambiguously; as discussed above, 'managing' patients for alcohol may have been taken to mean working with dependent drinkers, and comments on some questionnaires indicate that the wording of the question on barriers may have resulted in 8-13 cases of missing data for some items. One PCT also informed us that another study on alcohol was taking place at the same time as the current survey, which may have affected response rates or caused some GPS to have spent more time thinking about alcohol treatment than others. Also, in at least one PCT, a programme of training for GPs in brief interventions was underway, which again may have influenced the responses we received from some GPs in that area.

Conclusions

In light of the findings discussed above, from a sample of GPs in the English Midlands which are generalisable to the wider population of GPs in England, the following conclusions seem justified:

1. GPs see preventive medicine as a higher priority, and alcohol as a more important behaviour for public health, than they did ten years previously. The extent to which they see other GPs as sharing these views could be usefully investigated with further research.

2. GPs are not routinely asking patients about alcohol. Most do so only in response to physical indicators. The provision of support to facilitate GPs in asking patients about alcohol is recommended.

3. GPs report low numbers of patients being managed for alcohol, though they may have tended not to include those drinking excessively rather than dependently. Levels of identification could be increased through the adoption of screening for alcohol problems into the GP contract.

4. GPs feel more prepared to counsel for alcohol problems and more effective in doing so than they did ten years previously, though they perceive potential to deliver more in the way of alcohol intervention given further training. They may perceive a lack of a supportive environment for alcohol work, and might benefit from training and from interventions that target practitioner attitudes and offer of broader support.

5. Levels of postgraduate training in treating alcohol reported by GPs are low and lower than ten years previously. Further training should be made available to GPs.

6. GPs indicate that they may often be too busy to engage in interventions for alcohol problems and report lower therapeutic commitment than role security. Inclusion of alcohol treatment in the General Medical Services (GMS) contract, through the Quality and Outcomes Framework, might address this.

7. Better education about alcohol in schools, minimum unit pricing and further regulation of off-sales would be supported by GPs. Their responses suggest they would welcome being part of an approach to tackling alcohol problems, co-ordinated for instance with health education campaigns.

8. Postal surveys offer a useful means of accessing the views of GPs if carefully designed and targeted.

References

Appendices

Appendix 1
INITIAL LETTER TO GPs

Dear Dr,

Research: *A Survey of GPs' Attitudes to Alcohol Prevention*

Newcastle University & University of Leicester will soon be carrying out research in the East Midlands, supported by local DAATs. Ten years ago we undertook an influential collaborative study in your area for the WHO, to establish how general practitioners regarded identifying and engaging with alcohol problems. The forthcoming study aims to compare GPs' current views in this area with those from before a decade of government priority to reduce alcohol consumption. Findings will be widely publicised to inform practice and help develop national and local policy.

As a practising GP I know your views are essential to debate on these issues. I will be sending you a questionnaire modelled on that in the original study which will ask for your views on issues around alcohol prevention. Answers you supply will be treated as strictly confidential and held securely and separately from contact details. Knowing that as GPs we face considerable demands on our own time, the questionnaire is designed to take about 10 minutes to complete, and will be forwarded to only one GP per practice with a £10 voucher in recognition of your time. We will send you feedback on the overall findings at the completion of the study.

If you wish further information please contact the Project Manager Dr Graeme Wilson on 0191 222 5695 or at: g.b.wilson@ncl.ac.uk. Thank you for your attention to this,

Yours faithfully,

Dr Paul Cassidy
General Practitioner

On behalf of the research team:
Dr Paul Cassidy Teams Medical Practice, Gateshead
Dr Marilyn Christie School of Psychology, University of Leicester
Professor Nick Heather Division of Psychology, Northumbria University
Professor Eileen Kaner Institute of Health & Society, Newcastle University
Dr Catherine Lock Institute of Health & Society, Newcastle University

Funded by Alcohol Education and Research Council; NHS REC and R&D approval received.

Appendix 2
COVERING LETTER TO GPs

Dear Dr,

Research: *A Survey of GPs' Attitudes to Alcohol Prevention*

I wrote to you recently regarding the above study, undertaken by Newcastle University and University of Leicester, which follows up at 10 years a WHO survey of GPs in your area. I would now like to encourage you to complete and return the enclosed questionnaire in the postage paid envelope provided so that we can include your views as an individual professional in this study. As a practising GP, I know that your own time is a scarce resource. Hence we have tried to make this form as short as possible; a £10 voucher is also enclosed in gratitude for your time.

The knowledge gained will be valuable to the development of alcohol strategy and to the support of general practice in the East Midlands; DAAT teams in the East Midlands have indicated a strong interest, and we will feed back findings to you once our study is completed. All our staff are bound by the Data Protection Act and your answers will be treated as strictly confidential and held securely and separately from contact details.

You can contact the Project Manager, Dr. Graeme Wilson, on 0191 222 5695 or at: g.b.wilson@ncl.ac.uk with any questions about the study. Thank you very much for your assistance in this.

Yours faithfully,

Dr Paul Cassidy
General Practitioner

On behalf of the research team:
Dr Paul Cassidy Teams Medical Practice, Gateshead
Dr Marilyn Christie School of Psychology, University of Leicester
Professor Nick Heather School of Psychology & Sports Sciences, Northumbria University
Professor Eileen Kaner Institute of Health & Society, Newcastle University
Dr Catherine Lock Institute of Health & Society, Newcastle University

Funded by Alcohol Education and Research Council; NHS REC and R&D approval received.
This study is adopted by PCRN.

Appendix 3
REMINDER 1 TO GPs

Dear Dr,

Research on GPs' Attitudes to Alcohol Prevention

I have recently been in touch with you with a request to complete a questionnaire for our study for the Alcohol and Education Research Council on general practitioners' attitudes towards treating alcohol problems. I see this topic as important in the context of a developing national alcohol strategy involving primary care, and rising public concern in the UK with alcohol problems. A robust response from GPs will allow the research findings to communicate to policymakers and others vital experience and opinions of practitioners regarding the treatment of alcohol problems, and I would just like to reiterate how grateful we would be to receive a completed questionnaire from you.

In case you cannot locate the form, which we hope is short enough to minimise any impact on your time, I enclose another copy along with a postage paid envelope for its return. Your answers will be treated as confidential and held securely and anonymously; if you have any questions about the research please contact the Project Manager, Dr. Graeme Wilson, on 0191 222 5695 or at: g.b.wilson@ncl.ac.uk .

I hope you will be able to return the questionnaire; thank you for your assistance,

Yours sincerely,

Dr Paul Cassidy
General Practitioner

On behalf of the research team:
Dr Paul Cassidy Teams Medical Practice, Gateshead
Dr Marilyn Christie School of Psychology, University of Leicester
Professor Nick Heather Division of Psychology, Northumbria University
Professor Eileen Kaner Institute of Health & Society, Newcastle University
Dr Catherine Lock Institute of Health & Society, Newcastle University

Funded by Alcohol Education and Research Council; NHS REC and R&D approval received.
This study is adopted by PCRN.

Appendix 4
REMINDER 2 TO GPs

Dear Dr,

Research on GPs' Attitudes to Alcohol Prevention

I am contacting you with a further request to complete our survey questionnaire on GPs' attitudes towards treating alcohol problems. Given the importance of this issue for the developing national alcohol strategy I am very concerned to replicate the substantial response from GPs to our earlier survey for the WHO. We would still be extremely grateful to receive a completed questionnaire; your responses will help ensure that GPs' views on the treatment of alcohol problems are robustly communicated to policymakers.

In case you cannot locate the questionnaire, which we hope is short enough not to inconvenience you, I enclose another copy along with a postage paid envelope. Your answers will be treated as confidential and held securely and anonymously. If you have any questions about the research please contact the Project Manager, Dr. Graeme Wilson, on 0191 222 5695 or at: g.b.wilson@ncl.ac.uk .

I hope you will be able to return the questionnaire; thank you very much for your assistance,

Yours sincerely,

Dr Paul Cassidy
General Practitioner

On behalf of the research team:
Dr Paul Cassidy Teams Medical Practice, Gateshead
Dr Marilyn Christie School of Psychology, University of Leicester
Professor Nick Heather Division of Psychology, Northumbria University
Professor Eileen Kaner Institute of Health & Society, Newcastle University
Dr Catherine Lock Institute of Health & Society, Newcastle University

Funded by Alcohol Education and Research Council; NHS REC and R&D approval received.
This study is adopted by PCRN.

Appendix 5

Survey of General Practitioners' Attitudes to Prevention: Repeat of a World Health Organisation Collaborative Study Questionnaire

PCRN
Primary Care Research Network
East Midlands and South Yorkshire

University of Leicester

OFFICE USE ONLY

ID no

1

Please tick the box corresponding to your answer or write your answer where indicated.
All answers to this questionnaire will be treated in confidence.

1. How many years have you been practising as a general practitioner?

☐ years

2. In which year were you born

19☐

3. What is your gender?

Male ☐
Female ☐

4. Is your practice a:

Urban practice? ☐
Rural practice? ☐
Mixed Urban/Rural practice? ☐

5. Is it a:

Solo practice? ☐
Group practice? ☐

6. How many full time equivalent (FTE) general practitioners are there in the practice, including yourself?

☐

7. How many days per week do you work in general practice?

☐

8. How many general practice patients would you see in an average week?

0 – 50 ☐
50 – 100 ☐
101 – 150 ☐
More than 150 ☐

9. In total, how many hours of post-graduate training, continuing medical education or clinical supervision on alcohol and alcohol-related problems have you ever received?

None ☐
Less than 4 hours ☐
4-10 hours ☐
11-40 hours ☐
More than 40 hours ☐
Don't know/Can't remember ☐

10. At the present time, taking into consideration all your current responsibilities with patients, how high a priority do you place on disease prevention as an aspect of your practice?

Very high ☐
Somewhat high ☐
Somewhat low ☐
Very low ☐

11. Compared to other medical practitioners you know, how much emphasis do you place on disease prevention in your practice?

Much more	
Somewhat more	
Somewhat less	
Much less	

11 ☐

12. If the patient doesn't ask you about alcohol, do you ask about it?

All the time	
Most of the time	
Some of the time	
Rarely or never	

13. Please list the typical conditions which elicit your talking about alcohol

14. The following are behaviours that some health professionals believe to be related to health. How important do you think each of the following behaviours are in **promoting the health of the average person?** *(Please circle one number for each)*.

Behaviour	Very important	Important	Somewhat important	Unimportant
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Drinking alcohol moderately	4	3	2	1
d. Avoiding excess calories	4	3	2	1
e. Reducing stress	4	3	2	1
f. Responsible use of prescription drugs	4	3	2	1

g. Not using illicit drugs	4	3	2	1

15. Please indicate **the extent to which you obtain information** on your patients in each of the following areas: *(Please circle one for each).*

Behaviour	Always	As indicated	Occasionally	Rarely/Never
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Drinking alcohol moderately	4	3	2	1
d. Avoiding excess calories	4	3	2	1
e. Reducing stress	4	3	2	1
f. Responsible use of prescription drugs	4	3	2	1
g. Not using illicit drugs	4	3	2	1

16. Doctors vary in their counselling skills and training. How **prepared** do you feel when counselling patients in each of these areas: *(Please circle one for each).*

Behaviour	Very Prepared	Prepared	Unprepared	Very Unprepared
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Reducing alcohol consumption	4	3	2	1
d. Avoiding excess calories	4	3	2	1
e. Reducing stress	4	3	2	1
f. Responsible use of prescription drugs	4	3	2	1
g. Not using illicit drugs	4	3	2	1

17. How **effective** do you feel you are in helping patients achieve change in each of the following

areas? *(Please circle one number for each).*

Behaviour	Very Effective	Effective	Ineffective	Very Ineffective
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Reducing alcohol consumption	4	3	2	1
d. Avoiding excess calories	4	3	2	1
e. Reducing stress	4	3	2	1
f. Responsible use of prescription drugs	4	3	2	1
g. Not using illicit drugs	4	3	2	1

18. In general, **given adequate information and training**, how effective do you feel general practitioners **could** be in helping patients change behaviour in each of the following areas? *(Please circle one number for each).*

Behaviour	Very Effective	Effective	Ineffective	Very Ineffective
a. Not smoking	4	3	2	1
b. Exercise regularly	4	3	2	1
c. Reducing alcohol consumption	4	3	2	1
d. Avoiding excess calories	4	3	2	1
e. Reducing stress	4	3	2	1
f. Responsible use of prescription drugs	4	3	2	1
g. Not using illicit drugs	4	3	2	1

19. For a healthy adult man, what would you consider the upper limit for alcohol consumption before you would advise him to cut down?

Please record as …… standard drinks/units* per week

or as …… standard drinks/units* per day

For a healthy adult woman, who is not pregnant, what would you consider the upper limit for alcohol consumption before you would advise her to cut down?

Please record as …… standard drinks/units* per week

or as …… standard drinks/units* per day

*1 standard drink = ½ pint of beer = 1 small glass of wine = 1 small glass of sherry = 1 measure of spirits

20. Indicate how much you agree or disagree with each of the following statements about working with "problem drinkers". For this part of the question, "problem drinkers" refers to people with **hazardous or harmful alcohol use,** but excludes those dependent on alcohol.

Statement	Strongly agree	Quite strongly agree	Agree	Neither agree or disagree	Dis-agree	Quite strongly disagree	Strongly disagree	
a. I feel I know enough about the causes of drinking problems to carry out my role when working with problem drinkers	7	6	5	4	3	2	1	63
b. I feel I can appropriately advise my patients about drinking and its effects	7	6	5	4	3	2	1	64
c. I feel I do not have much to be proud of when working with drinkers	7	6	5	4	3	2	1	65
d. All in all I am inclined to feel a failure with drinkers	7	6	5	4	3	2	1	66
e. I want to work with drinkers	7	6	5	4	3	2	1	67
f. Pessimism is the most realistic attitude to take towards problem drinkers	7	6	5	4	3	2	1	68
g. I feel I have the right to ask patients questions about their drinking when necessary	7	6	5	4	3	2	1	69
h. I feel that my patients believe I have the right to ask them questions about drinking when necessary	7	6	5	4	3	2	1	70
i. In general it is rewarding to work with drinkers	7	6	5	4	3	2	1	71
j. In general, I like problem drinkers	7	6	5	4	3	2	1	72

21. Indicate how much you agree or disagree with each of the following statements about working with people who are **dependent on alcohol or have a severe problem with alcohol ("alcoholics").**

Statement	Strongly agree	Quite strongly agree	Agree	Neither agree or disagree	Dis-agree	Quite strongly disagree	Strongly disagree	
a. I feel I know enough about the causes of drinking problems to carry out my role when working with problem drinkers	7	6	5	4	3	2	1	73
b. I feel I can appropriately advise my patients about drinking and its effects	7	6	5	4	3	2	1	
c. I feel I do not have much to be proud of when working with drinkers	7	6	5	4	3	2	1	
d. All in all I am inclined to feel a failure with drinkers	7	6	5	4	3	2	1	74
e. I want to work with drinkers	7	6	5	4	3	2	1	
f. Pessimism is the most realistic attitude to take towards problem drinkers	7	6	5	4	3	2	1	
g. I feel I have the right to ask patients questions about their drinking when necessary	7	6	5	4	3	2	1	
h. I feel that my patients believe I have the right to ask them questions about drinking when necessary	7	6	5	4	3	2	1	
i. In general it is rewarding to work with drinkers	7	6	5	4	3	2	1	
j. In general, I like problem drinkers	7	6	5	4	3	2	1	

22. In the last year, how many times have you taken or requested a blood test (*eg blood alcohol, MCV, GGT)* **because of concern** about alcohol consumption? *(Please circle one number).*

Never	1
1 – 2 times	2
3 – 5 times	3
6 – 12 time	4
more than 12 times	5

23. In the last year, about how many patients have you managed specifically for their hazardous drinking or alcohol-related problems?

None	1
1 – 6 patients	2
7 – 12 patients	3
13 – 24 patients	4
25 – 49 patients	5
50 or more patients	6

75
76
77
78
79
80
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84
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86
87
88
89

24. The next two questions are about early intervention for hazardous alcohol consumption. This involves screening patients to identify those whose alcohol consumption places them at increased risk of disease, and then counselling identified problem drinkers about reducing their alcohol consumption.

Inquiries in a number of countries have revealed that many doctors in general practice spend very little or no time at all on early intervention for alcohol. A variety of reasons have been suggested as to why this might be so. For each one please indicate to what extent you think that reason applies by circling the appropriate number.

Statement	**Very much**	**Quite a bit**	**Little**	**Not at all**	**Don't know**
a. Alcohol is not an important issue in general practice	5	4	3	2	1

b. Doctors are just too busy dealing with the problems people present with	5	4	3	2	1
c. Doctors have a disease model training and they don't think about prevention	5	4	3	2	1
d. Doctors think that preventive health should be the patients' responsibility not theirs	5	4	3	2	1
e. Doctors are not sufficiently encouraged to work with alcohol problems in the current GMS contract	5	4	3	2	1
f. Doctors feel awkward about asking questions about alcohol consumption because saying someone has an alcohol problem could be seen as accusing them of being an alcoholic	5	4	3	2	1
g. Doctors do not know how to identify problem drinkers who have no obvious symptoms of excess consumption.	5	4	3	2	1
h. Doctors do not have a suitable screening device to identify problem drinkers who have no obvious symptoms of excess consumption	5	4	3	2	1
i. Doctors do not have suitable counselling materials available	5	4	3	2	1
j. Doctors are not trained in counselling for reducing alcohol consumption	5	4	3	2	1
k. Doctors believe that alcohol counselling involves family and wider social effects, and is therefore too difficult	5	4	3	2	1
l. Doctors do not believe that patients would take their advice and change their behaviour	5	4	3	2	1
m. Doctors themselves have a liberal attitude to alcohol	5	4	3	2	1
n. Doctors themselves may have alcohol problems	5	4	3	2	1
o. Doctors believe that patients would resent being asked about their alcohol consumption	5	4	3	2	1

25. Doctors in a number of countries have suggested a variety of things that could lead to more doctors doing early intervention for hazardous alcohol consumption. Please indicate for each item to what extent it **would** encourage you personally to do more early intervention for hazardous alcohol consumption, by circling the appropriate response.

Statement	Very much	Quite a bit	Little	Not at all	Don't know
a. Public health education campaigns in general made society more concerned about alcohol	5	4	3	2	1
b. Patients requested health advice about alcohol consumption	5	4	3	2	1
c. Quick and easy screening questionnaires were available	5	4	3	2	1
d. Quick and easy counselling materials were available	5	4	3	2	1
e. Early intervention for alcohol was proven to be successful	5	4	3	2	1
f. Training programs for early intervention for alcohol were available	5	4	3	2	1
g. Providing early intervention for alcohol was included in the Quality in Outcomes Framework (QOF)	5	4	3	2	1
h. General support services (self-help/counselling) were readily available to refer patients to	5	4	3	2	1
i. Salary and working conditions were improved	5	4	3	2	1

90
91

26. Over the past 10 years, how effective do you think the following government policies have been in reducing alcohol-related harm in England? *(Please circle one number for each)*.

Statement	Very effective	Quite effective	Slightly effective	In-effective	No opinion
a. Promotion of a 'sensible drinking' culture	5	4	3	2	1
b. Promotion of recommended guidelines on drinking limits and health information	5	4	3	2	1
c. Introduction of more flexible opening hours licensed premises	5	4	3	2	1
d. Stricter rules for the content of alcohol advertisements	5	4	3	2	1
e. More extensive considerations when granting licenses	5	4	3	2	1
f. Increased powers to enforce and penalise breach of licence conditions	5	4	3	2	1
g. Introduction of powers to ban anti-social drinking in areas	5	4	3	2	1
h. Introduction of powers to ban individuals from premises or areas following alcohol-related ASB	5	4	3	2	1
i. Sharpened criminal justice for drunken behaviour	5	4	3	2	1
j. Increased provision for brief interventions to prevent alcohol problems	5	4	3	2	1
k. Increased provision for treatment of alcohol problems	5	4	3	2	1
l. Introduction of local alcohol strategies	5	4	3	2	1

27. How effective do you think the following policy measures might be in reducing alcohol-related harm in England? *(Please circle one number for each)*.

Statement	Very effective	Quite effective	Slightly effective	In-effective	No opinion
a. Raise minimum legal age for drinking alcohol	5	4	3	2	1
b. Raise minimum legal age for purchasing alcohol	5	4	3	2	1
c. Lower BAC limit for drivers	5	4	3	2	1
d. Improve alcohol education in schools	5	4	3	2	1
e. Increase restrictions on TV & cinema alcohol advertising	5	4	3	2	1
f. Government monopoly of retail sales of alcohol	5	4	3	2	1
g. Institute minimum pricing for units of alcohol	5	4	3	2	1
h. General changes in alcohol price through taxation	5	4	3	2	1
i. Further regulation of alcohol off-sales (e.g. supermarkets, off-licences)	5	4	3	2	1
j. Make public health a criterion for licensing decisions	5	4	3	2	1
k. Statutory regulation of alcohol industry	5	4	3	2	1

111
112

28. Can you recall filling out an earlier version of this questionnaire from our team about 10 years ago?

Yes ☐
No ☐

29. If you would like to express further opinions or comment on the questionnaire or any other aspect of alcohol problems, please use the space below

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Please return this questionnaire in the postage paid envelope provided to:
Beth Edgar, Institute of Health & Society, Newcastle University, William Leech Building, Framlington Place, Newcastle upon Tyne, NE2 4HH

If you require another envelope please contact 0191 2226260