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“I’m not a real boozier”:

a qualitative study of primary care patients’ views on drinking and its consequences

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ABSTRACT

Background

The public health message around alcohol is complex, with benefits versus harms, the confusing concept of risk, and drinking guidance changing over time. This provides a difficult context for alcohol screening in primary care, with established barriers from the practitioner perspective, but less is known about the patients' perspective. This study explores patients' views on drinking.

Methods

Eligible participants were recorded as drinking above low risk levels in primary care. Six practices in North London participated. Interviews were in-depth, semi-structured, transcribed verbatim and underwent detailed thematic analysis.

Findings

Interviews were conducted with eight women and 12 men, aged 26 to 83 years, mostly educated to undergraduate level and of 'White' ethnicity. UK drinking guidance was viewed as irrelevant for reasons related to life stage, lifestyle and absence of harm. Dependence, loss of functionality and control were perceived as key features of problematic drinking. Healthy lifestyles, in terms of diet, exercise and not smoking, were thought to mitigate potential problems associated with alcohol intake.

Conclusion

The findings suggest that public health messages and brief advice should focus on harm experienced at different life stages, among people with different lifestyles, to challenge the ubiquitous view that *"I'm not a real boozer"*.

Key words: Alcohol consumption, primary care, health promotion, non-help seeking patients, qualitative interviews.

BACKGROUND

The public health message around alcohol consumption is complex. There are mixed messages around the harms and benefits of alcohol intake, with any amount of alcohol associated with at least seven types of cancer,¹ yet a possible protective effect for some cardiovascular diseases with moderate consumption.² Of one in four people who drink above the low risk levels in England,³ most do not experience harm, but are at risk of experiencing harm, such as disease, injury and lost productivity.⁴ Yet communication around health risks is hard to comprehend.⁵ Furthermore, UK guidance on the amount of alcohol people can drink to minimise their risk of harm has changed over time in relation to the number of units and time frames.^{6,7}

This complex public health message provides a difficult context in which to deliver alcohol screening and brief intervention (ASBI) in primary care. Despite international policy recommendations for its routine delivery,^{8,9} the mean rate of alcohol screening in primary care is found to be as low as 5.3% across Europe (ranging from 1.7% in Poland to 9.8% in Sweden).¹⁰ There is a substantial literature on barriers and facilitators to implementing ASBI from the health professional's perspective, with common barriers including lack of time, training and financial incentive, as well as perceived damage to the health professional – patient relationship.^{11–14}

Comparatively little research has sought to understand the patient and public perspective. Patients viewed ASBI as more acceptable when addressed in the context of broader lifestyle behaviours (e.g. health check) or where clearly relevant to presenting health problems.^{15,16} White collar workers perceived public health messages on alcohol-related health consequences to have little relevance, which reinforced views that their own alcohol use was controlled and acceptable.¹⁷ Older adults were also found to disregard advice on drinking, by associating problematic consumption with lack of control, rather than health harms¹⁸ which is currently the focus of ASBI and public health messages.

The purpose of this study was to explore the views of primary care patients who drink alcohol above low risk levels. Few people seek help to reduce their drinking; by gaining an insight into how people perceive the guidance, conceptualise problematic drinking, and receive advice from health professionals, we hope to mitigate patient barriers to receiving help and cutting down.

METHOD

This was a qualitative study using semi-structured interviews, with ethical approval granted from the National Research Ethics Service (NRES) 12/LO/0856. Participants were recruited from six general practices in North London and identified via New Patient Registration data, with these data constituting 80% of alcohol screening records.¹⁹ Adults recorded as drinking above low risk limits (at the time of study: >14 units / week for women, >21 units / week for men), but not dependent on alcohol, were eligible and invited to take part in the study in a letter from the practice. Interviews were conducted between April to May 2013 (nine interviews) and March to May 2014 (11 interviews). All patients who expressed an interest in taking part in the study were interviewed (see Box 1. Topic guide).

The interviews were digitally recorded and transcribed verbatim by a professional transcription company, removing any personal information. The data were analysed using detailed thematic analysis. The codes were generated deductively by examining the data with reference to areas of interest raised in the topic guide, and inductively, after noting and collating additional themes found in the data. The codes were applied systematically to the corresponding text in the transcripts by ZK and JM using Atlas.ti 6. Data extracts were collated under each code, translated from quotes into statements, and then organised into broader themes and sub-themes using Iterative Categorisation.²⁰ The process was reviewed and the themes discussed iteratively by our multidisciplinary research team.

FINDINGS

Participant characteristics

The 20 participants interviewed in this study were diverse in gender and age, but shared characteristics of being of 'White' ethnicity and highly educated (see Table 1). All interviews, except one, took place on the university campus. One interview took place at the participant's home at their request, due to mobility problems. Interviews lasted an average of 52 minutes (mean and median), ranging from 35 to 77 minutes.

Perceptions of the UK drinking guidance

The predominant view of the drinking guidance was that it was too general and irrelevant to the participants' situations. Participants set their own limits, which were largely based on how they felt, what they thought was acceptable, and whether it had an impact on what they wanted to achieve in life. Knowing one's own limits was intuitive *"you know your limits and then you go home, that's*

when you get in a taxi.” [15: female, 31, living with partner, working], based on their individual tolerance (e.g. related to body weight and height) and communicated by their body “when your body tells you, go easy. Enough for a bit” [16: male, 34, single, working]

Life stage

To some extent, the irrelevance of the guidance was related to life stage. The younger adults perceived older adults’ consumption of daily bottles of wine as concerning, whereas the older adults viewed younger people’s binge drinking weekends as problematic. Younger adults (mid 20s to mid 30s) felt they were in a transitional phase, and that they were enjoying themselves before they settled down and had children. The guidance was also perceived as irrelevant due to their abstinence during the week and the social acceptability of heavy weekend drinking among peers.

“as you get older, people I know tend to drink more regularly, but less, if that makes sense, or less intensely. And, so, it’s more of transition from what you’d call themed drinking to more regular mature drinking. However, I actually see the mature drinking as quite bad, it’s something that I don’t want to fall into the pattern of” [7: male, 28, single, working]

“How do you approach binge drinking with the very young? Because they are in an adolescent group which endorses it and all they do is feel terribly sick the next day and every now and then they do something terrible and regret it. It’s incredibly destructive and very, very bad that becomes then a social problem.” [4: Male, 83, married / civil partnership, retired]

The older adults (60+), also felt that that the guidance was irrelevant to their life stage. Many of these participants justified their drinking by regular visits to the GP who reportedly reassured them that their daily bottle of wine did not impact on their health.

Perceptions of problematic drinking

Participants’ perceptions of what makes alcohol consumption problematic varied, but overall focussed on harmful and dependent rather than risky drinking. The vast majority of participants perceived a drinking problem as no longer being able to function, where functionality varied from going to work, cooking, visiting the gym, to getting into debt and affecting mobility. Many participants perceived loss of control as another indicator of problematic drinking, demonstrated by the inability to stop drinking. Most participants used dependence as a benchmark for problematic drinking and talked about other people’s alcohol problems, such as a friend, relative, or neighbour

who was dependent on alcohol and either died from falling down stairs or being hit by a car, or were homeless or had neglected families. These were always extreme examples of harm, hence unsurprisingly, these participants did not perceive their own drinking to be problematic “*I’m not a real boozier*” [5: male, 69, married / civil partnership, retired].

Lifestyle

Drinking was considered by many as a lifestyle option, and associated with socialising. Many of the participants were reportedly health conscious, and talked a lot about feeling healthy. Among the younger adults, there was an awareness that too much alcohol was not good for their health, but a view that this risk was mitigated with regular exercise. Some participants managed the amount they drank around their training, e.g. leaving the pub early if going to the gym in the morning. Whilst some participants acknowledged ‘5 a day’ (the national campaign to promote consumption of at least five portions of fruit and vegetables a day) and the drinking limits as promoting healthy behaviour, several male participants felt there were too many messages, that these kept changing and were patronising.

“I do quite a lot of exercise and I feel healthy, I feel like that is also something that I can use in my own defence. That means that it doesn’t quite apply to me as much [drinking guidance] because, I try and look after myself in other ways” [13: male, 35, single, working].

Recommendations for communicating the guidance

Despite the perceived irrelevance of the guidance to their own drinking, a few participants looked favourably on the existence of guidance per se, it being the role of a responsible Government to advise the public on potential harm. A few participants suggested the guidance may have more impact, and be more trustworthy, if it was more obviously issued by medical experts, rather than the Government. Almost all participants remarked on the clear and ubiquitous message that smoking was harmful and causes cancer, whereas the message around alcohol was inconsistent and not as strong or simple.

“But cigarette smoking, [I] stop[ed] quite easily, because I know that does kill you. There’s no question of that” [5: male, 69, married, retired]

A common suggestion for improving the impact of the guidance was to make it more relevant, for example, by creating non-stigmatising typologies that different people could relate to, highlight

harms that were more meaningful to them, and present alternatives to drinking and sources of help. A few of the younger participants suggested highlighting more immediate harms, such as effects on work, exercise or relationships. Others mentioned the importance of their appearance, so to focus on dehydration and weight gain. The older participants expressed a preference for liver function tests, or positively framed messages around increase in longevity. Again, they mentioned the importance of relating this advice to someone drinking similar amounts, of a similar age and lifestyle.

“It might be worth having case studies, if you had person X, Y and Z, and person X was a 21 year old graduate, working for the first time, going out every night in the city person. Z was a single mother or a working mother. If you had different people that you could almost look at and say that is me and if that person X did have liver disease or stomach ulcer or whatever, people may be able to relate to that a bit more” [2: male, 30, living with partner, working]

Reaction to screening and advice on drinking

Most of the older participants said they would feel comfortable talking to their doctor about their drinking, that they would not be offended if asked about it, and this was their preferred source of help. Some participants talked about chest pains and chronic health conditions that meant frequent visits to the doctor, with one reportedly encouraged to drink for pain relief. These participants all said they would cut down if their doctor advised them to, however, they were told their drinking was not a problem and were therefore happy to continue. A few participants said their doctor reported to be drinking at the same level as them and used this as a benchmark for their drinking.

“I remember going for a medical once. I'd been working very hard in a very stressful situation abroad, and I'd got very bad chest pains. I had been drinking enormously. I had a check up, a heart specialist, and he said, well, do you drink? I said, maybe a bottle of wine a day. He said, that's fine. He said, you're okay. He said, oh, I drink the same as that.” [5: male, 69, married / civil partnership, retired]

A few participants talked about the embarrassment and stigma of discussing their drinking with their doctor. They were unsure of what a doctor could say, other than cut down or stop drinking. Some younger participants felt they would not be candid for fear of being labelled and recorded as an “alcoholic”. Most younger participants expressed a preference for searching the Internet for help with their drinking, with more credibility attributed to NHS websites, whilst a few would speak with

family and good friends. A few participants felt that questions about alcohol consumption would be less judgemental and more genuine if asked in the context of a health check, e.g. prefaced by how are you sleeping? has your weight changed? how's your drinking? It was also felt that the approach should be individualised, allowing people to put their drinking in context, rather than consisting of a conversation around units, which they viewed as "pointless". A popular suggestion was for an anonymous, non-judgemental service delivered by the NHS, advertised on TV, and open to people and their families – drinking at all levels of severity.

DISCUSSION

Main finding of this study

This study found primary care patients drinking above lower risk levels to view UK drinking guidance as irrelevant for reasons related to life stage, lifestyle and absence of harm. Problematic drinking was viewed in terms of dependence, loss of functionality and control, and was experienced by "others", i.e. different generations or those experiencing extreme harm. Patients perceived other positive health behaviours to mitigate harm caused by their alcohol consumption. Public health messages and brief advice in general practice should focus on the actual harms of drinking experienced at different life stages, among people with different lifestyles, rather than focusing on risk which was not associated with problematic drinking.

What is already known on this topic

The finding that the drinking guidance was irrelevant to the drinking behaviour of the primary care patients in this study, is echoed in research with different population groups.^{17,18,21} Depictions of problematic drinking were varied and constructed around other people's drinking. "The deviant 'other'"¹⁷ was used as a stereotype of problematic drinking in focus groups with White collar workers,¹⁷ and by people in mid-life in viewing problem drinking among younger adults.²² Emslie et al²² refer to this finding as "the process of 'othering'", where contrasting identities are created that distinguish between the healthy or acceptable drinker, versus the unhealthy or problematic 'other'.^{22,23} White collar workers were found to associate problematic drinking with loss of functionality, and adults in mid-life associated control and maintenance of responsibilities with an acceptable level of drinking.²² Furthermore, research with older adults found they were unlikely to change their behaviour without any obvious impact on their health,¹⁸ which resonates with our finding among older participants that reassurance that their level of drinking was not harmful to their health, meant that it was not problematic.

Participants placed an emphasis on feeling healthy and leading a healthy lifestyle, which related to not smoking, exercising and eating healthily. Yet these health behaviours were perceived as mitigating any harm caused by drinking. Participants were supportive of discussing their drinking in the context of other health behaviours, in line with previous research.¹⁶ This approach takes place in the context of new patient and NHS health checks, and is high on the research agenda.²⁴ However, whilst this is an acceptable approach, evidence on the effectiveness of multiple health behaviour change interventions for reducing alcohol intake is limited.^{25,26} People are least likely to want to change their drinking when presented with alternative behaviours in the NHS health check.²⁷ Furthermore, when delivered in-person, health professionals may choose to prioritise other health behaviours which they feel more comfortable discussing.

What this study adds

The findings from this research, and previous studies,^{17,18,22} suggests that there are several drinking typologies / identities that could be usefully communicated with the public. Qualitative research could be used to contextualise the typologies of different types of drinkers based on epidemiological data,²⁸ to show examples of tangible harms to health and lifestyle that are salient to people at different life stages, and with different lifestyles. These could be communicated through media campaigns. Another role of these typologies is to challenge the conception that an alcohol problem is synonymous with dependency, destitution, and loss of all control and functionality. In turn, greater options for help should be communicated, such as digital self-help interventions, which would mitigate the stigma of help seeking at an earlier stage.²⁹ These typologies could also be used in training with health professionals, to inform more meaningful discussions around alcohol with their patients, and to discourage comparison with their own level of drinking.

It has been suggested that brief interventions in primary care may be more effective if they address patients' concerns more directly.³⁰ Many of the characteristics of problematic drinking perceived by the participants in this study are included in the full AUDIT screening test, i.e. functionality, need for a drink, injury to self or others³¹. More meaningful discussions about alcohol could focus on conversations around these indicators of harm, rather than feedback on future risk of harm. They could also focus on the impact of alcohol on activities that are meaningful to the patient, such as gym training, or weight loss –health professionals must also stress that one health behaviour cannot mitigate the harms of another.

Limitations of this study

This is one of few in-depth qualitative explorations using individual interviews with primary care patients, drinking at risky levels, on their broader views on drinking. Participants were recruited from primary care practices in an affluent area of North London. The sample, whilst varied in age and gender, was largely 'White British' and well educated. Population levels of risky alcohol consumption are not associated with socio-economic status, but people from lower socio-economic groups are more likely to experience harmful multiplicative effects of combined alcohol use and other unhealthy behaviours, such as smoking, low levels of exercise and from being overweight or obese.³² Therefore, public health messages should target different socio-economic groups. Since conducting this study the drinking guidelines have changed, bringing the low risk limits for men inline with those for women. This is unlikely to have an impact on the findings as the limits were viewed as irrelevant by these participants.

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Box 1. Topic guide

Views on drinking

Opening statement:

The purpose of this research is to hear your thoughts on drinking and its potential consequences. There are no right or wrong answers – I just want to hear your views. All data will be anonymised.

Do you have any questions at this point?

1. Have you heard of the Government's recommended drinking limits? What do they mean to you?
2. What are your thoughts on these limits?
 - a. Prompt: Do you think they have an impact on your / other people's drinking behaviour?
 - b. Prompt: What do think are the consequences of drinking above these limits?
3. When is drinking problematic?
 - a. For others
 - b. For you
4. When should you consider reducing your drinking?
5. Most people drinking above these recommended limits do not seek help to reduce their drinking, why do you think this might be?
6. What would be your preferred source of help if you wanted to reduce your drinking?
 - a. Prompt: GP, nurse, other health professional, alcohol counsellor, Internet?
7. GPs and nurses are now expected to ask patients about a range of health behaviours, including smoking, diet, exercise and drinking. How do you feel / or how would you feel about them asking about your drinking behaviour? If it was suggested that you should reduce your drinking, how would that make you feel?
8. Why were you interested in this study?
9. Is there anything you would like to ask me?

Table 1. Participant characteristics

	n (%) N=20
Women	8 (40)
Age (mean and median)	46 years Range: 26 to 83
'White' ethnicity:	20 (100)
'White British'	15 (75)
'White European'	4 (20)
'White New Zealander'	1 (5)
Living with a partner	9 (45)
Single, divorced or widowed	6 (30)
Married or in civil partnership	5 (25)
Undergraduate degree	10 (50)
Postgraduate degree	4 (20)
College or sixth form qualification	2 (10)
Secondary school qualification	2 (10)
Diploma or vocational qualification	1 (5)
Other: "chartered".	1 (5)
Working either full or part-time	12 (60)
Retired	6 (30)
Unemployed	1 (5)
Other: "housewife"	1 (5)