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Barriers and facilitators to making an alcohol reduction attempt and strategies used among people who drink at risky levels in the United Kingdom: A qualitative study

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Abstract

Aims: To understand the motives, goals, and strategies of attempts to reduce alcohol among people who drink at risky levels in the United Kingdom (UK).

Methods: We ran six online focus groups with people in the UK who drink at risky levels (Alcohol Use Disorders Identification Test [AUDIT] score ≥ 8; *n* = 26). We asked about participants' reasons for making a reduction attempt or not, any goals they had, and any strategies used or considered. Transcripts were analysed using a codebook thematic analysis approach.

Findings: Barriers to making an alcohol reduction attempt included participants' knowledge (e.g., not perceiving their drinking as harmful), motives to drink alcohol (e.g., coping, enhancement), and the physical (e.g., accessibility of alcohol) and social (e.g., cultural expectations) environment. Facilitators included their knowledge (e.g., realising consumption levels), motives to drink less alcohol (e.g., health-related), and social support. Goals included complete abstinence, reduction in units, improved mental health, and improved relationships. Strategies included changing drinking contexts or the behaviour within them (e.g., not drinking at home), abstinence-based strategies, and tracking units.

Conclusions: People drinking at risky levels in the UK reported a range of motives for drinking alcohol and drinking less alcohol, goals and strategies. These goals were largely inconsistent with the UK low risk drinking guidelines. Future research should assess whether alcohol reduction interventions that incorporate goals relevant to the individual, with tailored strategies based on the individual's motives and goals for making a reduction attempt, are more effective than non-tailored strategies.

Introduction

Alcohol consumption has a significant global impact on public health with an estimated 4.7% of all deaths attributable to alcohol (World Health Organization, 2024). In the United Kingdom (UK), alcohol is a leading risk factor for early mortality, ill health and disability (Public Health England, 2016), as well as contributing to health inequalities (Boyd et al., 2021). There is a dose-response relationship between the volume of alcohol consumed and the risk of alcohol-related harm (e.g., stroke; Charlet & Heinz, 2017). People who drink alcohol at risky levels – whose drinking poses a significant risk of harm to their physical and mental health (Public Health England, 2016) – would benefit from making any reduction to their alcohol consumption (Charlet & Heinz, 2017). However, most people who drink at risky levels in the UK have not made a change to their behaviour – i.e., an alcohol reduction attempt – in the past year (Buss et al., 2025a, b, c).

The Capability, Opportunity, Motivation-Behaviour (COM-B) model posits that for a behaviour to occur, the person needs to have the capability and opportunity to engage in the behaviour, and be more motivated to enact that behaviour than any other behaviour at that moment (Michie et al., 2011). It provides a framework to identify what factors

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would need to change in order to change that behaviour (West & Brown, 2013). Capability refers to someone having the physical or psychological capacity to engage in the behaviour, including knowledge and understanding; e.g., that people are unaware of the low-risk guidelines for drinking (Buykx et al., 2018; Lovatt et al., 2015). Opportunity refers to the environmental factors that permit or promote a behaviour to occur; e.g., that people feel unsupported in alcohol reduction attempts (Khadjesari et al., 2015). Motivation refers to the brain processes (both automatic and reflective) that energise and direct behaviour.

If the opportunity and capability to change behaviour are present, then changes in alcohol consumption require that the motivation to not drink is stronger than the motivation to drink at that moment in time (West & Brown, 2013). Motives to drink alcohol include coping (D'Aquino et al., 2022), with alcohol used in an attempt to 'self-medicate' against painful experiences (Gilson et al., 2017). Pleasure is also a key component of drinking (Nicholls & Hunt, 2025) with social and enhancement motives for drinking alcohol (D'Aquino et al., 2022), meaning that alcohol reduction attempts could be perceived as negatively affecting someone's enjoyment and social life. On the other hand, the most common alcohol reduction motives reported among adults in England were improving fitness, losing weight, and preventing future health problems (Beard et al., 2017). Alcohol reduction motives reported by college students in Brazil and the United States (US) included a sense of responsibility, loss of control, adverse consequences, and family and religious issues (Epler et al., 2009; Faria et al., 2023). However, there are no standard measures of reasons for drinking less alcohol (Epler et al., 2009), and there is a limited understanding of the reasons for not making a reduction attempt.

Harm reduction approaches prioritise goals that are attainable, relevant and compatible with an individual's needs (Marlatt & Witkiewitz, 2002). Having such goals can improve self-efficacy (belief in capacity to attain a specific goal), which can be an important factor both in the likelihood of making an attempt and its success (Greenfield et al., 2000). Goals (i.e., what someone wants to achieve) are generally reported as consumption-related (e.g., moderation or abstinence), which may be due to only those options given to participants to choose from in studies (Enggasser et al., 2015; Schwebel & Orban, 2022). A wider-range of goals is reported when people are able to choose their own: drinking-related (e.g., reduced drinking); health-related (e.g., improving physical health); quality of life; basic needs; and money-related (Collins et al., 2015). Accordingly, it is important to ask people who drink at risky levels in the UK what goals are relevant to them.

While formal support, such as alcohol brief interventions (typically delivered in healthcare settings), have evidence for their effectiveness (Kaner et al., 2018), they are rarely received by risky drinkers in England (Kock et al., 2024). Therefore, it is important to know what informal strategies are used to reduce alcohol consumption (e.g., only drinking on weekends) outside of formal interventions. This is the first step in assessing how effective these strategies are and for whom, in order to be able to provide tailored guidance to people drinking at risky levels. Previous research using data from a British market research survey identified four distinct approaches: having fewer drinks; smaller sizes of drinks; reducing drinking occasions; and a mixed approach (Sasso et al., 2022). These different moderation approaches were associated with distinct drinking occasion characteristics and the main type of drink consumed (Sasso et al., 2025). For example, the 'smaller sizes' approach was more frequently reported in social settings and with consuming wine and spirits (Sasso et al., 2025). This highlights the role of social context and situational norms in strategies to change drinking. However, the measure used in these two studies to assess alcohol reduction strategies was limited to six response options focusing solely on drink-specific and frequency-based strategies.

A qualitative study among people drinking at risky levels in the UK investigated alcohol reduction strategies across drinking contexts and found four broad approaches: diluting and substituting drinks; reducing external pressure to drink; creating barriers to drinking; and setting new habits (Oldham et al., 2024). In this study, participants had to be interested in using an alcohol reduction app and the strategies were developed by researchers, although participants could suggest variations. A qualitative study in Australia examining how people who have reduced or stopped drinking by renegotiating their social rituals found four approaches were used to adapt their drinking: replacing alcohol with other drinks; replacing drinking with other social activities; changing the meaning of drinking rituals; and replacing drinking occasions with activities that achieve different goals (Bartram et al., 2017). This suggests that strategies used by people who have social drinking motives may be different from those who do not drink for social reasons. The Protective Behavioural Strategies Survey assesses alcohol reduction strategies, although this was developed for heavy alcohol use in US college students (Martens et al., 2005). The Global Drugs Survey has published a report of alcohol harm reduction strategies identified by drinkers globally, however this survey tends to recruit younger, more experienced drug-using populations (Global Drugs Survey, 2014). More research is needed to further explore what strategies people who drink at risky levels in the UK general population have used or might consider using.

We aimed to understand the experiences of making or not making an alcohol reduction attempt, motivations (including motives and goals), and strategies used among people who drink at risky levels in the UK using a qualitative focus group design.

Methods

Design

We ran six online focus groups using Microsoft Teams, with between two and six participants in each group, consistent with approaches in wider qualitative research (Guest et al., 2017; Plummer, 2017). Focus groups were used to facilitate in-depth discussion through group interactions (Hopkins, 2007), eliciting reflections on a wide range of experiences

and prompting reflection on points brought up by others (Flick, 2022). Three focus groups consisted of participants who had not made a past-year alcohol reduction attempt, and three consisted of those who had. The rationale for this distinction between groups was to ensure that we heard the diverse range of experiences around why some individuals had or had not made a past-year reduction attempt, without any individual feeling social pressure or defensive if their drinking behaviour differed from others in the focus group, as well as to understand the range of potential strategies or goals of interest across both groups.

Participants and Recruitment

The target population of this study was the general population of people who drink at risky levels in the UK to ensure a wide range of views and experiences were heard. People were eligible to participate if they drank at risky levels (Alcohol Use Disorders Identification Test [AUDIT] score ≥ 8), were aged 18 or over, and lived in the UK. Participants were recruited via Facebook and X, through physical posters around the University of Bristol campus and in the local community, and from an existing database held by the University College London Tobacco and Alcohol Research Group.

Procedure

Potential participants completed a screening survey in Qualtrics where they were shown the information sheet and screened based on the eligibility criteria. Eligible participants provided online informed consent before completing sociodemographic measures on gender, social grade, and ethnicity, and indicating whether they had made a past-year alcohol reduction attempt. Key sociodemographic characteristics (age, gender, social grade, ethnicity) were monitored and invitations were prioritised (though no specific quotas set) for participants with underrepresented characteristics in this study (e.g., minority ethnic groups in the UK).

Discussion points for the study were presented to the Sheffield Addiction Recovery Research Panel, a group with lived experience of alcohol dependence, and updated in line with feedback. Topic guides (Supplementary File 1) were piloted in an informal online focus group of five colleagues with expertise in tobacco and alcohol research and updated in line with their feedback (e.g., making it clear that participants did not need to answer any question they did not want to, and giving more examples or prompts for a few of the questions). The topic guides asked about their reasons for making a reduction attempt or not, any goals they had, and any strategies used or considered.

Researchers HM and CG facilitated the focus groups. HM started sessions by welcoming participants, clarifying ground rules, explaining the research aims, and that participants could withdraw at any time. An online breakout room with CG was available throughout for anyone who needed support or a break from the session. At the start of the session both HM and CG shared that they drink alcohol. Open-ended questions were used, and conversation between participants was encouraged (Krueger, 1998). Afterwards, participants were thanked for their time, debriefed on the study and signposted to relevant resources. Each participant was sent a £20 Love2shop voucher.

Analysis

The protocol, topic guide and analysis plan were pre-registered on the Open Science Framework prior to data collection (https://osf.io/w6xfa/). Following external peer review, we updated the analysis plan and used a codebook thematic analysis approach to better reflect the study aims. We used Template Analysis, a form of thematic analysis that emphasises the use of hierarchical coding (i.e., being able to place some order on the data from the start of the analysis) with a flexible approach (Brooks et al., 2014). We adopted a critical realist stance (Bhaskar & Hartwig, 2016) which recognises that while experiences of alcohol use are individually and socially constructed, alcohol has underlying causal mechanisms of action in a perspective-independent reality.

All focus groups were audio-recorded and transcribed using Microsoft Teams, then checked for accuracy, amended, and anonymised by HM, facilitating data immersion. The final sample size was judged based on on-going assessments of information power and richness of data (Malterud et al., 2016).

Data familiarisation was conducted by HM, CG and MS, reading through and engaging with the transcripts. Preliminary coding of two focus groups was conducted by CG and MS, with *a priori* themes based on the semi-structured questions asked in the focus groups. They then discussed the codes, organising them into meaningful clusters, including hierarchical relationships. An initial coding template was developed based on this subset of data and this template was then applied to a further two focus groups, whilst revising and refining the template before applying it to the final two focus groups. Differences in coding were discussed and resolved, resulting in a finalised coding template (available in Supplementary File 2), which was then applied to the full data set (all six focus groups).

Ethics

Ethics approval was obtained from the University of Bristol School of Psychological Science Research Ethics Committee (#17761).

Research Team and Reflexivity

Three female researchers, HM, MS and CG, conducted the interviews and analysis. All three researchers drink alcohol and have taken some form of steps to moderate their consumption. One researcher (HM) is a trainee Counselling Psychologist, trained in working relationally with clients. Another (CG) is an alcohol researcher and has previous experience conducting one-to-one interviews and qualitative analysis. The third researcher (MS) is an undergraduate psychology student undertaking a placement at the University of Bristol. We worked reflexively with the data, acknowledging the ways that our experiences and identities would impact data collection, analysis and interpretation. Participants did not know any of the research team.

Results

Sample Characteristics

Of the 210 people who completed the screening survey, 67 either did not meet the eligibility criteria or did not provide contact details for follow-up, 11 prospective participants failed follow-up screening tests to check their identity, and 106 did not respond, could not attend a group at the times offered, or did not attend after invitation. The final sample size was 26 participants across six focus groups (Table 1), with ongoing transcription and analysis during data collection to determine information power, richness of data, and when to stop further recruitment (Malterud et al., 2016). Focus groups lasted 57 minutes on average (ranging from 47 to 70 minutes) and took place from 05 June to 12 July 2024. We did not identify any patterns relating to participant characteristics while conducting the analysis, although this was not the focus of this study.

Table 1

Participant Characteristics

Characteristics	Overall (*n* = 26)	No reduction groups (*n* = 11)	Reduction groups (*n* = 15)
Age, mean (SD)	42.0 (13.20)	39.4 (8.78)	43.9 (15.71)
Gender, % female (*n*)	46.2 (12)	36.4 (4)	53.3 (8)
Ethnicity, % (*n*)			
Black	7.7 (2)	-	13.3 (2)
Asian	3.8 (1)	-	6.7 (1)
White	80.7 (21)	90.9 (10)	73.3 (11)
Prefer not to say	7.7 (2)	9.1 (1)	6.7 (1)
Social grade, % (*n*)			
AB	50.0 (13)	72.7 (8)	33.3 (5)
C1	23.1 (6)	18.2 (2)	26.7 (4)
C2	3.8 (1)	-	6.7 (1)
DE	23.1 (6)	9.1 (1)	33.3 (5)
AUDIT score, mean (SD)	16.2 (6.88)	14.6 (6.61)	17.4 (7.06)

Notes: *FG: Focus group; AB: Higher and intermediate managerial, administrative and professional occupations; C1: Supervisory, clerical, and junior managerial, administrative and professional occupations; C2: Skilled manual occupations; DE: Semi-skilled and unskilled manual occupations; unemployed and lowest grade occupations. SD: standard deviation.

Barriers to Making an Alcohol Reduction Attempt

Psychological Capability Facilitating Drinking

Some participants did not perceive their drinking as problematic, considered that being fit and healthy offset any negative effects, or highlighted that drinking was not affecting their day-to-day life. One participant stated that: *"I also don't think that my drinking is problematic at all. So, I just kind of feel like it's like any other enjoyment thing in life, like in moderation...I don't feel I need to cut at all"* P16 (No reduction, Female, 25-34).

Another element of psychological capability was a lack of knowledge around how much participants were actually drinking. Some considered the 14-unit weekly guidance as ridiculous and irrelevant, which was consistent with the scepticism and denial of national alcohol guidelines that some people have, for example, *"…drinking 14 units a week, which I think is a ridiculous level set by the government, which isn't evidence based and it really winds me up"* P3 (Reduction, Male, 45-54).

Participants also spoke about difficulties of making an alcohol reduction attempt in terms of finding it difficult to talk about it, as well as being unclear about what making a reduction attempt consists of. Some participants spoke about having no interest in drinking less or learning about the harms of drinking.

Environmental Factors Facilitating Drinking

The environmental factors that facilitated drinking alcohol, and were therefore barriers to making a reduction attempt, consisted of the physical, social, and cultural environments. Participants spoke about the accessibility of alcohol, mentioning the impact of unrestrictive licensing laws, and the ease of being able to get alcohol delivered to your home as factors that facilitated their alcohol drinking: *"You know you see people on drugs and stuff like that…I think alcohol is more accessible…"* P21 (Reduction, Female, 45-54).

The role of advertising in facilitating drinking was discussed, as well as the ease of drinking when there was no financial cost (e.g., on work expenses) or a limited financial cost (e.g., deals that made alcohol relatively cheap). Participants frequently spoke about the relatively high cost of no- and low-alcohol (NoLo) and soft drinks and how that disincentivised them to switch.

> *Even stuff like your soft drinks are ridiculously expensive. A pint of coke is almost comparable…to alcohol prices these days. So, a lot of the time there's not a lot of incentives from pubs and restaurants for people to choose a non-alcoholic option.* P20 (No reduction, Male, 45-54).

Participants described how certain activities such as being on holiday or at parties or events facilitated drinking alcohol, which connects with the social motive for drinking alcohol: *"There was sort of like a work party the other week and I drink a lot then for example, you know, so that that's my pattern really"* P25 (No reduction, Male, 35-44).

Participants described the social acceptability of drinking alcohol, including the cultural expectations both generally and in work contexts. There was discussion around the bravado of drinking alcohol, and peer pressure to do so. They highlighted the questioning they received and the enacted stigma around not drinking where a 'valid' reason was needed leading to discrimination. For example, *"…there's gotta be something wrong with you…If you opt out of*

drinking, you're not trustworthy...you're ill…You know, you're pregnant…Whatever it might be" P12 (No reduction, Female, 45-54).

Participants spoke about how reducing their alcohol use had, or they feared would have, a negative impact on their relationships, suggesting an implicit conformity motive for drinking alcohol:

> *Reducing your alcohol, it's kind of a pruning process when it comes to like people you interact with. You either don't want to interact with people as much, or people drop you because you're not their drinking buddy anymore...either you get used to being alone, or you find a new circle.* P1 (Reduction, Male, 55-64).

Motivation for Drinking

Participants described the habitual nature of alcohol consumption as part of their usual routine, how they spend time as a couple, or when smoking. A participant explained *"[it] helps me relax and I've just got into a habit of doing it and it just seems the normal thing for me to do now"* P15 (No reduction, Male, 45-54).

This habitual nature of drinking alcohol and the lack of thought or planning contrasted with the motives described for drinking, which were more goal-directed. These motives included socialising, connecting, and building trust with others, particularly when watching sport, *"I think it's more of a social thing, so going out with friends and just if others are drinking"* P16 (No reduction, Female, 25-34).

Other motives described were enhancement (enjoying the taste or feeling, or drinking to celebrate or as a reward), for confidence in social situations, and coping motives to alleviate negative emotions, including stress, depression and anxiety. A participant stated: *"I lost my business and it wasn't really any fault of my own…there was a lot going on and…to deal with it…I literally drank myself into oblivion every night"* P19 (No reduction, Female, 25-34).

Facilitators for Making an Alcohol Reduction Attempt

Knowledge Facilitating Drinking Less

Some participants reported the realisation of exactly how much they were drinking prompted them to track their alcohol intake; or the extent of the problem as a facilitator to making an alcohol reduction attempt. One participant mentioned that it was identifying themselves as an "alcoholic" that led to making a reduction attempt. A few participants spoke about wanting to scare themselves into making a reduction attempt by reading and learning about the health consequences of drinking alcohol.

> *Just kind of seeing it on a…basis of how many units consumed per week and per month…when it goes over what I think is the limit make a real effort in the kind of immediate weeks following to…be better.* P1 (Reduction, Male, 55-64).

A couple of participants referred explicitly to the role of taking part in the focus group itself and the dialogue around their drinking, that had in facilitated their thinking about drinking less alcohol:

> *It's been helpful having this conversation amongst the group today for me to kind of review my drinking…when you add up the units and then you look at the general guidance actually that is quite a lot and that probably if you've not got an issue now, it's something that maybe you need to kind of like look at.* P13 (No reduction, Male, 45-54).

There was some discussion around moderation versus abstinence. While some participants considered moderation an effective way to address alcohol-related harms, others did not know if it would work for them, and some struggled with moderation, finding abstinence easier: *"I've always thought it's either you're in or you're out. So, it got to the place where I was in there and I think it took experience to show me that it's not all black and white"* P5 (Reduction, Female, 18-24).

Environmental Factors Facilitating Drinking Less

There were factors relating to the physical, social and cultural environments that participants mentioned. Physical environmental factors included how financial cost facilitated drinking less alcohol, such as the relative cost of alcohol on-trade (bars and restaurants), compared with off-trade (supermarkets and retail stores), and having incentives and deals for non-alcoholic drinks. The accessibility of other options including water and soft drinks was also mentioned as being something that could help people to drink less alcohol. A few participants spoke about responsibilities restricting their alcohol consumption such as being on call for work, and not drinking in front of their children:

> *On a school night, we tend not to drink until they've* [their children] *gone to bed...I don't get drunk in front of them. Just because I don't want them to see that and I don't want to put them through it.* P12 (No reduction, Female, 45-54).

The importance of social support to make an alcohol reduction attempt was also mentioned. Participants described making joint attempts with friends or family, or being around others who were not drinking or who had reduced their drinking, which reduced social pressure to consume alcohol.

> *And then the other thing that I did was actually also get my partner involved, he doesn't drink. So, I think it was really helpful that he was there and if we would go out, he would not let me have a drink or, you know, buy me a mocktail instead or like an alcohol-free drink as well.* P11 (Reduction, Female, 25-34).

Motives for Drinking Less

Motives for drinking less concerned what made someone want to change in the first place. Several participants spoke about physical and mental health concerns and medical advice as motives for drinking less, as well as wanting to reduce the impact that alcohol had on fitness and athletic performance: *"There's inflammation of the lining around heart. Also, my cholesterol is slightly high as well, so it*

doesn't help me at higher risk of heart conditions. Uh, so that's sort of made me consider cutting down" P18 (No reduction, Male, 45-54).

Many participants spoke about the weight gain caused by drinking as a motive to drink less, and also more generally about wanting to improve their appearance as motivation: *"It goes to the point where I see myself putting on weight because of the volume of liquid and I stop because I know I need to pull my weight back"* P2 (Reduction, Female, 45-54).

Many participants talked in-depth about the harm they experienced from alcohol, which was a key focus of their motives to reduce drinking. Participants described wanting to avoid negative consequences, including aggressive behaviour, injuries, changes in mood, memory loss, hangovers, vomiting (and disgust at it), and to avoid ending up like someone they knew, *"...mainly due to watching other people you know get drunk and obviously when you get tipsy your mood changes. Sometimes you become jolly, sometimes become violent, and I think that that's a massive issue"* P17 (No reduction, Male, 25-34).

Personal loss related to alcohol, and making an attempt in support of someone else, were also mentioned by some participants as a motive.

> *Full disclosure, nine years ago my husband who was an alcoholic had a heart attack and couple of years prior to that, he'd got to the stage where he got kidney and liver failure…it got to the point where we couldn't have alcohol in the house…So seeing him go through that and then dealing with the aftermath of that I didn't drink for a very long time.* P2 (Reduction, Female, 45-54).

Some participants reported being motivated by the financial costs of alcohol and wanting to save money. Participants often reported that they wanted to prove that they could control their drinking, usually in relation to a previous attempt at short-term abstinence before returning to their previous drinking level. For example, *"So, I would guess probably since about 2010 I've made a choice of making sure I have time off just to make sure I am in control"* P3 (Reduction, Male, 45-54).

Some participants spoke about wanting to improve their relationships as a motive. Parents often reported the impact their drinking had on their children, their parental responsibilities, and wanting to be a role model. Performance at work or university was also reported by some participants as a reason to reduce their drinking: *"I had my dissertation this year, so I was...cutting down definitely just so I could focus and not have like brain fog with hangovers and things"* P9 (Reduction, Female, 18-25).

Goals When Making a Reduction Attempt

Goals concerned what a participant wanted to achieve. Participants mentioned a range of goals that they had or would consider having when making a reduction attempt. Some participants described alcohol-related goals such as complete abstinence, reducing their weekly units, only drinking on certain days of the week, or not drinking for a period of time. One participant stated, *"Yeah, mine was to abstain for the full month. Do not drink a drop until the 1st of February"* P7 (Reduction, Male, 25-34).

With the goal of reducing their weekly units, participants mentioned a goal of no longer needing to track their units, and some mentioned that they struggled with maintaining a lower level of consumption without it creeping back up again. Participants mentioned temporary abstinence as a goal, related to taking part in a campaign, specific life events or set alcohol free periods, with some participants mentioning trying to extend it beyond the original duration.

> *"I think for me it was 'cos I'd set off saying doing dry January, but I was going to see how long I could do…When I started off in January, I did three months and for me I think success is about when I do go back to drinking, being able to keep the level lower"* P8 (Reduction, Female, 55-64).

No participants mentioned a goal of drinking less than 14 units a week and one participant spoke about finding the recommendation off-putting: *"...I get fed up with being preached at about drinking less than 14 units. To me, that's just an arbitrary number. It means nothing"* P6 (Reduction, Female, 55-65).

Participants described goals intended to avoid any negative consequences from heavy drinking, and avoid dependency by preventing the escalation of current drinking habits. They talked about having improved physical or mental health, including improved fitness and better athletic performance. Weight loss and money saved were also mentioned as targets of alcohol reduction attempts. Participants spoke about being able to socialise without feeling like they needed alcohol: *"And goal is, I'll be able to quit and be able to socialise without drink"* P22 (Reduction, Male, 25-34).

Some participants had no specific goal in mind; others mentioned that they would find it hard to know what an appropriate goal would be, as they were not sure of how much they drank in the first place: *"People are being asked how much do you drink? So, if it was a goal scenario, they wouldn't even know where they are in the first place. So, it's hard to set that goal"* P26 (No reduction, Female, 25-34).

Outcomes from Changing Behaviour

Some participants who had reduced their alcohol intake reported positive outcomes from changing their behaviour. Examples of these outcomes were better relationships, physical and mental health, mood, sleep, self-fulfilment, having a healthier relationship with alcohol, saving money and weight loss.

Strategies Used or Considered During a Reduction Attempt

Participants described a range of strategies that they had used or might consider using during an alcohol reduction attempt. These included changing contexts of alcohol consumption, and changing behaviours within a drinking context. In terms of changing the context in which they

drank, participants spoke about avoidance strategies, including not having alcohol in their home, or avoiding certain places and people that they used to drink with. When participants talked about avoiding people, they described avoiding socialising with them altogether, or socialising in a different group to avoid a situation where drinking was encouraged, for example, *"I'm…sort of changing the sort of groups that I'm staying in, so having more friends that don't need drink to socialise and you realise it's kind of normal to not have to have drink in order to socialise"* P23 (Reduction, Male, 45-54). Participants also spoke about not drinking when at home or alone.

Participants talked about strategies to change their behaviour within the drinking context. This included having fewer drinks on any one occasion, only drinking within or before certain times, driving to prevent drinking, and substituting alcoholic drinks with either NoLo drinks, soft drinks or weaker drinks. When participants spoke about substituting with NoLo drinks, they also mentioned that there were nice options now, except for wine, and less stigma around choosing NoLo options. However, participants did describe how drinking NoLo drinks could prompt drinking alcoholic drinks: *"I drank alcohol free beer, which is actually quite nice…I tend to drink wine and alcohol free wine is horrible…But the beer, they actually get quite a decent flavour out of it"* P6 (Reduction, Female, 55-64).

A number of abstinence-based strategies were mentioned by participants, such as total abstinence, and participating in short-term periods of abstinence. Participants also spoke about having a certain number of alcohol-free days each month. Some participants talked about finding public campaigns motivating, but also that they usually took place in winter months (e.g., Dry January) and that they found the weather dreary, impacting negatively on their likelihood of taking part. Others described that they were more likely to pick their own month or period of time so that they were more in control of the plan. The short-term periods of abstinence were often linked with the motive of wanting to show control over their drinking:

> *We (my crowd) all kind of pick a month…I'm gonna have a month off because you know it is good for you and it does kind of prove a point that I'm not stuck in the routine in the cycle.* P3 (Reduction, Male, 45-54).

Participants talked about only drinking on certain set days, like at the weekend, but that sometimes these rules were blurred in terms of what counted as the weekend, for example if they did not have work on a Friday. Some participants described tracking their units and alcohol-free days, either manually or via an app. Using social support and seeking accountability by informing their friends or family who were supportive was also mentioned as a strategy.

There was also talk of substituting drinking alcohol with physical activity, or other hobbies or activities. Some participants also mentioned that the strategies they used varied and were flexible day-to-day depending on how they were feeling. A few participants mentioned that they did not use any strategies or have any support during their attempt.

Discussion

Summary of Findings

People drinking at risky levels in the UK reported a wide range of barriers and facilitators to making an alcohol reduction attempt, and a range of strategies they have or would consider using. There were factors around an individual's knowledge, their motives to both drink alcohol, to drink less alcohol, and their physical, social and cultural environment that impacted whether or not they would make an alcohol reduction attempt, which mapped onto the COM-B model (Michie et al., 2011). This study was focused on an individual's attempt to reduce their alcohol consumption, and not the policy levers that exist such as reducing availability, for which there is strong evidence (Public Health England, 2016). Despite this, several barriers and facilitators at the policy-level such as the role of accessibility and effects of licensing laws, and the cost of alcoholic drinks compared with NoLo drinks were mentioned by participants. Environmental factors facilitating drinking alcohol were mentioned more regularly and by more participants than environmental factors facilitating a reduction in drinking alcohol.

The motives to drink alcohol mentioned by participants as part of the barriers to making an alcohol reduction attempt aligned with established drinking motives models (Cooper, 1994; D'Aquino et al., 2022), with motives of coping, enhancement (including taste), social and confidence identified. In this study, we did not identify participants explicitly talking about drinking alcohol to conform – part of the drinking motives model established among young people (Cooper, 1994) – although participants reported experiences reflecting social norms around drinking and the consequences of non-conformity, such as the negative impact that changing drinking may have on relationships, and needing to find new social groups. Participants also reported changing their social situations as a strategy to reduce their harm from alcohol, which aligns with previous research finding that individuals who had reduced or stopped drinking renegotiated social rituals to avoid negative social consequences (Bartram et al., 2017). In this study, participants reported stigma when not drinking, or drinking less, both in terms of fear of encountering negative consequences (anticipated or felt stigma) and discrimination based on the unacceptability of not drinking (enacted stigma; Katainen et al., 2022). This highlights the importance of considering the social environment and the contexts in which drinking occurs when someone is making an alcohol reduction attempt, and the value of incorporating social support structures in these attempts.

This study found participants reported value-driven motives to drink less (e.g., being a role model, supporting someone else making an attempt), which were not identified in previous research (Beard et al., 2017; Epler et al., 2009; Faria et al., 2023; Kale et al., 2025). These value-driven motives reflect autonomous motivation, which drives greater self-determination than amotivation or controlled motivation (e.g., avoiding negative consequences), and this shift to more self-determined motivation is a proposed mechanism underlying behaviour change according to the Self-

Determination Theory (Richards et al., 2021; Ryan et al., 2008). Future research could investigate whether these value-driven motivations are associated with more successful alcohol reduction attempts than those associated with controlled motivations.

One of the barriers discussed was people not knowing how much they were drinking (indicating a lack of knowledge) or not perceiving their drinking as problematic or harmful (despite all participants drinking at risky levels), which is consistent with other research (Morris et al., 2025). Interestingly, other participants mentioned realising how much they were drinking as a facilitator to making a reduction attempt, along with clarity around moderation (rather than abstinence) being a valid end goal. Given that the goals participants spoke about were inconsistent with the UK low risk drinking guidelines of 14 UK units a week, this suggests that problem recognition and highlighting that moderation or reduction, even a small amount, as a goal could be an important target for an intervention to encourage risky drinkers to make an alcohol reduction attempt. It is suggested that careful messaging would be required to ensure that people knew what they could do (response efficacy) and that they felt capable of doing it (self-efficacy), particularly given some participants reported not knowing how to go about reducing their alcohol consumption. The extended parallel process model (Popova, 2020; Witte, 1992) posits that if someone considers a threat (alcohol harm) both serious and likely to happen to them, how they respond will depend on their self-efficacy. If self-efficacy is high, then this usually results in changed beliefs and behaviours in line with the messaging, though if low, then people typically engage in defence mechanisms like message avoidance or denial.

A range of strategies to reduce alcohol consumption were mentioned including strategies relating to changing their drinking contexts (e.g., not drinking at home or not alone), changing their behaviour within their drinking context (e.g., substituting alcoholic drinks with NoLo, soft or weaker drinks). Abstinence-based strategies such as participating in short-term periods of abstinence, as well as having a number of alcohol-free days each month, and drinking only on certain days were mentioned, alongside tracking their units, seeking social support, and substituting drinking alcohol with another activity or hobby. Furthermore, there were a wide range of goals reported beyond alcohol-related ones, including health-related, avoiding negative consequences, and weight loss goals. Similar themes were mentioned across motives to drink less for some participants, and goals for others (e.g., improving mental health was mentioned as the goal for one participant and mentioned as the motive that led to the attempt for another participant). The motives were conceptualised as what made someone want to change in the first place, and the goal was what they wanted to achieve, and were typically different. This highlights the heterogeneity between different people's alcohol reduction attempts and the importance of better understanding whether alcohol reduction interventions that incorporate goals that are relevant to and resonate with the individual, with strategies tailored to the individual based on their motives and goals are more effective.

Implications

This study shows that there is a wide range of responses across people who drink at risky levels in terms of their motives for making, or reasons for not making, an alcohol reduction attempt, strategies, and goals for the attempt. These findings also highlight the importance of the drinking context in which strategies are used, as found in previous research (Sasso et al., 2025), and that relevant and effective strategies are likely to depend on the individual's drinking characteristics. Future research should evaluate whether tailored and personalised support based on someone's drinking context, motives, reasons, strategies and goals is a more effective approach than non-tailored approaches.

Participants reported experiences reflecting the consequences of non-conformity and the anticipated and enacted stigma when not drinking, or drinking less (Katainen et al., 2022). Given that participants spoke about changing their drinking contexts as a strategy to reduce their harm from alcohol, this has important implications for future interventions in terms of incorporating social support in these attempts, rather than focusing solely on the individual.

Participating in the focus groups appeared to foster reflective motivation for some participants and in one case resulted in a participant making a reduction attempt. Taking part in relationally facilitated focus groups can create a safe space for people who drink at risky levels to consider their own alcohol use and encourage reflective motivation to make an alcohol reduction attempt (MacNeill et al., 2016). The effect of taking part in reflective discussions around alcohol use on long-term alcohol consumption could be investigated.

Strengths and Limitations

This study had a number of strengths. The focus groups allowed for diverse perspectives and experiences of alcohol use in people who drink at risky levels, with the vast majority of participants invited to a focus group attending, and offering thoughtful responses to the questions. The analysis allowed for a rich data interpretation, which took account of the positionality of the two researchers involved in data collection. This study was an important first step in improving our understanding of the motives, strategies and goals relating to alcohol reduction attempts though more work is needed to understand how tailoring strategies and goals to motives will work in practice.

The study also had a few limitations. Participants of higher social grade were overrepresented in the focus groups. Most groups were reflective of the national average for different ethnic groups (UK Government, 2021), though there was still an underrepresentation of minority ethnic groups. This led to one participant asking why they were the only participant from a minority ethnic group after their focus group had concluded. This was welcomed and reflected on. The research team had tried to ensure diversity across each focus group though conducting focus groups with mostly white participants affects the experiences of participants from minority ethnic groups and could be seen to perpetuate "white gaze" – that the default perspective is a white one (Rabelo et al., 2021). The design of future focus group

studies could be improved by running dedicated focus groups for participants from minority ethnic groups. There may have also been differing perspectives and potential power dynamics at play by having mixed focus groups in terms of gender and socioeconomic background (as well as ethnic background). The facilitators of the focus groups attempted to manage this by clarifying ground rules and boundaries at the start of each session (e.g., respect others' experiences and opinions, and to feel free to speak up if your experience is different) and holding time boundaries to ensure that every member of the focus group had time and space to speak. The scope of this study also focused on the individual motives, and participants were not explicitly asked about the wider determinants of health and the context of the social environment (the role of the alcohol industry, socioeconomic deprivation) and their role in reducing alcohol harm.

Conclusions

People drinking at risky levels in the UK reported a range of motives both for drinking alcohol and drinking less alcohol, and their goals and strategies. The wide range of alcohol reduction goals reported were largely inconsistent with the UK low risk drinking guidelines of 14 units a week. Therefore, alcohol reduction interventions that focus on this 14-unit goal are not likely to be relevant to or resonate with many individuals. Future research should assess whether alcohol reduction interventions that incorporate goals that are relevant to and resonate with the individual, with tailored strategies based on the individual's motives and goals for making a reduction attempt, are more effective.

Declaration of Interests

HM, OMM, ASA, AH, MS, MSN, and MRM have no conflicts of interest to declare. MO and JB have received funding from Alcohol Change UK (ACUK) for a separate ongoing research project on alcohol-free and low-alcohol drinks that began in January 2025. CG worked on a project funded by Alcohol Change UK (ACUK) that ran from September 2021 to March 2023, with a no cost extension running until March 2025. Since beginning those projects, the authors have become aware that ACUK received less than 0.6% of its funds in 2024-2025 from Lucky Saint, an organisation that produces and sells non-alcoholic drinks, and owns a pub that sells standard alcoholic drinks. In March 2025, Lucky Saint became an associate member of The Portman Group, a self-regulatory organisation that is fully funded and controlled by the alcohol industry. ACUK has a strict policy of not accepting any funds from, nor being subject to any influence whatsoever from, the alcohol industry, including through its investment portfolio. ACUK has stated that it remains in full compliance with its policy.

Data Availability Statement

The data that support the findings of this study (anonymised focus group transcripts) will be made openly available on the University of Bristol Data Repository on paper acceptance.

Author Contributions

Each author certifies that their contribution to this work meets the standards of the International Committee of Medical Journal Editors.

HM: Conceptualisation, investigation, formal analysis, writing – original draft, writing – review and editing;

OMM: Conceptualisation, writing – review and editing;

ASA: Conceptualisation, writing – review and editing;

MO – Conceptualisation, writing – review and editing;

JB: Conceptualisation, writing – review and editing;

AH: Writing – review and editing;

MS: Formal analysis, writing – review and editing;

MSN: Writing – review and editing;

MRM: Conceptualisation, writing – review and editing; and

CG: Conceptualization, investigation, funding acquisition, formal analysis, writing – original draft, writing – review and editing, supervision.

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