1 Qualitative Review for Experience of Care – Included Studies

1.1 Experience of alcohol problems

Ref ID	Sampling Strategy	Design/Method	Population/Diagnosis	Results	Limitations
Burman 1997 (USA)	Participants recruited through newspaper advertisements.	A semi-structured interview process from which specific themes and patterns emerged and could be coded and subjected to a comparative content analysis.	38 participants who considered themselves to have had a severe alcohol problem, had been abstinent for at least one year and who had no participation in alcohol abuse treatment or self-help groups during the two years prior to achieving abstinence.	Most participants reported making conscious decisions not to drink, often as a result of an accumulation of events. Recovery delays were related to an ingrained belief that drinking was a fundamental part of the person. A.A. treatment was often seen as too religious and hard to relate to. Instead, people reported using supportive others, avoidance of alcohol-related environments or substituting drinking for another addiction. Previous abstinence success and seeing another person giving up drink successfully helped to promote abstinence. To help achieve abstinence, respondents set themselves a time limit, told others of their plan, or kept reminders of negative experiences. Participants reported positive and negative abstinence consequences including having more energy, improved memory, increased awareness of surroundings, Edginess, shaking and family problems.	No official alcohol diagnosis
Hartney2003 (UK) Untreated drinkers experience of readiness to change	Sample recruited from West Midlands community, using newspaper, bus shop advertisements, posters, leaflets mail shot and word of mouth.	Quantitative and qualitative component of study. Confidential semi-structured interviews at the Uni. Of Birmingham or another location (home or place of work) 2 hour interviews. Based on rounded theory	N=500 untreated drinkers with a weekly consumption of at least 50 units of alcohol if male, 35 units if female, for at least 27 weeks of previous year. All between 25-55 years of age.	Participants described ability to, and ways of thinking about./initiating change in drinking (coping/moderation/reduction strategies) Self-evaluation of drinking behaviour an ongoing problem(motivation to drink, observation of other drinkers, drinking taboos, looking for signs of dependence) Motivation to change was often related directly to a specific change in some other area of one's life (e.g. health problems, pregnancy, resolution of past problems)	

				2 requirements to change taking place : cognitive requirement in terms of recognition of the need to change, and a behavioural requirement in terms of change being implemented.	
Jethwa2009 (UK) (Paper published; interviews (10) unpublished)	Individuals were chosen to include a variety of alcohol consumption levels & socioeconomic backgrounds.	Open-ended interviews to gather a life history.	N=10 participants with a history of alcohol dependence were interviews about their life histories and drinking patterns. All individuals were abstinent at the time of study (duration of abstinence: 1 month – 3 years)	No picture of a "typical alcoholic" While some service users drank for the taste of alcohol, others started drinking due to a stressful life event or trigger (e.g. depression or breakdown of a relationship) Decision to quit or reduce drinking oftentimes happened as a response to a turning point or negative life events.	The 10 patient interviews were unpublished and paper is written to reflect social and psychological aspects of alcohol misuse as a whole; rather than have a specific focus on the patient interviews.
Mohatt2007 (USA) Natural recovery in untreated drinkers.	Convenience sample	Cross sectional qualitative research design and community based participatory research methods. Open-ended and semi structured interviews gathering extensive personal life histories. Grounded theory and consensual data analysis techniques.	N=57 participants for Alaska natives. Participants were nominated and self-identified as being alcohol-abstinent at least 5 years following a period or problem drinking.	Individual enters into a reflective process of thinking over consequences, leading to periods of experimenting with sobriety and cycle of abuse (return to drinking). This leads to a turning point (hitting rock bottom) leading to a decision to remain sober. Stage 1 sobriety (active coping strategies) Stage 2 sobriety – living life beyond coping	Sample confined to specific groups of native-Americans in Alaska; may not generalise to wider UK population.
Nielsen 2003 (DENMARK)	Randomly assigned patients at an Alcohol Treatment Centre (recruited from a previous trial)	Semi-structured interviews were based on pre-coded interview schedules. The patient was encouraged to talk about his/her expectations and experiences of treatment and therapist. Interviews lasted between 45-90 mins.	Participants (N=27) were all seeking alcohol treatment in Denmark.	Interviews produced various narratives of drinking. A moral aspect concerned with personal development and change is seen. Participants could be classified as cultural drinkers, symptomatic drinkers and pathological drinkers. How individuals explained their drinking problem was not related to duration of drinking problem, actual amount of alcohol patients drank or how it was drunk. Patient's perceptions of alcohol problems were grounded in the way the drinking pattern was interpreted when compared to concepts like normality and deviance.	

Rolfe 2005	No mention of sampling method	Participants completed an interview including forced choice questions, a 'changes chart' and a qualitative interview.	Participants (N=17, mean age 45 years) were heavy drinkers (50 drinks/week if male, or 35 if female, for at least 27 weeks prior to study entry). Participants had to have received no treatment in the past 10 years.	Participants reported needing to, having to and being able to as reasons for stopping drinking. Needing to, e.g. because of health problems, was reported by 6 participants. Only 2 participants sustained a decrease in drinking. The remainder reduced drinking initially then re-evaluated the necessity of drinking reduction. Having to, e.g. for employment reasons, was reported by 5 participants. Their drinking gradually increased, but to a lesser extent than previous levels. Being able to, e.g. due to successful medication, was reported by 7 participants. These participants sometimes reported drinking to relieve stress.	Unclear what the non-drinking related demographics of the sample are. Unclear exactly what the interview questions entailed
Yeh 2009	Purposive sampling was used to select participants in an Alcoholics Anonymous group and a psychiatric hospital in Northern Taiwan	Semi structured interviews conducted in 2 settings	Participants (N=32) all had an alcohol use disorder history. Of these N=9 attended AA meetings. Population had been sober for an average period of 62.4 months, with periods of sobriety ranging from 15-105 months.	Participants experienced three stages. In the Indulgence stage, they felt they had (no control over alcohol consumption. This was then followed by an ambivalence stage. At some point, participants typically experienced a turning point, where they attempted to become abstinent (self belief and acceptance).	Although the study attempts to highlight experience of illness in a non-European culture, its generalisability to the UK may be limited. The participant group was predominantly male.

1.2 Access and engagement

Ref ID	Sampling Strategy	Design/Method	Population/Diagnosis	Results	Limitations
Vargas2008 (BRAZIL) Conceptions and attitudes of nurses from district basic health centres	Purposive sampling selected according to their work shift with the purpose of interviewing nurses from each period at each institution	Descriptive study Directive and semi-structured interviews Content and thematic analysis as data analysis.	N=10 nurses working in a secondary referral unit, specialized in caring for individuals with chronic and/or acute complications in Brazil.	Nurses presented negative attitudes towards moderate alcohol use and considered alcohol as something harmful, regardless of quantity. Nurses who use alcohol more permissive towards alc. Use, those who claimed abstinence rejected consumption. Nurses have poor knowledge of alcohol	Nurses' attitudes cannot be generalised to nurses working in the UK necessarily.

				dependence. Negative attitudes towards those with alcohol dependence; express little optimism for recovery. Even being sick, they are not always seen that way See patients as opportunistic and bad tempered persons. Alcohol addicts as people who present repetitive problems and recurrently seek healthcare.	
Dyson 2007 (UK)	No mention of sampling method	Narrative method approach Face to face interviews	Members of AA (N=8) who declared themselves to be alcoholic and had been in sobriety for a minimum of one year.	Behaviours indicated they were aware of their alcohol problem but were reluctant to admit it openly for fear of other people's reactions. GPs were regarded as helpful but nurses and other health workers were seen as less sympathetic and understanding and more dismissive. It was felt that nurses should have more training and re-think their approach to alcohol dependence.	Diagnosis was self-declared their diagnosis and so may not be accurate. Study lacked description of methods and analysis.
Lock 2004	A random sample of patients registered with GPs took part in a focus group. These were supplemented with a purposive sample of patients recruited using market research methods in northeast England.	Each focus group was moderated by an experienced researcher using a semi-structured topic guide. A second researcher acted as an observer and assisted with the validation of the data. Questions were open ended and a funnel approach was used, starting with general questions about health and lifestyle and gradually focusing on alcohol-related issues.	N=31	Participants said they responded positively to advice when it was given in an appropriate context and by a health professional with whom they had a good relationship and rapport. Overall the GP was deemed the preferred health profession to discuss alcohol issues and deliver brief alcohol interventions. It was considered to be the 'role' of a GP to deliver these interventions.	Although multiple recruitment strategies were employed, there were no patients aged 27-44.
Vandevelde2003 (BELGIUM)	Purposive sampling.	Semi-structured interviews open-ended.	N=11 professionals N=11 service users	Professionals/service users regarded communication difficulties most important – notions of honour and respect made it difficult to	

Cultural responsiveness in substance-abuse treatment		Professionals participated in focus groups.	Representing substance abuse treatment centres in Ghent and suburbs. Study focused on population that has a Turkish, Moroccan, Tunisian or Algerian ethnic background, which reflected distribution of these subgroups in general population.	talk openly about emotional problems. Small structural changes (e.g. incorporating words from service users' mother tongue) may facilitate change. Absence of ethno-cultural peers in substance abuse treatment facilities, mostly Western staff. Would be beneficial to have more culturally diverse staff. Professions suggest working through medical dimension which might facilitate treatment f minority clients (as emotional problems most often expressed through physical symptoms)	
Vandermause 2009	This phenomenological study recruited women recovering from alcohol dependence by word of mouth and using flyers .	In-depth interviews following a Heideggerian orientation to dialogue reflecting receptivity and reflexive conversation.	Women (N=5) recovering from alcohol misuse.	Women often waited until their symptoms were severe before they sought health care services. Women did not know how to present themselves. They all had consistent negative self images or characteristics and self-deprecating references throughout their testimonies. All of the women recalled experiences that showed the tangle between alcohol and physical symptoms. Many wanted their symptoms discussed separately from alcohol issues even if they were aware of the integration Reluctance to acknowledge alcohol-related problems was associated with stigma. When women did attend clinics, they expressed frustration with the system. A positive experience with a particular healthcare provider or alcohol specialist was able to be quickly recalled and related passionately.	Results cannot be generalised to men.
Nelson-Zlupko 1996	Women attending a comprehensive specialised treatment	Participants indicated which of 24 treatments they had received, and were then asked open-ended	Participants were women (N=24, mean age 35 years) receiving specialised and non-specialised drug-treatment	75% of the treatments received were in outpatient settings. 25% were in inpatient settings.	Small sample size. Selection bias- volunteers may have felt

	program for drug-dependent women were contacted.	questions about service utility. Interviews were conducted by master's level social workers. Responses were audio-taped and recorded in writing.	services. The primary drugs of abuse were heroin (79%) and cocaine (21%). Other drugs used included alcohol (42%), marijuana (75%), sedatives (48%), non-prescription opiates (42%), methamphetamines (8%) and amphetamines (4%)	The most widely available services were individual counselling, therapeutic monitoring, health care monitoring, psychological evaluation and addiction education. Assistance in getting to treatment was rated as the most helpful for maintaining sobriety. Individual counselling and counsellor characteristics were important in determining treatment retention. Sexual harassment was often reported in drug treatment programs. Child care was a central part to recovery. However, this was not widely available in treatment. Most co-education treatment groups left women feeling unable to express themselves. Failure to support women led to treatment failings. Women needed to be viewed as individuals, not in light of their illness. Other factors that were important for treatment were therapeutic medication, race, gender, prenatal health care and routine pregnancy testing. Too much structure in treatment was also viewed as unhelpful.	more strongly about services than non respondents. Findings cannot be generalised to individuals non in specialised women's treatment groups. Alcohol was not the primary drug of dependence and most women were on additional methadone treatment. Results may not generalise to those whose primary drug of abuse is alcohol, or to those on drug-free treatments.
Copeland 1997	Participants were recruited through print media advertisements Sampling strategy not mentioned	Participants answered questions on demographics, life experience, substance use history, lifestyle and substance dependence, factors associated with behaviour change and factors associated with the cessation of substance use.	Women (N=32, mean age 35) who had recovered from alcohol or other drug use problems for over a year without the use of any formal intervention. 44% were dependent on alcohol 37% were injecting drug users 20% were dependent on psychostimulants	Reasons for not seeking assistance included social stigma, a preference for social support, past experience of services and self-reliance. Most women knew of at least one treatment service such as residential rehabilitation, counselling, 12-step groups and Alcoholics Anonymous. Barriers to treatment seeking included feeling different to those were seen as needing those services, financial cost, childcare responsibilities,	Unclear how the interviews were conducted or coded Retrospective assessment of alcohol disorders.

			20% were dependent on heroine 5% were dependent on hypno sedatives and cannabis	time constraints and the inappropriateness of treatment models. Perceptions of self-help groups were largely based on media portrayals, for example as highly religious organisations.	
Rolfe 2009	Purposive sampling	Critical discourse analytic approach. Interviews used mixed quantitative and qualitative methods, with each interview including a semi structured qualitative interview.	Of the total study population (N=24), 17 of the women drank heavily at time of interview (at least 35 units a week) with 2 women drinking over 100 units/week. Mean weekly consumption among sample was 50 units/week.	Alcohol was used as self-medication and for pleasure and leisure. Women needed to perform a balancing act in order to protect against a stigmatized identity of a "manly woman" and "addict"	
Orford 2006 Why people enter treatment (part of the UKATT alcohol trial)	Participants were self-referrals to non-statutory alcohol problem treatment agencies in 3 areas of England and Wales.	The study consisted of open-ended discussion and semi-structured interviews according to a brief interview guide. Interviews lasted approximately 20 minutes and were conducted part way through assessments, which took on avg. 2,.5 hours to complete	Participants in the interview (N=98) reported drinking 27 standard drinks per drinking day, and were abstinent on average of 30 days in previous 3 months.	Most patients sought out treatment because they noticed their drinking getting heavier or out of control, were more than they should or in such a way that is was affecting their health and family. Most had a trigger, e.g. being prosecuted for drunk driving or having a physical incident that pushed them into seeking professional help. Reasons for seeking professional over self help included helplessness, recommendations from a primary careworker, already being in the treatment system, physical or mental health problems, a strong belief in counselling or a medical model, coercion by the legal system, or seeking sympathy.	

1.3 Experience of assessment and treatment

Ref ID	Sampling Strategy	Design/Method	Population/Diagnosis	Results	Limitations
Hyams 1996 (UK)	All clients were attending a National health service therapeutic day unit for people with alcohol	The centre's usual procedure for allocating clients to assessment procedures was used. Clients with referral requests were sent	131 clients, mean age 38.1 years, who were being assessed for an alcohol problem (mean SADQ score= 27.4).	Most clients rated the assessment favourably and felt at ease with their worker. Over half the clients were satisfied with the	Did not assess individual client factors, which may influence ability to form a therapeutic relationship, and thus impact on engagement levels.

	problems.	appointment letters. Before the assessment interview, clients completed the SADQ, DSSI and a demographics questionnaire. Interviews were audio-taped. Following the interview, clients completed the 'Client's experiences and satisfaction questionnaire'	Participants were excluded if they were assessed for a court report, were not assessed by one of 6 selected nurses, were not assessed individually, were too unwell to take part, were a re-referral, or if there was insufficient time to complete the interview.	competence of the worker and most saw the therapeutic relationships as open and honest. However, a third felt their worker's understanding was only superficial. 90% of clients reported finding the interview style helpful, but over half the clients would have liked more time to ask questions. 90% of clients felt some emotional release as a result of the interview, and most felt they had learned something. A total of 51.1% of clients were considered 'engaged' in treatment. Those who reported a good therapeutic relationship with the worker were more likely to engage than those who had a negative experience (e.g. feeling criticised). Most clients preferred a frank approach.	
Orford2006 (UK) Positive changes reported in drinking during previous 3 or 12 months.	Convenience sampling	Open-ended interviews.	N=198, all part of the randomized UKATT trial, comparing motivational enhancement therapy & social behavioural network therapy for people with alcohol dependence.	UKATT treatment allowed participants to think differently about their alcohol behaviour (e.g. feeling understood, gaining insight into their behaviour) and seeing the benefits of change. Treatment facilitated support from family and friends	Convenience sample from a previous randomised controlled trial – positive aspects of treatment may not generalise to other psychological treatments for alcohol dependence.
Allen2005 (UK)	The first six clients to have completed a cognitive-behavioural intervention as part of a project evaluating the effects of a new alcohol treatment were included in the study.	One-to-one 45-60 minute interviews were conducted within 10 days of completing treatment.	Participants were heavy drinkers (N=6, mean age 34.5 years), who all had the drinking goal of becoming abstinent.	Fears initially related to the social environment. As treatment progressed, they became more centred on concerns for the future. Social environment concerns included worries about the social culture of the withdrawal centre. These were largely influenced by cultural norms. Despite some positive medication experiences, participants experienced concerns regarding medication its effects. These worries were elevated by encouragement to take medication, and a lack of information regarding what was being prescribed and why. Taking medication reduced some participants' sense of control. Physical effect concerns focussed on the potential	It is hard to generalise from this institution (a detox facility in the grounds of a large psychiatric hospital adjacent to a prison) to others. Accounts were retrospective.

				pain and distress of withdrawal. Cultural assumptions and past experiences strengthened these fears. Concerns about the future included fears regarding coping in alcohol-related situations, rejoining social drinking circles, and being marked as different as a result of abstinence. These fears were especially prominent in participants with numerous past abstinence attempts.	
Smith 2004 (AUSTRALIA)	A theoretical sampling method was used to select clients experiencing alcohol withdrawal who had self-referred to a single healthcare facility.	The study used semi-structured in-depth interviews with probing questions if necessary. A life history approach was used to prompt rich descriptions of participants' experiences of alcohol withdrawal. This provided an interpretive framework for exploring intimate thoughts and actions.	Participants were Caucasian men (N=8) who were experiencing alcohol withdrawal as a result of alcoholism.	Participants reported feelings of shame and a wish for nurses to be sensitive to clients' feelings. Participants felt a loss of control feelings, and a wish to be able to express feelings, perhaps through therapeutic communication and counselling via nurses. Many feelings of anticipation towards the future were also expressed. These included anxiety about employment, family concerns, and managing a life without alcohol	Sample may not be representative due its focus on Caucasian men only.
Bacchus 1999 (UK)	Study was conducted at 2 inpatient programmes in inner South London. One site was a 20-bed, 30 day programme for drug users. The second was a 13-bed, 10 day acute admission programme for clients with drug and/or alcohol dependence Patients were randomly selected from occupancy records.	Researcher-administered semi-structured interviews with lasted approximately 1 hour. Interviews were structured around referral and admission procedures, therapeutic relationships, therapeutic programme and contextual factors such as the physical environment and the availability and quality of facilities.	Most participants were cocaine dependent, but some alcohol dependent individuals were also interviewed. The alcohol dependent participants (N=42, mean age 36 years) made up 38% of the total study population, and their data was analysed separately.	Frustration was expressed about lack of communication and liaison between the client and referring agency during waiting period. The most positive aspect of treatment was considered to be the relaxed atmosphere during in treatment. The main criticism of treatment was restriction of visitors to each service. Patients felt they needed family support, particularly those with children and partners Therapeutic rapport between patient and therapist was considered crucial. Staff with non-judgmental attitudes towards clients was seen as integral to treatment success.	Generalisability of results

Dyson 2007 (UK)	No mention of sampling method	Narrative method approach Face to face interviews	Members of AA (N=8) who declared themselves to be alcoholic and had been in sobriety for a minimum of one year.	Behaviours indicated they were aware of their alcohol problem but were reluctant to admit it openly for fear of other people's reactions. GPs were regarded as helpful but nurses and other health workers were seen as less sympathetic and understanding and more dismissive. It was felt that nurses should have more training and re-think their approach to alcohol dependence.	Diagnosis was self-declared their diagnosis and so may not be accurate. Study lacked description of methods and analysis.

1.4 Experience of recovery

Ref ID	Sampling Strategy	Design/Method	Population/Diagnosis	Results	Limitations
Burman 1997	Participants recruited through newspaper advertisements.	A semi-structured interview process from which specific themes and patterns emerged and could be coded and subjected to a comparative content analysis.	38 participants who considered themselves to have had a severe alcohol problem, had been abstinent for at least one year and who had no participation in alcohol abuse treatment or self-help groups during the two years prior to achieving abstinence.	Most participants reported making conscious decisions not to drink, often as a result of an accumulation of events. Recovery delays were related to an ingrained belief that drinking was a fundamental part of the person. A.A. treatment was often seen as too religious and hard to relate to. Instead, people reported using supportive others, avoidance of alcohol-related environments or substituting drinking for another addiction. Previous abstinence success and seeing another person giving up drink successfully helped to promote abstinence. To help achieve abstinence, respondents set themselves a time limit, told others of their plan, or kept reminders of negative experiences. Participants reported positive and negative abstinence consequences including having more energy, improved memory, increased awareness of surroundings,	No official alcohol diagnosis

				edginess, shaking and family problems.	
Mohatt2007 (USA) Natural recovery in untreated drinkers.	Convenience sample	Cross sectional qualitative research design and community based participatory research methods. Open-ended and semi structured interviews gathering extensive personal life histories. Grounded theory and consensual data analysis techniques.	N=57 participants for Alaska natives. Participants were nominated and self-identified as being alcohol-abstinent at least 5 years following a period or problem drinking.	Individual enters into a reflective process of thinking over consequences, leading to periods of experimenting with sobriety and cycle of abuse (return to drinking). This leads to a turning point (hitting rock bottom) leading to a decision to remain sober. Stage 1 sobriety (active coping strategies) Stage 2 sobriety – living life beyond coping	Sample confined to specific groups of native-Americans in Alaska; may not generalise to wider UK population.
Morjaria2002 (UK) Spirituality, AA affiliation and experience of recovery	Sampling method not mentioned	In depth semi structured interviews. Analysis: Grounded theory	N=10 n=5 South Asian men receiving individual or group counselling with South Asian therapists either in NHS or non-statutory specialist alcohol treatment service n=5 white members of Alcoholics Anonymous groups)	Spirituality & religion played importance role in experience of recovery. AA participants – experience reflected those described in AA's big book. Found spirituality and connectedness to a higher power as treatment went on South Asian participation – reaffirmation of existing beliefs rather than conversion type of experience in AA group.	Small sample and specific ethnicity studied, as well as treatment modality (E.g. AA) therefore may not generalize to wider UK population.
Orford2002 (UK) Experience of close relatives of untreated heavy drinkers	Drawn from community cohort of West Midlands.	Detailed semi-structured interviews with family members only.	N=50 close relatives of 50 heavy drinkers	Most family members recognised drawbacks to relatives drinking and engaged in efforts to change or stop it. Many relatives emphasised the benefits and drawbacks of their relatives drinking Expressed other people's support for their relatives drinking (e.g. the spouse of their relative doesn't see it as a problem_ Justify their drinking problem now with how it used to be (not so much of a problem now.. because..) Many carers emphasised they did not want to be intolerant.	Self-selected sample; therefore potential selection bias.

				Family member uses controlling tactics and try to be tolerant.	
Yeh2009	Purposive sampling was used to select participants in an Alcoholics Anonymous group and a psychiatric hospital in Northern Taiwan	Semi structured interviews conducted in 2 settings	Participants (N=32) all had an alcohol use disorder history. Of these, 9 attended AA meetings. Population had been sober for an average period of 62.4 months, with periods of sobriety ranging from 15-105 months.	Participants experienced three stages. In the Indulgence stage, they felt they had (no control over alcohol consumption. This was then followed by an ambivalence stage. At some point, participants typically experienced a turning point, where they attempted to become abstinent (self belief and acceptance).	Although the study attempts to highlight experience of illness in a non-European culture, its generalisability to the UK may be limited. The participant group was predominantly male.

1.5 Carer's perspective

Ref ID	Sampling Strategy	Design/Method	Population/Diagnosis	Results	Limitations
Orford1998a (UK and MEXICO) Carers perspective	No mention	Cross sectional interview and questionnaire studies Long(3-4 hours) semi-structured interviews.	Broad sample (including both drugs and alcohol) interviews separate family members in both Mexico and England. Family members from England (Southwest) and Mexico city. N=207 family members, mostly partners or parents.(n=100 English families, n=107 Mexican families)	Family members from England (Southwest) and Mexico city. N=207 family members, mostly partners or parents. Three main ways of coping : tolerating (tolerating family members drinking behaviour or supporting them, sacrificing emotions/finances), withdrawal (passively withdrawing from family members alcohol problem, e.g. telling them to leave the house) and engaging (actively supporting change, communicating about drinking behaviour)	
Orford1998b (UK and MEXICO) Social support in coping	No mention	Long(3-4 hours) semi-structured interview with a key family member	Broad sample (including both drugs and alcohol) interviews separate family members in both Mexico and England. Family members from England (Southwest) and Mexico city. N=207 family members, mostly partners or parents.(n=100 English families, n=107 Mexican families)	Mexican families support networks more dominated by their own families and neighbours; whereas English families derive a significant amount of support from more diverse networks, including their friends and professionals (in addition to family).	
Orford2002 (UK)	Drawn from community cohort of West Midlands.	Detailed semi-structured interviews with family members	N=50 close relatives of 50 heavy drinkers	Most family members recognised drawbacks to relatives drinking and engaged in efforts to	

Experience of close relatives of untreated heavy drinkers		only.		change or stop it. Many relatives emphasised the benefits and drawbacks of their relatives drinking Expressed other people's support for their relatives drinking (e.g. the spouse of their relative doesn't see it as a problem_ Justify their drinking problem now with how it used to be (not so much of a problem now.. because..) Many carers emphasised they did not want to be intolerant. Family member uses controlling tactics and try to be tolerant.	
GanceCleveland2004 (USA)	Theoretical sampling	Qualitative evaluation using ethnographic method	N=21 students at a suburban high school in Midwestern United States Setting: large multicultural Midwestern suburban school district including students from middle and lower class socioeconomic backgrounds.	School based support groups for adolescents with an addicted parent included increased knowledge, enhanced coping, increased resilience, improved relationships and improved school performance.	Researcher also was the co facilitator of both focus groups which may have influenced the participants reports. No male participants
Murray1998 (CANADA) Adolescent perception of having a parent with alcoholism	Participants were accessed through contacts made with A.A. members, as a result of being an acquaintance of a researcher, or as a result of attending a counselling department of a local high school.	Participants were interviewed three time using an intensive, unstructured interviewing style. Interviews ranged in time from 1-2 hours. Each participant was given the opportunity to explore, explain and describe in their own words what it was like living with parental alcoholism.	Adolescents (N=5, aged 13-19 years) who had a parent with an alcohol use disorder.	Professionals must focus on the meaning of the experience of growing up in an alcoholic home from the perspective of the individual who lived it. Nurses in hospitals, educational facilities and community settings need to be aware of the adolescent's experience of parental alcoholism and get training on how to deal with this population.	No real sampling method in place. No explicit key themes or suggestions identified by the authors.

1.6 Experience of Staff

Ref ID	Sampling Strategy	Design/Method	Population/Diagnosis	Results	Limitations
Aira 2003 (FINLAND)	Four mental health centres representing rural and town communities were selected.	Physicians took part in a qualitative semi-structured interview, based around a loose interview schedule. All interviews were conducted by the same researcher. Interviews were audio recorded and transcribed.	Practicing physicians (n=36, mean age 42 years) from four primary health care centres	The following factors influenced the initiation of alcohol discussion: If patients did not bring up the issue themselves, physicians found it awkward. They also reported unease at potentially stigmatising the patient. Physicians only asked about consumption when the consultation was in some way related to alcohol. If physicians were aware of an alcohol problem, they reported having to find an appropriate moment in which to raise the issue. Physicians reported making attempts to evaluate the patient based on characteristics like age, appearance and profession. None of the physicians were trained to manage early alcohol problems during training. They could not define risky limits on alcohol drinking. None had self-help books available for patients, despite seeing patients who were reluctant to visit specialist clinics. Expectations of intervention effectiveness were low. None of the physicians asked patients for follow up visits following counselling sessions, partly due to time constraints.	The interviewer was a GP, which may have led to potential bias during the interview stage in terms of guiding the questions.
Beich 2002 (DENMARK)	A pragmatic study was conducted initially, based on the phenomenological approach. GPs were recruited from an earlier WHO brief intervention study.	GPs took part in individual or focus group qualitative interviews. The 2 hour group interviews and 1 hour individual interviews took place 3-12 weeks after the period of pragmatic study.	GPs (N=24) from four Danish counties in Denmark were interviewed. All participated in the WHO project on implementing brief interventions for excessive alcohol use.	GPs who tried a screening and brief intervention programme in their practice reported the extra workload of brief interventions onerous. GPs had problems in establishing rapport with excessive drinkers located by screening. Many heavy drinkers resisted advice on modifying their drinking.	Generalisability questioned as participating doctors in this study may have been more committed to lifestyle interventions than the average GP.

Kaner2008 (UK) Exploring GP's drinking and its influence on intervention practices	Maximum variation sampling on basis of gender, work pattern, practice location, clinical experience and prior involvement in a brief alcohol intervention trial. Phase 2: 70-90 min interviews.	Semi-structured interviews lasting 45-90 mins Analysis: Saturation analysis Deviant case analysis	N=29 general practitioners self-selected into the study; combination of gender, urban/suburban practices	Shared drinking practices could increase empathy for their own patients, and facilitate discussion. GP's own drinking behaviour could also serve as a "benchmark" wherein patients drinking could be measured against their own drinking, and only those drinking more would be labelled " at risk" Subjective judgements about determining risky behaviour, thus some GPs draw on own drinking experience to initiate discussions. Primary care nurses overlook patients whose drinking behaviour was similar to their own.	Subjects selected to maximize variation of perspectives and achieve saturation of views; so findings may not generalize to other health contexts or cultures. Subjects also self-selected (may have had particular interest or alcohol/research) and may represent views of GPs overall.
Lock 2002 (UK)	The study used a combination of convenience and purposive sampling. The sample consisted of nurses from practices in the UK that had previously been invited to participate in an implementation trial of GP-led brief alcohol intervention.	Semi-structured in-depth interviews based on a flexible topic guide.	Primary health care nurses (N=24) from GP practices in the UK (northeast). All nurses had experience with alcohol-abusing patients and with delivering alcohol-specific interventions.	Nurses felt that there was little training available for working with alcohol interventions. There were many barriers to working on alcohol interventions including fears about provoking negative reactions, losing rapport with patients, confusion about conflicting messages concerning alcohol consumption and health, reticence about tackling a socially sensitive issue, health professionals' own use of alcohol and inadequate training and higher prioritisation of other health issues over alcohol.	The attitudes in the north east do not necessarily reflect the view of nurses across England. There was open access to the data and discussion between authors, reducing anonymity and leading to speculation regarding the interviews.
Vandermause2007 (USA)	Participants recruited from a list of advanced practice nurse prescribers. A random selection of participants were given the chance to participate and were sent a postal invitation.	Opening question followed by a narrative and in-depth interviews. Analysed using Heideggerian hermeneutic research methods.	American practice nurse (N=23) prescribers who had worked in primary care.	Nurses understood the prevalence of overuse, but struggled to name alcohol use disorder for fear of seeming judgemental. Nurses could not delineate the cause of alcohol problems and approached treatment in a variety of ways. Some used screening tools routinely, but otherwise they were rarely mentioned. Personal experiences and the perceived acceptability of alcohol use greatly influenced diagnostic patterns. Unique styles were developed to fit given situations.	Unclear how much experience with alcohol abusing patients the nurses had. Interviews conducted face-to-face leaving room for social desirability bias. Small sample, non-generalisable. Not clear what questions were asked, or whether all participants received the same topics for conversation.

Vandevelde2003 (BELGIUM) Cultural responsiveness in substance-abuse treatment	Purposive sampling.	Semi-structured interviews open-ended. Professionals participated in focus groups.	N=11 professionals N=11 service users Representing substance abuse treatment centres in Ghent and suburbs. Study focused on population that has a Turkish, Moroccan, Tunisian or Algerian ethnic background, which reflected distribution of these subgroups in general population.	Professionals/service users regarded communication difficulties most important – notions of honour and respect made it difficult to talk openly about emotional problems. Small structural changes (e.g. incorporating words from service users' mother tongue) may facilitate change. Absence of ethno-cultural peers in substance abuse treatment facilities, mostly Western staff. Would be beneficial to have more culturally diverse staff. Professions suggest working through medical dimension which might facilitate treatment f minority clients (as emotional problems most often expressed through physical symptoms)	Limited to experience of certain ethnic backgrounds only