Difficult conversations in the workplace about alcohol: learning from the experienced

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Abstract

While some organisations may provide alcohol information and support to individuals with alcohol dependence, studies have shown that referrals often occur very late. Understanding how managers and colleagues can have a conversation about alcohol may help ensure referrals are not delayed. This research sought to explore the experiences of those who have had, or wish they had, a conversation with a colleague about alcohol use.

Semi-structured online interviews (N=14) were conducted with individuals who responded to adverts requesting experiences of having a conversation with a colleague about alcohol. Interviews were transcribed and interrogated for themes using Braun and Clarke's (2006) six stage approach to thematic analysis. Nvivo software was used to evaluate the content of the themes and identify word similarities and coding similarities. 17 subthemes were identified. These were grouped by signals, barriers, and components..

Signals included a pressurised environment, individuals not being at their best, displaying changes in performance or behaviour, and alcohol-specific signals such as alcohol withdrawal were evident. Barriers included environmental influences where drinking is never discussed, often due to fear of consequences or lack of knowledge or training, or a drinking culture is present. Components included evidence that conversations should be collaborative, be separate from performance management and be treated in line with mental health support.

Recommendations for organisations include difficult conversation training, and other activities that support discussion about alcohol to reduce stigma and encourage acceptance. Work environment risk assessments to mitigate the impact of the environment in contributing to alcohol use and access to mental health support, signposting to services, and others who have lived experiences of alcohol related problems as a source of support.

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1 Introduction

Researchers have found links between stress in the workplace and alcohol consumption or an increased risk of alcohol dependency (Anderson, 2010). In the workplace, consequences of excessive alcohol consumption can include absenteeism and lateness (Bacharach, Bamberger & Biron, 2010), loss of productivity and poor performance (Carell, Hoekstra & West, 2011), poor co-worker relations, and inappropriate behaviour leading to suspension or disciplinary action (Anderson, 2010).

Organisations often have formal policies and procedures in place for managing many of these issues, including dedicated alcohol or substance abuse policies. Additionally, a range of interventions have been trialled both in research and within organisations themselves, such as employee assistance programs to deal with significant cases of substance abuse (Anderson & Larimer, 2002). Webb et al., (2009) conducted a systematic review of workplace interventions for alcohol related problems, identifying just 10 intervention studies. These studies included interventions such as counselling, employee assistance programs, and peer support programs. A separate meta-analysis evaluated the effects of computer-delivered programs (Portnoy et al., 2008). Other studies and reviews have explored the effects of mandatory screening for alcohol and drug use (Cashman et al, 2009) and embedding alcohol programs within health promotions activities or programs in the workplace (Sieck & Heirich, 2010). Whilst these reviews and studies produced varying evidence for the success of these interventions, it demonstrates that work is being done to address alcohol use in the workplace and that supporting employees through intervention is a priority for some organisations.

Despite these initiatives however, evidence suggests that employees are often not referred to these interventions until they are experiencing significant problems in the workplace (Anderson & Larimer, 2002). This raises questions for how organisations and managers can identify and communicate with individuals who may be experiencing problems associated with alcohol misuse to engage them in effective interventions or workplace support. These conversations are likely to be difficult and without adequate training or support, avoided.

Having difficult conversations about alcohol has been addressed in academic literature in relation to medical and family contexts, but not with respect to conversations with colleagues in the workplace. Based on Miller and Rollnick's (1991,200) work, FRAMES is an acronym and approach recommended for medical practitioners to use in conjunction with the Alcohol Use Disorders Identification Test developed by the World Health Organisation. Practitioners are recommended to Feedback personal risks, emphasise the Responsibility to change drinking patterns, deliver clear Advice to change drinking patterns, provide a Menu of strategies for changing behaviour, demonstrate Empathy and alliance, and support the individual's Self-efficacy for change. This evidence-based recommendation may be difficult to apply in the workplace setting where there are likely to be added

complexities relating to performance management and power-based interactions. Sawyer et al (2017) considered conversations between parents and children recommending considerations of modelling healthy drinking habits, timing of conversations, taking an informal approach to the conversation and specific recommendations about what to talk about such as avoiding mixing alcohol and drinking at a steady pace. Whilst providing sound advice to parents, interactions in the workplace need to focus on adult-to-adult conversations.

Advice for healthcare practitioners having difficult conversations is prolific with several recent reviews of advice and guidance (e.g., Anderson et al., 2019; Aydin, Bastarcan & Kaptanoglu, 2020; Stephens et al, 2021; Collini, Parker & Oliver, 2020; Johnson & Panagioti, 2018; Albury et al., 2019; Brighton et al, 2017). These healthcare conversations relate to 'breaking bad news' and end of life planning. Here, the practitioner needs to share information, treatment plans and recommendations. This is quite different to a colleague or manager approaching an individual at work about drinking.

Kanner et al.(1999) conducted a postal survey of general practitioners (GP's) which demonstrated that only 21% of GP's felt effective in helping patients reduce alcohol consumption, despite 83% suggesting feeling prepared to counsel excessive drinkers. Insufficient time, training and support from policy were the main reasons cited as barriers to brief alcohol intervention. Concern that patients would resent enquiry about alcohol issues was cited by 21% of those surveyed (Kanner et al, 1999) with many practitioners reporting a lack of confidence, knowledge, skill and guidance, resulting in reluctance to initiate difficult conversations (Parry et al. 2014). Given that experienced healthcare professionals can experience barriers to supporting individuals with alcohol related problems, there are likely to be many challenges for individuals to approach these conversations in the workplace.

This research therefore seeks to explore the experiences of those who have had, or wish they had, a conversation with a colleague about alcohol use. Specifically, we seek to identify the signals, barriers, and components of conversations at work about alcohol. The intention is that these will inform recommendations and potential interventions to help develop skills and confidence in having these conversations.

2 Method

Design

The study took a qualitative approach to explore the experiences of individuals in the workplace. The research was approved by the University of Hertfordshire Ethics Committee.

Participants

The study was advertised on LinkedIn and via DrinkAware. The advert asked for volunteers who had had (or wish they had) a conversation with a colleague about alcohol at work. 22 participants volunteered, 8 of which later cancelled or were unable to join the online call. 5 participants were female and 9 were male (N=14). The conversations they were discussing ranged from current or recent situations to 20 years ago (on average 8.7 years ago). 3 discussed having the conversation about their colleague's drinking, 8 were about their own drinking, and 3 had conversations about both their own drinking and someone else's, on separate occasions. Participants talked about experiences in a range of industries including media, education, hospitality, sales, and the public sector.

Interviews

Participants who made contact were sent a consent form and information sheet and asked for a convenient time to meet online. They returned the completed consent form in advance of the interviews and met with the researcher via Zoom. Their consent to the recording of the interview was confirmed in person. Interviews were semi-structured in nature, intended to be flexible to explore the circumstances and experiences of each individual. Participants were asked to share the specific circumstance and what happened. The signals that the conversation was needed and what they found difficult were also explored. At the end of the interviews, participants were asked to share what they would recommend to others about having a conversation about alcohol use in the workplace. The interviews each took between 20 and 40 minutes.

Data analysis

With participants' permission, all interviews were recorded and later transcribed (removing names and identifying information). Braun and Clarke's (2006) thematic analysis approach was used to review the transcripts. Theme analysis was used to inductively analyse the data and identify emerging themes. The transcripts were also analysed deductively based on the objectives of the research: to identify signals, barriers, and components of these difficult conversations at work about alcohol. NVivo, specialist software, was used to support the analysis. In particular, it provided an opportunity to evaluate the content of the themes and identify potential links between themes in terms of word similarity or coding similarity.

3 Results

The analysis was conducted using Braun and Clarke's (2006) six-step approach to thematic analysis. A collaborative approach was taken – using three researchers to conduct the analysis with discussions to compare coding, confirm themes and discuss implications.

Step 1 - All interviews were transcribed and anonymised. All researchers reviewed all the transcripts.

Step 2 – Familiarisation – this involved reviewing the transcripts and looking at the topics of concerns. A summary of all each interview and the key messages and stories was produced (see table in Appendix I).

Step 3 – Coding – key messages and quotes were coded with 'initial codes'. A list of the 58 initial codes can be found in Appendix II). These were highlighted as signals, barriers, components, recommendations, and other codes.

Step 4 – Emerging Themes – the codes were again reviewed sorted into emerging themes. Appendix II highlights the themes the initial codes were assigned to. They were assigned based on the content and similarity with other quotes. These themes were grouped by signals, barriers, and components. Appendix III shows the emerging themes, sub themes, and component codes for 'signals' of the need for a conversation, 'barriers' to having the conversation and 'components' of a helpful conversation.

Step 5 – Reviewing themes – themes were reviewed to ensure meaningful groupings, limiting any overlap of content (distinct themes), and ensuring the themes were representative of all the conversations.

The theme 'Direct Explanation' had just one individual who had initiated the conversation about their own drinking with their line manager (none of the others did this). It was decided to keep this to highlight it was just one and a rare occurrence. This helped to establish that initiating conversations about one's own drinking is difficult.

Word similarity cluster analysis to check they were each distinct. None of the individual themes were identified as having similar words ($r<0.3$). Each of the groups of themes (signals, barriers, and components) was also representative of at least 12 of the 14 interviews.

Coding similarity cluster analysis was also conducted to establish where codes appeared in the same files. Two pairs of codes exceeded the Jaccard coefficient threshold of 0.7:

- When participants mentioned '*avoiding the conversation*' they also tended to highlight the need to be able to '*provide mental health support*' as part of the conversation.
- When participants mentioned the need to '*take a friendly and supportive approach*' in conversations, they also highlighted the value of providing '*opportunity to talk to people who have been through the same thing*'.

Step 6 – **Defining and naming** involved word frequency analysis and a content review of each sub-theme to ensure that we were using words from the participants in describing the analysis. Two themes were changed to better reflect the words of the participants. Table 1 below highlights the most common words in the grouped themes. Tables 2-4 provide the final analysis of each group of themes, with descriptions and quotations from the participants.

Table 1: *Word frequency analysis: most common words in themes*

Themes	Common words
All	people, drinking, manager, support, culture
Signal	arrogance, attitude, behaviour, blaming, irritable
Barrier	office, drinking, encourage, culture
Component	wellbeing, healthcare, people, relationship, resources

Table 2: *Final analysis of themes relating to SIGNALS a conversation is needed*

Sub-theme	Description	Pps	Refs	*Quotations*
Drinking	Drinking at work – lunchtimes and after work.	11	29	*"So yeah, drinking at lunchtimes and drinking after work for years and years" [P7]* *"I've seen people sit down and edit a video with a bottle of Jack Daniels" [P12]*
Not at best	Drinker may show signs of low self-esteem or not performing but still 'just enough'.	9	21	*"I was unable to function at my best" [P1]* *"feelings of low self-esteem and you know feelings of shame" [P10]*
Secretive	Drinker is hiding their drinking and may find others who drink to hide within group	9	20	*"People who have a problem with alcohol, we are incredibly good at hiding it" [P5]* *"I'd hide drinks, take drinks in the drinks, cans of wine, cans of gin tonic in my briefcase" [P7]*
Pressurised	Drinker is 'self-medicating' in response to stresses and pressures of work (& life)	8	18	*"It became obvious that she was having lots of personal problems" [P3]* *"I used to deal with stress by drinking" [P10]*
Alcohol withdrawal	Hangovers are common, there may also be shaking, lethargy or alcohol odour	7	14	*"He would wreak of alcohol but again, it was just part and parcel of him" [P2]* *"Shaking, you know physically with the withdrawal from alcohol" [P10]*
Persona	Drinker puts on a front – maybe arrogance or defensiveness	6	17	*"I was arrogant, I was blaming everyone else" [P4]* *"Very kind of over the top, built excuses" [P5]*
Absent	Drinker is often late or absent from work, particularly on Mondays	6	12	*"Absence – there's a joke in recovery that we never did Mondays at work" [P5]* *"the signals were lateness and unrealistically explained sickness" [P6]*
Direct explanation	Drinker explains they have a problem with alcohol	1	1	*"told him I felt I had a drink problem and that's why I've been off so I was really upset about the situation but he gave me a written warning and then very shortly after I left of my own choice, jumped ship,"*

Table 3: *Final analysis of themes relating to BARRIERS to having a conversation*

Sub-theme	Description	Pps	Refs	*Quotations*
Drinking culture	It is normal to drink – it is part of the work activities and social time.	13	62	*"This was a work hard play hard culture" [P2]* *I put myself in positions where you know I had jobs where I could drink, I found the jobs where drinking was part of it [P7]* *I think there's this notion that certain careers or industries are drinking cultures but every industry that I've ever been involved in there's always been a drinking culture per se [P9]* *there has been a culture of sort of , like from, from management of going out for parties and sort of, and booze in the office for time to time [P5]*
Never Discussed (Originally coded as avoiding the conversation)	High levels of anxiety about having a conversation and assuming others will do it; Uncomfortable talking with more senior individuals or other differences	10	30	*I guess I was just relying on someone else to do it, maybe not senior enough to do [P12]* *And then I went back after the two weeks and, at the end it was never discussed, [P10]* *he worked very hard to the organization and he obviously sacrificed a lot,[P2]*
Lack of knowledge/ training	There is ignorance around how to talk about alcohol	8	18	*I think you should speak to them, which I found quite difficult, having had no training [P10]* *felt like I didn't really have the tools to kind of know if I should have confronted her or what was the right thing to do in that situation, [P3]*
Problem tolerated	Drinking is excused, ignored, or sometimes protected by senior teams	6	32	*"It was dismissed a lot of the time by people in authority" [P1]* *"His line manager was very protective of him" [P2]* *"As long as I delivered the work they tolerated it" [P8]*
Drinking encouraged	Those not drinking are not part of the 'in group'; not drinking is ridiculed	6	25	*the sales guys would take clients out for boozy lunches to seal the deal, [P13]* *the fridge in the kitchen was just always full of alcohol [P14]* *If you weren't in the club you were an outsider.[P5]*
Stigma	Alcoholism is not discussed or acknowledged; Individuals will not share they are in AA	6	18	*the parody in America, if you say you're on a 12 step program they can see that as a plus because they see it as it means you're going to be reliable, honest you're not going to try and not come in but I still think in this country, there is, there is still, however much we talked about it in sort of more woke ways, there is still a stigma attached to it [P1]* *I'm not comfortable, not currently comfortable being completely open about my drinking in a work environment,[P6]*

Table 4: *Final analysis of themes relating to COMPONENTS of a helpful conversation*

Sub-theme	Description	Pps	Refs	*Quotations*
Remember it is an illness (Originally coded as disease)	It is important to respect that it is an illness and approaching it like that will help show respect	11	35	*it's an illness it's not great it's not something that's they can switch on and off themselves.[P6]* *I see it as an illness now so it's hard it's hard for me to talk about it,[P7]* *no thought of her or other people, it's all about me, it's a selfish condition and illness and that ruined my life [P9]*
Provide opportunity to talk to others	It is really helpful to talk to others who have been through the same. This needs to be kept separate from performance management	8	24	*I approached it from the point of view as a friend rather than a supervisor role…. I think you know somehow that the performance management needs to be separate from the help. [P11]* *What really helped me was hearing stories from people who had been there done it got the t shirt [P5]* *somebody to talk to who's not a doctor, who's not a psychiatrist, who's not know your line manager or HR etc. [P6]*
Ask questions & listen (Previously coded as Friendly & supportive)	Allowing individuals to talk, listening without agenda, and identifying routes to support	7	29	*I just ask supportive questions that make people think about what they're going through [P5]* *something along the lines of Oh, I noticed something [P2]* *always approach it with a helpful constructive manner rather than aggressive manner [P5]*
Provide mental health support	Use mental health pathways and support; Don't ignore	7	24	*my current organization's private healthcare has an addiction package you could call [P10]* *they look after our physical and mental wellbeing.[P12]* *it would be helpful to have kind of professional kind of you know, proper counsellors and mental health workers [P11]* *there's a lot of shame around it as well, so you know to change that conversation without that perception, reducing the shame around it would be really useful.[P6]*
Avoid these!	A number of horror stories shared where individuals were given immediate formal warnings without any welfare support.	5	13	*I was not very supportive, I don't think, in the way I dealt with it. I definitely talked down to her, just told it to sort herself out. Such an idiot [P6]* *the big boss essentially got me in the room and had that thing of saying 'sort yourself out.[P8]*

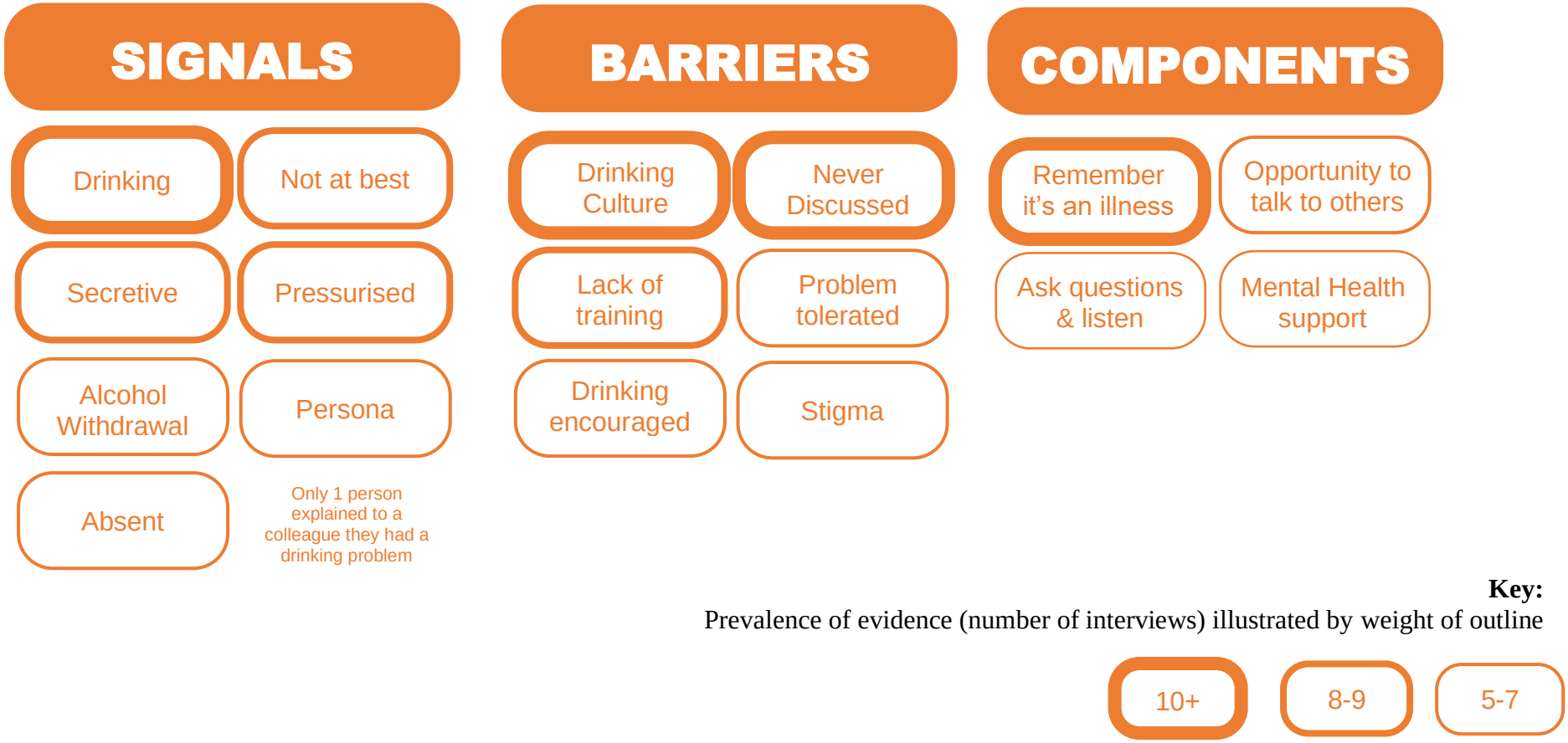

Figure 4. *Visual Summary of final themes and subthemes from interviews*

4 Discussion

Participants shared a wide range of personal experiences, including their own drinking at work, and those who were onlookers concerned for colleagues. The interviews identified a variety of specific signals a conversation about alcohol might be required, barriers to having the conversation and recommendations for the components of that conversation.

There were a variety of **signals** a conversation in the workplace about alcohol might be required. Alcohol specific signals noted by individuals included drinking in working hours and observing alcohol withdrawal such as hangovers, shaking, lethargy and smelling of alcohol. Individuals sharing their own experiences of drinking noted that they were adept at hiding their drinking or seeking out others who also drank a lot. This secretive behaviour may make identifying alcohol use more challenging and may mask the alcohol specific signals. Some individuals also reflected on the work persona they had developed – some talking about an over confidence or arrogance and others talking about being excessively defensive and blaming others. There were also more generalised performance issues highlighted – not being at their best, reacting to pressures of work and absences. These could be signals of other issues aside from drinking but do highlight a conversation would be useful, nonetheless. All these signals highlight the complexity of identifying drinking at work and when this may be an area for concern.

The signals highlighted are reflective of some of the signals noted in the medical field. For example, clinical assessment is advised when there are clear signs of intoxication or withdrawal, demonstrated through physical signs such as slurred speech, fine action tremors, or restlessness (Connor, Haber & Hall, 2016) or being prompted by patient behaviour such as repeated demands for sick leave, not keeping up appearances, or unusual or out of character behaviour (Lid & Malterud, 2012).

The strongest theme related to the **barriers** of having a conversation about alcohol concerned the influence of the workplace culture, where drinking is seen as part of the job and drinking excessively is normalised. Some commented on how drinking was actively encouraged by colleagues and management while not drinking was ridiculed. In some circumstances, individuals observed those who had a clearly drank to excess were tolerated or even protected by colleagues. Other themes relating to the barriers concerned the wider work environment and provide some further detail about how this can stop conversations happening. Individuals reported alcohol use as something that was never discussed. For some, there was a stigma about alcoholism that individuals wanted to avoid talking about. Some of the participants who were recovering alcoholics commented they were not comfortable being open about their experiences. For those talking about approaching a colleague about drinking, it was common that they felt ill-equipped to start the conversation or to know how to deal with it. This mirrors the findings around difficult conversations in the medical field, where

practitioners report a lack of support, training, guidance, and policy as some of the main barriers to initiating conversations with patients (Albury et al, 2019: Parry et al.2014). Encouragingly however some evaluations of interventions to help practitioners respond to individuals with alcohol related problems demonstrated an increase in confidence and indeed overall wellbeing as the interventions helped to reduce anxiety around the issue (Brighton et al. 2017; Johnson & Panagioti, 2018).

The themes relating to **components** of conversations mostly came from the parts of the interviews where individuals shared their recommendations, having had some experience. Individuals were keen to emphasise alcoholism is an illness. Approaching it as an illness and showing respect for the individual is essential. Taking a supportive approach, involving asking questions and listening was also highlighted as vital. Alongside a supportive approach, individuals consistently recommended that it is helpful to have an opportunity to talk to others who have had similar issues. This of course is quite difficult if they are in a work environment where excessive drinking is not discussed, as noted in the themes related to the barriers. Individuals also recommended aligning responses with mental health pathways as they felt that those with alcohol related problems are often self-medicating in response to other issues. Avoiding making the conversation about alcohol a performance management conversation was also recommended. Only one person shared an experience where they had initiated a conversation about their own drinking. In this example, the individual was immediately given a written warning. Individuals emphasised the importance of responding with support and kindness. The components focus on a broader approach than those recommended in the medical field where a menu of potential support or solutions is encouraged (as in the FRAMES approach by Miller and Rollnick, 1991, 2002). It is perhaps unrealistic to expect everyone in an organisation to understand specific courses of action an individual can take in response to alcohol use. It is the environment and openness to having a conversation that is emphasised within this research.

The **most common themes** (those mentioned in more than 10 of the interviews) across the signals, barriers and components highlighted the role played by the work environment. The most common signal noted was simply drinking during working hours. Individuals talked about "*drinking at lunchtimes and drinking after work*" [P7] often with clients and colleagues. The most common barriers highlighted by participants was a culture of drinking in the workplace and drinking or problems associated with drinking, never being discussed. Individuals talked about "*a work hard, play hard*" [P2] culture and highlighted the role senior managers play in encouraging that atmosphere saying "*management were going out for parties … and there was booze in the office*" [p5]. Where alcohol use was noticed, individuals shared they were "*relying on someone else*" [P12] to address the issues. Others observed that alcohol use was noticed but tolerated, "*as long as I delivered the work, they tolerated it*" [P8].

The components of having a helpful conversation highlighted by participants could be used to address the issues of the work environment highlighted. Individuals recommended a supportive approach, asking question and listening - "*something along the lines of oh I noticed something*" [P2]. Keeping conversations separate to performance management and proving opportunities to talk to others who have been through similar issues were other recommendations that could help. Recognising that alcoholism is an illness was the strongest theme in the components of conversations, noting "*it is an illness… not something they can switch on and off themselves*" [P6]. Participants also highlighted the value of aligning the response to alcohol use with providing mental health support which represents an opportunity for organisations to learn from the recent increase in focus on wellbeing and mental health.

Recommendations

The overarching recommendation that come from these interviews is the need to create work environments that encourage supportive conversations. This has potentially wider benefits as supportive relationships in the workplace has been shown to have additional benefits in terms of wellbeing (Mensah, 2021), improved performance and satisfaction (Bulinska-Stangrecka & Bagienska, 2021).

Part of the process of creating the supportive work environment will need to involve making alcohol use part of wider conversations in the workplace. Sharing stories of drinking and stories of change will encourage this. This will help to reduce the stigma associated with alcohol use, help to reduce reticence or uncertainty about raising the issue and potentially allow individuals to access help without fear of reprisal.

Clarity around performance requirements is likely to be an essential part of a supportive working environment (Park & Choi, 2020). However, raising concerns about alcohol use need to be kept separate from performance management conversations. Examples shared within the interviews highlighted that instead of addressing the alcohol use, action was taken against individuals, and this impacted their willingness to seek help and support.

Not only did participants make a specific recommendation to include support around alcohol use within mental health pathways in organisations, but there is also an opportunity to learn from other initiatives around mental health support and wellbeing. Storytelling has been a valuable tool for encouraging conversations about mental health (Stargatt et al, 2022) and within healthcare to encourage health behaviour change (Shaffer et al, 2018; Park et al., 2021). This too could be a technique to encourage a supportive environment and reduce the stigma associated with alcohol use.

To realise the potential benefits of creating a supportive work environment, individuals and managers will require knowledge and skill development around having conversations about alcohol. Where existing training developing manager skills about having difficult conversations exists, there is opportunity to add consideration about alcohol use as a topic. Guidance for how to have the conversation is required. This is likely to increase confidence in talking about alcohol and could have similar benefits seen where healthcare practitioners also reported less anxiety and improved wellbeing (Johnson et al., 2018).

Limitations and further research

In many of the interviews, individuals were talking about significant and long-term drinking. Others discussed incidents that may have been isolated. It could be helpful to develop a clear definition of when alcohol use is cause for concern. Without this, it is difficult to fully evaluate signals and recommendations. It could be argued that whether a situation is isolated or symptomatic of a long-term illness, a conversation coming from a place of kindness is likely to be beneficial.

Many of the conversations discussed in the interviews related to situations from several years ago. In the rapidly changing context of the workplace, it is possible that they do not reflect current circumstances or experiences. It may be valuable to collect further data from current experiences.

Some of the themes identified as signals of alcohol use overlap with signals of other potential issues. This is likely to be circular in contributing to concerns about raising the topic in conversation and makes providing support for managers regarding the signals of alcohol use more challenging. Further research is required to design and evaluate training interventions that upskill managers to have a difficult conversations at work about alcohol. This would provide a stronger evidence base.

There is perhaps a conundrum evidenced within the recommended components of conversations about drinking. Here it is highlighted that individual needs to be ready to change – some may say that there is little an organisation can do until an individual is ready. They may be in a no-win situation.

Conclusions

Alcohol use in the workplace is often masked by the work culture and where it is identified, conversations are often avoided. Like other sensitive conversations required in the workplace, individuals may feel ill-equipped to approach the issue – guidance and training could bring greater confidence. Learning from those who have had a conversation about alcohol use, this research has highlighted the importance of: creating a supportive workplace environment, linking approaches to mental health pathways, and reducing the stigma associated with talking about alcoholism. Individuals may need to be ready to change but getting the support required, starts with a conversation.

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Appendix I : Interview participant summaries

Participant	Job role / Industry	Time since conversation	Gender	Industry	Conversation with..	Key messages
1	Secretary	10 yrs ago	Female	Sales & Education	About self with line manager – initiated herself	It's a disease that still has a stigma associated with it Kindness is required when responding Status and gender affected how treated
2	HR manager	15 yrs ago	Female	Energy industry	Individuals about their drinking (in previous job 10+ yrs ago)	Drinking was an accepted part of work. If delivering still, it was 'swept under the carpet'. Age difference and seniority made it difficult to address any concerns More confident now, with life experiences and seniority.
3	Project manager	Current	Female	Academic	Employee on a field trip, drinking too much and behaving inappropriately	The drinking was symptomatic of other issues. Found it difficult to know 'what is too much' and she herself was drinking at the event. No response from the individual – made her question her approach, herself and her own management skills
4	Senior Manager	18 yrs ago	Male	Logistics	About self with directors	Nothing was interesting – planning when to drink at all times but still functioning and progressing in career. Labelled as a drunk at work – no welfare consideration Arrogant response to being fired – 'you need me' and continued drinking
5	IT Manager	10 yrs ago	Male	Media	About self	Secret drinker. Lost two jobs due to poor performance. Lateness, absence 'never do Mondays'. Work culture encouraged the use of alcohol. Now feels more confident to stand up for self and the focus on well being and mental health in the workplace helps.
6	Manager	8 yrs ago	Male	Hospitality	About self And to employees	Moved to different jobs to hide the 'problem'. Industry encouraged drinking but given warning. Had to give someone a final warning (in a different role) when drinking himself and was not caring – felt 'awful' about doing it and had no training .

7	Company owner	5 yrs ago	Male	Sales	About self	Drank to give himself confidence and reduce anxiety. Colleagues said they could smell alcohol and asked if everything was ok (regularly). Sought help afterwards.
8	Researcher	2 yrs ago	Male	Public Sector	About self	Drinking regularly and after some time it started to affect his performance at work. Boss simply said, 'sort yourself out'. Support only when he attempted to take own life
9	Combination	5 yrs ago	Male	Hospitality Logistics	About self	Changed jobs from as was drinking too much and it was very available. But also found that alcohol was at the centre of the new work culture too. Described a range of excessive drinking at work but no one addressed it.
10	Manager	5 yrs ago	Male	Sales	About self About member of staff	Blackout experiences and aggressive with staff. Took time off work and nothing further said. Actively drinking himself when required to address problem with member of staff – no training, told to just do it. Felt like a hypocrite. Now better procedures and training in place for wellbeing
11	Academic	10 yrs ago	Male	Nursing	About self	Came to work smelling of drink. Kept away from others to avoid being found out. Never addressed at work. Would have helped to have others share their experiences, access to counsellors and mental health workers.
12	Journalist	13 yrs ago	Male	Media	About manager	Manager was drinking on the job. Sent home and a year off work. Not talked about formally but gossiped about. Felt unable to have a conversation due to seniority
13	Editor	20 yrs ago	Female	Publishing	About colleagues	Lots of drinking in the workplace and it was expected to drink. Felt uncomfortable but unable to express that. Left the job.
14	Administration	2 yrs ago	Female	Charity	About colleagues	Alcohol readily available at work. Not comfortable – raised it with managers and they simply added diet coke to offering. Made her feel left out. Left the job.

Appendix II: Initial Codes

Initial Code	Files	Refs	NEW THEME
1. Attitudes have changed	1	1	B_ DIFFERENCES BETWEEN INDIVIDUALS
2. DB_avoiding conversations	4	7	B_AVOIDING CONVERSATIONS
3. B_dismissed	2	3	B_'PROBLEM' TOLERATED
4. B_drinking culture	5	22	B_DRINKING CULTURE
5. B_drinking encouraged	4	10	B_DRINKING ENCOURAGED
6. B_gender differences	1	1	B_DIFFERENCES BETWEEN INDIVIDUALS
7. B_ignorance	3	6	B_LACK OF KNOWLEDGE OR TRAINING
8. B_known problem but not addressed	2	3	B_'PROBLEM' TOLERATED
9. B_lack of knowledge about alcoholism	2	2	B_LACK OF KNOWLEDGE OR TRAINING
10. B_lack of training (Codes)	1	2	B_LACK OF KNOWLEDGE OR TRAINING B_ DIFFERENCES BETWEEN INDIVIDUALS
11. B_older colleague (Codes)	1	1	B_ DIFFERENCES BETWEEN INDIVIDUALS
12. B_others protective	1	1	B_PROBLEM TOLERATED
13. B_status - treated differently	1	1	B_DIFFERENCES BETWEEN INDIVIDUALS
14. B_stigma	5	12	B_STIGMA
15. B_tolerated	1	1	B_PROBLEM TOLERATED
16. B_tolerated (Codes)	1	1	B_PROBLEM TOLERATED
17. B_workplace culture	4	9	B_DRINKING CULTURE
18. B_wouldn't mention at interview	1	1	B_STIGMA
19. barrier	5	17	ALL QUOTES RECODED
20. C_bigger than themself	1	1	C_REMEMBER IT IS A DISEASE
21. C_immediate written warning	1	1	C_AVOID THESE
22. C_no welfare support	1	1	C_AVOID THESE
23. C_not drinking was discouraged	2	3	B_DRINKING ENCOURAGED
24. C_remember it is a disease	4	7	C_REMEMBER IT IS A DISEASE
25. C_self medicating	2	2	C_REMEBER IT IS A DISEASE
26. culture	5	33	ALL QUOTES RECODED
27. R_clear expectations	1	1	C_FRIENDLY & SUPPORTIVE
28. R_colleagues acceptance that i'm not drinking	1	1	C_FRIENDLY & SUPPORTIVE

29. R_friendly approach to offer help	3	5	C_FRIENDLY & SUPPORTIVE
30. R_mental health first aiders (Codes)	1	1	C_MENTAL HEALTH SUPPORT
31. R_mental health pathway access (Codes)	2	4	C_MENTAL HEALTH SUPPORT
32. R_rehab healthcare package (Codes)	1	1	C_ MENTAL HEALTH SUPPORT
33. R_seperate help from performance management	2	4	C_SEPARATE FROM PERFORMANCE MGMT
34. R_talking to others who have been through it too	3	10	C_OPPORTUNITY TO TALK TO OTHERS WHO HAVE BEEN THROUGH IT
35. R_they need to be ready	3	4	C_REMEMBER IT IS A DISEASE
36. R_time off for recovery	1	1	C_MENTAL HEALTH SUPPORT
37. recommendations	4	35	ALL QUOTES RECODED
38. S_absenteeism	3	3	C_ABSENT
39. S_arrogance	2	4	C_OVER CONFIDENCE
40. S_direct explanation	1	1	S_DIRECT EXPLANATION
41. S_drink boosted confidence	1	1	C_ (OVER) CONFIDENCE
42. S_drunk at work	1	1	S_ DRINKING AT WORK
43. S_found others doing the same	1	1	NOT CODED
44. S_hiding drinks	2	8	S_ SECRETIVE
45. S_hungover	2	4	S_ALCOHOL WITHDRAWAL
46. S_low self esteem, shame	2	2	S_NOT AT BEST
47. S_low self esteem, shame (Codes)	2	2	S_NOT AT BEST
48. S_needing money to feed the habit	1	1	S_PRESSURED
49. S_not at best	3	6	S_NOT AT BEST
50. S_out of hours drinking	3	3	S_DRINKING
51. S_self medicating	3	4	C_REMEMBER IT IS A DISEASE
52. S_shaking from withdrawl (codes)	1	1	S_ ALCOHOL WITHDRAWAL
53. S_sleeping	1	1	S_ ALCOHOL WITHDRAWAL
54. S_smell of alcohol	3	3	S_ ALCOHOL WITHDRAWAL
55. S_stress	1	2	S_PRESSURED
56. signals	5	40	ALL QUOTES RECODED
57. alcoholic side effects	2	3	S_ALCOHOL WITHDRAWAL
58. alcoholic traits	3	4	S_SECRETIVE