Appendix 16a: experience of care study characteristics

Qualitative review for experience of care – included studies

Experience of alcohol problems

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
Burman, 1997 (US)	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	N = 38 Participants who considered themselves to have had a severe alcohol problem, had been abstinent for at least 1 year and who had no participation in alcohol misuse treatment or self-help groups during the 2 years prior to achieving abstinence	Most participants reported making a conscious decision 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 AA 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 alcoholism diagnosis
Hartney *et al.*, 2003 (UK) Untreated drinkers' experience of readiness to change	Sample recruited from West Midlands community, using newspaper and bus stop advertisements, posters, leaflets, a mail shot and word of mouth	Quantitative and qualitative component of study Confidential semi-structured interviews at the University of Birmingham or another location (home or place of work) 2-hour interviews	N = 500, 25 to 55 years of age Untreated drinkers with a weekly consumption of at least 50 units of alcohol if male and 35 units if female for at least 27 weeks of previous year	Participants described ways of thinking about initiating, and ability to initiate, 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)	No limitations found

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
		Based on rounded theory		Motivation to change was often directly related to a specific change in some other area of life (for example, health problems, pregnancy, resolution of past problems) Two requirements to change taking place: (a) cognitive requirement, in terms of recognition of the need to change, and (b) behavioural requirement in terms of change being implemented.	
Jethwa, 2009 (UK) (Paper published; interviews [10] unpublished)	Individuals were chosen to include a variety of alcohol consumption levels and socioeconomic backgrounds	Open-ended interviews, to gather a life history	N = 10 Participants with a history of alcohol dependence were interviewed about their life histories and drinking patterns. All individuals were abstinent at the time of study (duration of abstinence: 1 month to 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 (for example, 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 the 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
Mohatt *et al.*, 2007 (US) 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 Alaskan Native Americans Participants were nominated and self-identified as being alcohol-abstinent at least 5 years following a period of problem drinking	Individual enters into a reflective process of thinking over consequences, leading to periods of experimenting with sobriety and cycle of misuse (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	N = 27 Participants 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	No limitations found

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
		Interviews lasted 45 to 90 minutes		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 with concepts such as normality and deviance	
Rolfe *et al.*, 2005	No mention of sampling method	Participants completed an interview including forced choice questions, a 'changes chart' and a qualitative interview	N = 17, mean age 45 years Participants were heavy drinkers (50 drinks per 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', for example 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', for example for employment reasons, was reported by 5 participants. Their drinking gradually increased, but to a lesser extent than previous levels 'Being able to', for example, 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 were Unclear exactly what the interview questions entailed
Yeh *et al.*, 2009	Purposive sampling was used to select participants in an AA group and a psychiatric hospital in Northern Taiwan	Semi structured interviews conducted in two settings	N = 32 Participants 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 to 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

Access and engagement

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
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	N = 32, mean age 35 Female participants 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 20% were dependent on heroine 5% were dependent on hypnosedatives and cannabis	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 AA Barriers to treatment seeking included feeling different to those were seen as needing those services, financial cost, childcare responsibilities, 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	Unclear how the interviews were conducted or coded Retrospective assessment of alcohol disorders
Dyson, 2007 (UK)	No mention of sampling method	Narrative method approach Face-to-face interviews	N = 8 Members of AA 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, 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	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	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	

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
	market research methods in North East England	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		It was considered to be the 'role' of a GP to deliver these interventions	
Nelson-Zlupko *et al*., 1996	Women attending a comprehensive specialised treatment program for drug-dependent women were contacted	Participants indicated which of 24 treatments they had received, and were then asked open-ended questions about service utility. Interviews were conducted by master's level social workers. Responses were audio-taped and recorded in writing	N = 24, mean age 35 years Female participants receiving specialised and non-specialised drug-treatment services The primary drugs used 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%)	75% of the treatments received were in outpatient settings. 25% were in inpatient settings 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 participate 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	Small sample size Selection bias: volunteers may have felt more strongly about services than non-respondents Findings cannot be generalised to individuals not 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 misuse is alcohol, or to those on drug-free treatments

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
Orford *et al.*, 2006 Why people enter treatment (part of the UKATT alcohol trial)	Participants were self-referrals to non-statutory alcohol problem treatment agencies in three 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 average 2.5 hours to complete	N = 98 Participants in the interview reported drinking 27 standard drinks per drinking day, and were abstinent an average of 30 days in the previous 3 months	Most patients sought out treatment because they noticed their drinking getting heavier or out of control, were drinking more than they should or in such a way that is was affecting their health and family Most had a trigger, for example 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 care worker, 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	
Rolfe *et al.*, 2009	Purposive sampling	Critical discourse analytic approach. Interviews used mixed quantitative and qualitative methods, with each interview including a semi structured qualitative interview	N = 24 Of the total study population, 17 of the women drank heavily at time of interview (at least 35 units a week) with 2 women drinking over 100 units per week. Mean weekly consumption among sample was 50 units per 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 stigmatised identity of a 'manly woman' and 'addict'	
Vargas & Luis, 2008 (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, specialised 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 used alcohol were more permissive towards alcohol use; those who claimed abstinence rejected consumption Nurses had poor knowledge of alcohol dependence Negative attitudes towards those with alcohol dependence; expressed little optimism for recovery	Nurses' attitudes cannot be generalised to nurses working in the UK necessarily

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
				Even when unwell, people with alcohol use problems are not always seen that way Patients seen as opportunistic and bad-tempered persons Alcohol addicts were seen as people who present repetitive problems and recurrently seek healthcare	
Vandermause & Wood, 2009	This phenomenological study recruited females 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	N = 5 Female participants recovering from alcohol misuse	Participants often waited until their symptoms were severe before they sought health care services Participants 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 participants 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 participants 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 males
Vandevelde *et al.*, 2003 (BELGIUM) Cultural responsiveness in substance-misuse treatment	Purposive sampling	Semi-structured interviews open-ended Professionals participated in focus groups	N = 11 professionals N = 11 service users Representing substance-misuse treatment centres in Ghent and suburbs	Professionals/service users regarded communication difficulties as most important – notions of honour and respect made it difficult to talk openly about emotional problems Small structural changes (for example, incorporating words from service users' mother	

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
			Study focused on populations with a Turkish, Moroccan, Tunisian or Algerian ethnic background, which reflected distribution of these subgroups in general population	tongue) may facilitate change Absence of ethno-cultural peers in substance-misuse treatment facilities, mostly Western staff. Would be beneficial to have more culturally diverse staff Professionals suggested working through medical dimension, which might facilitate treatment of minority clients (as emotional problems most often expressed through physical symptoms)	

Experience of assessment and treatment

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
Allen *et al.*, 2005 (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 to 60 minute interviews were conducted within 10 days of completing treatment	N = 6, mean age 34.5 years Participants were heavy drinkers 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 and 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 focused on the potential 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	It is hard to generalise from this institution (a detoxification facility in the grounds of a large psychiatric hospital adjacent to a prison) to others Accounts were retrospective

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
				marked as different as a result of abstinence. These fears were especially prominent in participants with numerous past abstinence attempts	
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 which 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	N = 42, mean age 36 years Most participants were cocaine dependent, but some alcohol-dependent individuals were also interviewed. The alcohol dependent participants made up 38% of the total study population, and their data was analysed separately	Frustration was expressed about a lack of communication and liaison between the client and referring agency during the 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	N = 8 Members of AA 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
Hyams *et al.*, 1996 (UK)	All clients were attending an NHS therapeutic day unit for people with alcohol problems	The centre's usual procedure for allocating clients to assessment procedures was used. Clients with referral requests were sent appointment letters Before the assessment interview,	N = 131, mean age 38.1 years Participants were being assessed for an alcohol problem (mean SADQ score = 27.4) Participants were excluded if they were	Most clients rated the assessment favourably and felt at ease with their worker Over half the clients were satisfied with the competence of the worker and most saw the therapeutic relationships as open and honest. However, a third felt their worker's	Did not assess individual client factors, which may influence ability to form a therapeutic relationship, and thus impact on engagement levels

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
		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'	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	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 (for example, feeling criticised). Most clients preferred a frank approach	
Orford *et al.*, 2006 (UK) Positive changes reported in drinking during previous 3 or 12 months	Convenience sampling	Open-ended interviews	N = 198 Participants were all part of the randomised UKATT trial, comparing motivational enhancement therapy and social behavioural network therapy for people with alcohol dependence	UKATT treatment allowed participants to think differently about their alcohol behaviour (for example, 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
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	N = 8 Participants were Caucasian males 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

Experience of recovery

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
Burman, 1997 (US)	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	N = 38 Participants considered themselves to have had a severe alcohol problem, had been abstinent for at least 1 year and had no participation in alcohol-misuse treatment or self-help groups during the 2 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 AA 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
Mohatt *et al.*, 2007 (US) 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 Alaskan Native Americans 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 misuse (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.

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
Morjaria & Orford, 2002 (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 the NHS or non-statutory specialist alcohol treatment service n = 5, white members of AA	Spirituality and religion played important roles in the experience of recovery AA participants – experience reflected those described in AAs' *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 (for example, AA) therefore may not generalise to wider UK population
Orford *et al.*, 2002 (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 (for example, the spouse of their relative does not see it as a problem) Justified their current drinking problem by comparing it with how it used to be ('not so much of a problem now… because…') Many carers emphasised that they did not want to be intolerant Family member used controlling tactics and tried to be tolerant	Self-selected sample; therefore potential selection bias
Yeh *et al.*, 2009	Purposive sampling was used to select participants in an AA group and a psychiatric hospital in Northern Taiwan	Semi structured interviews conducted in two settings	N = 32 Participants 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 to	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

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
			105 months		

Carers' perspective

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
Gance-Cleveland, 2004 (US)	Theoretical sampling	Qualitative evaluation using ethnographic method	N = 21 Female students at a suburban high school in the Midwestern US Setting: large, multicultural, Midwestern, suburban school district including students from middle and lower 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
Murray, 1998 (CANADA) Adolescent perception of having a parent with alcoholism	Participants were accessed through contacts made with AA 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 times using an intensive, unstructured interviewing style. Interviews ranged in time from 1 to 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.	N = 5, aged 13 to 19 years Adolescents with 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
Orford *et al.*, 1998a (UK and MEXICO) Carers perspective	No mention	Cross sectional interview and questionnaire studies Long (3 to 4 hours) semi-structured interviews	N = 207, n = 100 English families, n = 107 Mexican families Broad sample (including both drugs and alcohol) interviewed separate family members in both Mexico and England Family members, mostly partners or parents, from England (Southwest) and	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, for example telling them to leave the house); and engaging (actively supporting change, communicating about drinking behaviour)	

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
			Mexico City		
Orford *et al.*, 1998b (UK and MEXICO) Social support in coping	No mention	Long (3 to 4 hours) semi-structured interview with a key family member	N = 207, n = 100 English families, n = 107 Mexican families Broad sample (including both drugs and alcohol) interviewed separate family members in both Mexico and England Family members, mostly partners or parents, from England (Southwest) and Mexico City	Mexican families' support networks were more dominated by their own families and neighbours, whereas English families derived a significant amount of support from more diverse networks, including their friends and professionals (in addition to family)	
Orford *et al.*, 2002 (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 (for example, the spouse of their relative does not see it as a problem) Justified their current drinking problem by comparing it 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 used controlling tactics and tried to be tolerant	

Experience of staff

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
Aira *et al.*, 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	N = 36, mean age 42 years Practicing physicians 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 such as 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 *et al.*, 2002 (DENMARK)	A pragmatic study was conducted initially, based on the phenomenological approach GPs were recruited from	GPs took part in individual or focus group qualitative interviews The 2-hour group interviews and 1-hour individual interviews	N = 24 GPs from four counties in Denmark were interviewed All participated in the WHO project on	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	Generalisability questioned as participating doctors in this study may have been more committed to lifestyle interventions than the average GP.

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
	an earlier WHO brief intervention study	took place 3 to 12 weeks after the period of pragmatic study	implementing brief interventions for excessive alcohol use	Many heavy drinkers resisted advice on modifying their drinking.	
Kaner *et al.*, 2006 (UK) Exploring GPs' 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 to 90 minute interviews	Semi-structured interviews lasting 45 to 90 minutes Analysis: saturation analysis, deviant case analysis	N = 29 GPs self-selected into the study; combination of gender and urban/suburban practices	Shared drinking practices could increase empathy for their own patients, and facilitate discussion GPs' own drinking behaviour could also serve as a 'benchmark' wherein patients' drinking could be measured against their own alcohol consumption, 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 were selected to maximise the variation of perspectives and achieve saturation of views, so findings may not generalise 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	N = 24 Primary health care nurses 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 northeast 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
Vandermause, 2007 (US)	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	Opening question followed by a narrative and in-depth interviews Analysed using Heideggerian hermeneutic research methods	N = 23 US practice nurse 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	Unclear how much experience with alcohol-misusing patients the nurses had Interviews conducted face-to-face, leaving room for social desirability bias Small sample, non-generalisable

Study	Sampling strategy	Design/method	Population/diagnosis	Results	Limitations
	invitation			Personal experiences and the perceived acceptability of alcohol use greatly influenced diagnostic patterns Unique styles were developed to fit given situations	Not clear what questions were asked, or whether all participants received the same topics for conversation.
Vandevelde *et al.*, 2003 (BELGIUM) Cultural responsiveness in substance-misuse treatment	Purposive sampling.	Semi-structured interviews open-ended Professionals participated in focus groups	N = 11 professionals N = 11 service users Representing substance-misuse 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 (for example, incorporating words from service users' mother tongue) may facilitate change Absence of ethno-cultural peers in substance misuse treatment facilities, mostly Western staff. Would be beneficial to have more culturally diverse staff Professions suggest working through medical dimension which might facilitate treatment of minority clients (as emotional problems most often expressed through physical symptoms)	Limited to experience of certain ethnic backgrounds only

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