Exploring Alcohol Workplace Policies and Practices through the Lens of Health Promotion Theory

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in the Faculty of Health and Medicine, Division of Health Research, Lancaster University

Lolita Alfred

RMN, BSc (Hons), MSc (MPH)

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Declarations:

The candidate has already achieved 180 credits for assessment of taught modules within the blended learning PhD Programme.

The candidate declares that this thesis is her own work and it has not been submitted for the award of a higher degree elsewhere

Supervisors:

Dr Mark Limmer and Dr Abigail Morris

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To God be the Glory

Abstract

Background & Aim: Against a backdrop of avoidable alcohol-related mortality, morbidity, and social problems; literature has identified that alcohol-related problems are also experienced in workplaces. Workplaces are regarded as an arena with untapped potential for supporting health promotion and alcohol harm reduction for employees. One of the ways that workplaces can contribute is through developing alcohol workplace policies (AWPs) and practices that are health-promoting. There is however a paucity of empirical theoretically underpinned research on the extent to which AWPs and practices are informed by health promotion principles. The current PhD study aims to address this gap.

Methodology & Methods: A qualitative case study of two public sector organisations in England was conducted. It drew on data collected from documents in both organisations, and 16 semi-structured interviews with policymakers and non-policy makers. Data analysis was undertaken using Ritchie and Spencer's (1994) Framework Analysis Method. All processes of data collection, analysis and interpretation were informed by a health promotion theoretical framework which comprised of Bronfenbrenner's Ecological Systems Theory (1979) and the WHO Healthy Workplace Framework (2010).

Results: Three themes were identified from the data, namely, Misaligned Voices; The Grey Areas; and The Wider Determinants, Meanings and Purpose of Alcohol. These themes encapsulated how AWPs and practices show persistent tensions regarding alcohol treatment versus prevention, and discipline versus treatment. The existence of AWPs and the lingering fear that these are more about discipline and performance has contributed to the unintended consequence of driving alcohol problems underground rather than promoting employee early help-seeking. The themes also capture how misaligned and divergent views around 'alcohol problem framing' are inadvertently contributing to inconsistent ways of managing alcohol problems in the workplace. Using the health promotion theoretical framework enabled the study to uncover the entangled influences of personal, socio-cultural, environmental/workplace and politico-economic factors on employee drinking, and on how AWPs and practices are shaped in the workplace.

Conclusion: The thesis concludes by examining the implications of the case study findings, and makes recommendations for future research, policy, and practice. It acknowledges that workplaces provide support for and investment in systems of treatment for individuals who may be dependent on alcohol. However, the focus on prevention and the overall health-promoting potential is limited because of the misaligned voices, grey areas and unintended consequences of AWPs. Workplaces need to consider policy and practices around alcohol from a wider health promotion theory-based perspective. The thesis contributes to the body of knowledge by presenting a health promotion theoretically underpinned '10 Point Checklist' that workplaces can use alongside their existing AWP development, implementation, and evaluation processes. This will enable a more proactive, upstream approach towards employee alcohol health promotion and prevention of alcohol problems.

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List of Abbreviations

AWP	Alcohol Workplace Policy
AUDIT	Alcohol Use Disorders Identification Test
AOD	Alcohol Or Drug
CIPD	Chartered Institute for Personnel Development
DH	Department of Health
EST	Ecological Systems Theory
EU	European Union
HEI	Higher Education Institution
HSE	Health and Safety Executive
IAS	Institute for Alcohol Studies
NHS	National Health Service
PHE	Public Health England
PIS	Participant Information Sheet
TUC	Trades Union Congress
UK	United Kingdom
US or USA	United States of America
WHO	World Health Organization

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Chapter 1
Introduction & Background

1.1 Thesis Introduction

The negative effects of excessive alcohol consumption on health, social and economic outcomes are well documented in the literature. These effects are also experienced at a workplace level. One approach towards tackling alcohol-related harm and contributing to alcohol health promotion is through the development and implementation of alcohol workplace policies (AWPs). This thesis presents a study exploring the extent to which AWPs and practices are or can be health-promoting. In this first chapter, the background provides a brief synopsis of the context, followed by an overview of the remaining chapters in the thesis.

1.2 Background

1.2.1 Scale of the Alcohol Problem

Alcohol (also known as ethanol) is a drink enjoyed by many, and it forms an important part of some cultural, religious, and social activities for individuals that choose to consume it (Baggott, 2011; World Health Organization [WHO], 2018). Alcohol contributes to economies worldwide. Data from 2017 shows that the global alcoholic beverage market was $1,439 billion, and this was expected to rise to approximately $1,684 billion by 2025 (Prasannan, 2018).

Despite these positive aspects, alcohol is a major public health concern. In England, alcohol related harm costs approximately £21.5 billion, and this figure is more than twice the cost of harm associated with illicit substance use (Public Health England [PHE], 2018). The WHO (2018) Global Status Report on Alcohol and Health presents sobering statistics on the scale of alcohol attributable mortality, morbidity, and harm. The report identifies that alcohol is

implicated in over 200 health and injury conditions (such as Hypertension, some Cancers, Stroke, Heart Disease, Depression and Liver Cirrhosis). Recent evidence also points to a causal relationship between harmful alcohol use and the incidence of Tuberculosis and HIV/AIDS. Alcohol is not only a risk factor in communicable and non-communicable diseases (as highlighted above), but its harmful impact extends to society at large – with statistics showing it is implicated in crime and disorder, road traffic accidents, domestic violence, child abuse and neglect (WHO, 2018). Research also highlights the environmental impact of alcohol, for example wine has a water footprint (the amount of water required to produce wine) of 870 m^3/ton (Mekonnen and Hoekstra, 2010) - this can be a 'hidden' but detrimental impact to settings where water is scarce.

Annually, more than 3 million deaths (which represents 5.3% of global deaths) are attributable to alcohol. These statistics differ slightly when factors such as gender (7.7% deaths for males, and 2.3% of deaths for women); and age (alcohol is attributable in 13.5% of deaths among 20-39 year olds) are taken into consideration (WHO, 2018). To put the scale of alcohol-related mortality into perspective; alcohol attributable deaths are higher than deaths from health conditions such as Diabetes Mellitus, Alzheimer's, and Tuberculosis (Karuga, 2018). These global statistics are based on 2016 data and may well have changed since the onset of the COVID-19 pandemic and lockdown measures have blurred the boundaries between home and work life. Using the UK as an example, PHE recently analysed trends in alcohol consumption and harm, and the results showed an increase in total alcohol-specific deaths driven by an increase in alcoholic liver disease deaths that were above levels seen before the COVID-19 pandemic. Furthermore, a comparison of data from March 2020 and March 2021 showed a 58.6% increase in people who reported drinking at harmful levels (PHE, 2021). Similarly, other research conducted during the COVID-19 pandemic shows that employed individuals were more likely to report consuming alcohol than those who were unemployed (Alcohol Change UK, 2020).

1.2.2 Europe & United Kingdom

From the 2.3 billion individuals who are current alcohol consumers globally, more than half are situated in the Americas, Europe, and Western Pacific (WHO, 2018). Europe has the highest levels of per capita alcohol consumption out of all the WHO regions (WHO, 2018). Nearly 60 years ago, England had one of the lowest rates of alcohol consumption in Europe, but this has increased as the Global Drugs Survey shows UK respondents report getting drunk 51 times in the previous 12 months, compared with a global average of 33 times (Winstock et al., 2019). There is a clear need for more work to be done in Europe and the UK to investigate and address drivers of excessive consumption, and subsequently reduce any associated harms.

Most of the health harms are related to the pattern of alcohol consumption and the volume consumed (WHO, 2018) - this is most commonly referred to in the literature as 'excessive drinking'. How individuals view excessive consumption may vary from person to person (Harkins et al., 2010), however in the UK campaigns have placed emphasis on using "units" as the objective measure for identifying the different risk levels associated with the units of alcohol consumed (NHS Warrington, 2011; Department of Health [DH], 2016). Following a review of scientific evidence on the effects that alcohol has on health, the UK Chief Medical Officers (CMO) published updated guidelines which recommend that in order to keep risks to health lower, men and women (who choose to drink) should not consume more than 14 units of alcohol a week (spread evenly over 3 or more days in the week) (DH, 2016).

1.2.3 Effects of Alcohol on the Workplace

Alcohol (and drug) misuse are considerable issues within society, and for individuals who are employed, these issues are mirrored in the workplace (Chartered Institute of Personnel Development [CIPD], 2020). In the UK, 60% of employers report problems because of staff drinking excessively (Alcohol Concern, 2014). Working-age adults, particularly those aged 25-59 years old,

are reported to be the heaviest drinkers and they exhibit the highest alcohol-related mortality worldwide (Institute for Alcohol Studies [IAS], 2017). Individuals with alcohol-related problems are likely to hold jobs for shorter periods and have higher sickness absence rates in comparison to other work colleagues (Health Development Agency [HDA], 2004; Bhattacharya, 2019). Roche et al. (2016) add that the rate of absenteeism increases with frequency and riskier levels of consumption. Alcohol-related absences, loss of productivity, unemployment, and premature death of economically active individuals in the UK results in over 17 million working days lost each year (National Collaborating Centre for Mental Health [NCCMH], 2014), and costs approximately £7 billion annually (Public Health England, 2016). It is important to note that these figures may be higher because there is the potential for underreporting of alcohol-related absences as workers may fear being stigmatised or disciplined (Roman and Blum, 2002; Reynolds, 2008).

The workplace also experiences problems associated with alcohol-related presenteeism – in the UK for example, over 200,000 employees report going to work with symptoms of a hangover daily (Rehm, 2009; Alcohol Concern, 2014). Although some authors suggest that partial productivity associated with presenteeism is better than being absent altogether (Johns, 2008), other authors vehemently argue against this highlighting that the costs associated with presenteeism are much greater than those of absenteeism (Standard, 2012). This is because reduced concentration, poor performance and the likelihood of making mistakes (associated with working while inebriated or hungover) may pose a risk to an individual's safety as well as that of their colleagues and the public (Aviva, 2008; Standard, 2012; Alcohol Concern, 2014). Furthermore, working while inebriated or hungover can potentially tarnish the image and reputation of an organisation (Austin and Ressler, 2012).

The majority of individuals who are in employment, will spend most of their time at work, therefore the workplace has a captive audience (McPartland,

1991) and is regarded as a domain with untapped potential for addressing alcohol use in the broader framework of harm reduction, disease prevention and health promotion (Roman and Blum, 2002; Anderson and Baumberg, 2006). With the growing requirement for employees to work longer (reflected in the raised statutory retirement age in many European countries), there is a need to ensure that workers health is enhanced so they can remain in employment for longer (Robroek et al., 2021). The World Health Organisation (WHO) (2011) identifies that the health of the workforce is important for productivity and sustainability of national and regional economies, therefore employers should have a vested interest in ensuring they try to help protect the health of their workforce.

1.2.4 Alcohol Workplace Policies

As the literature above shows, there is a strong health, economic and social case for supporting employees in the workplace setting. Key longstanding international agreements that instigated and reinforced the principles of health promotion (The Ottawa Charter and The Jakarta Declaration) also highlighted the importance of settings-based health promotion practice (WHO, 1986; WHO, 1997). Policies are a key part of settings-based health promotion approaches that can contribute towards encouraging employee healthy behaviour (Robroek et al., 2021). Furthermore, identifying and implementing effective policies aimed at reducing alcohol related harm is a key public health imperative (Fitzgerald et al., 2016). AWPs have been consistently identified as a strategy for improving employee health and safety (Powell,1994; Pidd et al., 2016; CIPD, 2020). AWPs are documents that clarify rules and organisational expectations of employees with regards to alcohol consumption at work, work-related functions (on or off-site), as well as implications of reporting for duty while under the influence of alcohol. AWPs are important because they enable organisations to have a consistent approach to managing and supporting employees with a range of alcohol-related problems (CIPD, 2007). The value of having policies specific to alcohol in the workplace is underscored as it complies with law on health and safety at work (Health and Safety Executive, 2019). In recognition of the need for

AWPs to be developed and evaluated, there has been a steady increase in research around this topic (Henderson et al., 1996; Anderson, 2010; Alfred et al., 2021). There is an indication in this literature, that harnessing the health-promoting potential of AWPs can support employees and help reduce alcohol-related harm (Ames 1992; CIPD, 2020). A scoping exercise for the literature review in this thesis did not yield any literature reviews that synthesize the research on health-promoting/focussed AWPs. This gap will be addressed in the literature review within *Chapter 2. E*lements of the literature review were published during the PhD (Alfred et al., 2021).

1.2.5 Policy Landscape

Alcohol has a direct impact on 14 out of 17 of the health-related United Nations Sustainable Development Goals[1] (SDGs) which aim to provide a more equitable and sustainable future for all people by 2030 (Bakke, 2018; Movendi International, 2021). As such there are a variety of policies, strategies and guidance documents developed to support the global efforts to work towards alcohol harm reduction.

In the current global policies and strategies on alcohol, there is acknowledgement that alcohol is a public health problem, and unanimous commitment and actions towards reducing excessive consumption and alcohol-related harm across populations. However, there is inconsistent emphasis on the workplace and its role in alcohol health promotion within this. For example, the WHO Global Strategy to Reduce the Harmful Use of Alcohol (2010) and the more recent WHO SAFER Alcohol Strategy (2018) both draw attention to a number of 'high impact' areas for action with regards to reducing

[1] SDGs are a collection of 17 interlinked global goals developed by the United Nations General Assembly in 2015. The goals are - No Poverty; Zero Hunger; Good Health & Wellbeing; Quality Education; Gender Equality; Clean Water and Sanitation; Affordable & Clean Energy; Decent Work & Economic Growth; Industry Innovation & Infrastructure; Reduced Inequalities; Sustainable Cities & Communities; Responsible Consumption and Production, Climate Action; Life Below Water; Life On Land; Peace, Justice, and Strong Institutions; Partnerships for the Goals.

alcohol-related harm; but they do not mention workplaces. There are other global guidance documents such as the WHO Global Plan of Action on Workers Health 2008-2017 (2007) which state the importance of protecting and promoting health in the workplace and building in worker health within other policies - however this does not mention alcohol as one of its examples for workplaces to consider. Omitting alcohol as a consideration for workplaces is a missed opportunity for workplaces to harness alcohol health promotion. As of October 2021, it is promising to see that the draft 'WHO Global Alcohol Action Plan 2022-2030' calls for ambitious global alcohol strategy, and places AWPs amongst the areas for action.

In the UK, there is also inconsistent emphasis on the workplace role across policies, strategies, and guidance documents. For example, there are workplace focussed professional bodies such as the CIPD (professional body for human resources and people development) that are championing how workplaces can contribute towards alcohol harm reduction and health promotion through workplace policies and a variety of other supportive initiatives such as alcohol brief interventions (CIPD, 2020). The Trades Union Congress (TUC) and the Health and Safety Executive (HSE) who are active in their efforts to improve working life, have also produced and updated guidance on developing AWPs and managing alcohol use at work more generally (TUC, 2019; HSE, 2020). However, on the other hand, the current National Institute for Health and Care Excellence (NICE) Alcohol Use Disorders Prevention Public Health Guidance (PH24) makes very minimal mention of alcohol in the workplace setting (NICE, 2015). The Royal College of Physicians (2012) identifies this as a "missing knowledge area" which needs to be addressed in order to support workplaces. The literature review and empirical work of this thesis contributes to the knowledge in this area, so as to inform the development of national guidance that will allow for a more consistent approach to managing alcohol in UK workplaces.

In England, AWPs were identified as a key recommendation within the earlier national Strategy for Alcohol (The Prime Ministers Strategy Unit, 2004), and the 'next steps' strategy in 2007 titled 'Safe Sensible Social' (HM Government, 2007). Both these documents clearly articulated actions such as 1) working with organisations, supporting earlier identification of workers with alcohol problems, 2) setting up the Department of Health (DH) website with alcohol-related information for workplaces and employee support, and 3) the Home Office commitment to including alcohol in the National Workplace Initiative which trains company representatives on handling drug use in the workplace (The Prime Ministers Strategy Unit, 2004; HM Government, 2007). However, all these aspects are not evident in the current National Strategy for Alcohol, which is nearly 10 years old, and makes very minimal mention of alcohol in relation to workplaces. It only mentions, in a single line that "*we would expect to see progress on workplace alcohol education and prevention programmes*" (HM Government, 2012 p18). Given that this is the current national steer and coordinating document regarding alcohol harm reduction for England, it is unclear whether the minimal mention of the workplace role signifies a reduced priority for workplaces support or not.

The European Union (EU) Alcohol Action Plan (2012) gives more clarity about the workplace role and considerations for harm reduction and health improvement in this setting. The UK may well be working towards this action plan too, however given the UK departure from the EU through Brexit[2] it remains unclear if the UK alcohol strategy will still be aligned to the EU, or if the UK will update its national strategy post-independence. Either way, now presents an opportune time for the UK national alcohol strategy to be updated to reflect progress regarding the workplace role in alcohol health promotion and a renewed (and visible) commitment to the work that is still required for the future.

[2] Brexit combines the words 'British' and 'exit', denoting the United Kingdom's decision in a 23 June 2016 referendum to withdraw from the European Union (Lalić-Krstin and Silaški, 2018).

1.2.6 Chapter Summary

The background chapter has captured the scale of the alcohol problem globally, and more specifically in the UK. It highlights that the problems are mirrored in the workplace, and one of the strategies for workplaces to contribute towards employee health promotion and alcohol harm reduction is through developing and implementing AWPs. The following section provides an outline of the remaining chapters of the thesis.

1.3 Overview of the Thesis

The remaining chapters of the thesis will comprise of:

Chapter 2: A scoping review of the extant literature on health focussed AWPs, laying the groundwork for the empirical study that will follow.

Chapter 3: The theoretical framework that underpins the interview schedule, data collection, analysis, interpretation, and discussion of the study findings.

Chapter 4: An account of the methodology and methods used in the study.

Chapters 5, 6 & 7: The study results; namely, Misaligned Voices, The Grey Areas, and The Wider Determinants, Meaning and Purpose of Alcohol

Chapter 8: A discussion of the results, situated within the context of the literature reviewed in Chapter 2, the wider literature and theoretical framework. Chapter 8 also demonstrates how the results relate to gaps identified in the literature, and what the study findings contribute to the existing body of knowledge on health focussed AWPs.

Chapter 9: A reflection on key elements of the research process, and researcher reflexivity.

Chapter 10: A summary of the thesis, re-stating how the study has addressed the research question and objectives, and what implications the findings have for policy, practice, and future research.

Chapter 2
Literature Review

2.1 Introduction

Chapter 1 outlined the negative effects of alcohol on the workplace, highlighting a growing interest in the role of AWPs as a strategy for supporting alcohol health promotion within workplaces. This chapter builds on that by presenting a scoping review which captures literature on what is known about health focussed AWPs. The scoping review approach was based on the guidance by Arksey and O'Malley (2005) to ensure the review remained structured, methodical, and rigorous in relation to the development of the review question, search strategy, study selection, data charting, and synthesis of the results. However, unlike a 'pure systematic review', the scoping review approach does not purport to identify all existing studies on a topic of interest (Hart, 1998). Nor does it necessarily seek to include critical appraisal of papers; but rather it poses a review question/topic, then broadly maps key studies to examine the extent, range, and nature of research activity on a topic (Arksey and O'Malley, 2005). The scoping approach was particularly useful for identifying the breadth and depth of literature because there were no apparent empirical literature reviews that have mapped and synthesized the existing body of knowledge on health focussed AWPs. The current scoping review lays the foundation for the PhD empirical work.

During the PhD (in 2021), some sections of this scoping review were published as part of a broader review exploring the impact of AWP on employees and workplaces. A copy of the published paper can be obtained from the International Journal of Workplace Health Management webpage through the following weblink: https://www.emerald.com/insight/content/doi/10.1108/IJWHM-10-2019-0130/full/html.

2.2 Search strategy

An initial unstructured search of the literature (on Google Scholar and Academic Search Ultimate in January 2018) showed many papers dating back to the 1980's regarding national and global policy on alcohol, however there was little research (comparatively) on AWPs. The unstructured search informed the development of robust search terms, established feasibility of the review, and informed the decision to not apply any date limits to the database search.

2.2.1 Search Terms & Electronic Database Search

The systematic literature search was undertaken in February 2018, then updated in May 2021 to see if any additional empirical literature had been published since the original search (Centre for Reviews and Dissemination [CRD], 2009). The scoping review sought to answer the specific question: *'What does the literature say about alcohol workplace policy in relation to health or health promotion for employees?*' The review question was formulated using the Schiavo and Foster (2017) "Who What How" framework, which is recommended for the development of searchable questions that have a focus on interventions such as policy. The key search terms (identified from elements of the review question) were: *"alcohol OR drug* OR substance use OR substance misuse OR substance abuse" AND "work OR workplace* OR work-place* OR job OR organization* OR organisation* OR company OR business* OR companies" AND "policy OR policies OR programme* OR strateg* OR guid* OR intervention*.* The positioning of the Boolean Operators *"OR"* and *"AND"* enabled the location of potentially relevant papers that could answer the review question. The terms 'health' or 'health promotion' and any related synonyms were initially used in the database search, however, this yielded very few records because the search was too specific - therefore the decision was made to only apply these terms at the end when reviewing the full text articles.

The search was performed on 5 online academic databases, namely: Academic Search Ultimate, Business Source Complete, CINAHL, Medline Complete, and PsychINFO. These databases were selected for their likelihood to yield literature on AWPs, which cuts across the disciplines of business/company information and health research. No date and country limits were applied, although for pragmatic resource constraints reasons, it was necessary to include papers published in the English language only.

2.2.2 Web-based Grey Literature & Hand Search

Academic database searching can be useful for accessing a vast number of resources on any chosen topic (Wright, 2015). However not all potentially relevant literature can be identified in this way because some literature is not published or controlled by commercial publishers (Boland et al., 2017). In line with recommendations by Dundar and Fleeman (2017), reference lists of included papers, and grey literature sources were searched electronically and by hand to make the literature search more comprehensive. Grey literature is not always published in the same format as papers in peer reviewed journals, but it may take the form of reports, theses and informally or unpublished work (CRD, 2009). Grey literature is sometimes criticized for not following conventional processes, standards of reporting and peer review that would instil confidence in its robustness (Adams et al., 2016). However, for purposes of the current review, the decision was taken to include grey literature because of its potential to contribute current knowledge (Albino et al., 2011; Martin & Assenov, 2012) to the topic of AWP which is still a relatively under researched area (Meister, 2018). Furthermore, including non-academic or non-commercially produced literature minimized the risk of publication bias within the review (CRD, 2009). Searching for grey literature required much broader search terms because of source indexing differences, therefore using the key terms *'alcohol' 'workplace' 'policy'* was sufficient to yield potentially relevant literature. The grey literature search was performed on Google Scholar, professional and human resources management websites (Chartered Institute of Personnel Development [CIPD] & ExpertHR), trade publications (Personnel Today and Management Today), and one UK based alcohol charity (Alcohol

Concern). Specific literature review databases (York Centre for Reviews and Dissemination, Cochrane, and the Joanna Briggs Institute) were also searched to rule out any existing or current reviews on the same topic. Thesis databases EThOS and ProQuest-Thesis, as well as the grey literature website OpenGrey were also searched. Finally, one expert in alcohol policies was contacted to see if they were aware of any additional empirical work that might not have been published.

2.2.3 Study Selection

The electronic database search yielded 690 records, and a further 18 records were obtained through web-based grey literature and hand searching. This brought the total number of records located to 708. Duplicate records were removed, leaving 446 papers which were screened according to title and abstract (CRD, 2009). A further 399 records were eliminated at this stage because they did not meet the scoping review inclusion criteria (*see Table 1*). This left 47 papers which were selected for full text reading, however because the Lancaster University Library service could not locate 2 of these records, only 45 papers were read in full. A further 25 papers were excluded at this stage because they did not meet the inclusion criteria, and this left a final number of 20 papers that were included in the scoping review. One additional paper was obtained through citation searching of the included papers and this brought the final number of included papers up to 21. The final list of included papers comprised of 14 peer-reviewed papers and 7 reports/grey literature. *Figure 1* presents a decision flowchart outlining the process followed to select the papers that were relevant for answering the literature review question.

Table 1: Inclusion & Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• English language • Workplace policies on alcohol (including broader drug or substance misuse policies that encompass alcohol use/misuse) • Focus on all paid or volunteer workers • Policy focussed on workplaces/organisations • Studies exploring alcohol workplace policy in relation to health promotion • Studies from any country • Studies using any empirical research design • Grey literature (including PhD's or Masters theses)	• Studies referring to global, national, or local (city level) policy • Papers that did not explore or investigate alcohol workplace policy as a key element of the research • Studies on students (unless the studies investigated the student population in relation to their full time or part time employment) • Studies that focussed on employee testing policies only (because a review on this was done by Pidd and Roche in 2014) • Commentaries or discussion papers

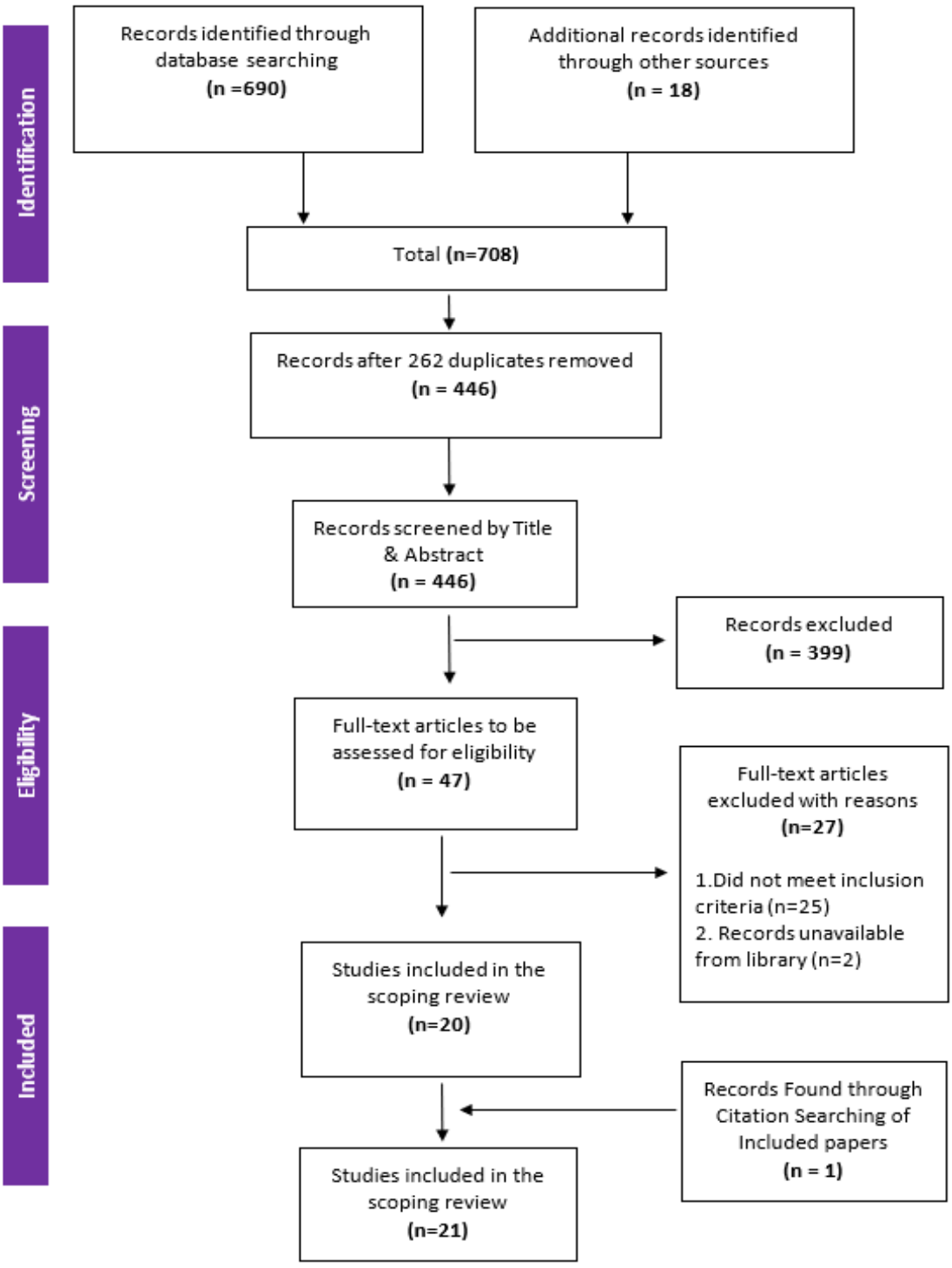


Figure 1: Study Selection Flowchart (from PRISMA - Moher et al., 2009)

2.3 Charting the Data

In line with the scoping review framework developed by Arksey and O'Malley (2005), data from the included 21 papers was 'charted' onto an excel

spreadsheet, enabling the extraction of descriptive contextual information from each paper. The key information charted from each paper included author/s surname, year of study publication, study location, population of interest, study aim/s, study design and key results aligned with the scoping review question.

2.4 Characteristics of Included Studies

The 21 included papers were published between 1992 and 2021 (Ames et al., 1992; Howie & Carter, 1992; Braddick, 1993; Godfrey et al., 1993; Baggott & Powell, 1994; Powell 1994; Zhang et al., 1999; Eriksson et al., 2004; Wickizier et al., 2004; Pidd et al., 2006; Larson et al., 2007; Brown, 2008; Harkins et al., 2008, Koeppe et al., 2010; Moore et al., 2012; Rodriguez-Jareno et al., 2013, Bush and Lapari, 2014; Cheng and Cheng, 2016, Pidd et al., 2016, Pidd et al., 2018; and Orlowski, 2021). The studies were undertaken in the United Kingdom (n=6), USA (n=6), Australia (n=4), then n=1 each for Sweden & Taiwan. N=2 studies were from multiple countries across Europe, and n=1 study collected data from USA & Israel. The studies employed a variety of study designs including qualitative studies, quantitative studies (such as surveys, quasi experimental designs, non-randomised controlled trials) and mixed methods or case study designs (which often involved combining surveys with qualitative interviews and some documentary analysis). Sample sizes in the studies ranged from 22 participants (for qualitative studies) to 115 million participants (from large national survey data). The combined papers represented Manufacturing, Catering, Construction, Transport & Storage, Water Supply Sewage & Waste Management, Chemical industry, Alcohol Breweries & drinks businesses, Health and Social Care, Armed & Uniformed Services, Electricity Gas Steam, Air Conditioning Supply and Gas/Fuel industries. A brief summary of included papers can be seen in *Appendix 1.*

2.5 Data Synthesis

The included papers were heterogeneous methodologically, therefore they were synthesized using the narrative synthesis guidance by Popay et al. (2006) which provided a structured way of synthesizing papers that have different designs. Narrative synthesis involved interrogating results to explore relationships within and across the findings from the papers; creating labels to describe the relationships and emerging patterns from each paper; then grouping the labels into clusters denoting areas of similarity or emerging themes across the papers (*see Table 2*). Finally, the robustness of the synthesis and themes produced were assessed by checking the papers again to ensure that the themes sufficiently represented the key findings from the papers in line with the literature review question.

2.6 Findings/Themes

In alignment with the aim of this review, 6 themes emerged from the included papers (*see table 2*).

Table 2: Themes

	Theme: Ambivalence about alcohol problems and AWP uptake	**Theme: Policy content that aligns with health promotion goals**	**Theme: Disciplinary policies vs treatment policies**	**Theme: Legitimacy of the workplace role in alcohol prevention & health promotion**	**Theme: Holistic approaches to alcohol health promotion at work**	**Theme: Link between AWPs and employee consumption patterns**
Ames et al. (1992)	X		X			
Howie & Carter (1992)	X					
Braddick (1993)	X	X				
Godfrey et al. (1993)	X	X	X			
Baggott & Powell (1994)		X	X			
Powell (1994)	X	X	X			
Zhang et al. (1999)	X				X	X
Eriksson et al. (2004)	X			X		
Wickizier et al. (2004)					X	

Pidd et al. (2006)				X		X
Larson et al. (2007)	X				X	X
Brown (2008)			X		X	
Harkins et al. (2008)		X	X	X		
Koeppe et al. (2010)					X	
Moore et al. (2012)			X	X		X
Rodriguez-Jareno et al. (2013)					X	X
Bush & Lapari (2014)	X					X
Cheng & Cheng (2016)	X		X	X		
Pidd et al. (2016)					X	X
Pidd et al. (2018)				X	X	X
Orlowski (2021)				X	X	X

2.6.1 Ambivalence about Alcohol Problems & AWP uptake

Ambivalence about alcohol problems at a societal level and also in the workplace setting was outlined in the studies conducted by Ames et al. (1992); Howie & Carter (1992); Braddick (1993); Godfrey et al. (1993); and Powell (1994). During their investigations, the studies highlighted that AWP was regarded as a strategy for workplaces to contribute towards health promotion. For example, in the paper by Braddick (1993), AWP was a recommended way for workplaces to contribute towards meeting NHS Scotland's national target to achieve a 20% reduction in the proportion of people drinking above safe limits by the year 2000. However, the potential for workplaces to develop and implement the type of AWPs that could contribute to health promotion was hindered partly because workplaces (and workers) were not convinced that AWP can have a moderating effect on employee excessive alcohol consumption (Godfrey et al., 1993). Furthermore, as shown in the study by Eriksson et al., (2004) which sought to explore employer and employee views on workplaces taking part in alcohol prevention, it concluded that there was little interest in prevention. Powell (1994) highlights workplaces were doubtful that implementing AWP could benefit productivity and cost reduction. The development and implementation of AWP was set against a backdrop of an ambivalent culture around alcohol (Ames et al., 1992) and this was potentially compounded by the societally accepted view that alcohol was beneficial to health when consumed in moderation (Braddick, 1993).

There was little concern about employee drinking, except when it visibly impacted on workplace performance and safety (Eriksson et al., 2004). Howie and Carter (1992) in their study which explored policies for smoking as well as policies for alcohol in the workplace revealed that 33% of the companies surveyed had alcohol policies, and most companies that did not have AWPs were not interested in developing these. Zhang et al. (1999), Eriksson et al. (2004); Larson et al. (2007); Bush and Lapari (2014); & Cheng and Cheng (2016) also capture between 20% to 40% of workplaces that did not have AWPs in their studies. Employees who were heavy drinkers were more likely to report the absence of AWP, and this finding has remained consistent over

time (Zhang et al., 1999; Larson et al., 2007; Bush and Lapari, 2014). Workplace policies for smoking were more prevalent than those for alcohol, possibly because of the strong evidence linking smoking to cancer, and emerging evidence at the time regarding the effects of passive smoking on non-smokers (Howie and Carter, 1992). The significance of evidence as a requirement to shape workplace decisions on policy adoption and implementation is seen here, and Godfrey et al., (1993) suggests workplaces were therefore understandably ambivalent about alcohol problems in the workplace context, and they needed more evidence to be convinced that other policies (apart from those that were disciplinary), such as the health focussed AWPs, could be worth workplaces investing in.

2.6.2 Policy Content that Aligns with Health Promotion Goals

There was growing evidence of the importance of aligning policy content with health-promoting goals in five studies (Braddick, 1993; Godfrey et al., 1993; Baggott and Powell, 1994; Powell, 1994; Harkins et al., 2008). Despite the ambivalence identified in the earlier theme, efforts to encourage the development and adoption of health focussed AWPs continued, and the literature spotlighted policy content that would best align with a health focus. Although there was no consensus amongst the papers about what content would be most ideal, Braddick (1993) suggested that the inclusion of clarity around drinking within workplace premises, education of managers to enable earlier identification of alcohol problems in employees, and education on alcohol harm for employees, would all be key to AWPs that were more health-promoting. Braddick (1993) highlights however that regardless of AWP presence in 13 out of 14 health board organisations surveyed in the study, these policies did not include the elements that were health-promoting. AWPs at the time (in the 1990's) had not fully assimilated those elements that would be considered more health-promoting (Godfrey et al., 1993).

2.6.3 Discipline versus Treatment

Eight studies explored aspects of discipline and/or treatment as elements of AWP (Ames et al., 1992; Godfrey et al., 1993; Baggott & Powell, 1994; Powell 1994; Brown et al., 2008; Harkins et al., 2008; Moore et al., 2012; Cheng and Cheng, 2016). Some studies identified that health focussed AWPs were a positive move that re-orientated alcohol problems towards being recognised and accepted as a health issue (Ames et al., 1992), however adopting health focussed policies posed a challenge. This was because historically (at least since the 1970's where Health and Safety Law was introduced) organisations were operating disciplinary policies on alcohol predominantly to deter drinking at work and to ensure worker safety while on the job (Harkins et al., 2008). Furthermore, discipline orientated policies were driven by external legislative and regulatory pressures, rather than internal organisational/employer forces (Baggott and Powell, 1994) suggesting different approaches to AWP development and implementation were influenced by equally different reasons. Introducing health focussed policies created tension between the original disciplinary policies and the newer health focussed policies because these operated from contrasting viewpoints. For example, the disciplinary AWPs focussed on worker safety first, with dismissal if there was non-compliance with AWP; and the health focussed AWPs were predicated on the belief that alcohol issues needed to be regarded as a health matter and as such, employees required support rather than dismissal (Ames et al., 1992; Baggott and Powell, 1994; Powell, 1994). Some of the challenges were related to workplaces favouring discipline-oriented policies because they were associated with tangible operating cost reductions, while the benefits of health-oriented policies were associated with seemingly intangible factors of prevention (Powell, 1994).

Notably in the qualitative study by Baggott and Powell (1994), managers in workplaces with discipline orientated AWPs tended to take a health approach informally with employees to support and signpost them for further help - although this remained at the discretion of the manager. Given that disciplinary policies were the 'norm' at the time, it was not surprising that when participants in the Godfrey et al. (1993) study were asked how alcohol-related

issues were managed at work, the top three responses cited were verbal warning, written warning and then dismissal- which were all discipline orientated. Counselling was the fourth most common response. Even where there was a dual focus on discipline and treatment, employees recognised the disciplinary element first. Brown (2008) recommends that an effective workplace policy approach should be heavily weighted towards support, rehabilitation, and access to counselling, than on punishment and discipline. The extent to which this is achievable and the conditions that would make this a possibility requires further empirical exploration.

2.6.4 Legitimacy of the Workplace role in Alcohol Prevention and Health Promotion

There were seven studies that explored the legitimacy of the workplace role in preventing alcohol problems, and promoting health in the workplace (Eriksson et al., 2004; Pidd et al., 2006; Harkins et al., 2008, Moore et al., 2012; Cheng and Cheng, 2016; Pidd et al., 2018; and Orlowski, 2021). Even when there had been a shift from ambivalence about alcohol being problematic in the workplace from the earlier alcohol workplace research of the 1970's to 1990's; towards research showing greater awareness of the health risks associated with alcohol consumption; the study by Eriksson et al. (2004) shows that employers and employees viewed the workplace role as only intervening when there was a visible problem with alcohol - and not for prevention. There was some doubt that workplaces could legitimately have a role in controlling individuals drinking and this raised questions about the extent that workplaces could influence employee behaviour beyond the workplace (Eriksson et al., 2004; Harkins et al., 2008). For example, the mixed methods study by Harkins et al (2008) illustrates that although a third of employers (31.1%) felt that employee alcohol consumption outside of work negatively affected their organisation; they believed that employees' activities in their spare time was not the business of an employer and there was little that could be done by employers to reduce employee consumption that takes place outside of the workplace. This was further compounded by the finding that not all workers who drank heavily outside of work had problems in their

job performance. And so, by this logic, if workplaces found it hard to intervene even when there were noticeable problems in the workplace, it is understandable then that they will be even less inclined to believe they can intervene when there were no visible problems or impact on work performance. On the other hand, however, some of the more current studies suggest that AWP was acknowledged as a preventative and health promotional tool (Pidd et al., 2006 and Pidd et al., 2018).

The earlier concerns highlighted by studies from the 1990's with regards to the content of AWP not being fully aligned with health promotion goals was echoed by studies published in the last 10 -15 years. Though the shift in the latter research shows AWP increasingly had clearer aims to help reduce employee drinking and support health, however very few specified how this was going to be done. Eriksson et al. (2004) for example, collected data from 16 companies and highlighted that most of their AWPs made vague statements such as "*knowledge should be spread by means of broad informational measures'' p273*, and furthermore, the primary-prevention activities often mentioned the provision of information and education, but these were mostly directed at managers and/or union representatives rather than the workforce as a whole. Some of the policies identified that information would be provided to employees as a preventative measure, though they fell short of clarifying what this information would consist of or when it would be delivered. The study on businesses across the city of Liverpool, UK by Harkins et al. (2008) identified a similar shortfall of AWPs, highlighting that policy content tended to target mainly heavy or dependant drinkers. Given that non-dependant drinkers who occasionally drink excessively make up a larger number of alcohol-related work performance problems (Weise et al., 2000); the Harkins et al. (2008) study identified that policies which focus only on dependant drinkers missed an opportunity to contribute towards health promotion, health improvement and primary prevention of ill health in all workers that drink alcohol. Eriksson et al. (2004) articulate that AWPs at the time had health promotion aims, but their fuller content indicated that they had been formulated to meet the regulatory requirements more than to serve the alcohol health promotion and prevention needs of employees.

There were other practicalities of the workplace that cast doubt on the extent to which AWPs could achieve the health-promoting intentions because the policies were sometimes confusing and not always enforced. Orlowski (2021) noted that individuals whose workplace had formal policies in place were 0.13 times less likely to drink alcohol at work however other factors like whether staff have the perception that policy is enforced by managers can influence the decisions to adhere to policy or not. Policy is presented as a deterrent to staff drinking alcohol during working hours (Moore et al., 2012), however in some settings this was not always the case. Two studies in particular emphasize this point. Moore et al. (2012) whose mixed methods study of a bar chain which included 1294 survey responses and 67 interviews identified that some workers were likely to violate their AWP because the policy was confusing. Cheng and Cheng (2016) found a similar violation of policy and ineffective AWP which was attributed to the outsourcing conditions, the precarious work contracts of outsourced construction workers, supervisors undermining the AWP by allowing vendors on site of a 'no alcohol allowed' environment, and worker beliefs that alcohol actually enhances job performance. Workers in the Cheng and Cheng (2016) study knew there was a prohibitive AWP but still drank alcoholic drinks at work anyway.

2.6.5 Holistic Approaches to Alcohol Health Promotion at Work

Nine studies presented investigations into the effects of implementing health focussed AWP as a part of a holistic/comprehensive approach to enhance the health-promoting potential of the workplace (Zhang et al., 1999; Wickizier et al., 2004; Larson et al., 2007; Brown et al., 2008; Koeppe, 2010; Rodriguez-Jareno et al., 2013; Pidd et al., 2016; Pidd et al., 2018; and Orlowski, 2021). This is because it was felt that although AWP played an important role and was associated with significantly decreased odds of high-risk drinking [OR: 0.61] (Pidd et al., 2016); using AWP as a lone solution to tackle alcohol problems in the workplace was unlikely to be effective, nor sufficient (Larson *et al*., 2007 and Brown *et al*., 2008). The adoption of holistic/programme approaches would be more likely to achieve health promotion because they

ideally would include a variety of other components alongside AWP, such as employee assistance programmes, provisions to protect worker confidentiality, referral pathways, occupational health support, manager training on earlier identification of alcohol problems, employee alcohol education, rehabilitation, workplace design and promotion of consistent health messages (Wickizier et al., 2004; Pidd et al., 2006; Larson et al., 2007; Brown, 2008; Koeppe et al., 2010; Rodriguez-Jareno et al., 2013; Cheng and Cheng, 2016; Pidd et al., 2016; Pidd et al., 2018). Additional aspects such as involving staff in the development and implementation of policies, developing monitoring systems and regular evaluation were also essential for a holistic approach (Brown *et al*., 2008; Rodriguez-Jareno *et al*., 2013 and Pidd *et al*., 2016). Using Wickizier et al., (2004) as an illustration of the impact of the holistic approach, the study results showed the holistic approach had a statistically significant ($p< 0.05$) impact on reducing the incidence of serious occupational injuries that required four or more days off work particularly in construction services and manufacturing industries. A particular strength of this study was its pre-post quasi-experimental design with a non-equivalent comparison group to assess the impact of the holistic/programme approach on injury risk, measured in terms of differences in injury incidence rates.

Other studies concur with the holistic programme approach in reducing likelihood for employee consumption, citing that it is the holistic nature that strengthens potential health-promoting outcomes, sees benefits of reduced alcohol-related employee sickness absence, increases likelihood of employee help-seeking, results in better attitudes towards alcohol more generally and creates a shared sense of ownership of the AWP and approaches taken in the workplace (Brown et al., 2008; Koeppe et al., 2010; Pidd et al., 2018).

Studies included in the literature review also compared the different types of policies and programme approaches, which ranged from detailed and universal/comprehensive/holistic types, through to those that were more basic. Basic policies included alcohol education, awareness-raising, and

signposting. For a policy to be regarded as comprehensive it went beyond this and included additional aspects such as involving staff in the development and implementation of policies, developing monitoring systems and regular evaluation. Comprehensive or universal policies also emphasized capacity building for managers to undertake screening and alcohol brief interventions. However, it appeared as though even the basic policies and programmes had a positive influence on drinking, with Rodriguez -Jareno (2013) stating that these had influence on consumption regardless of whether an employee was a risky drinker or not.

2.6.6 Link between AWP & Employee Consumption Patterns

There were nine papers in the review that highlighted statistically significant associations between AWP presence and employee consumption (Zhang et al., 1999; Pidd et al., 2006; Larson et al 2007; Moore et al., 2012; Rodriguez-Jareno et al., 2013; Bush and Lapari, 2014; Pidd et al., 2016; Pidd et al., 2018; Orlowski, 2021). Having an alcohol policy in the workplace was beneficial for employees with some studies demonstrating it was associated with reduced odds of heavy or hazardous consumption levels (Pidd et al., 2016); and the reduced likelihood of work-related drinking or drinking during working hours (Pidd et al., 2006; Larson et al., 2007). Also, there were associations with an overall reduction in consumption regardless of whether a worker was a heavy drinker or not, however, this considered policy alongside other interventions such as employee assistance and staff support as highlighted in the previous theme about holistic approaches (Rodriguez-Jareno et al., 2013). Three studies in particular allowed for trend analysis of this result- all three papers where based on annual national survey data on drug use and health in the USA and they showed that employees who were heavy drinkers were most likely to report the absence of AWP, and that this finding had remained consistent over time (Zhang et al., 1999; Larson et al., 2007; Bush and Lapari, 2014). Employees were less likely to drink at work where there was a formal policy on alcohol, however Orlowski et al. (2021) indicate the presence of AWP does not completely mitigate workplace drinking, therefore more is required alongside AWP, reinforcing the earlier theme on holistic approaches.

2.7 Gaps in the Reviewed Literature

The need for AWPs to have a health focussed strand has been encouraged since the 1950's by scientists from Yale University supported by groups such as the American Medical Association and Alcoholics Anonymous (Cahalan, 1970 cited in Ames et al., 1992). The current scoping literature review located available papers which tell the story of health focussed AWP development and implementation over time. The review identifies the role that AWP plays in health and alcohol health promotion of employees; however it also highlights the initial challenges that accompanied the introduction of health focused AWP. The challenges included a general ambivalence about alcohol problems among the population and in the workplace context, to the extent that even when the health risks associated with alcohol and its impact on the workplace were established; introducing health focussed AWP resulted in tension between existing 'discipline policies' and the newer 'treatment/health focussed policies. Over time, there was acknowledgement of alcohol problems in a work context and consequent recommendations for health focussed AWPs, however this then raised questions on the legitimacy of the workplace role in prevention and alcohol health promotion and doubts about whether the workplace had the required expertise to focus on employee health in that way. Nevertheless, the review shows a slow but continued focus on research around AWPs, exploring what the content of health focussed AWP should look like, and recommendations for holistic alcohol workplace policies and approaches. This was particularly strengthened by large scale national surveys which established links between AWP and programmes and employee consumption levels - making a compelling case for developing and implementing AWPs.

The current scoping review reveals 3 important gaps

1) Firstly, in England there is a need for more contemporary research on AWPs and approaches with regards to the extent that these are health-promoting. Despite some initial doubts about the preventative role that AWPs (and workplaces) could actually play regarding alcohol health promotion, the literature reviewed demonstrated that over time, the

health focussed and preventative role of workplaces was encouraged and can be harnessed. However, the empirical studies that first addressed analysis of health focussed AWPs in the UK (England & Scotland) were undertaken 20-30 years ago, and although there are more recent studies into AWPs and approaches, these are largely from the USA and Australia. Context is a key factor in how policy or approaches may be adopted. Given that over the years there has been more evidence around how to enhance alcohol health promotion (for example alcohol screening and brief interventions in workplaces that can be integrated into policies), it is therefore important to provide a current picture of the extent to which AWPs are health-promoting in a UK workplace context.

2) Secondly, there is a need for further empirical exploration of the dual policy (discipline versus treatment) conundrum in workplaces and what this looks like in contemporary practice. The review illuminated the consistent recommendation for workplaces to adopt AWPs, and the earlier problems created by the introduction of health focussed AWPs (given the dominance of disciplinary policies at the time). However there has been limited empirical exploration of how this challenge is being managed or whether these two policy types have been successfully integrated within contemporary workplaces. It is important to provide clarity on this to understand whether AWPs are supporting employee health promotion and whether health focussed AWPs have been embraced.
3) Thirdly, there is a paucity of health focussed AWP studies that are theoretically underpinned. While some of the included papers within this review offered insights into health focussed AWP development and implementation approaches, none of them explicitly identified whether the design, conduct or analysis of their research was underpinned by health promotion theory. We know from the wider literature that research underpinned by evidence based theoretical principles is recommended, and that there is a paucity of AWP and programme research that demonstrates theoretical underpinning (Wolfenden et al., 2018). Theoretically underpinning the research will go some way

towards ensuring greater potential for implementation into practice (Petticrew et al., 2004). This is even more pertinent because the current review highlights there are still between 20% - 40% of workplaces that do not have AWPs, yet there is research (although limited) on AWP potential to benefit workers and workplaces.

With the above in mind, the empirical work of the PhD seeks to address the gaps through investigating and answering the following research question and objectives:

Research Question

To what extent is AWP development and implementation underpinned by health promotion principles?

Research Objectives

1. Explore how and why AWP are developed and implemented in the workplace.
2. Explore the extent to which health promotion theory and principles underpin the development and implementation of AWP.
3. Establish then analyse whether there are any factors that hinder or facilitate the processes of development and implementation from a health promotion perspective.
4. Explore how and in what ways policies and approaches to implementation of AWP can be enhanced to improve their potential for promoting healthy employee consumption.

2.8 Review Strengths and Limitations

In the interests of transparency and acknowledgement of areas in the review that might have been enhanced, this section outlines the review strengths and limitations. The search for relevant papers was comprehensive, and while

every effort was made to identify papers that investigated and analysed health focussed AWPs, some papers may have been missed. As a result, the scoping review does not purport to be a fully exhaustive account of all available literature, however in alignment with the review question it was able to capture key emerging ideas, trends and shifts over time with regards to health focussed AWPs. Naturally, the inclusion and exclusion criteria (useful for focussing the review) may have resulted in selection bias. Furthermore, the studies in this review were predominantly from the continents of Europe, Australasia, and North America therefore the results would need to be interpreted cautiously outside of these contexts as different settings, nuances of culture, norms, expectations, and workplace rules may differ. The English Language inclusion criteria may have resulted in the omission of relevant papers written in other languages, although it is acknowledged that this was applied for pragmatic, and resource constraint reasons. Finally, the review did not include a quality appraisal. However, this is in keeping with Arksey and O'Malley's (2005) vision for scoping review methodology which aims to map the broad scope of literature available on a topic as a useful way of identifying gaps to inform future research directions.

2.9 Chapter Summary

This chapter reviewed the literature exploring what is known about health focussed AWPs, concluding that AWPs present a unique, but untapped strategy and opportunity for supporting alcohol health promotion of the workforce. There is more that workplaces can do to develop and implement AWPs and approaches that can support health promotion. The gaps identified in the review point to the need for contemporary UK based research that explores the health-promoting potential of AWPs including whether some of the earlier challenges of adopting these, have been resolved. As the study will be underpinned by health promotion theory, the following chapter (Chapter 3) will outline the health promotion theoretical framework that will be used to investigate the gaps identified in the literature review.

Chapter 3
Theoretical Framework

3.1 Introduction

Chapter 2 highlighted a gap in the current UK specific literature regarding health focussed AWPs; establishing that none of the papers reviewed explicitly referred to their research being informed by underpinning theory. Theoretically underpinned research is recommended for strengthening research findings and the potential for implementation of research findings in practice. Given that the PhD study aim was to explore the extent to which AWPs and practices are underpinned by health promotion principles, it was prudent to select a health promotion theoretical framework to inform the research. The chosen theoretical framework comprised of Bronfenbrenner's Ecological Systems Theory (1979) and the World Health Organization Healthy Workplace Framework (2010). The following chapter will begin by providing some background information on health promotion, healthy settings, and healthy workplace policies. It will then explain how and why the health promotion theoretical framework was selected to investigate the extent to which AWPs and practices are underpinned by health promotion principles.

3.2 Health Promotion Principles, Strategies and Action Areas

Health promotion is '*the process of enabling people to increase control over, and to improve, their health'* (WHO, 1984, p4). This well-recognised definition was formally adopted at the first WHO International Conference on Health Promotion - The Ottawa Charter of 1986. The Ottawa Charter was informed by a variety of documents and discussions, including seminal work such as the 1974 Lalonde Report, and the 1978 Declaration of Alma Ata. What these key influencing documents and discussions have in common is the increasing recognition that for health to be promoted or improved, there was a need to look beyond individuals or hospitals alone, and to consider wider environmental, social, and economic factors (Burton, 2010; Newton, 2014). Since the Ottawa Charter, there have been further WHO International

Conferences on Health promotion; namely, the 1997 Jakarta Declaration on Health Promotion into the 21st Century, and the 2005 Bangkok Charter for Health Promotion in a Globalized World. These have strengthened and enhanced support for health promotion globally, and emphasised consideration of the wider determinants of health, social responsibility for health, reducing health inequalities and creating supportive settings/environments and healthy policies (WHO, 1997; WHO, 2005; Burton, 2010).

As a key element of modern public health, health promotion seeks to prevent ill-health and promote health in the population by addressing the wider determinants of health (Wilson, 2009). WHO (1984) articulates the core principles of health promotion as including **engaging and involving the whole population within the settings of everyday life**. This is in recognition of the need to look beyond individuals who may be at risk of specific diseases, and to increase the whole populations' access to information about health and how it can be attained by all. Health promotion also encourages effective public participation and the **development of problem definition and decision making life skills, whether individually and/or collectively**. The principle of **action on the determinants of health** calls for involvement of all sectors (not just health services) in the promotion of health. A key element of this involves all levels of government assuming responsibility and developing action to ensure that the environment (which may be beyond the control of individuals) is conducive to health. Another key principle of health promotion is the **combination of diverse but complementary methods** of communication, education to empower the population, change in organisations, legislation/regulation, policy support, community development and activities aimed at reducing health hazards. The final key principle relates to **health professionals embracing and developing capabilities and capacity for education and health advocacy** to support and enable health promotion. These core principles are summarised and presented in the Ottawa Charter (1986) as '3 Strategies and 5 Action areas' that facilitate the goal of promoting health in the population.

The 3 strategies are:

- Enable
- Mediate
- Advocate

The 5 Action Areas are:

- Build Healthy Public Policy
- Create Supportive Environments (Healthy Settings)
- Strengthen Community Action
- Develop Personal Skills
- Reorient Health Services

3.3 The Workplace as a Healthy Setting

Healthy settings gives prominence to the importance of context when considering health promotion (Whitelaw et al., 2001). As a key action area of the Ottawa Charter, healthy settings recognises that the environments in which people work, live, and learn all have the potential to either promote or hinder health (Whitehead, 2006). Using the workplace as an example of a healthy setting, evidence shows that the work environment can either be a contributing factor for good health (NICE, 2015) or ill-health. In Europe, workplaces are implicated in approximately 1.6% of disease burden through fatal and non-fatal injuries, carcinogens, ergonomic hazards, and psychosocial stress (Hodgins et al., 2016). Through concerted efforts of workplaces to promote health of employees, there have been some measurable improvements to worker health. For example in the UK, since 1994, there has been a 77% reduction in non-fatal injuries, and a reduction in 87% of fatal injuries (Hodgins et al., 2016). It is with this in mind that health promotion in a workplace setting is regarded as a '*win win situation for both employer and employee'* because the employer benefits from improved staff health, productivity, and reduced sickness absence; and the employee

benefits from being healthier, feeling supported in the workplace and having an enhanced working life (Hodgins et al., 2016 p19; Koko and Baybutt, 2022).

Health promotion in a work setting involves organisations exploring how the workplace can be changed or enhanced, then creating conditions that enable workers to have optimal health in that setting (Hodgins et al., 2016). However, the intersection between work and health is complex, and this can present challenges to workplaces implementing health promotion despite knowing that it is beneficial for employees and employers (Whitehead 2006; Newton, 2014). There is a need for workplaces to understand the wider determinants of workplace health, and various holistic models of health promotion such as the Dahlgren and Whitehead model, and the WHO Healthy Workplaces Framework may help to show the determinants, and the complex interplay between these (Dickson-Swift et al., 2014; Hodgins et al., 2016). Whitehead (2006) suggests settings based health promotion requires holistic, organization wide, long term investment and commitment, as well as supportive policies that are aimed at promoting health in the workplace.

3.4 Health Promoting Policy and It's Relevance to the Study

The Ottawa Charter highlights that a central element to healthy and supportive environments is supportive policies that have health promotion at their core. Policy has the potential to galvanise efforts, direct and place emphasis on the health promoting activity required to support people within workplaces (Hodgins et al., 2016). Policies also show organisational commitment to employee health and wellbeing (Whitehead, 2006). In the case of alcohol, there may be a variety of workplace interventions aimed at reducing alcohol related harm in employees, however it is highlighted that interventions are likely to have a more beneficial impact on employee drinking patterns if they are part of a comprehensive alcohol workplace policy that also includes support, signposting for those with drinking problems, and an outline of disciplinary or capability procedures (HDA, 2004). It is with this in mind

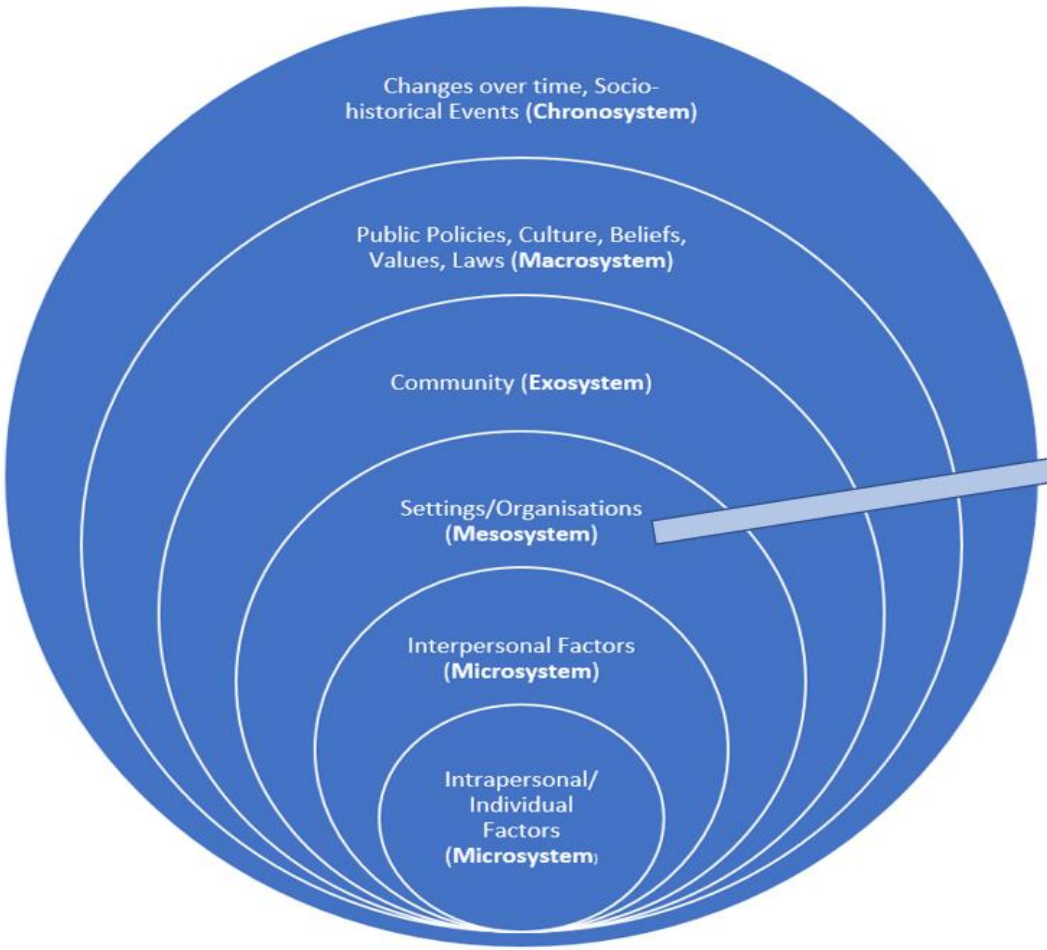
(coupled with the gaps identified in the literature review (Chapter 2), that the focus of the empirical work of the PhD is on the extent to which AWPs and practices are underpinned by health promotion principles.

3.5 Choosing a Suitable Theoretical Framework

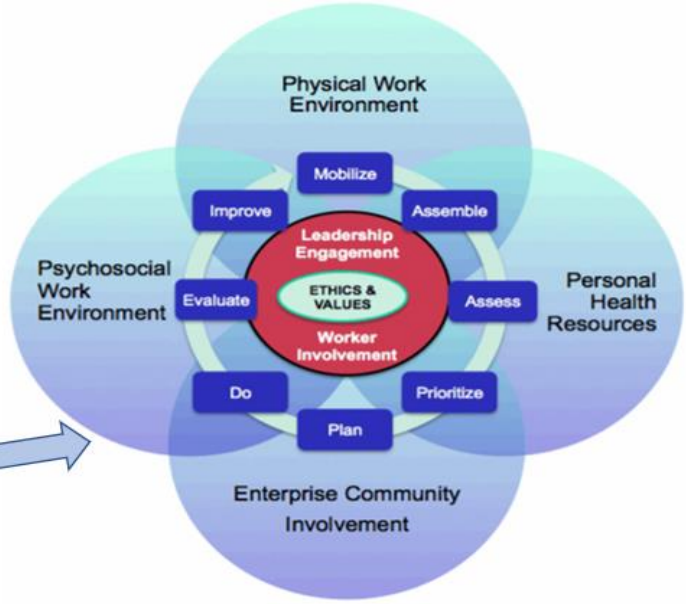
There are several theories that could have potentially informed the study; therefore some thought went into deciding which underpinning theory would be most appropriate to use. Theories that pertain solely to policy development and implementation (which is not within the scope of this thesis to discuss) were ruled out because they are not designed with health promotion in mind. Therefore, only health promotion theories were explored to determine the most suitable approach. There were numerous options (more than 35 behaviour change models alone) including; the Transtheoretical Model by Prochaska & DiClemente (1982) which believes that behaviour change is a process with distinct stages that an individual cycles through to achieve their desired change; the Theory of Planned Behaviour which is a motivation theory that focuses on the role of intention towards a behaviour, concluding that a strong intention to carry out any behaviour increases the likelihood of the behaviour happening (Ajzen, 2002); and the Health Belief Model which proposes that an individual's belief in a threat of illness/disease combined with the belief in the effectiveness of a recommended health behaviour or action, can predict the likelihood that the person will adopt the recommended behaviour (Becker, 1974). All these theories focus on the individual only, and this is a well-established criticism of many health promotion models (Golden and Earp, 2012). Furthermore, given the PhD interest in studying alcohol policy in relation to organisations, it was essential for any chosen theory to capture policies that are evolved in the wider context and environment (Hill, 1997). The study therefore required a health promotion theoretical framework that would not only represent the individual, but also the wider organisational context, environment, relational and cultural factors.

3.6 Health Promotion Theoretical Framework

The ideal health promotion theoretical framework for the thesis was a combination of Bronfenbrenner's Ecological Systems Theory and the World Health Organization's Healthy Workplace Framework (*see Figure 2*). Both were founded upon health promotion principles, and their combination provided a holistic lens with which to view, conduct and analyse the study findings. These two will be explored in more detail overleaf, including an outline of their advantages, disadvantages, and consideration of how their use might impact the empirical work of the PhD.



Graphic Representation of the Ecological Systems Theory (adapted from Bronfenbrenner 1979)



World Health Organization Healthy Workplace Framework (2010)

Figure 2: The Study Theoretical Framework

The ***Ecological Systems Theory*** was chosen because it acknowledges that individuals are situated within wider social context and describes the interactive characteristics of individuals and environments that underlie health and health behaviours (Golden and Earp, 2012). The literature uses the terms ecological theory, social ecological model, social ecological theory, and ecological systems theory interchangeably - however for purposes of consistency in this thesis, the term Ecological Systems Theory will be used. This theory was first proposed by Bronfenbrenner in the 1970's based on understanding child development as a complex system of relationships, affected by multiple layers of influence which include the Microsystem, Mesosystem, Exosystem, Macrosystem and Chronosystem (Guy-Evans, 2020) (*see Figure 2*). It has since been extended beyond understanding child development and is commonly used across social and public health research areas including suicide prevention and domestic violence prevention programmes (Centres for Disease Control and Prevention [CDC], 2019). The Ecological Systems Theory is welcomed as an approach because unlike other existing approaches that are unilateral, or bio-medical based, the Ecological Systems Theory introduces consideration of the influence that environments and social contexts have in shaping health and health behaviours (Golden and Earp, 2012). The diagrammatic representation of the Ecological Systems Theory has been adapted by various authors over the years with some versions outlining four layers and others outlining up to six or seven nested layers of influence, however the key elements remain intact with regards to addressing the interrelationships between the layers of influence and the acknowledgement of environmental factors outside of the individual as contributors to health.

The ***WHO Healthy Workplace Framework*** was chosen because it provided specific areas for consideration with regards to workplace context and the interrelationships and connections between the individual, the work environment, institutional factors, and immediate community influences. The framework was formulated following a review of literature on what frameworks

can be used collaboratively by employers and employees to improve health in the workplace. The framework provides an outline of the avenues of influence, process and content components that are central to creating a healthy workplace (Burton, 2010). The framework highlights that support from leadership, involving employees and the integration of healthy workplace initiatives in an organisations' business strategy are all crucial elements of successful healthy workplace programmes (Burton, 2010). It also offers an eight-step process, which guides workplaces through a continual improvement process that involves a systems based approach to: policy development, creating awareness, providing education, skill building opportunities and environmental support (Burton, 2010; Hodgins et al., 2016).

3.7 Advantages & Limitations of Theoretical Framework

The combination of the Ecological Systems Theory and WHO Healthy Workplace Framework was considered to be a strength because what one lacked, the other made up for. For example, the Ecological Systems Theory provided a broad overview of the layers of influence, however when it came to the mesosystem (organisation) layer of influence, it was not specific enough to allow sufficient analysis of the various workplace factors that would influence the health-promoting potential of AWPs and approaches in the study. This is where the WHO Healthy Workplace Framework was useful because it offered a specific outline of the factors and areas of influence regarding having a more health-promoting workplace (which includes policies like AWP). The WHO Healthy Workplace Framework alone would have been insufficient because beyond the workplace context (and immediate community) it provided little steer with regards to those wider influential factors beyond the workplace, and so here the Ecological Systems Theory augmented this by allowing for exploration of the wider public policy, culture, laws of the macrosystem, and the changes over time of the chronosystem layer. Together, the Ecological Systems Theory and WHO Healthy Workplace

Framework provide an ideal approach with which to explore the health-promoting potential of AWPs and practices in organisations.

Both these approaches are well used in public health research (for example the CDC (2021) use of Ecological Systems Theory to better understand violence and the effect of potential prevention strategies). However, a criticism that the WHO framework and Ecological Systems Theory have in common is that although they give the impression that creating sustainable health improvements would be most effectively achieved if all the layers and avenues of influence are targeted simultaneously, the reality is that it is more challenging to intervene across all layers at the same time. Stokols (1996) suggests (with regards to the Ecological Systems Theory specifically) aiming to influence at least 2 layers is sufficient at any one time.

Despite this however, the advantage of both approaches is that they enable the identification of the influences on health (in this case, an identification of how AWP approaches and practices in the workplace are designed to facilitate promotion of health and alcohol health improvement/alcohol harm reduction) and as such, provide opportunities for solutions to be conceived and situated within the multiple layers and avenues of influence. For example, if interpersonal-level and institutional-level factors are identified as problematic in the workplace, AWPs can be better formulated to incorporate the creation of change in social relationships and organisational environments (Golden and Earp, 2012). This is important to establish for AWPs because if their health-promoting potential can be harnessed and improved (as identified in *Chapter 2*), this can support health promotion and prevention of alcohol-related harm for employees.

3.8 Chapter Summary

In summary, Chapter 3 has identified and justified the use of a holistic health promotion theoretical framework comprising of the Ecological Systems Theory and WHO Healthy Workplace Framework that will underpin the empirical study. Using this holistic theoretical framework in the current study aligns with what literature highlights as a need for more ecological approaches to public health and health promotion research (McLaren and Hawe, 2005). Furthermore, as the literature review (Chapter 2) identified a paucity of theoretically underpinned research, using the health promotion theoretical framework will enable the study to address this key gap in the literature, while also enabling understanding of the extent to which AWPs and practices are health-promoting. Next, Chapter 4 presents the methodology and methods, articulating how the empirical work of the PhD was designed, conducted, analysed, and concluded.

Chapter 4
Methodology & Methods

4.1 Introduction

This chapter presents the theoretical and philosophical viewpoints that underpin the study, including a justification for using a qualitative case study design to address the research question and objectives. It outlines the research methods used to select and access cases, then to gather and analyse the data. It also explores some of the methodological challenges of undertaking the study, including the steps taken to maintain rigour and trustworthiness. Elements of this chapter will be presented in the first person to demonstrate the part that I played in the development and implementation of the research and my positionality.

4.2 Philosophical View

"Different ways of viewing the world shape different ways of researching the world" (Crotty, 1998 p66)

Ontology and epistemology (which are concerned with the nature of reality and how knowledge is examined or understood), provide the foundation and orientation of research. Understanding these ways of being and ways of knowing is crucial to making sense of the research process and how ~~a~~ researchers philosophical viewpoints may shape their relationship with the participants and how data is collected, viewed, and then presented (Denzin and Lincoln, 2003; Crotty, 1998). With the research purpose in mind, this study adopts a relativist ontology and constructivist epistemology based on the assumptions that there are multiple truths and angles to reality; and that knowledge or understanding of the world is constructed through people's experiences and interactions with the world and context around them (Mertens, 2005; Flick, 2018). This resonates with my own worldview. I am

currently an academic in England, however my journey began in Zimbabwe where I was born and raised, and it saw me relocate to England at the age of 19 to undertake nursing education, subsequently practicing as a mental health nurse, and then later as a public health practitioner. My ideas, views, and what I know to be true or real have been constructed through my interactions in these different professional, social and cultural contexts. With a relativist ontology, I value multiple realities, and feel that the way in which individuals can understand knowledge, our thinking processes and each other is achieved through gathering and interpreting these multiple perspectives. I have therefore naturally gravitated towards a research project that asks questions and calls for a study design and methods that align with my worldview. *Figure 3* (guided by Crotty, 1998) provides a visual illustration of this.

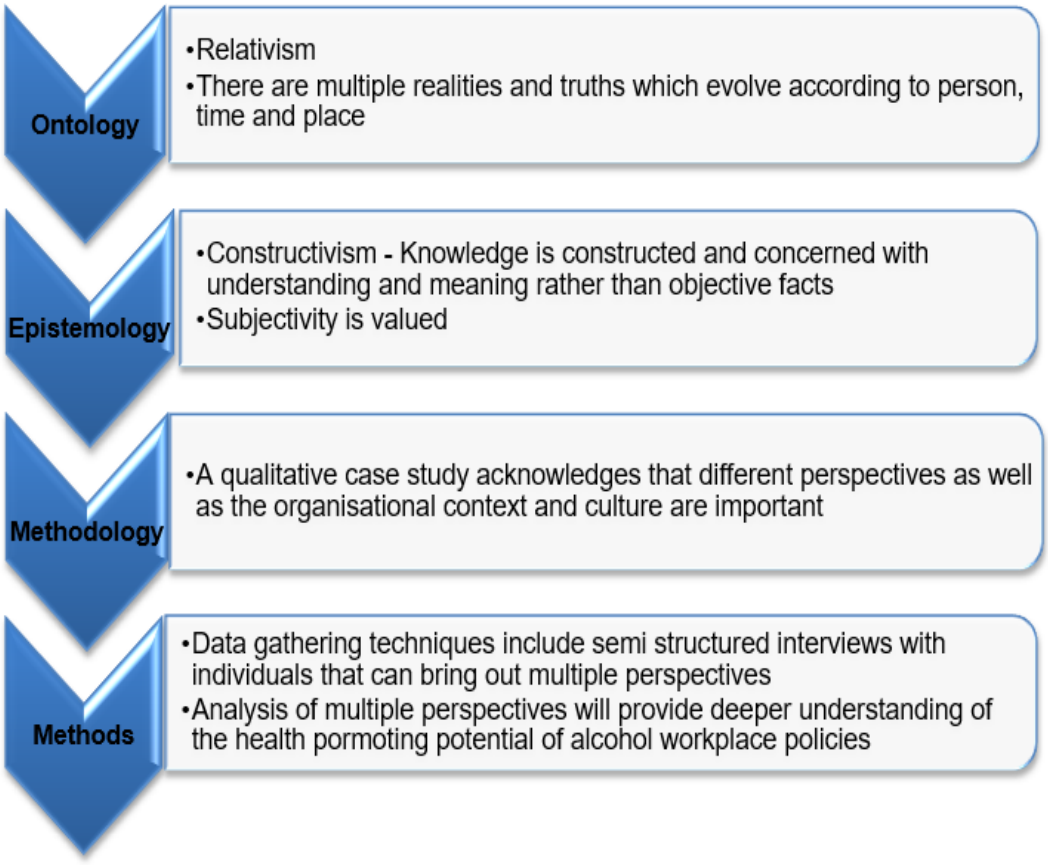


Figure 3: Link between Ontology, Epistemology, Methodology & Methods

4.3 Methodology

4.3.1 Qualitative Case Study Design

To fill the gaps identified in the literature review (chapter 2), the current study seeks to explore how and why AWPs are developed and implemented with a focus on illuminating the extent to which this is underpinned by health promotion principles. Research which seeks to understand the "how" and "why" of phenomena; particularly where there is a paucity of empirical knowledge, is best investigated through case study designs (Baxter and Jack, 2008; Costley et al., 2010). Case studies are defined as a research methodology that seeks to provide an intensive systematic investigation about a person, a group of people or a unit (Heale and Twycross, 2018). Case studies are a popular design in organisational research because they often facilitate understanding of phenomena within their context (Yin, 2014). Therefore, this was an ideal design for the current study because the complex phenomena of health focussed alcohol workplace policymaking and how this is implemented; needed to be understood within the organisational context.

Depending on the purpose of a research project, case studies offer flexibility of choice regarding whether to use qualitative, quantitative, or mixed methods approaches. I opted for a qualitative approach to the case study because the emphasis was on gaining a deeper understanding of the health-promoting potential of AWP and practices including how these are shaped, as opposed to establishing cause and effect. The qualitative approach to the case study also aligned well with my constructivist orientation to knowledge therefore the study was designed using guidance from Stake (1995) who writes clearly about the shape of qualitative case studies and the areas of complexity and contextuality that make up the "case". Stake also has a different but apt way of labelling qualitative methods. For example, instead of "sampling technique" (which is quantitative vernacular), Stake uses the term "selection of cases" which brings out the essence of the individualistic, and qualitative approach to obtaining participants for a case study. The work of Yin (2014) (although

primarily designed to shape quantitative case studies), was also used in the current study because it provided structure and a systematic approach for me to plan and conduct the study as a novice researcher. Combining elements from the two (Stake & Yin), provided the best approach to the current case study research.

4.4 Methods

4.4.1 Selecting the Cases

Case studies allow incorporation of a variety of data sources and methods in order to achieve a deeper and broader understanding of phenomena (Gray, 2018). The downside to this is that they often generate an overwhelming amount of data and can sometimes result in an inadvertent loss of focus regarding what is being investigated (Yin, 2014). To mitigate against this, it is important to begin by deciding what the unit of analysis is. This calls for setting parameters or boundaries around what will be explored, much like inclusion and exclusion criteria. Yin (2014) refers to this as “binding the case”. In this study, binding the case involved articulating the research questions, and then identifying “alcohol policy making and application within organisations” as the unit of analysis. The study was interested in analysis at an organisational level. This was initially difficult because data collection involved interviews with individuals, therefore it was important for me to remain cognisant of the need to understand data from individuals, but then also bring this back to analysis in relation to what it meant at an organisational level. More detail on this is in the data analysis section of this chapter. Binding the case also involved the use of theory, which provided a clear direction for what was to be explored (Yin, 2014). In this instance, AWP needed to be understood in relation to health promotion theory because the study was interested in the health-promoting potential of workplace policy on alcohol. This study was therefore ‘bound’ to Bronfenbrenner’s Ecological Systems Theory and the WHO Healthy Workplace Framework, which have health promotion at their core and workplaces as a context for this conceptualization of healthy workplace policies.

Once the parameters were set, case selection was biphasic - the first phase involving selection of organisations, and the second phase requiring selection of staff participants from within the organisations. Both phases used purposive selection to ensure inclusion of typical cases that exhibited the specific and homogenous characteristics that aligned with the study purpose (Creswell, 1998).

Phase 1

Two organisations (which will interchangeably be referred to as two cases) were selected in the first phase of the case study. Involving two organisations aligned with what Stake (1995) identifies as a 'Collective Case Study', because simultaneously studying both organisations was *"… instrumental to learning [about the extent to which AWPs and practices are underpinned by health promotion] but there [was] important coordination between the individual [organisations]" (p3).* As this was a qualitative collective case study, representativeness or comparison between the organisations was not the aim. Rather, the two organisations were selected with the view of maximizing learning, developing an in-depth and broader understanding of AWP and practices phenomena as they occurs within both organisations. Two cases were chosen because it gave greater analytic advantage than the exploration of just one case (Yin, 2014), and it also allowed for additional analysis regarding whether different contexts influence aspects of AWP approaches and practices. One case was a higher education institution (HEI), and the other was a National Health Service (NHS) trust. Both were public sector organisations with approximately 3000 staff each (HESA, 2014; Wiki 2017). In order to address the research aim, it was important to engage with organisations that had alcohol policies in order to be able to analyse the extent to which these were health-promoting. Therefore the two organisations were purposively selected due to their adoption of workplace alcohol policies, and also because they were public sector organisations with a commitment to the common good and workplace policies aimed at supporting staff. To allow for

greater analytic advantage, these policies differed in scope and comprehensiveness (one policy was more comprehensive and had more detail than the other).

The cases were both from the same region in the north of England, and they were selected because this region has some of the highest percentages of those who consume alcohol at harmful levels in England (ONS, 2017). From a public health perspective, the organisations employ a diverse range of staff and serve populations that have stark health inequalities and some of the highest levels of socio-economic deprivation in England (ONS, 2018). Furthermore, greater numbers of alcohol-related admissions are recorded from those living in the most deprived quintiles in the region (JSNA, 2015). Some of the more recent developments and attempts at regenerating neighbourhoods in the region have seen housing developments being built around food and drink; with “gin bars”, public houses and clubs providing central points for alcohol-related socialisation for the communities. There are no reliable statistics on NHS staff drinking, however the NHS trust was also selected based on an attempt made by Drinkwise Northwest (2010) to survey NHS staff drinking. This report outlined that 22% of NHS staff drink at increasing or higher risk levels, and that one in ten staff went to work with a hangover. This is slightly higher than the general population for women (14%) and lower than for men (30 %) (Health Survey for England, 2020). The HEI institution was selected based on general concerns over academics drinking (Anonymous Academic, 2016), and evidence that points to university staff being susceptible to developing alcohol problems as a coping mechanism for managing job related stress (Wright & Winslade, 2018).

Phase 2

The study was open to all staff in each organisation because the WHO Healthy Workplace Framework emphasises staff participation in policy development, therefore regardless of expertise, it was important to capture views from wider

staff/employees. There was also purposive selection of staff that had direct roles or responsibilities in relation to policy development and implementation from within the two organisations. There is a risk of selectivity bias that can sometimes accompany purposive selection because participants with an interest in the study may volunteer to participate (Macnee and McCabe, 2008). However, in this study the purposive selection technique was appropriate because it ensured that participants were able to contribute in line with the study purpose. It was more difficult to identify all relevant staff who would be involved in policy development (apart from senior managers and human resources for example) therefore snowballing was also used, where participants were asked if they could recommend anyone who was involved in the policy development process that might be interested in participating.

There is no real consensus in the literature around what is an ideal number of participants to have in a case study that uses a qualitative approach because this is often influenced by a number of factors such as what the research aims are, what the discipline is and what constitutes quality (Baker and Edwards, 2012). Nevertheless, for purposes of offering a numerical guide, various authors give estimates of anywhere between 1 and 60 participants for graduate level research projects (Brannen, 2008; Adler and Adler, 2012). Considering this numerical guide, as well as what King et al. (2019) refers to as the “diversity criterion”, this study ensured the participants were able to provide a reasonable variety of positions in relation to the research topic. In other words, participants had to fall under two main categories, namely.

1) policy developers/implementers or senior managers
2) any other staff with no defined role in developing or implementing policies (non-policy makers)

Participants came from a variety of areas such as Occupational Health, Human Resources, Senior & Middle Management, Trainers/Lecturers, Information Technology, Union Leaders, Healthcare Assistants, Nurses,

Administrative & Catering Professionals. The participants were grouped into the two categories of ‘policy makers’ and ‘non-policymakers’ (instead of identifying them according to occupation/role) (see *Table 3)*. Recognising the moral and ethical responsibility to maintain anonymity as stated in the research ethics approval application, the two categories were used to ensure participants were not identifiable. Furthermore, this allowed for direct quotes from participants to be used to illustrate the study findings without compromising anonymity. For greater anonymity, the organisations were labelled as Organisation 1 and Organisation 2. This ensured that any descriptive details of the organisational contexts did not inadvertently compromise anonymity. A total of 16 participants took part (n= 10 from Organisation 1, and n= 6 from Organisation 2).

Table 3: Participant Demographics

	Participant Anonymised Role	Participant Pseudonym	Organisation	Interview Location	Interview Mode
Policy Makers	Policymaker	Debra	Organisation 1	Organisation 1 premises	Face to Face
	Policymaker	Jo	Organisation 1	Organisation 1 premises	Face to Face
	Policymaker	Veronica	Organisation 1	Organisation 1 premises	Face to Face
	Policymaker	Temperance	Organisation 1	Organisation 1 premises	Face to Face
	Policymaker	Johnny	Organisation 1	Organisation 1 premises	Face to Face
	Policymaker	Olivia	Organisation 2	Telephone	Telephone
	Policymaker	Mary	Organisation 2	Organisation 2 premises	Face to Face
	Policymaker	James	Organisation 2	Organisation 2 premises	Face to Face
All other Staff (Non-Policy Makers)	Other Staff /Non-policy makers	Christine	Organisation 1	Organisation 1 premises	Face to Face
	Other Staff /Non-policy makers	Dana	Organisation 1	Organisation 1 premises	Face to Face
	Other Staff /Non-policy makers	Nancy	Organisation 1	Organisation 1 premises	Face to Face
	Other Staff/Non-policy makers	Beth	Organisation 1	Organisation 1 premises	Face to Face
	Other Staff /Non-policy makers	Stella	Organisation 1	Organisation 1 premises	Face to Face
	Other Staff /Non-policy makers	Lara	Organisation 2	Organisation 2 premises	Face to Face
	Other Staff /Non-policy makers	Jessica	Organisation 2	Organisation 2 premises	Face to Face
	Other Staff /Non-policy makers	Chloe	Organisation 2	Organisation 2 premises	Face to Face

4.4.2 Access to the Cases

Ethics approval was obtained through the Lancaster University Faculty of Health Research Ethics Committee (Approval ID Number: FHMREC16053) (*see Appendix 2*), and the NHS IRAS Proportionate Review & Health Research Authority (HRA) approvals processes (IRAS ID: 210478). These committees offered scrutiny of the research project to ensure that the plans showed research integrity and adhered to the ethical cornerstones of research. Approval letters issued by the committees were then used to seek permission for access to staff from the organisations.

Internal organisational processes for access to participants varied according to departments within each organisation, and these processes were not always clear. This can present challenges for researchers, not because staff are not interested in participating, but because of the need to go through a large number of gatekeepers within each area to obtain “permission” for access to staff (King et al., 2019). This can be time consuming given the deadlines for research completion (Farquhar, 2013). It was useful to remain aware that as a researcher I was approaching the organisations ‘turf’ (Stake, 1995, p25) and that the organisations main priority was not my research study, but rather their core function as businesses. Having contacts on the inside of organisations can facilitate initial access (Easterby-Smith, 2018), because the cold calling approach does not always work for establishing access. Contacts signposted and provided introductions to appropriate individuals and gatekeepers who then advised the best way to advertise the study, and access staff. Using contact details obtained from publicly available information on both organisations websites; initial contact was made with the research and development team for Organisation 2, and the research ethics committee administrator for Organisation 1.

To raise awareness of the study and to access staff participants, processes differed within the organisations. In Organisation 2, this involved an initial

organisation-wide e-newsletter recruitment call (using a flyer- *see appendix 3*), contacting departments or areas using contacts provided by the research and development team, and then snowballing through staff who participated as the research progressed. In Organisation 1, some departments had less formal processes for access and were happy for flyers to be left in their reception or staff areas, while other departments preferred for me to attend team meetings to give a verbal overview of the research purpose and then staff who wished to participate in the study would provide me with their contact details after the team meeting.

4.4.3 Gathering the Data

4.4.3.1 Sources of Data

Stake (1995) identifies that data gathering starts before there is a commitment to undertake a study – at the literature review stage. Information gathered here can inform the interview schedule design and be incorporated into the data analysis later on. It is crucial to select the best sources of information that can generate in depth understanding on the phenomena. The best sources for this study included a combination of primary sources (interviews) and secondary sources (policies, emails communication). Embracing multiple sources of data allows for “data triangulation” which is good for strengthening the findings and enhancing study credibility (Bryman, 2012).

Collecting the data from these various sources was relatively straightforward; the challenge, however, was how to manage it all. Knowing how to work with each source of data requires some thought, skill, and additional quality checks and controls (Ellis, 2010). All the data was managed electronically through a combination of Microsoft Word and Excel to catalogue written transcripts, policy documents and emails for data analysis, and as suggested by Bryman (2012) this created an audit trail to enhance the study’s dependability.

4.4.3.2 Primary Sources

Interviews

Respondents who were interested in participating or those who wanted to find out more information about the study were provided with a participant information sheet (PIS) (*see appendix 4*). As all participants had to be employees of either of the two organisations and as all had work email addresses therefore the PIS was sent via email. The PIS satisfied conditions of disclosure, comprehension, competence, and voluntariness (Streubert and Carpenter, 1999) and this enabled individuals to make informed decisions about whether to participate or not. Those who were willing to take part after reading the PIS were asked to sign a consent form (see *appendix 5)* electronically or in person on the interview day to indicate their consent to participate. Consent was not a one-off event, but rather, it followed what Polit and Beck (2017) calls “process consent” which requires researchers to remain cognisant that consent can change from day to day within the lifecycle of a study. This allowed candidates the choice to withdraw their consent; and in this study, participants were informed of their right to withdraw at any point up until two weeks post data collection. This was written into the PIS, consent form and mentioned verbally on the day of interview.

The main source of data was 1:1, semi-structured interviews with staff. As a data collection method, interviews allow a researcher to be present to respond to participants contributions, and probe for further exploration (Gillham, 2000). The interviews ranged in length from 33 minutes to 67 minutes and they were facilitated between September 2017 and January 2019. It was not intentional for data to be collected over such a long period of time however recruitment was slower due to organisational pressures, restructures, funding cuts and time for some participants. An extension to the recruitment period was requested through an HRA ethics amendment to enable more time to access interested participants. However, the time period revealed the changing and complex nature of organisations, as well as their business priorities, allowing this to be captured through the course of the study

and this will be discussed briefly in the results and discussion sections of the thesis. Interviews allowed different perspectives and experiences of AWPs and practices to be explored. This remained true to the relativist notion of honouring multiple realities, and interviews were a way of discovering and portraying these multiple realities (Stake, 1995). The semi-structured format allowed for specific questions and prompts to be developed and used as an interview schedule (see *appendix 6)* while also creating some flexibility for participants to speak about the aspects that they wanted to expand on more freely.

Setting plays an important part of the interview process, with suggestions that participants feel more comfortable and able to share more openly and freely on their own turf (Gillham, 2000). The interview setting was a combination of the researchers office (which worked well for those who were constrained by practicalities of not having a room at their own work premises to conduct the interview) and the participants work offices/premises. There were no apparent differences in freedom, or openness of sharing with interviewees who came to the researcher's office in one of the organisations, versus those who preferred it facilitated on their own turf.

The interviews were predominantly face to face; however one participant preferred a telephone interview. Taking the notion of interviewee convenience as paramount (Gillham, 2000), it was more convenient for the participant to have a telephone interview because they did not have free access to a private room/space in their workplace. Furthermore, because of their job role, they were only able to spare their lunch hour and this would not have been enough to travel to a different location for purposes of an interview. Building in this kind of flexibility is viewed positively because it lessens any unnecessary burden on participants (Easterby-Smith, 2018). Apart from not being able to read body language for cues on how the respondent is reacting throughout the interview (Gray, 2017) there were no significant or notable differences in researcher-participant dynamics from the interviews that were facilitated face

to face or via telephone. The same methods for establishing rapport (a key ingredient in successful qualitative interviewing) (King et al., 2019) were used, for example exchanging pleasantries at the beginning, establishing trust, and prioritising participant comfort. It was however easier to take written notes in the telephone interview because there was no need to worry about aspects such as breaking eye contact with a participant, or the appearance of active listening skills (as one would in a face-to-face interview). All interviews provided insights into the area of alcohol and the workplace as well as AWP approaches and practices.

All interviews were recorded on a portable recording device, then deleted once files were transferred onto a password protected computer and the BOX secure online storage facility. One disadvantage of recording devices is the chance they might fail, and this happened for one of the interviews. Fortunately, I had a backup recording device that I used to capture the remainder of the interview. Interviews were transcribed using the intelligent verbatim technique, which omits some filler words such as umm, ahh, (this kept the transcription costs lower as the project was not funded). Some of the interviews were transcribed using a transcription service, and in order not to lose the “immersion” that comes with transcribing these on my own, I ensured I repeatedly listened to all the audio recordings and read through the transcripts several times. The recordings transcribed by the transcription service were shared using the BOX online secure storage system (transcriptionist signed a confidentiality agreement before accessing these) and they confirmed deletion of the recordings and transcripts once I had confirmed receipt of the completed transcripts. The BOX link was then “unshared”. I checked the transcripts for accuracy and added manually any expressions that felt relevant to understanding the context or essence of what participants were saying, for example laughter or exaggerated/emphasised words. Yin (2014) regards this as a good way to ensure findings portray the participants real meaning and how they view matters. Once participant and organisation demographics were tabulated, the transcripts were then

anonymised (removing participant, organisation names, places, and any identifiers).

An interview schedule (*see appendix 6)* was used to guide the interviews, and this had a mixture of closed and open ended, non-leading questions around the areas of interest. The interview schedule was also designed with the Ecological Systems Theory and WHO Healthy Workplace Framework in mind to ensure questions could capture information and discover meanings in line with the purpose of the research. For example, the question prompting for stories on alcohol within the workplace drew on the “individual, interpersonal (microsystem) and organisational (mesosystem)” layers of the Ecological Systems Theory. Participants were able to discuss and raise points around what factors may affect individual behaviours, attitudes and beliefs, any organisational culture influences on how alcohol is viewed or accepted, and policy practices around this at an organisational level. The same question also prompted consideration of the avenues of influence (from the WHO Healthy Workplace Framework), such as what “personal health resources” in the workplace setting support and encourage alcohol health improvement and healthy lifestyles by the employer. The interview schedule took a logical order to the questions, which is good practice (Farquhar, 2013), however I found that allowing some flexibility for participant stories to lead the direction ensured participants could expand on the areas that they wanted to. This required me to be more aware of any digressions, and to have a way of reeling discussions back in line with the purpose of the study. To facilitate the interviews, I sometimes shared examples from my personal and professional experiences regarding alcohol and the workplace, and Gray (2018) acknowledges it is acceptable to do this particularly if it can help participants connect with the questions, and to visualise the areas of researcher interest in line with the study purpose. Furthermore, this two-way sharing was aimed at making the interviews feel less like an intrusive, one-sided interrogation for participants, particularly as some questions may have been viewed as a test of knowledge (about alcohol policy development or application); or scrutiny

into how participants perform their day-to-day job (which was more of a consideration for those directly involved in policy development and implementation). With this in mind, it was important to remain aware that interviews can make staff feel judged and vulnerable (Gray, 2018). Where a researcher brings their own experiences into an interview, it is important to be aware of the potential for this to influence participant responses to fit the researcher's narrative (King et al., 2019). However, in light of my belief that knowledge is constructed, the approach used in this study demonstrated constructivism. I did however ensure that what I shared was kept to a minimum so that the participant's voices and views were dominant.

Diary/field notes

Brief notes were made during and after each interview to capture initial thoughts and anything noteworthy such as any animated responses. Diary notes are an authentic way to provide an audit trail, and capture the essence based on what was happening at the time, and in the interview moment (Costley et al., 2010). The diary notes were scanned and uploaded onto the BOX online secure storage system so that they could contribute to showing my thoughts about the data and any decisions I made as the interviews progressed. Again, this contributed to method triangulation which went some way towards enhancing the credibility of the study (Denscombe, 1998). Diary notes particularly during the first few interviews, contributed to the refinement of interview questions and development of further prompts to use in the remaining interviews (Lathlean, 2010).

4.4.3.3 Secondary Sources

The distinction between primary and secondary sources of data is not always clear (Gray, 2017). For purposes of this thesis, the definition that will be used is offered by Easterby-Smith, (2018); who regards secondary data as polices or documents that are developed for an entirely different purpose but are then deemed relevant to the aims of a research study. Documents can provide a

distinctive take on reality in their own right (Atkinson and Coffey, 2011 cited in Silverman, 2011). Furthermore, documents are regarded as a valuable source of information in case study research because they can provide insight into organisational priorities, values, context, and culture (Gray, 2017).

Participants were asked if they could provide any documents or emails/ communications that they might be aware of or have access to in relation to alcohol and the workplace, and more specifically policies to do with alcohol. Some documents were obtained by virtue of my "insider access" and this yielded email documentation for example. *Table 4* outlines the documents obtained and how they were accessed. Anonymised versions of the documents were stored on the BOX secure electronic database, and those provided as paper copies were scanned and added to the electronic database for indexing (while the hard copies were kept in a locked filing cabinet) (Yin, 2014).

Table 4: Types of Documents Used

How documents were accessed	Documents
Provided by study participants	Mission statements, values & behaviour statements Drug & Alcohol Policy documents
Documents sourced via insider access	Emails

4.4.4 Analysing and Interpreting the Data

Amalgamating and analysing multiple primary and secondary sources of data allowed for *"converging lines of enquiry"* (Yin, 2014, p120) which strengthened the study findings, and enhanced its trustworthiness (Silverman, 2013). Ellis (2010) describes each of these sources like the pieces of *"a puzzle, where the combined parts tell a story of the whole system being investigated, [and] thereby enhancing understanding of the whole".* The task of analysing and

interpreting the pieces of the puzzle; and reducing the large volume of information in order to answer the research questions (Swanborn, 2010), began with the challenging question of how to do it? It is necessary to have a plan for how this will be executed (Yin, 2014). With this in mind, Framework Analysis which was first developed by Ritchie and Spencer in the 1980's was used (Ritchie and Spencer, 1994). Framework Analysis is a popular approach to analysis which originated from social policy research, and it sits within the wider family of thematic and content analysis (Gale et al., 2013). It was chosen because of its systematic approach to qualitative data analysis, and the flexibility it offers for incorporating analysis of documents. The process for Framework Analysis had seven iterative stages as presented below.

1) **Transcription of interviews**. The transcripts, as well as the diary notes, documents and policies were uploaded electronically onto BOX. This made data more easily retrievable (Gray, 2018)
2) **Familiarization with the interviews.** This was done by repeated listening to audio recordings, and repeated reading of the interview transcripts. At this stage, the adaptation included repeated reading of documents and policies. Preliminary notebook/reflexive diary entries about the researchers' thoughts following each interview and the documents were also read at this stage. These thoughts outlined sense making of each individual piece of data/interview/document as a whole, and was "*rapid but purposeful, directed but not bound by [my] research questions"* (Jackson and Bazeley, 2019, p27).
3) **Coding.** Transcripts were coded line by line. Labels (that described interpretation of the interview conversations) were assigned and colour coded. The coding was done in two rounds- the first round aimed at bringing out participant areas of emphasis, then the second round of coding was conducted to capture elements that were aligned to the research question and the abstract elements of the health promotion theoretical framework. The two coding rounds were then amalgamated to ensure that all areas of significance were identified, even if they did

not initially appear to address the specific research objectives. Coding of the documents was treated in the same way as the interview transcripts, by highlighting specific sections of the written text. Documents were scanned for any reference to alcohol, substances or health and wellbeing for example.

4) **Developing an analytic framework.** An initial 'framework matrix' was developed using the predefined abstract categories from the Ecological Systems Theory and WHO Healthy Workplace Framework. This initial framework matrix was refined as interview and document analysis progressed.

5) **Applying the analytic framework.** This stage involved indexing transcripts and documents using the analytic framework. This included assigning abbreviations for easy identification of codes without the need to use the full labels.

6) **Charting data into the framework matrix.** Key quotations from the transcripts and documents were charted into the framework matrix according to the relevant abstract theoretical framework category.

7) **Interpreting the data**. This element of the framework analysis method involved identifying characteristics and differences in the data that was charted into the categories of the framework matrix. Further exploration of connections between the quotations in each category, and sense making of the data enabled preliminary themes to be identified. Diary notes on key ideas that emerged from the interviews and documents were also incorporated into the data interpretation stage, thereby enabling the themes to be refined. Another important element of the interpretation stage were the discussions I had with my thesis supervisors. Gale et al., (2013) identifies that discussions with others (such as members of the research team or practitioners) can enable the development of more robust interpretations and themes in the data.

Analysis was done for each case (organisation) individually, thereby providing an overall picture of what the interviews and documents in the organisation portrayed in relation to the study question and objectives. Then analysis was undertaken across the two cases to identify any patterns, similarities or divergences (Yin (2014).

4.5 Chapter Summary

This chapter presented the methodology and methods used to undertake the empirical study. As the intension was to take a reflexive approach to writing this chapter, it provided an insight into some of the experiences and challenges I had at the various stages of the conduct of the study, and how I navigated these. The next chapters (5, 6 & 7) will present the study results.

Chapter 5
Results: Misaligned Voices

5.1 Results Introduction

The following chapters (Chapters 5, 6 & 7) outline the results of the study. The literature review revealed an increasing acknowledgement of the notion that AWPs can be health-promoting (Pidd et al., 2016). The consequent research purpose was to explore the extent to which AWP development and implementation practices are underpinned by health promotion principles. The study used the Ecological Systems Theory and the WHO Healthy Workplace Framework as a lens through which the health-promoting potential was investigated, and the following results represent the participants contributions aligned with the study purpose. Participants offered insights regarding how policies could be developed/refined to further enhance their health-promoting potential. Participants were best placed to do this as they had intimate knowledge of their organisational context - which was key to understanding their experiences, as well as their thoughts about what works and what can be enhanced. The suggestions made within participant narratives also contributed to the implications for practice (*Chapter 10*), ensuring that the study findings and recommendations remained embedded within the participants contributions and not just a mere interpretation provided by the researcher.

Three main themes emerged from the data - Misaligned Voices; The Grey Areas; and The Wider Determinants, Meanings & Purpose of Alcohol. Each had two sub themes within, and these represented key areas of interest from the study aligned to the research question. For each of the themes, a descriptive account of the data will be provided, supported by relevant direct quotations from the participant narratives and document excerpts. Given that the study draws on two different types of data (participant interviews and documents); two different organisations (Organisation 1 and Organisation 2); and two different participant roles in relation to policy development

(policymakers and non-policymakers); the divergence and commonalities between and within these will be outlined for comparative purposes, and then discussed in more depth within the discussion chapter (*Chapter 8).*

5.2 Misaligned Voices

The theme of ‘Misaligned Voices’ encapsulated the divergence of views, practices, and written expectations in relation to management of alcohol problems in the workplace. The consequent analysis and discussion of these divergent voices (*in Chapter 8*) has relevance with regards to understanding each organisations’ approach to policy development and implementation practices (in relation to alcohol health promotion); and the factors influencing the divergence/misalignment. A table of the theme development can be seen in *Appendix 7.*

5.3 Framing of Alcohol Problems

Across the policymakers, non-policy makers, and policy documents, there were nuanced and varied descriptions of behaviours and characteristics that may be exhibited by someone with potential alcohol problems. For example, frequency of arriving at work late after a heavy night drinking, low mood, and poor attitude. This differential framing of the characteristics associated with alcohol problems was important because it had some bearing on how alcohol was viewed and the consequent approaches to managing issues around alcohol in the workplace.

For example, the wording in the policy documents showed frequent reference to the term “treatment”, and a description of the characteristics that would be part of diagnosing alcohol dependence. This suggested a recognition of dependence as a “problem” and commitment to supporting individuals in need of treatment, which was positive. However, from an alcohol health promotion

and prevention perspective, the policy documents "voice" was silent. The quotation below illustrates how dependence problems and treatment were emphasized

> *"The policy aims to minimise problems at work arising from alcohol and substances [and] support those affected with alcohol and substance related problems by encouraging treatment where possible"* Organisation 1 Policy Document

> *"This policy is concerned with all forms of problems associated with substance misuse and includes alcohol, controlled drugs, prescribed and self-prescribed drugs, glues gasses and solvents…… and identify and support employees whose misuse of alcohol or other substances may pose a risk to themselves , clients or colleagues and facilitate their rehabilitation"* Organisation 2 Policy Document

As shown above, the policy document for Organisation 2 was slightly different in comparison to Organisation 1 in that it made a more visible statement with regards to the policy applying to 'all problems' associated with alcohol misuse. While this could arguably encompass all the different risk levels (as identified by the AUDIT screening tool), however the policy use of the term "all problems" is vague, and when it comes to the specifics, the language used alludes more to identification of problems that are visible (in affecting work performance, and risk to safety) and strong emphasis on encouraging access to treatment much like the Organisation 1 policy.

The policy documents showed that both organisations had a clear health orientation, (emphasized by frequent reference to the term "health and safety" within both their policies) and both showed they would view issues concerned with alcohol dependence as an ill health issue for which employees would receive support. However, when looking at the balance of health versus safety (based on running simple word frequencies on the terms "safety" and "risk" versus the terms "health", "health promotion" or "prevention", it was clear that risk and safety were more prominent. The emphasis on safety was evident in

the policy aims, justifications for why the policies were developed in the introduction/rationale, and in the justifications for how alcohol-related issues involving risk would be managed in the work setting. Moreover, the policy voices were silent on alcohol health promotion or prevention. In the illustrative quotation below, a problem (according to the policies) was therefore framed as an alcohol-related issue that constitutes a performance or safety concern at work and the policies were therefore not regarded by staff as being concerned with health promotion or prevention

> *"….so, the challenge is it's [alcohol workplace policy] not necessarily focussed on health and wellbeing as such, it's not… I mean, it is in terms of it, it talks about referring to occupational health but you can only do that if the individual's sort of willing to, you know, willing to kind of do that and willing to admit they've got a problem…..*." Debra - Organisation 1 Policymaker

Furthermore, this emphasis on risk (and employee performance related to alcohol) was illuminated by the excerpt below which suggests when managers became involved, their responsibility was limited to discussing issues related to work performance & alcohol use and not necessarily about health in relation to the employee's consumption levels.

> *"Health and safety responsibility rests with the manager for each area. Where there is an immediate safety concern as a result of alcohol or substance abuse a manager may require an individual to leave their place of work for the day…….. The discussion [that consequently happens between manager and employee about their alcohol use] should be confined to issues directly related to the employee's work performance and behaviour unless the employee volunteers other matters"* Organisation 1 Policy Document

This policy statement above appears to limit managers' ability to initiate conversations around health behaviours. Furthermore, if an employee does not perceive their alcohol consumption as problematic or detrimental to their

health, then it is likely that they will not raise this in discussion with their manager. This presents a paradox regarding employer responsibility and where that should start and finish. There were several other policy statements like this, which suggested (at least in how the policies were written) that both workplaces placed more concern for safety and performance related outcomes than on health.

Given the already identified emphasis on support for treatment, the Organisation 1 policy document then understandably presented a binary approach to managing alcohol problems at work. That is; employees with problems recognised as dependence received treatment support and recognition of their struggle with alcohol as a health problem; while those with a problem that manifested as isolated cases of intoxication which affected their job performance were viewed as a conduct issue and were more likely to be managed in a disciplinary way. Notably, the way that the below policy excerpt is written does not explicitly show acknowledgement of the AUDIT[3] 'increasing risk' and 'higher risk' drinking categories as 'problems' which are more likely to present as occasional cases of intoxication

> *"Where a person's dependency continually or repeatedly interferes with their work the [organisation] will treat such a case as an ill-health issue. Problem drinking or substance misuse maybe an illness and as a result the sufferer requires special assistance and treatment to assist recovery. Cases that are not related to a physical or psychological dependence but are simply isolated cases of intoxication resulting in unacceptable or even dangerous behaviour will be regarded as a conduct issue which may lead to disciplinary action."* Organisation 1 Policy Document

[3] The Alcohol Use Disorders Identification Test (AUDIT) is an alcohol screening questionnaire that helps to identify the different risk levels associated with alcohol intake. The risk levels are on a continuum, encompassing 'Low Risk', 'Increasing Risk/Hazardous Drinking', 'Higher Risk/Harmful Drinking' and Potential Dependence'.

On the other hand, the policy document for Organisation 2, while still heavily focussed on treatment and support for problems that have been identified, does show some indication of the organisations attempt at prevention and health promotion for those who may not have alcohol dependence problems, by encouraging sensible drinking. It is worth noting though that this prevention statement is a couple of lines in a document that is over 10 pages long so it can be easy to miss this emphasis on prevention. Furthermore, without any additional information provided alongside the policy to articulate what 'sensible drinking' and 'excessive consumption' are, these terms are left open to subjective interpretation of what constitutes sensible, and excessive.

> *"[this policy] aim[s] to…. promote a progressive change in attitude towards sensible drinking and alert employees to the risks associated with excessive consumption of alcohol"* Organisation 2 *Policy Document*

When it came to managing alcohol problems at work, policymakers reported that they had not managed many cases of problematic alcohol use in the workplace through the use of company policy, and as such, there was the perception that there were no real alcohol problems in the workplace. Despite this, there was acknowledgement that alcohol problems may be largely hidden in the workplace setting because they are only identified as problems once they begin to interfere with job performance.

> *I've not actually come across any cases where we've had any kind of alcohol dependence o*r *any issues with alcohol or anything like that……. but, you know, I'm sure that there are cases that happen that we don't necessarily know about…. I think, you know, it does depend on because I can imagine that people hide, people hide it very well"*. Debra- Organisation 1 Policymaker

Alcohol was also framed by non-policy makers as a paradoxical issue. On one hand concern for public health with regards to excessive consumption while

on the other hand the very same excessive consumption is a source of laughter and camaraderie to a certain degree. Sometimes this was with little consideration of whether an employee might actually be struggling with their alcohol consumption. This was demonstrated by the following quote from Stella, and the mass email document below

> *"…I've seen [the] jokes about oh just pass me the gin…. So, I don't think we're secretive about it. Yeah, were probably quite overt about our relationship with alcohol... Although, that immediately then brings to mind…. imagine if you're a recovering alcoholic, working in that environment. How……irksome that might be that other people ARE laughing and joking and putting up little pictures of this and, you know, in the restrooms and stuff like ooh, when they are actually overcome those problems, or trying to overcome those problems, or suffering with those problems..." Stella-* Organisation 1 *Non-policy maker*

> *"If anyone is around about 16:30 today, we are going over to the [pub] for a while for a couple of ~~bottles~~ drinks till about 18:00. Would love to say goodbye with a hug"* Organisation 1 *mass email*

In this section we see misalignment in how alcohol problems are framed. Firstly, non-policymakers and the policy documents identify alcohol problems using criteria that relate to dependence (which does not align with contemporary public health view of alcohol problems that presents problems or risk levels on a continuum). Focussing on dependence (as a problem) means workplaces are well set up to support treatment for employees, however there is less specific mention of, or support for the prevention of alcohol problems in the workplace. This means policy is more reactive, than proactive. Then secondly, both organisations' policy emphasis on "health and safety" is viewed by non-policy makers as a concern for worker performance and productivity than on health.

The following section on the policy versus the reality provides further examples of misaligned policy, policymaker, and non-policy maker voices in

how alcohol problems are viewed and more specifically, illuminates how policies and practices are consequently shaped.

5.4 The Policy vs The Reality

The policy versus the reality sub-theme articulates the complex reality of policy implementation which was not always aligned with what was written in the policy documents. Policy was viewed as important by policymakers and non-policy makers alike, but this sub-theme revealed that sometimes policy did not consider the practical and contextual aspects of implementation in a workplace setting. For example, when asked about how suspicion of an alcohol problem would be managed; the procedural elements of the process were evident within the participant responses, but on the surface, what stood out was that policy (in this process of what to do) was a formal process whereas the reality of how employees viewed and managed any concerns revealed the informal, complicated, difficult, and sensitive nature of addressing alcohol issues at work. The narratives demonstrated that colleagues could not (and did not always) separate their feelings of care and concern for their colleague. Furthermore, if colleagues were to experience alcohol-related problems at work, the repercussions on the colleague's livelihood made raising alcohol concerns in the workplace a genuine challenge. This was despite the policy documents from both organisations encouraging staff to alert occupational health and management if they suspect a colleague has alcohol related problems. Allowances were sometimes made, using what appeared to be actions that ran parallel to, and not always in sync with the policy documents. At the heart of this misalignment was the participants belief that policy serves a disciplinary function.

> *"it's like your work family, especially when you've been here as long. So, I would like to think I'd care, I'd do what I could for that person but maybe see if I could access any support from the [organisation] as well…. because that could massively affect somebody's career, reputation…… I mean, maybe it's the way I've been brought up, but I just like to think that, you know, someone would hold out that hand of care to me, if I had [alcohol problems] it wouldn't [be] just, you've gone*

> *against the policy and that's it, you're kind of out. It would be can we do anything to support and help…I just think that maybe we should try…… not to the point where we're ignoring it, by any means, but I guess it's a fine line, isn't it, really?*" Jo- Organisation 1 Policymaker

The managers responsibility in both the Organisation 1 and Organisation 2 policies were clearly articulated. However, policymakers and managers in particular, noted an element of avoidance - preferring not to dig too deep into staff's private lives lest they uncover a multitude of issues that go against the AWP. For example, where social media forums like Facebook show staff consuming excessive amounts of alcohol (which is potentially problematic) this was managed by asking staff to be careful of what they put online. There was a sense that managers created distance with employees when it came to socialising so as not to uncover anything that they may then need to act on. Underlying this is a salient acknowledgement that staff are most likely drinking alcohol in ways that might have spill over effects on the workplace and may not stand up to policy scrutiny at work.

> *"I would go on all the nights out. However, I have had to really, really pull back [after becoming a manager] ……On a weekday, I don't know what the staff members do and I'm not one to pry. unless they're on Facebook and then I can actually clock them on Facebook, erm, which I have done on a few occasions and one was where they actually rang in sick the next day…. reason was basically, she'd had sunstroke, 'cos it was a very hot weekend, [pictures on Facebook showed] she was out on a beach with numerous bottles of alcohol and subsequently ended up with sunstroke. However, by the amount of alcohol she'd drunk, it was not sunstroke, but she did come back with a tan….we do mention Facebook within the business meeting as well, so Facebook is mentioned. Be mindful of what you post, when you post it and how you post it"* Mary, Organisation 2 Policymaker

Another area of misalignment between policy and employees was related to the issue of discipline. Despite the policies asserting their health and support focus for those who are dependant, the reality of alcohol policy is that it was still integrated into other policies such as discipline, which reinforces the

strongly held employee belief that alcohol policy is associated with disciplinary action, and the consequent fear that comes with the potential that an individual might lose their job. Policymakers across both organisations however, suggested that disciplinary action was rare in the workplace - and the policy documents reflect this by outlining the supportive measures taken by organisations around alcohol issues in the workplace particularly where an employee wishes to take up the support. However, this did not align with the employee's views regarding what they thought would happen if an alcohol issue (whether minor or major) was formally raised about a colleague's (or their own) drinking. They believed disciplinary outcomes were more likely, and the support function of policy was not evident to them. There was agreement between policymakers and non-policy makers across both organisations that policy should be more supportive and that the support element should be communicated more explicitly in order to change the perception that colleagues will always risk being disciplined if any alcohol issues are reported.

> *"The [institution name] has got a policy…. but I think it's also now built-in to other policies such as discipline"* Johnny- Organisation 1 Policymaker

> *"…I don't know that I would be able to have a frank discussion with my manager; I'd be worried that I'd be taken down a capability route if I were to say, erm… "I feel really stressed out; I'm drinking". Or let's say there was no stress and I chose to be a big drinker anyway. I don't think I could have that conversation, 'cos I'd be scared of the implications of admitting that".* Nancy- Organisation 1 Non-policy maker

> "……*it would be more about trying to get that individual help rather than a punitive action type of thing. I suppose it's; you know, the issue is if they don't recognise it and won't get help, that's the bit that, you know, it would be quite difficult"* Debra- Organisation 1 Policymaker

Perhaps what remains poignant is that the intentions for policy in the workplace are to be supportive to employees who may have alcohol problems,

but because of the reality of the fear that employees have about being open regarding an alcohol problem they often don't let their employers know about any early struggles with this until it is at a point where the drinking is impacting on performance, and the policy may then need to be used punitively. This is a misalignment between what policy says and the reality of what employees think and believe. Furthermore, it represents an unintended consequence of having AWP, in that while it is supportive and encourages employees to seek helper earlier, it is having the opposite effect and hindering this early help-seeking. The excerpt from Debra's interview below illustrates this best.

> *"……because it's [alcohol problems] something that people hide, I think it's quite difficult to enforce a policy or to use a policy because it's not necessarily something that people are very open about, you know, so in terms of developing it, it's sort of, you know, it ends up like when you read this policy, It ends up being quite punitive in terms of, you know, if you were found at work to be in charge of a piece of machinery and you were intoxicated then we would take you down the disciplinary procedure. Rather than that dealing with the underlying [health] issue of that particular…. individual because obviously that would be something that you'd have to do down the disciplinary procedure"*
> Debra- Organisation 1 Policymaker

Another area of misalignment between policy and employees (which included policymakers and non-policy makers) was confidentiality. Within the Organisation 1 & Organisation 2 policies there were assurances of confidentiality however employees (and some policymakers) did not trust managers or human resources (HR) assurances and examples of where this had been breached previously (albeit in areas unrelated to alcohol) were given. From the perspective of employees, Occupational Health was the only part of the organisations trusted to maintain confidentiality. The data revealed that while there may be a willingness to be open about struggles with alcohol, the stigma associated with this could be a hinderance. Furthermore, not trusting the confidentiality level of the organisations fed into their existing worry about negative repercussions on a colleague's job if alcohol issues were identified. This brings into sharp focus how no staff member would want to

willingly disclose an alcohol problem if they could not trust that their confidentiality would be maintained

> *"I know it'd be tricky because you would want that anonymous element to it, potentially. You wouldn't want your colleagues knowing, "Oh, I'm just going to go and chat about my drink problem." …. And it's just kind of like, and I've heard of other incidents where you kind of think, actually, you should think human resources is confidential but it's not that. I think Occupational Health is and that's different but..."* Jo – Organisation 1 Policymaker

When it came to questions around the health-promoting function of policy, misalignment was seen amidst the policymakers themselves. For example, some policymakers in Organisation 1 believed that policies should reflect health promotion more visibly, while others in the policy making circles did not view this as a priority for the workplace. Therefore, the attempts of those who believed in it were sometimes thwarted by the final decisions of those who did not. Despite the inclusion of "health" in the alcohol policies, there was also a lack of clarity around whose responsibility it was for "health promotion" in both organisations. The assumptions were that it was a service best provided by occupational health, while other accounts suggested occupational health had cuts to their funding and their role no longer visibly included health-promoting activities (including for alcohol) in the workplace. Furthermore, although according to policy, managers were seen as responsible for health and safety of employees, the nature of alcohol and the difficulties around having a conversation with a colleague around their alcohol use needed to be considered. At the end of the day, it seemed no-one was really overseeing alcohol health promotion, and the support available was reserved for those who are dependant and require treatment.

> *"We do less health promotion work now … and that's because of funding. We don't do the proactive stuff, we used to ask people and do the Audit-C questionnaire, say for example, for alcohol, we used to ask about smoking errrm lifestyle and all that's gone now, because we just do not have the resources…."* Olivia, Organisation 2 Policymaker

Although policy exists, employees were not referring to this to guide their actions, but rather referred to inherent knowledge to guide their expectations and their behaviour regarding alcohol. Moreover, there may have been an element of group think, following what others were doing or making decisions to drink at work by seeing others doing it, and not necessarily based on a knowledge of what policy in the workplace says about whether it was allowable or not.

> *"…. There's an assumption that nobody will be drinking and there's no expectations set when we do have a Christmas lunch. I mean, when we had these previously, when the previous [manager] was here, he would quite openly be drinking glasses of wine on the lunchtime…. So they would be openly drinking, so it was kind of expected that it was fine for everybody else to have a drink because they [the manager] were drinking so nobody would feel uncomfortable about having a glass of wine because, like I say, they've set the tone already…. But other than that, there's not really any big drinking. But I don't know where the expectation's come from, I suppose"* Beth- Organisation 1 Non-policy maker

The narratives across both organisations also centred around the difference in implementation practices based on whether the individual with problematic alcohol use was a colleague or whether they were a customer (a customer being patients in the NHS and students in the HEI). Narratives distinguished between practice that's part of day-to-day work with customers, versus practice that relates to how one would respond to a colleague. Working with customers was presented as easier or clearer, while handling the same alcohol problems with colleagues was more difficult.

> *"It would probably be easier to confront a [customer] because we have a sort of, almost a duty of care to our [customers]. We are, you know, we're responsible, I don't know what the word is… With a [customer], it's a professional relationship… But with my colleagues, it's a personal and a professional relationship and although I have a sort of moral duty, I don't have an implicit process duty…. there's no guideline to say this is what you do, so I think it would be harder"* Dana- Organisation 1 Non-policy maker

> *"It always makes me think sometimes when I've worked in the [organisation] is the fact then when somebody is actually maybe has problems themself say with alcohol, that the empathy is not the same when it's a work colleague… the empathy seems less I think for any anybody whose actually working in the [organisation]. Errm, it's not recognised and it always it always baffles me when you are a caring person, that you can't care for somebody who's working alongside you because they're not a [customer]. It's hard to explain what I think, I just know that I don't like it…." Chloe-* Organisation 2 *Non-policy maker*

With employees, alcohol issues were not raised or challenged as much, whereas with students or patients, the duty of care prompted that identification and finding ways of supporting.

> *People often said she [a staff member] had an alcohol problem and she was… You know, erm… And she actually slipped twice. Broke her arm twice erm… And had some time off and… Everybody always says "oh, she probably slipped when she was pissed" but again, it's all… Nobody ever questioned about that….* [if it was a customer] w*e would have been saying "how much alcohol are you drinking? Has that contributed to your fall? Or… You know? I think it's very difficult, as staff, we must persevere to support each other but I don't think we do, sometimes. Nobody actually says to you, when you've had a really stressful day, "how do you go home and relax?" Because you [hear] people go "I can't wait to get home and have a gin and tonic". Then we laugh. But actually, if you're having to have that gin and tonic every night to de-stress, then is that becoming, is it becoming a problem? Jessica -* Organisation 2 *non-policy maker*

Furthermore because of its very difficult nature when issues are raised or discussed by managers during supervision for example this often seemed to be about covering ones back. The following quote illustrates this in the way the manager ensures recording is done. There is greater difficulty there when there are issues of power and seniority at play and the issue of covering up for liked and/or respected colleagues is an important barrier to the implementation of policy.

> *"There was [a manager] and she had alcohol problems; she used to have a bottle in the drawer. You know? People knew of it but never actually did anything… But again, that is the culture; you would never have dared say to a [manager]…Or if you would have gone to one of the other… [staff] and said something. It was very much kept amongst themselves, wasn't it? "Oh you know, she's fine, don't you know?" ….Yeah, there was a lot of covering up".* Jessica, Organisation 2 non-policy maker

5.5 Chapter Summary

In summary, this chapter has demonstrated the various areas of misalignment between what policy states, what policymakers and non-policy makers believe and how they consequently manage issues to do with alcohol in the workplace. Some of this misalignment relates to how 'problems' are defined. For example, it is understandable that if alcohol dependence is the , that the emphasis of support would be treatment focussed, and this is what we see happening within both organisations. There was indication that current work practices are based on a deficit model- waiting for the problem to be apparent first before feeling it was legitimate enough to intervene. What is also evident is that the health promotion and prevention voice is silent. The following chapter (Chapter 6) presents the findings that explored the areas of "silence" and missed opportunities for health promotion emphasis in AWPs and practices in both organisations.

Chapter 6
Results: The Grey Areas

6.1 Introduction

This chapter presents the areas of uncertainty surrounding alcohol in the workplace as identified by the study participants and the documents analysed. The areas of uncertainty or policy grey areas encompassed hangovers, as well as missed opportunities for AWP and practices to be more health-promoting. This was a significant area to highlight because individuals operated within these grey areas, making decisions, and holding views about alcohol in the workplace context amidst the uncertainty. They filled any gaps with their own interpretations or other sources of information that were not necessarily outlined or endorsed by the organisational alcohol policies. It is important to understand this as an influence on implementation practices, and overall, how it contributes to, or hinders the health-promoting potential of the workplace. It is also important as it goes some way towards illuminating consistency issues around management, interpretation, and implementation of AWP.

6.2 What About Hangovers?

The first area that presented a level of uncertainty in the workplace was regarding hangovers. All participants knew what hangovers were, and the impact these can have on slower or poor performance at work if one attends work with a hangover. However, the uncertainty related to both Organisation 1 & 2 policies not making any reference to or giving clear direction about what to do in relation to employees attending work with a hangover. That is, except for vague mention of employees needing to “ensure they are fit to work”, which was open to interpretation. This lack of clarity understandably meant employees and managers would manage hangovers in the ways that they thought best. As the quotation below illustrates, there were however some suggestions of how workplace policies might address hangovers, (albeit with

some hesitancy) from some policymakers across both organisations- and there were different views about how this could be done, how it would be policed and what this would look like.

> *"Yeah, just as I say, it might be slightly difficult [writing hangovers into policy]. Or you could you know, just include it to say, you know, staff are expected to turn up for work in a fit state to be here kind of thing and that type of thing. It could just be a couple of lines….if staff are not deemed to be fit enough to be at work then they would be sent home or however, you know, however you want to put it. No, and that's it, and I think it would only really be, you know, if somebody really couldn't do the job and was sat there with their head in their hands while being sick or having to run off. It's that more severe, isn't it?"* Debra- Organisation 1 Policymaker

> *"Yeah, just just walking about the [organisation] like with a rough head and it's like a sore head and just like I've got a headache, and they've still managed to work but not probably a slower kind of work than usual I think people tolerate just think that's there they can see it as a norm you know but I often wonder if there wasn't if they couldn't work if there was sat in the office all day saying I'm hungover but because they're actually still managing to do the job but at a slower pace probably then I don't think it gets flagged up" Chloe*- Organisation 2 *Non-policy maker*

Some of the narratives highlighted there were no problems related to alcohol at work, although simultaneously they spoke of the frequency with which staff attended work while hungover. This gave a sense that hangovers were not labelled as a "problem" in the way that public health and Departments of Health might. However, part of the issue with hangovers was that they were a normalised part/outcome of drinking and thought to be associated more with younger workers and casual or temporary staff. Of the policymakers and workers who consumed alcohol, most admitted to having had at some point (in their younger days) gone to work with a hangover and there was an element of planning around how this could be managed around their work schedules.

> *It's [hangover] not acceptable. They know that it's not acceptable through, you know, through their own [professional regulatory body codes of conduct]. I mean, I'm sure, we've all come to work at some point with a hangover, we've all done it….But there's a difference between being slightly hungover and being incapacitated. And, you know, I can't, to be fair, I can't even, over the last two years, I can't think of an occasion when somebody's come in and they've even had a hangover. James*- Organisation 1 *Policymaker*

However, in the absence of policy or guidance clearly articulating a view regarding the problematic nature of hangovers, participants made sense of this in their own individual ways and managed it (in this grey area) by placing hangovers on a scale- where a mild to moderate hangover was acceptable. But the point at which it became unacceptable to attend work was a judgement made according to the extent that the hangover was likely to affect an individual's work performance and safety. There may even be an unwritten and unsaid expectation that it is preferrable for employees to attend work while hungover (if it was mild) rather than take time off sick as illustrated in the quote below, it shows a work ethic that will not allow alcohol to hinder work attendance, even when an individual is experiencing a hangover. It was interesting that here, work performance again was the main concern, and not necessarily the health or prevention of ill-health of someone experiencing a hangover

> *"I mean have I come to work with a hangover, I probably have. I have a social life at home, and I've probably come to work with a hangover but not terribly significant. I don't recall ever, ever having not gone to work coz of a hangover"* Stella- Organisation 1 Non-policy maker

There was also an element of planning around drinking practices that may be associated with work, or work colleagues. For example, in Organisation 2 where the policy was more prohibitive, the participants spoke of the routines and rituals they would follow to accommodate drinking or nights out, some involving taking the next day off work. However, in Organisation 1, were the policy was more permissive (except for safety critical jobs such as those

involving driving and handling machinery), participants seemed to talk more of shuffling things around and doing lighter work on the day after a heavy night of drinking. It was a process that involved making decisions and planning around how to manage their hangovers while still attending work.

> *So generally speaking, erm, the day after, it's a case of coming and go for coffee and breakfast straight away, then go back and try and sit quietly and just find… Really mundane, simple job that you can sit and do quietly, rather than interacting with people. So, it's compromising, isn't it? And just kind of… Seeing what you can shuffle around.* Nancy-Organisation 1 Non-policy maker

The complex nature of hangovers was also discussed, with some participants highlighting that it is still attached to stigma, and as such any solutions to managing it within organisations would need to de-stigmatize it and create opportunities for staff support in order to make an impact. The quotation below articulates this best.

> *"Well, you know, I think it's breaking down the barriers and breaking down that stigma. Obviously, it's the understanding from everybody that people do go home and have a drink and sometimes they do drink excessively for whatever reason……And, you know, again it's about understanding that and trying to support the individual if they are, you know, drinking excessively on a consistent basis. Because we all go out occasionally and get drunk and have a good time. And one of the ways, in fact, where an employer could recognise that is removing the stigma about hangovers. So, if you've gone out and had a drink, you know, come into our bar and you will find various sort of hangover cures or people you can talk to. I saw something on Facebook the other day… where is it in, somewhere in Scandinavia, it was in one city. It was in Amsterdam, I think, of all places, Amsterdam where there's a hangover bar. So, you go in, you've had a rough night or you've come straight from a club and you go in and it's got nice comfortable beds to lie on, lots of drinks and food which will help restore you, quiet music, and stuff like this. And I'm thinking, you know, you can be a bit cynical about it and have a laugh about it at the same time……it's really a support mechanism. It's saying, you know, I suppose the danger might be that if you enjoy the hangover bar, you're going to go out and do it again. But I don't think that's going to happen in the majority of cases, you know, it's not something you want to go there to but it's something nice*

> *and, you know, when you're feeling that way. And why wouldn't the employer do that because, you know, if you think about it, how much, I mean, this is where we talk about the data. How much sickness absence is related to drink? I mean, everybody, "Sorry, I've got a cold, I'm not feeling very well, blah, blah, blah….* We've all done that and really what it is, is we've just been out with our mates and we only got in an hour ago…..*I'm feeling rough, there's no way I can go into work but what about if I went into work and there was somewhere I could sit and relax for two hours and have some support and somebody to talk to and somebody saying, "Don't worry about it." It makes a difference, you know, and it raises the awareness then on both sides. And I think then, you've raised the awareness, I think in a psychological way, you probably don't want to do that too often. Because, you know, whereas the opportunity to just go out, get plastered and then ring in sick the next day is an easy one and everybody can do that without being penalised for it. Obviously if you did it every Monday, obviously HR are going to pick that up, but the majority of people don't."* Johnny- Organisation 1 Policymaker

In the absence of clarity on how to manage hangovers- employees and employers alike made up their own strategies, as illustrated by the quotation below,

> *"They would be taking a swig. And I remember [staff member], sometimes when he was drunk at work, his PA used to lock him in the office and make sure he couldn't get anywhere"* Johnny – Organisation 1 Policymaker

In summary, hangovers seem to have been experienced by most of the participants in the study (either personally or through colleagues) and given this occurrence it seems to be a real missed opportunity for AWP to address this in policy- legitimately because this can impact on safety, but also because a hangover symbolises drinking to excess which has health impacts too. It leaves the question of why are hangovers not addressed in policy. The current study goes some way towards showing the complexity of doing so, but more research is needed into looking at the feasibility and the best ways to do this that would not further stigmatize or result in covert responses if it is policed

more than it is now. The following section will explore further areas that lack clarity or represent missed opportunities for workplaces and AWPs to promote health.

6.3 Missed Opportunities to Enhance Health-promoting Potential

AWP development and implementation practices were characterised as having numerous missed opportunities to enhance the health-promoting role of policy and practices. For example, for a policy to truly represent the needs of the organisation an important part was having the data to inform the understanding of the workplace population needs- and this was lacking as demonstrated below. The importance of data was underscored as a way to ensure that not only are the workers needs understood, but this would create opportunities for workplaces to respond more appropriately to those areas of need in relation to alcohol.

> *"So, a health needs analysis, that's, we need to start the health needs analysis stage. Umm But without the data… we don't know what the organisation, the employees are suffering from"* Veronica - Organisation 1 Policymaker

There was also a missed opportunity for the workplace policy making to be more proactive and upstream. Policy was seen as being reactive, and there was no appetite to make any significant changes unless something drastically wrong or bad happened first to trigger a change or emphasis on policy. This was particularly the view in Organisation 1 where the AWP had not been reviewed since 2008. There is the suggestion that public health advice for promoting and preventing ill-health with regards to alcohol might not have been fully incorporated into policy making and implementation practices as these remain very dependence/treatment focused in the workplace setting. When contributors to policy making suggest a change in the policy there is

resistance to doing so, and health promotion although beneficial, is not necessarily seen as a priority by all. However, this view seems to be influenced by the perception that there are no actual problems with alcohol in a workplace context. This brings us back to the original issue of a lack of data to show the scale of the problem in the workplace. The following interview and AWP extract illustrates this,

> "…. *we have been campaigning ever since to try and have it [the policy] reviewed and changed but it's been reviewed and not changed. Because they feel that it's adequate for the organisational needs. Yeah, there is absolutely no appetite for that change….In fairness…we're not aware, overtly of any massive alcohol problem, it's the odd case here and there. But we all know that alcohol rates are increasing in, certainly in the older age group because they go home on a night and the first thing they do is reach for a glass of wine.* Veronica – Organisation 1 Policymaker

> *"Author: HR Directorate*
>
> *Version: Version 1*
>
> *Last Version Issued: October 2008*
>
> *Consultation process: HR, Union Representatives…*
>
> *Review Date: Not Stated" Organisation* 1 Policy Document

The policies showed lack of clarity on an issue that was central to staffs anxieties about alcohol and discipline. The policy wording suggested support would be provided to staff who divulge an alcohol problem and accept help, while on the other hand suggesting regardless of whether the alcohol use was a health problem or not, a disciplinary line of enquiry would be instigated. This was particularly the case if an employee's alcohol use was associated with poor performance or risk. This serves as a barrier for staff who are already worried about the implications of being open and honest about any struggles they may be having with their alcohol use. Furthermore, there is a missed opportunity to reinforce the support element which policymakers and managers say far outweighs the use of discipline in both organisations

> *"If, as a result of the investigation, it becomes apparent that the employee has a genuine alcohol/substance misuse problem, and the employee admits to this, the appropriate support rehabilitation will be provided.... In other than the most serious cases, where the manager and member of staff acknowledge the health problem and agree a course of action aimed at rehabilitation, disciplinary action will normally be inappropriate. There may, however, be occasions when some form of disciplinary sanction is warranted"* Organisation 2 Policy Document

There was a missed opportunity to present policy in clear and accessible ways. For example, participants highlight the inaccessibility, and sometimes impenetrability because of how they are written. There was a sense that this needed to be practical for everyone to read and understand, and this clarity was necessary to provide clear direction for managers to follow. For example, having a policy on the intranet assumes every employee has internet facilities, however this may exclude groups who do not have work (or home) access to the internet. This is a missed opportunity to be more inclusive.

> *"The policies are not that easy to read, as in literally it's just like words. What does that mean to me practically....., so to expect our staff, all of them, to be able to look at a policy, understand what that means to them in the workplace, I don't think it's always that easy. So then things like that get ignored and people don't follow the policies and procedures because it's, kind of, I don't get that. I learn better when I can sort of relate to it in context of the workplace or what I'm doing at the time, and I don't think I'm unusual like that. Sometimes, I know they're needed there for a reason and for legal reasons but is there a, like, dummies policy guide? You know, like Dummies Guide…*" Jo- Organisation 1 Policymaker

> *Because they send out a policy and we've got to adhere to it but then when you read it, it's not really workable. So, you could actually iron it all out before it came out… And some of these people haven't been on the shop floor for God-knows how many years. They don't know the real world… They don't know that you've got [a large workload] …like really? And you want me to put this policy in because…?" Mary-* Organisation 2 *Policymaker*

Some suggestions are for organisations to look for more creative ways to communicate their alcohol policies- more engaging ways that can help staff be more familiar with this because in the absence of more accessible and readable policies, staff make decisions about alcohol and process to follow - they fill in the gaps with their own knowledge from other sources which may not always align with the organisational position.

> *"I don't know really, I think, again, I know we've done, we've sessions here. There was one several years ago where [theatre company] did a kind of role-play scenario on the stage…..we all kind of watched it and it hit home because you could see what they were doing, as opposed to sat there reading…….Yeah, there was kind of, I guess it was facilitating and there was interactions and somebody asking questions and I guess people, it made people think a little bit more than….but, for me, that's kind of like, it's no use just giving a policy or something in writing and, tick box, you've been trained, or you're aware of it. Yeah, just a bit more…"* Jo – Organisation 1 Policymaker

Importance of consultation, with the right people was highlighted, and the need for policy to be developed from the bottom up however the narratives identified that there were missed opportunities to do so, for example engaging with individuals who may have experienced alcohol problems at work and their insights into creating workable, health-promoting AWP would be invaluable. The narratives identify that opportunities are not explicitly publicised for that chance to be involved.

> *"If there was people there on some, yeah, just working together on creating policies or, that make sense to the average person, that they're not too… I'm sure there'd be people that would……. But quite a lot of time, you get the impression that, and again, probably quite rightly for legal reasons, there's, decisions, and policies are put together without considering the people it impacts on"* Jo- Organisation 1 Policymaker

Although involving those with lived experience of alcohol problems in the workplace was recommended, it was also acknowledged there are challenges

to this. As identified by the quote from Stella, it can be very exposing given that employees may already be weary of revealing alcohol problems in the work setting, and there may also be logistics around how to identify those employees and potential issues to do with confidentiality. Nevertheless, one of the key findings from the data was that opportunities for involvement were limited as the below excerpts show.

> *"it's a really complex thing, because I suppose as an organisation, there's, there's two angles aren't they, there's the employees take on it, and then there's the employers take on it as an organisation, but then the people within that, enacting the policy and procedure representing the organisation and I imagine that some people are better than others at dealing with a situation like that that might be quite interesting to know what you know, if you would speak to somebody who has had alcohol problems and their work has known about that and has, then supported them through some sort of recovery it would be really interesting to know what worked for them……"* Stella – Organisation 1 Non-policy maker

> *"I mean, people are just a bit cynical about being consulted aren't they?, I think, you know, if, if, because we work for quite a big organisation, so that if they were to do some sort of consultation with the staff group as to what would be helpful and whatnot, if that person's anonymity could be assured, actually, in a big organisation, they are likely to remain anonymous. But in small organisations people just know what responses are coming from who don't they? but the thing with consultation is getting buy in from people, because how do you show them sufficiently Well of their anonymity and, yes, sort of not put them at risk really of compromising they're something that actually is a private issue, ……I think it would be quite hard to make people feel safe*. Stella- Organisation 1 non-policy maker

The potential to embed health promotion into existing structures is identified as a missed opportunity by participants from both organisations.

> *"I think it [alcohol workplace policy] needs to be prominent, I think we need to be reminded of it periodically and make sure that it's being revised regularly and not just allowed to fall off the agenda and then 10 years later you realize it's completely out of date with the guidance*

that's on it. Err, I mean, there's slight cost implications to that aren't there because it takes a person to be given some time to do that. or a group of people to do that. I think in the appraisal is there scope to say you know in an appraisal, how you've had all these documents? Are any of these err topics that you want to pick up on, do you feel there's anything you wanted to bring to the table today, I don't know. Is the appraisal is that all about performance review is it about actually nurturing staff…." Stella- Organisation 1 Non-policy maker

6.4 Chapter Summary

In conclusion, this chapter has highlighted the various areas that lack clarity in AWPs and practices. By spotlighting these grey areas and missed opportunities for the AWPs and practices to be more health-promoting, this naturally identified within participant narratives some suggestions for how these opportunities might be harnessed and enhanced in the future to better support alcohol health promotion at work. Next, Chapter 7 will present the study findings in relation to some of the underlying wider influences on drinking in a work context, and their relevance with regards to how alcohol health promotion can be enhanced in consideration of these influences.

Chapter 7
Results: The Wider Determinants, Meanings & Purpose of Alcohol

7.1 Introduction

This chapter presents participants' accounts regarding the varied reasons why drinking may occur – including context, what it means for employees when they consume alcohol, the influence of cultural or societal standards and the potential role of the workplace as a driver for drinking. More importantly, these were aspects and influences that the participants felt needed to be understood in order to inform any workplace policies or strategies that seek to support employee health promotion. These influences are best captured by the theme 'Wider Determinants, Meanings and Purpose of Alcohol' and will be presented in this chapter according to the sub-themes: Personal, & Socio-Cultural Meanings, and Environmental & Politico-Economic Considerations.

7.2 Personal & Socio-Cultural Meanings

This subtheme captured the personal, social, and cultural meanings that participants attached to drinking in the workplace context. The participants narratives often gravitated towards story telling about occasions where alcohol was consumed by employees, and the purposes for which alcohol was consumed in these instances. The first example which was common across participants in both organisations was that of alcohol being consumed as part of celebrations- including student graduations, staff retiring and team days or nights out. This put the workplace (however corporate) firmly in the social space which gave room for social activities that involve alcohol to occur. The differences were that Organisation 2, because of its prohibitive policy, alcohol was not available nor consumed on the premises, rather these were planned as team nights out. While Organisation 1 on the other hand, events or occasions involving alcohol consumption could happen during the working day as it had a more permissive policy, and alcoholic beverages were sold on

the premises. It was noteworthy that when asked about how drinking or consumption was guided, Organisation 2 participants were able to cite that their organisation did not allow alcohol consumption on premises. Whereas most participants from Organisation 1 had no recollections of what the policy said exactly, but they tended to refer to “expectations of being professional”, or they used other staff or managers drinking as a barometer for what was viewed as acceptable at events where alcohol was served. All participants from Organisation 2 felt that the prohibitive policy was the correct approach for this type of organisation to take. However, the policy for Organisation 1 which was more permissive and allowed staff to make their own decisions about consuming alcohol on duty (except for safety critical roles) received more mixed views about it. Mixed views where some agreed the policy was appropriate, while others suggested that even if the policy is permissive, no-one should consume alcohol while on duty. For some policymakers and non-policy makers who chose to consume alcohol during the working day in Organisation 1, they sometimes questioned themselves or wondered if that was acceptable or not. Dana and Debra’s interview extracts below demonstrate this.

> *“…. and if people wish to have a glass of wine or champagne, then they should be permitted to. You know, if you think of a wedding, you toast the bride. You know, if you think of public events, there’s usually alcohol there. So, it is very much entrenched in our culture, alcohol, yeah. Within the UK very much so….*” Dana- Organisation 1 Non-policy maker

> *“Interestingly we went out for Christmas lunch, just across, a few of us went across the road to [pub name] and a lot of us just had soft drinks but then the odd one or two did have an alcoholic drink and you kind of think, “Ooh, you’re going back to work in the afternoon and is that OK? Is it frowned upon?” I think one of the girls who was sat next to me, she said, “Well, can I have one?” It was like its kind of up to you and it’s a bit,*

> *you don't really know because you're at work, you sort of think you shouldn't…"* Debra- Organisation 1 Policymaker

In chapter 5, the finding that employees valued their colleagues to the extent of referring to them as 'work family' was highlighted. It is understandable then that when there are celebratory occasions such as staff retiring, colleagues would celebrate these in a similar way to how they would outside of work with their own families and other friends. For those that choose to consume alcohol, this would form an important part of those celebrations and momentous occasions. Other work-related drinking, particularly in Organisation 1 went beyond social cohesion with 'work family' and had meanings associated with professional networking and career development. One example (which was raised by several Organisation 1 participants) was that of an exclusive "old gentleman's club" culture that operated in the organisation canteen where there was a special table known to always be reserved for senior [staff] and managers. It was a table where alcohol was a key part of the meetings or gatherings that took place there. The table was even given a special name (which will not be mentioned here for anonymity purposes). This demonstrated how some entrenched workplace cultures that involve drinking may take place, and the deeper meaning or purpose that these serve beyond the simple act of consuming alcohol (for those that choose to drink). The interview excerpt below illustrates this best

> *"…. where the [restaurant] is, I don't know how long you've been here….. but before the refurbishment, there used to be the [restaurant name], so we used to do formal meals just through there. And there was always a [special table] were, what I'd class as old-school [staff] and I won't name names but there are still people [in the organisation] that would, they'd come in every lunchtime, this one table, and it was specific people would sit there. And they would, one particular gentleman might get a bottle of wine on a Monday, it might last him the week, he might need to top it halfway through the week, but he'd always have a couple of glasses of wine with his lunchtime meal. It just tickled us because we'd look at him like, "And then you're going to [work] afterwards? … they were just funny creatures of habit…. It's old-school people or people that have been doing it out of habit for years"*. Jo- Organisation 1 Policymaker

On a more personal or individual level, participants highlighted that there was something rewarding about having a glass of wine or a drink at the end of a long exhausting day at work. Alcohol was viewed as a treat with some looking forward to this as a way to unwind,

> *"You know, 12, 15-hour days, like long days… it [alcohol] was a nice little perk. But I guess times change, budgets became tighter, and they don't do that now [giving staff a free drink at the end of a shift]. I'm sure it wasn't part of the policy, it was one of those, on the quiet really….Yeah, because it was just a nice, it was a nice thank you, it was a little thank you that just, you've worked well, guys, so we've not stopped…. and it was at the end of the shift so people would be going home and it was, you know, those that were driving wouldn't or, you know, most of the people were walking or would share cars or whatever, it was just, yeah, it was an informal nice thing to end the night..." Jo*- Organisation 1 *Policymaker*

Another issue that was highlighted as a consideration for workplaces is the influence society has on what is viewed as acceptable. For some, increased and higher risk drinking is seen as a normal part of UK drinking culture and participants identified that it can be seen as a badge of a good night out. Furthermore, given that alcohol may be viewed as a way to unwind, some participants mentioned it becomes easy to justify the ways we drink - because there is a reason behind it. The two quotations below portray this view

> *"So that that glass of wine that happened every night in the evening, there was always a justification for it……. but it was sort of, it was pointing out that actually its becoming normalized to have an alcohol consumption that is actually on the brink of or just over the guidelines. And yet it not be deemed as an alcohol problem"* Stella- Organisation 1 Non-policy maker

> *"Some people don't acknowledge it [excessive drinking] as a problem because it's within the social norms. Everybody drinks."* Mary-Organisation 2 Policymaker

To summarise this section, we see that whether there is a prohibitive policy or a permissive one, employees will find ways to engage in activities that have meaning and give a sense of belonging, team cohesion, or professional development which may sometimes involve alcohol consumption. Alcohol consumption (for those that choose to partake) is a normalised part of UK society and culture, and although employees will generally fit drinking in around what policies exist, we see from the interviews that it was easier and clearer on how staff could plan this with a prohibitive policy. But where policy is more permissive there are a lot more variations and questions around what may or may not be acceptable. Alcohol serves many different purposes and has different meanings to those that choose to consume it within the workplace context. Understanding these meanings is important because it can enable better targeted and informed approaches to AWPs and practices that are aimed at promoting staff health. The next section will present further considerations that were environmental, economic, and political in nature, as influences on the extent to which policies and approaches to alcohol were or could be health-promoting.

7.3 Environmental & Politico-Economic Considerations

Environmental considerations were a key feature in the narratives with all participants mentioning the risk of employees using alcohol to cope because of increasing and relentless workloads. Participants across both organisations mentioned the constant change, state of flux and organisational restructures that often came with anxieties and uncertainties around involuntary change in job roles, redeployment and even redundancies. This was very relevant to how they conceptualised health and the causes of potential drinking problems, and this is an important consideration for workplace policy and strategies

because although an individual worker may choose whether to drink alcohol or not (and what other coping strategies they use), some of the factors that underlie those choices to drink were influenced by the environment that some workers had no control over. The environment was presented as a potential driver for drinking, while simultaneously (as seen in Chapter 5) hindering help-seeking despite the AWPs stating employees would receive support.

> *"There's always the in-house joke of it [work] drives you to drink. And I can understand that at the moment.... Yeah, because of the stresses that you are under. And I mean, it's like… I've never relied on alcohol, but I can see where some people it may do…you can see actually from different points of view, so you would either be attracted to it [alcohol], knowing what you do know from past experience. Or it drives you the other way, but it depends on the person then, doesn't it?* Christine-Organisation 1 Non-policy maker

Policymakers and non-policy makers from both organisations also engaged in some analysis around where the responsibility should sit, given that environmental factors can contribute to individual decisions about excessive consumption. The key essence of these contributions were about not only recognising that environmental and systemic factors can influence drinking, but that responsibility needs to be shared between employees and employers and solutions must reflect this shared approach. So, for example, not just having an expectation that the individual will engage in alcohol treatment (as that would be placing responsibility with the individual) but that the organisations can contribute to ensuring the environment is not so hostile to begin with, or that where environmental and systemic influences are identified that the organisations play a part in developing and implementing some solutions that are pro-health. The shared responsibility and action across all layers of the system were regarded as the ideal way to contribute to alcohol health promotion

> *“But then it’s difficult as well. Where does that ownership lie in terms of…you know, the things that are going on at work, it’s so hectic and it’s so busy that one of the impacts is that people are drinking more. There’s a responsibility of the organisation to do something, there’s also the person that has that individual responsibility…. You know, not everybody goes home and has a drink and has an outlook and we’re all different, aren’t we, but… I don’t know, So then you kind of think we’re all responsible for our own… For the way that we deal with scenarios, aren’t we? Nancy-* Organisation 1 Non-policy maker

The environment was also seen as having potential to be more protective, as shown by one participant in Organisation 1 who suggested that those who are happy in their job, have supportive colleagues and less work pressure may not feel the need to develop coping strategies such as alcohol consumption. And so, it becomes a conversation around environment and whether this can be improved as a preventative/protective measure reducing the chances of drinking being used as a coping mechanism to manage workload and stress.

> “*Yeah, I mean, I never once wake up thinking I don’t want to go to work, I'm quite happy coming in, like I said, just working with my lovely colleagues, and it’s just rewarding…. And obviously we don’t have the same pressures as [other staff], because when we leave the job on an evening, I don’t have to then go back and do loads of [work] or. We might answer a few emails and stuff like that and some of my colleagues will work outside their hours but generally, we have a good work-life balance, so I think that probably helps…. it’s maybe the stress levels that maybe have some kind of relationship to alcohol” Beth-* Organisation 1 Non-policy maker

From an economic perspective, there was an awareness of the challenges that both organisations were facing. Policymakers and non-policy makers from both organisations recalled stories of their experiences of cuts and cost savings which had resulted in colleague redundancies (and the workloads were redistributed amongst remaining staff). Other participants spoke of being lucky to still be employed but noted that their job security in the future was no

longer certain. Core services were not immune to these cuts as disinvestment in workplace health promotion interventions was also outlined by the participants who had the knowledge of this. And so, the challenge of finite budgets when it comes to health promotion was raised as a threat to alcohol policies and approaches being enhanced and there was less of a health promotion focus as a result. The excerpt from Stella's quote articulates this challenge.

> *"...and if you think about an organisation like this, how it's under the carwash financially, how are they gonna why would they just off their own back decide to prioritize the health of their employees, when there's so many other priorities that they're having to consider for me it falls, right down there, off the radar. Unless they're incentivized to do so…"* Stella- Organisation 1 Non-policy maker

Although on the other hand, some participants pointed out that prevention and health promotion should not cost organisations much, outlining the opposite where emphasis on treatment is likely to cost more if alcohol problems become more severe, they can take much longer to recover from. Stella's interview continues by analysing where the downward trend in public health steer for organisations began around areas such as alcohol, (and other healthy settings work in schools) - identifying the overarching influence of political agendas on what we see (or do not see) in relation to alcohol health promotion and other public health initiatives at an organisation level.

> *"…It doesn't have to cost lots of money to institute information giving, awareness raising, err support services and things like that. I just it's a no brainer to me I think organisations are weak that they don't grasp the public health responsibilities more assertively … of course public health were wiped out weren't it, in, was it 2012?...public health was all handed over to local authorities and was subsumed by their priorities and it was so close to moving towards organisations being nurtured towards taking the public health responsibilities more seriously that's my feeling. I think that the current political climate is completely undermining of the public health agenda, whatever the topic"* Stella- Organisation 1 Non-policymaker

7.4 Chapter Summary

This chapter has canvassed the importance of considering environmental, social, cultural, and personal contributors to drinking, and also the wider economic and political influences on the extent to which workplaces can focus on alcohol health promotion and preventative strategies. The chapter also shows that while the workplace (environmental factors) may be a driver for drinking, it is also unintentionally serving as a hinderance to help-seeking. When considering solutions, there is potential for workplace policies and approaches to acknowledge the environmental and systemic factors in order to embrace alcohol health promotion. Next; Chapter 8 delves into discussion about some of the factors identified in the study results as underlying influences on the health promoting potential of policy and practices around alcohol at work.

Chapter 8
Discussion

8.1 Introduction

The empirical study sought to investigate and answer the following question:

Research Question:

To what extent is AWP development and implementation underpinned by health promotion principles?

The specific objectives were to:

1- Explore how and why AWP are developed and implemented in the workplace.
2- Explore the extent to which health promotion theory and principles underpin the development and implementation of AWP.
3- Establish then analyse whether there are any factors that hinder or facilitate the processes of development and implementation from a health promotion perspective.
4- Explore how and in what ways policies and approaches to implementation of AWP can be enhanced to improve their potential for promoting healthy employee consumption.

To answer the research question, the study was underpinned by a health promotion theoretical framework consisting of Bronfenbrenner's Ecological Systems Theory and the WHO Healthy Workplace Framework. The current chapter discusses the results of the study (from chapters 5, 6 & 7) considering the health promotion theoretical framework, existing literature, and the study contributions. The following chapter is presented according to the contributions that the current study makes to the body of knowledge around AWPs and practices.

8.2 Empirical Contribution 1: Understanding the Persistence of Misaligned Voices regarding AWP and Practices

Through exploring how and why AWPs are developed and implemented in the workplace, and the extent to which health promotion theory and principles underpin AWPs (***Study Objectives 1 & 2***), the first key finding, and contribution of the current study is the identification of a range of persistent misalignments and tensions. The misalignments were between policy and the perceptions and practice of employees and employers regarding alcohol issues at work. The tensions mainly centred around health versus safety, and treatment versus prevention. This finding resonates with what previous literature has identified (Ames et al., 1992), however the current study advances understanding around the persistent nature of these tensions. Furthermore, the current study articulates how the persistent misaligned voices are contributing towards inconsistent approaches to managing alcohol problems and limiting the potential for alcohol health promotion in the workplace setting. The following section will discuss these persistent tensions in more depth.

8.2.1 Health vs Safety

In the current study, non-policy makers across both organisations perceived AWP aims as disproportionately focussed on safety and performance concerns rather than employee health. Notably, this view was misaligned with the reality presented by policymakers who assured both safety and health were regarded as equally significant priorities for the organisations. This health versus safety tension represented more than just a difference in perspectives. It seemed to be more about a fundamental divide between the ideologies that inform what ‘workplace safety and performance’ is about, and what ‘concern for health’ should look like. While it is not a criticism that these areas represented different ways of thinking, it was however noteworthy that

if employees did not connect with the notion that the workplace is equally concerned about their health, they would understandably be less likely to consider drawing on workplace support for any struggles they may have with their alcohol consumption. The misalignment was arguably reinforced by the very policies whose overarching emphasis on safety was evident throughout the wording of the aims, and in the explanations for how alcohol-related issues would be managed. The policy documents referred to health, but this was overshadowed by reference to safety, risk and employees being fit for work to enable optimum performance. Non-policy maker narratives gave some indication of why they strongly held the view that the workplace was more concerned about safety and performance. They explained that they understood AWPs as being originally conceived with workplace safety in mind. This resonates with literature that outlines the original rudimentary focus on preventing alcohol-related workplace accidents and providing guidance for workplaces to manage any alcohol-related issues (CIPD, 2007; Austin and Ressler, 2012; Alcohol Concern, 2014). At the time, health promotion was not traditionally viewed as part of the workplace remit (Williams, 1994). The main argument being that managers may not necessarily be experts in health; therefore it was more prudent to leave health matters to the health experts.

Debates on whether workplaces can legitimately go beyond employee safety and performance to encompass employee health have been discussed in the AWP literature over the last 30 years (Ames et al., 1992, Eriksson et al., 2004). It raises questions around why this continues to be a persistent tension. Particularly because the wider literature acknowledges that workplaces' role has evolved to encompass the dual duty to provide a safe working environment, as well as health promotion and prevention of ill-health through addressing lifestyles and psychosocial stress (Addley, 1999). The current study shows that for non-policy makers, the focus on health promotion regarding alcohol was not visible enough within policy. It is therefore understandable that employees may not ordinarily view the workplace role as one of supporting alcohol health promotion. This has relevance for practice

because if workplaces hope to support alcohol health promotion, it might be useful for them to consider how the message of alcohol health promotion is communicated and make this more visible within AWPs.

8.2.2 Treatment vs Prevention of Alcohol Problems

Having discussed the health versus safety/performance tension in the previous section, and the acknowledgement that safety/performance was viewed by employees as the predominant concern; it was interesting to note that non-policy maker narratives also simultaneously acknowledged their organisations duty to support individuals who struggle with alcohol dependence. The way in which the current study makes sense of this is that when health is considered alongside safety/ performance in a workplace context; the balance of the scale tips towards safety/performance as the predominant concern according to employees. However, when exploring the way 'health' was viewed as a concept on its own (through the health promotion lens) there was a notable divide between treatment and prevention. The workplace role was legitimately understood to involve focussing on 'treatment' as the approach to supporting employee health, rather than 'prevention'. For example, through engaging participants in conversation about whether they had seen any alcohol health promotion in their organisations, all participants said there was no visible alcohol health promotion. However, when asked about whether they felt the workplaces offer support for those who struggle with addiction, non-policy makers identified that workplaces would (or should) provide support for treatment. This finding identifies the persistence of another misalignment which centres around the tension between employee perceptions that workplaces limit their support to pathways of treatment for dependence, and not for the prevention of alcohol problems or alcohol health promotion. Focussing on treatment for dependence only is misaligned to the public health view that encourages consideration of both treatment and prevention to provide support for individuals with a wider range of alcohol problems (Babor et al., 2001). Moreover, the current study makes a novel contribution by illuminating how the tension is ultimately challenging and

limiting the extent to which AWP and approaches can contribute to prevention of alcohol problems.

Part of what underlies the persistent tension between treatment and prevention might be related to the way alcohol problems were framed. Alcohol problems and the articulation of what constitutes a health issue in the work context was framed by both organisations' policy documents in binary terms. The binary being, that alcohol problems at work are either a result of potential physical and psychological alcohol dependence (and hence treated as a health issue); or they are a behavioural problem. In the literature review (Chapter 2), it was highlighted that public health research on alcohol problems recognises different levels of risk (along a continuum) associated with drinking. These risk levels are identified by the World Health Organization's AUDIT screening tool as "low risk" "increasing risk/hazardous drinking" "higher risk/harmful drinking" and "potential dependence" (Babor et al., 2001). In the current study, participants (particularly those holding clinical roles within both organisations) recognised this continuum. However, when it came to managing alcohol problems (in a workplace context), they tended to do so according to the binary approach outlined in their organisational policies. This demonstrated that the binary view of alcohol problems might be affecting the way alcohol issues are managed at work. Lack of recognition of the problems that lie between the binary points is identified in the wider literature as '*low problem recognition*'. This is described as a characteristic seen in individuals who drink at increasing risk/harmful levels because they do not always identify themselves as having a 'problem' of dependence (Tucker et al., 2004). Efforts have been made to understand why individuals may frame alcohol problems in a binary way in the wider literature. For example, Morris and Melia (2019) explain that considering the complex nature of alcohol problems, the binary view articulates addiction in a simplified way. Even though this may be at the cost of overlooking any nuanced problems that sit within the continuum.

Low problem recognition was also particularly important to understand in a workplace context (as presented in the current study), because of the risk that this reduces the likelihood of individuals seeking help or support if they do not see themselves as fitting into the category of alcohol dependence (Morris and Melia, 2019). This might be one explanation for some of the non-policy maker responses in the current study. Viewing alcohol problems in binary terms might have influenced how employees (with low recognition of alcohol problems along the continuum) responded to their colleagues in the absence of them exhibiting the signs normally attributed to alcohol dependence (e.g. repeated use of alcohol despite any negative consequences). The current study contributes insight into how low problem recognition or framing of alcohol problems influences the way participants approached alcohol in the workplace.

Low problem recognition or problem framing may also potentially be contributing to the persistence of the treatment versus prevention tension. It was evident that both organisations were very well set up to support treatment for dependence through occupational health and signposting colleagues to specialist alcohol or addiction services. However, when participants described undertaking alternative ways of managing problems not identified as dependence (e.g., the occasional colleague hangover being managed by locking them in the office to ‘sober up’), this illuminated the point that the organisations AWPs did not have clearly articulated ways of managing problems that fell outside of the ‘dependence’ category. That is, except for the case of the policy for Organisation 1 which states occasional policy infractions would be viewed as behavioural misconduct and therefore subject to potential disciplinary action. There seemed to be a gap in terms of recognition and provision of support for colleagues along the fuller AUDIT defined continuum of alcohol problems. This meant individuals who were consuming alcohol at increasing or higher risk levels may not be receiving alcohol health promotion advice and support in the workplace setting. Problem framing and low problem recognition is discussed in the literature with regards to the wider population.

The current study presents a unique contribution to understanding alcohol problem framing and low problem recognition in a workplace context.

What the current study also shows (regarding emphasis on treatment and less focus on prevention) is that the disease model of alcohol problems remains prevalent. The disease model presents alcohol dependence or addiction as a disease (Moore et al., 2017). The literature review showed a pre-occupation with individualised approaches to managing dependant drinkers in the 1990's (Godfrey, 1993). On the other hand, the Ecological Systems Theory provides a holistic approach that recognises individuals, societal structures, environment, and biology as impacting on health, and ill-health (Bryan, 2009). Considering the Ecological Systems Theory in the current study was illuminating because it revealed that the disease model of health and addiction dominates how alcohol problems are perceived in the workplace, and this lies only within the microsystem. For workplaces, just like in the wider population, it is necessary to go beyond focussing only on dependant drinkers and adopting AWPs and approaches that address all employees that drink alcohol. This will help maximise the opportunity to support health and well-being at work (Harkins et al., 2008). The literature also identifies that the larger proportion of alcohol related work performance problems are from individuals who periodically drink excessively but are not dependant on alcohol (Weise et al., 2000). Moreover, in line with the seminal work by Rose (1981) on the prevention paradox, (which suggests greater population health gains can be obtained by also focussing on reducing alcohol misuse in the far larger population of non-dependant drinkers); it can be concluded that AWPs that limit their focus to dependant drinkers only may be missing the opportunity to contribute towards health promotion and primary prevention of alcohol related problems.

8.3 Empirical Contribution 2: The Unintended Consequences of AWP Development and Implementation

Through exploring whether there were any factors that hinder or facilitate the health promotion potential of AWP (***Study Objective 3***) another key contribution of the current study is its identification of the unintended consequences that AWP development and implementation has had. Literature describes unintended consequences of policies or interventions as the unanticipated positive or negative policy or intervention effects that developers of the policies/approaches may not have originally conceived (Oliver et al., 2019). The body of empirical literature on AWPs has not explicitly identified unintended consequences of introducing and implementing AWPs. This gap has also been highlighted in a recent systematic review exploring the implementation of workplace-based policies or practices on tobacco, alcohol, diet, physical activity, and obesity (Wolfenden et al., 2018). The current study fills this gap by uncovering some of the unintended consequences of AWP development and implementation and exploring what these mean for employees and employers regarding approaches to supporting individuals who may be struggling with their alcohol consumption. The following section will outline how the unintended consequences are hindering AWP potential to support employee early help-seeking. It will also articulate how the unintended consequences result in different or inconsistent responses to alcohol problems at work.

8.3.1 Preventing Early Help-seeking

Participants in the current study outlined that they (or their colleagues) would more likely hide alcohol problems than seek help earlier in a workplace context. This is an unintended consequence because despite the policies from both organisations encouraging employees to seek help early; the AWPs were inadvertently driving alcohol problems underground and reducing potential for early help-seeking. Non-policy makers explained that not seeking help earlier was not about rejecting any potential support, but rather, it was based on the

fear that divulging an alcohol problem to a manager would put them or a colleague under scrutiny and risk disciplinary action. This fear was reinforced by the policy wording which was very clear on the potential for disciplinary action even if the alcohol concerns were regarded as a health issue. This was particularly the case where any problematic alcohol consumption intersected with risk to the safety of the individual or others. The reality however was that employers and policymakers outlined that discipline was always a last course of action, and both organisations were much more supportive in their approach to assisting individuals who may need help regarding their alcohol consumption. Nevertheless, the significance of the fear that non-policy makers had about discipline and dismissal was that it would mean potential loss of income and pose a threat to an individual's survival and their ability to look after themselves or their family. It presents a threat to some of the most basic human needs and rights which are about survival, and security (Kunst, 2017).

Unintended consequences happen for various reasons such as poor policy design, lack of clarity regarding policy procedures or goals, and inappropriate evaluation techniques (Oliver et al., 2019). It was evident in the current study (as already identified in Chapter 8.2), that a lack of clarity about the AWPs health promotion intentions meant staff were not able to re-conceptualise the workplace as being concerned about their health when it came to alcohol related issues. Furthermore, in this case, they would not be able to re-conceptualise what early help-seeking for alcohol struggles might mean in a workplace context (aside from the view that it would lead to scrutiny and disciplinary action). The current study findings resonate with the outcomes of a recent survey by CIPD (2020) which highlights there was a lack of information or clarity in over two thirds of organisations regarding what happens once an employee divulges an alcohol problem. If the current views around AWP being associated predominantly with discipline and dismissal are to be dismantled or reframed, more work is required to understand how this can best be done. Furthermore, working with employees and ensuring clear

communication of the organisations commitment to alcohol health promotion will be of paramount importance.

Another finding in the study related to how AWPs (such as the prohibitive policy of Organisation 2) created a norm whereby individuals who went against that norm and drank alcohol at work were relegated to the edges of that environment because of their ‘unacceptable’ behaviour. For some participants, this ‘pushing to the fringes’ created stigma around being associated with consuming alcohol at work and having resultant alcohol related problems. Furthermore, the stigma perpetuated the reduced likelihood that individuals would voluntarily admit to having alcohol problems. The study highlights that stigma combined with fear of discipline or loss of a job was enough for participants to be reluctant about divulging any alcohol problems at the early stages. The key issue being the introduction of AWPs and the shift in expectations around alcohol and the workplace over time may have inadvertently driven alcohol problems underground and reduced the chances for early help-seeking.

Although unintended consequences are not always avoidable, they ‘*could be partially mitigated by better use of theory and evidence, better involvement of stakeholders in concurrent design and evaluation of policies, and appropriate evaluation systems’* (Oliver et al., 2019, p1). In the current study, better involvement of employees was a recommendation made by non-policymakers who were acutely aware of the lack of publicised opportunities for policy development involvement. From the perspective of enhancing AWP health promotion potential, this resonates with recommendations from the WHO Healthy Workplace Framework which places worker involvement in policy and intervention planning as a key consideration for workplaces (Burton, 2010). The current study goes further to suggest (according to non-policymaker narratives) that employees who have experienced alcohol problems in the work setting would be an asset to developing workable realistic policies and

approaches that are supportive of employees at any stage of their experience with alcohol problems.

Involving individuals with lived experience of alcohol (or drug) problems in the development of policy and approaches in the workplace is underscored in the literature (Association of Participating Service Users [APSU], 2020). It is therefore important for organisations to consider the practicalities of how to do this, particularly because of the unique challenges in the work setting such as fear of divulging alcohol problems, the stigma and marginalisation that individuals with lived experience of alcohol problems may face (New South Wales Ministry of Health [NSWMH], 2005). Organisations would need to ensure that the work environment is one that employees can trust, and that they feel safe enough to openly speak with confidence about their experiences and thoughts about what might enhance AWP and approaches to supporting individuals experiencing alcohol problems. There would also be a need for organisations to create an environment in which employees feel their participation is welcomed, and that their contributions will be respected and valued (NSWMH, 2005). Organisations might find it helpful to also think about how involvement might take place, for example, considering an appropriate level of involvement from the spectrum of choices such as ***consultation*** (where employees provide feedback on plans, proposals, and processes) and ***co-production*** (where employees have equal involvement as employers in the development and evaluation of policies and approaches) (National Mental Health Commission, 2018). Organisations may also consider in person involvement of individuals with lived experience; anonymous canvassing of wider staff opinions and recommendations which would ensure staff anonymity. Furthermore, organisations can consider involving representatives or advocates from consumer organisations that might contribute on behalf of groups of individuals with lived experience of alcohol problems – this would also offer individual employees a level of anonymity (National Health and Medical Research Council [NHMRC], 2018). More research is however needed that explores effective ways to achieve meaningful involvement of individuals with lived experience in AWP and approaches in an organisational context.

8.3.2 Inconsistent Approaches to Managing Alcohol Problems

The current study identifies that non-policy makers were sometimes using informal processes of managing colleague alcohol-related problems. This was despite having the organisation AWPs to guide their response to supporting colleagues who may be struggling with their alcohol use. For example, when managing colleague hangovers - this ranged from locking a colleague in the office for them to 'sober up'; to re-arranging ones working day so that they had a 'lighter day' to enable working while hungover. This may be an unintended consequence because as highlighted by CIPD (2007), AWPs were conceived with the aim of introducing consistent ways of managing alcohol problems. However, in the current study the findings show this was not always the case. One explanation for this might be that the AWPs in both organisations did not make explicit mention of how to manage hangovers or issues that were not necessarily associated with potential alcohol dependence. In the absence of more specific policy steer around managing alcohol problems that fall outside of the dependence category, it is understandable that participants responded to arising situations using the best ways they could. There is an opportunity here for workplaces to offer more explicit guidance as part of their AWPs to enable more consistent approaches to managing the range of alcohol problems.

8.4 Empirical Contribution 3: Theoretically Underpinned Understanding of AWP and Workplace Drinking

Another novel contribution of the current study is its use of the health promotion theoretical framework (comprised of Bronfenbrenner's Ecological Systems Theory and the WHO Healthy Workplace Framework) to explore how and in what ways AWPs and practices could be enhanced to improve their health promoting potential (***Study Objective 4***). The importance of theoretically underpinned research is underscored (as noted in Chapter 3),

because it strengthens research findings and the potential for implementation of the findings into practice (Petticrew et al., 2004). The following section presents an overview of what the study contributes as a result of having undertaken the research through the health promotion theoretical framework lens.

8.4.1 Political Considerations

The Ecological Systems Theory (in its outermost **macrosystem** and **chronosystem** layers) acknowledges that any health promotion activity is set against a backdrop of wider political and policy influence on health. It is important for this to be recognised. In this study, considering these outermost layers of influence brought into sharp focus some of the drivers for the decisions participants made about whether to drink in a work context or not, and what types of policies and approaches were adopted around alcohol in the two organisations. For example, drink driving law was identified as a major influence on whether participants and their other colleagues chose to consume alcohol or not, and also how much they consumed. Participants across both organisations described in great detail scenarios where ritualistic planning took place around team days or nights out, operating a designated driver system or ensuring that taxis could be hired to take individuals home after a day/night of drinking. All this was in line with adhering to drink driving law. The study demonstrates that wider legislative or regulatory policy has the potential to influence practices at an individual and organisational level. In the background chapter (Chapter 1), the current national policy and strategy in the UK does not clearly articulate the alcohol health promotion role of the workplace, and this represents a missed opportunity to provide national support for alcohol health promotion in workplace settings.

From a political ideology perspective, drink driving law can be identified as an example of a paternalistic policy/approach, where population members are instructed not to drink and drive. It is understandable that drink driving law is

there to ensure not only the safety of the individual who is drinking, but it is also to protect the safety of others. This paternalistic approach was evidently working at least to deter drinking and driving of employees interviewed as they took into consideration that responsibility when they were on team days or nights out. Drink driving law was an external influence on the participants' individual practices around drinking. Likewise, considering the policy for Organisation 1 which only stipulated zero tolerance for safety critical jobs like drivers, this too was influenced by an external paternalistic policy climate. For example, law under the Transport and Works Act 1992 was adhered to, as it stipulates that it is a criminal offense to operate or work on the transport system while unfit due to alcohol or drug use (Smithee, 2017).

Considering the internal workplace context (prompted by the **Core** area of the WHO Healthy Workplace Framework), both organisations operated AWPs that were paternalistic, however they had slightly different policies, which may partly be due to the type of setting and the influence of different political ideologies in these settings. To understand this a little bit more, it is necessary to first explain that there are variants of paternalism - hard paternalism (i.e., restricting alcohol consumption altogether), medium paternalism (i.e. tax or subsidies), and soft paternalism (i.e. nudges) (Kirchgässner, 2017). With these levels in mind, having a policy that did not allow any consumption of alcohol at work, Organisation 2 can be described as taking a 'hard paternalistic' approach to its policy making and this is justified on the grounds of reducing potential third-party harms to the public. The central argument of third-party harms is obtained from John Mills' Harm Principle which indicates that the government can legitimately coerce or exercise power over community members if this means preventing harm to others (Sunstein, 2014). On the other hand, Organisation 1 with its 'hands off' nudging approach, was more indicative of a softer version of paternalism. Holland (2007) outlines that even in a predominantly liberal political climate, some paternalistic approaches may be adopted in cases were there may be the potential of third-party harm (to others in the vicinity of the individual). Either

way, in the current study, both organisations took the paternalistic approach to policy in recognition that there is a need to prevent third party harm, and if an employee chooses to drink at work, they are liable for any harm they may cause to others in their work environment.

When it came to having policy, both organisations adopted a paternalistic approach where workplace safety was concerned - with Organisation 2 taking a harder line across the whole organisation than Organisation 1 (although the Organisation 1 was equally hard paternalistic where specific safety critical roles were concerned). However, when viewing the policy approaches from a health promotion perspective, the approaches were firmly liberal and individualistic in both organisations - meaning, individuals had the choice to seek support if they needed it. This approach respects the right for individual workers to exercise their personal liberty, autonomy, and individualism. The difficulty with ideologies that emphasize individualistic approaches is that they may not fully appreciate the wider factors that can influence the decisions that individuals make (Shain and Kramer, 2004). This can fuel inequalities, for example, because those who are better off financially and not dependant on the state for support will fare better with their health (Massey, 2009). Furthermore, choice without the factors that facilitate positive choices (such as balanced workloads, and job security which most participants from both organisations said they did not have) gives the impression that individuals are in full control, when to some degree it is those wider factors that may influence whether employees decide on a positive or harmful direction regarding alcohol consumption (Shain and Kramer, 2004).

Health presented as an element of an individual’s behaviour could lead to the assumption that victims are fully to blame for their own illnesses because alcohol consumption is regarded as a modifiable health behaviour. In the case of alcohol and addictions, the blame culture is very prevalent. Some of the policymakers and non-policy makers in the study were cognisant of this, outlining that at the end of the day, regardless of workload pressures or any

other external factors, employees still have the choice. While some may choose to use alcohol excessively to cope with stress, others may choose exercise instead. Victim blaming can be reduced by acknowledging that individuals have some responsibility for their health and the choices they make, and evidence suggests some genetic and epigenetic factors (Morozova et al., 2012). But some of the responsibility lies within the macro-level factors such as policies that influence people and their health (Bean, 2008). The WHO suggests a narrow focus on the individual risks missing out opportunities to influence the wider workplace factors to improve health (WHO, 2010). Despite some paternalistic policy interventions like workplace policy, literature does continue to show that policy interventions alone may not work for some groups of alcohol consumers, and it is therefore important to consider personal and wider workplace factors (James et al., 2021) in order to build a multi-layered approach towards harm reduction and alcohol health promotion.

8.4.2 Environmental Considerations

The quality of environments and how to shape healthy settings for healthier lives has been spotlighted in the current public health domain. In relation to alcohol (and drug) use, the CIPD (2020) outlines the importance of greater preventative action and employer support particularly during difficult social and economic times when individuals are likely to be more vulnerable and experience greater anxiety. Now presents an opportune time for workplaces to rethink approaches and move beyond the individualistic and deficit-based models of AWP and practices. The role and relevance of health promotion that encompasses the work setting presents a useful starting point. Literature highlights that the workplace setting can either be a driver for drinking, or it can be designed to protect against work-related drinking (Ames et al., 2000). This section of the discussion will explore environmental influences further in relation to the study findings and existing literature.

When considering the work environment, WHO (2010) outlines that it is easy for workplaces to focus on the 'physical' aspects of the work environment because the workplace health revolution began with an emphasis on reducing physical work hazards. The concern for physical safety at work is also where the drive to condemn drinking in workplaces started during Victorian times, because alcohol impeded the ability of workers to safely operate machinery/equipment (Nicholls, 2009). In the current study, the emphasis on safety was discussed in Chapter 8.2 as one of the tensions and misalignments seen in the data. To expand on this, the WHO Healthy Workplace Framework presented an opportunity for examining factors beyond the '**Physical Work Environment**'. It created an opportunity to spotlight the other spheres of influence such as the '**Psychosocial Work Environment'** which suggests that if workplaces take action to improve the psychosocial elements related to the workplace, this can contribute to improved employee health (Burton, 2010). The psychosocial work environment and its relationship with potential alcohol use came into sharp focus when participants across both organisations in the current study identified sources of workplace stress such as increasing workloads, constant change, and job insecurity as legitimate drivers for drinking. These aspects were not always considered as part of AWP development, nor the general health promotion approach in the organisations within this study. However, they were recognised by policymakers and non-policy makers as a constant underlying threat for developing alcohol problems. The perception of work overload in existing research has been shown to have a strong association with injuries among young workers, and psychosocial hazards can be associated with injuries in either a direct or indirect manner (Wickizier et al., 2004). When employees lack sufficient influence over working conditions, they may also lack the control necessary to reduce any risks associated with their working conditions. As an indirect threat to health, workers experiencing psychosocial hazards may have poorer sleep hygiene, experience low mood and increased likelihood of turning to excessive alcohol use as a coping strategy (WHO, 2010). All policymakers and non-policy makers from both organisations in the current study spoke of the heavy workloads that were outside of the employees

control; redundancies that resulted in the remaining colleagues being required to absorb additional workloads left by the departing staff; and the emotional toil that this took. All this was acknowledged by the participants as potential drivers for drinking problems.

The environmental influences trigger a realisation that approaches to health promotion are still tailored predominantly to the physical health environment than on the psychosocial environment, although more research and efforts are being made to improve the latter (Giles et al., 2017). In addition to a focus on physical safety, the current study showed that there is still a preference for an individualistic approach (with the emphasis being on offering support and treatment for those who may be dependent on alcohol). Individual (personal health resources), resilience and sense of self efficacy are important, however the physical and psychosocial aspects of the working environment such as workload can influence the extent to which workers can care for their own wellbeing or maintain their own personal resources (Shain and Kramer, 2004). The evidence regarding workplace health promotion indicates that programmes will only be effective at enhancing employee health and wellbeing when the interventions address individual as well as environmental factors (Shain and Kramer, 2004; Chartier et al., 2017).

What this thesis uncovers is that while individualistic policy approaches present the intent to support individuals with alcohol dependence problems, they can inadvertently place blame on the individual if there is failure to fully recognise the role of environmental influences. The study echoes what is known in the wider literature about the need to consider job design, workload, and contributes to knowledge by presenting potential opportunities to address this in a more meaningful way. For example, policymakers and non-policy makers across both organisations highlighted that additional support could be offered through appraisals - managers addressing some of the potential

stressors like work design and balancing workloads. Such conversations may be sensitive in nature; however, James et al. (2021) underscore the importance of these conversations as part of workplace health and safety education and occupational health assistance to enable provision of appropriate advice and support. There were also suggestions that opportunities to incorporate alcohol screening and brief interventions in the workplace would allow for early identification (and early support) for employees who may be consuming alcohol at an increasing or higher risk level. Furthermore, the narratives in the study suggested that opportunities for earlier intervention should be incorporated into AWP to show workplace commitment towards alcohol health promotion, and not just treatment for alcohol dependence alone.

8.4.3 Socio-Cultural Considerations

The socio-cultural purpose that alcohol serves in a work context was evident in the current study. Any effective policies and strategies would need to understand these socio-cultural meanings to ensure they are responsive and appropriately targeted to the context. The following section explores this in more detail.

The workplace as a social space was highlighted throughout the policymaker and non-policy maker narratives, with a recognition that alcohol served a very specific purpose for some employees across both organisations. Contrary to the perception that the workplace is a corporate space, the narratives gave the sense that the 'corporate' and the 'social' were intertwined. With colleagues spending much of their time together in the work setting (for those working full time, that is approximately 37.5hrs per week), hence, that feeling of colleagues being regarded as a '*work family*' was highlighted in the narratives. Alcohol served a purpose in the workplace, and this echoes what the literature says around the role of alcohol in building work connections

(Graves et al., 1982 cited in Social Issues Research Centre, 1998). The WHO Healthy Workplace Framework and the Ecological Systems Theory both recognise the role and relevance of the social/interpersonal element, emphasizing that these interpersonal influences (such as relationships with other colleagues) are a significant contributor to health and wellbeing. Most people are naturally social and may seek to belong in the settings that they enter, and this was evident in the ways that the narratives explained how alcohol (for those that choose to consume it) played a part in aspects of their work relationships and functions.

Alcohol has a symbolic function as well in the workplace. Literature refers to drinking (like rituals) being a vehicle for constructing the world and defining key transitions in life (Douglas, 1987). For example, alcohol served at momentous occasions such as student graduations and staff retirements in this study, it demonstrated that alcohol was a ritualistic marker for these occasions. This is embodied in the literature with regards to the types of alcohol served as well- with prosecco and champagne often being the alcoholic beverage of choice for these key celebratory moments. It is understandable how drinking in these contexts becomes a social act that facilitates colleagues social bonding (Douglas, 1987). This was seen in the current study through the participants often becoming animated when they recalled planning for team days or nights out which sometimes involved alcohol consumption. Participants also identified that the ‘social lubricant’ effect of alcohol allowed some colleagues to be more open with each other and speak more freely about any work related challenges they may be facing.

In the study, non-policy maker and policymaker stories captured their views regarding alcohol at work, sometimes using stories related to workplace drinking culture seen in television programmes such as Madmen which showed what was acceptable in the 1950’s and what has evolved into unacceptable practice in some workplaces today. The literature has many

examples of the significant socio-cultural elements associated with work related drinking. The office drinking culture which was prominent until the late 1960's and work-related functions that often-involved alcohol were seen as a way to keep employees around for longer hours while fostering internal connections (Ames et al., 2000). Even where AWPs were in place, supervisors or managers were known to tolerate drinking during work hours for purposes of ritualized celebrations, sales activities, worker solidarity, and avoiding work disruption (Ames et al., 2000). Shifting towards contemporary practice however, there is a less permissive culture regarding consuming alcohol during work hours, dependant on the workplace culture, environment and nature of the organisation or job roles.

8.5 Chapter Summary

Using the health promotion theoretical framework exposed the entangled range of factors that employers and workplaces need to take into consideration when approaching alcohol health promotion and the development of AWPs in the work setting. The discussion chapter highlighted those debates which are seen in wider society regarding alcohol problem framing, emphasis on dependence and treatment rather than prevention, and tensions between paternalism versus collectivism are all mirrored in the workplace setting. The discussion also demonstrated how some of the issues debated (such as how the introduction of AWPs may have had an unintended consequence of driving drinking problems underground) have hindered the potential for AWPs to be health-promoting because employees are more likely to hide problems rather than be open about them at the earlier stages.

The chapter also analysed the continued focus on individualistic approaches in policy and interventions for employees who may have alcohol problems. Furthermore, that the individualised approaches can fuel problems of stigma, and fail to recognise the influence of the work environment in the development

of alcohol problems. There is a need to consider the workplace environment (such as employee workload) and other wider factors such as societal views, socio-cultural meanings, and the purpose that alcohol serves for employees that choose to drink, as these all have some bearing on how alcohol problems are viewed by employees and employers. This also has some bearing on how support structures are consequently set up in the work context (which in the present study represented available support for treatment and not for prevention). The findings from the current study outline that workplaces are interested in supporting employee health, and their systems are set up to support those struggling with alcohol dependence, however when this is viewed through the health promotion lens, the approaches currently used are more reactive rather than proactive. Adopting more proactive approaches such as AWPs that address all risk levels associated with drinking would go some way towards providing opportunities for health promotion and prevention of more severe alcohol problems developing.

The next chapter (Chapter 9) will provide a critical reflective account of the research process and my experience as the researcher. Then Chapter 10 will bring the thesis to a conclusion, highlighting some recommendations for research policy and practice that are informed by the study results and the areas explored within the current discussion chapter. In addition, Chapter 10 presents a '*10 Point Checklist for Healthy Alcohol Workplace Policies and Practices'* that I have developed based on the key areas from the current study findings and discussion. This checklist makes a novel contribution to the body of knowledge, and workplaces/policymakers can use it to enhance the health promoting potential of their existing AWP development, implementation, and evaluation processes.

Chapter 9
Reflexivity

9.1 Introduction

Reflexivity and reflection in research practice are important. Although there are different approaches to reflection and reflexivity (Alvesson and Skoldberg, 2018), a key element particularly for research that draws on qualitative methodology and methods, is the *"critical self-reflection on one's biases, theoretical predispositions, preferences and so forth [acknowledging that the researcher may be] part of the setting, context, and social phenomenon he or she seeks to understand. [Reflexivity] can be a means for critically inspecting the entire research process*" (Schwandt, 2001 p. 224). It is with this in mind, that the following chapter offers an open and honest reflection on some of the key experiences, study strengths, limitations and reflexivity into my positionality and influence as a researcher in the current study.

9.2 Recruitment, Data Collection and Analysis as an Insider Researcher

The methodology chapter (Chapter 4) offered some reflexivity in relation to my positionality (constructivist epistemology and relativist ontology), and how this influenced the study development and plans for undertaking recruitment and data collection. The current section builds on that by reflecting on the recruitment, data collection and analysis processes in relation to my 'insider researcher' status. I was an insider researcher in one of the organisations because I was researching a social group that I was also a member of (Greene, 2014). This meant I had prior knowledge and understanding of the group studied, and this offered me many of the literature acknowledged advantages such as having an already established rapport with some participants and therefore easier access to potential participants (Greene, 2014). My experience mirrored what has been acknowledged in the literature

with regards to my insider knowledge making it easier to recruit because I knew who to contact for access/recruitment permissions and processes were much quicker than they were for the organisation where I was an 'outsider researcher' (Unluer, 2012). Furthermore, once the recruitment email was sent, it was easier for colleagues to spontaneously ask questions about the study when they came across me on the organisation premises. On reflection, my insider status may have had some bearing on who volunteered for the study and may have led to more participants volunteering than in the other organisation where I was an 'outsider'.

I remained mindful that my prior knowledge and insider member status could lead to potential biases and challenges. For example, having existing knowledge of participants' roles and some of their day-to-day experiences regarding alcohol at work meant it was easy to overlook asking these questions directly in the study. I put in place strategies to mitigate this risk and increase the trustworthiness of the study by ensuring I developed and followed the interview schedule which prompted me to ask questions regardless of whether I already had the answers to these as an insider. It was also important for me to communicate this with participants- the following extract demonstrates how I incorporated this into the interviews

> *'Thank you for volunteering to participate in this research study… I am mindful that I already know your role in the organisation, but for purposes of the recording and collection of data, would you be able to start off by telling me what your role is within the organisation…'*

During the interviews, I also remained cognisant of what O'Leary and Hunt (2016) identify as the potential power dynamic between the insider researcher and participants. In a couple of the earlier interviews with participants who knew my nursing background and interest in alcohol health promotion, they mentioned *'...you will probably know a lot more about this topic than me actually…'* therefore it was important for me to redress this by communicating the value of their perspectives and that even if they were not necessarily

experts in alcohol, their ideas, experiences, and thoughts would help develop a broader understanding of the topics discussed. This was aligned with my constructivist epistemology, and relativist ontology - valuing subjective multiple realities and believing that knowledge is constructed.

For both organisations, I found value in sharing some of my experiences and stories and these reduced chances of the interviews feeling like one sided interrogations and created an environment where construction of knowledge could occur. For the organisation where I was an ‘outsider’, sharing my stories was particularly useful for building trust and rapport. I did however have to acknowledge the potential for the approach to ‘sharing my experiences’ to influence the study direction somewhat. To mitigate this risk, I ensured my analysis and interpretations were grounded on the participants views rather than what my own experiences and views were.

9.3 The Balance Between Anonymity and Thick Description

As a healthcare professional I have always valued and upheld the need to maintain patient confidentiality and anonymity; I see this as a moral and ethical obligation. Therefore naturally, confidentiality and anonymity were at the forefront of my mind when I designed the research study. Chapter 4 details all the steps I took to maintain participant and organisation anonymity such as using pseudonyms and not identifying participants specific job titles. However, after the first draft of the case study write up, my supervisors identified that some areas of the case study (even though anonymised), were inadvertently compromising the organisations and key participants’ identities. I had to look back at the whole thesis and realised I was faced with one of the challenges highlighted in the literature, which is the tension between providing the thick description and contextual details of places, events and people that are a key feature of case study reporting (Stake, 1995); and the need to maintain anonymity of the organisations and participants (Bickford and Nisker, 2015). I

found that my initial attempt at providing thick description compromised anonymity in the current study. For example, providing organisational statistics produced by the organisations themselves (from the public domain) meant I was citing the organisations by name. Describing the roles of participants (to provide context to some of the views expressed) made it easier to deduce who they were because some had unique job roles within the organisations. I decided to privilege anonymity over some thick description to honour the anonymity that I had assured in the research proposal and ethical approval. Therefore, in my revised reporting, I anonymised the organisations by labelling them as ‘Organisation 1’ and ‘Organisation 2’; and anonymised sources of data that were authored by the organisations (in the references and reference list). I also used what Bickford and Nisker (2015) refer to as ‘square bracketing’ within the reporting of direct quotations to obscure some details which could identify the organisations and participants. This has been a learning curve for me because it demonstrated that anonymity needs to be considered not just at the data collection and results presentation stages of a research study, but throughout the case study report from introduction to the reference lists and appendices.

9.4 Decisions on the Data Analysis Process

At the research proposal stage, my data analysis strategy included undertaking cross case synthesis. This changed once it came to doing the actual analysis. As a novice who had never undertaken a case study before – my research proposal identified cross case synthesis based on the recommendation by Yin (Yin, 2014). This made sense as elements of the case study structure were based on the work of Yin. When it came to data analysis, I understood the overarching idea of cross case synthesis however I struggled to fully operationalise this. Further reading to unravel where I was struggling highlighted that although Yin’s approach is helpful, it is rather vague when it comes to detailing the specifics of the analytical techniques (Evers & van Staa, 2010). Yin himself notes that the analytic strategies he writes about are not

easy to use and require '*much practice to be used powerfully*' (Yin, 2014 p142). Furthermore, I felt I needed more guidance on how I could analyse and make better sense of the documents I had collected. Through discussions in supervision, and informal conversations with peers/colleagues, I came to fully appreciate the importance of using analytic approaches that would yield the best results aligned with the methods I had chosen. On reflection, it was necessary for me to look at alternatives that would be suited to the qualitative case study approach I had chosen. With this in mind, I decided to change my analytic approach to 'Framework Analysis' by Ritchie and Lewis (1994) as it allowed me to incorporate thematic analysis for the qualitative interviews and content analysis for the documents collected. For future research projects, it will be crucial for me to understand the analysis methods or techniques that I propose in advance or at least pursue training to ensure I am confident to use these.

9.5 Reflecting on What I Could Have Done Differently

In addition to what I have identified above (regarding having a better understanding of the chosen data analysis methods before writing future research proposals), I have reflected on what else I could have done differently if I had the opportunity to undertake the current PhD study all over again. Firstly, I would explore the use of NVivo software technology for facilitating data coding, analysis, and theme development. Analysing the data manually in the current study was helpful, but I appreciate that if future projects are bigger and have more data, NVivo might help to make the analysis process more manageable (Gray, 2017), and also more accessible electronically.

Secondly, I would consider the use of 'member checking' at the data analysis stage. Member checking is described as a technique whereby a researcher shares their interpretations with the participants to obtain feedback on whether the interpretations represent their contributions (Shenton, 2004; Alexander,

2019). According to Yin (2014) asking participants to review the draft case study report and provide feedback would have been a useful way of adding construct validity to the case study. That said, it would be important for me to weigh this against the criticisms of member checking that are offered by Morse (2015), such as, what happens if a participant disagrees with my interpretations (given that the interpretations would be an amalgamation and synthesis of all the interviews). I would also need to consider the additional burden that member checking may place on participants time on top of what they may have already given for the interview.

9.6 Study Strengths and Limitations

The following section outlines the study strengths and limitations drawing on Lincoln and Guba's (1985) Trustworthiness Criterion (credibility, dependability, confirmability, and transferability). A 'Case Study Reporting Checklist' was also completed and placed in Appendix 8 of this thesis.

Making the decision to privilege anonymity means there are some areas of the case study which lack the thick, descriptive contextual details that are part of case study reporting. This is a limitation; however O'Leary and Hunt (2016) acknowledge the complexity of balancing anonymity and thick description, suggesting that were this is a potential concern, researchers need to try and find a balance. I ensured that although there were less contextual details in the final case study report, the results chapters 5 - 7 presented ample verbatim quotations to enable readers to connect my interpretations with the quotations and data extracts they were grounded upon. To enable further confidence that my interpretations were based on the participants meanings, I checked my understanding of their contributions during each interview - reflecting back certain statements they made and checking if I had understood these in the way they had intended. These strategies enable greater authenticity and can allow readers (who wish to transfer the study findings to their own settings) to

make a judgement on the level of ***Transferability*** of the findings (Lincoln and Guba, 985).

The use of 2 organisations and a small sample limits the current study's generalisability because findings or applications may vary in different organisational contexts. However, it is important to note that generalization was not the goal of this case study - but rather, it sought to establish a more in-depth understanding of AWP and practices and their health-promoting potential within the two participating organisations.

The study paid particular attention to building in credibility (through a technique known as *triangulation*) at the study design stage. Triangulation is defined as the use of more than one source of data or method to develop a comprehensive understanding of the topic under investigation (Alexander, 2019). A strength of the current study was its use of *data triangulation* (collecting data from 2 organisations, and from staff occupying different roles and levels of involvement with policy development and implementation). Furthermore, another strength was the use of *method triangulation* (using different methods of data collection) by collecting data through interviewing staff and collecting documents such as policies. All this validated the data as it was informed by different perspectives, and consequently showed the study's ***Credibility.***

Another strength of the current study is that the methods were systematic, well documented and the process of inquiry was clearly articulated within the Methodology and Methods chapter (Chapter 4). This is a well-known technique for enhancing a study's ***Dependability*** (O'Leary and Hunt, 2016). Furthermore, me keeping a reflexive diary that detailed all stages of the research process and paying particular attention to my influence as a

researcher at each of the stages enhanced ***Confirmability***. Koch (1994) cited in Nowell et al. (2017) notes that this allows readers to trace the researchers justifications for the methodology and methods they used and the decisions they made throughout the research process.

9.7 Chapter Summary

The reflexivity chapter has provided an outline of my influence as a researcher on the conduct of the study, and highlighted that while there were some limitations, I made effort to build in and then undertake the study using known strategies for enhancing trustworthiness. The next chapter (Chapter 10) will bring the thesis to a close by outlining what the implications of the study findings are, and the key recommendations for research, policy, and practice.

Chapter 10
Conclusion: Implications and Recommendations for Future Research, Policy & Practice

In response to gaps identified in the literature about the relative paucity of current UK based, theoretically underpinned research on the health-promoting potential of AWPs; the PhD study investigated the following question,

Research Question:

To what extent is AWP development and implementation underpinned by health promotion principles?

The specific study objectives were to:

1. Explore how and why AWPs are developed and implemented in the workplace.
2. Explore the extent to which health promotion theory and principles underpin the development and implementation of AWP.
3. Establish then analyse whether there are any factors that hinder or facilitate the processes of development and implementation from a health promotion perspective.
4. Explore how and in what ways policies and approaches to implementation of AWP can be enhanced to improve their potential for promoting healthy employee consumption.

The study results presented in Chapters 5, 6 & 7, and the discussion in Chapter 8 provided the underpinning empirical evidence that answered the above question and highlighted key implications of the findings. The empirical evidence has been used to inform the following recommendations for research, policy, and practice.

10.1 Recommendation for Practice

The recommendations for practice are as follows:

- Workplaces are encouraged to work towards changing the narrative that predominantly associates issues of alcohol with discipline and dismissal. For example, organisations can do this by spotlighting stories that demonstrate positive examples of the supportive and health focussed role of the workplace. Workplaces can also harness opportunities to raise awareness of alcohol workplace policies, and more specifically highlighting what support or employee assistance options are available. Opportunities such as alcohol awareness week can also be used to build awareness and alcohol health promotion.
- A key contribution of the current study is the '10 Point Checklist' (see table 5). The current study recommends that workplaces can use the checklist to enhance their existing AWP development, implementation, or evaluation processes. The checklist is a theoretically underpinned collection of the key areas that workplaces can focus on to enhance the health promoting potential of their policies and practices. Using the checklist will also enable workplaces to demonstrate a more proactive and upstream approach to alcohol health promotion in the workplace.

Table 5: '10 Point Checklist' for Health-Promoting Alcohol Workplace Policies & Practices

'10 Point Checklist' for Health Promoting Alcohol Workplace Policies & Practices	
1. Collect organisation specific data to establish the scale of alcohol-related problems and enable a fuller understanding of the alcohol health promotion needs of employees in the organisation.	
2. Use the Alcohol Use Disorders Identification Test (AUDIT) as a reference point to explicitly address identification and support provision for all risk levels associated with alcohol consumption. The risk levels to incorporate are 'Lower Risk Drinking', 'Increasing Risk Drinking', 'Higher Risk Drinking' and 'Potential Dependence'.	

3. Make alcohol health promotion and provision of support more visible in policy documentation and other health related communication in the organisation.	
4. Consider equitable and more inclusive access to alcohol health promotion for employees within the organisation. For example, consider that issues of location and lack of technology may inadvertently limit access for some employees.	
5. Clarify what the organisation's expectations are regarding hangovers and how these can be managed in the workplace.	
6. Create opportunities for involving employees in policy development (particularly those with lived experience of alcohol problems). This will enable more responsive approaches to policy and alcohol health promotion support.	
7. Clarify whose role it is to oversee alcohol health promotion and prevention activities aimed at supporting employees within the organisation.	
8. Managers should receive training (such as alcohol screening and brief interventions training) to enable them to contribute towards opportunistic identification and support of staff that may be at risk because of their level of alcohol consumption.	
9. Incorporate well-being check-ups as part of supervision or staff appraisals because these may open additional opportunities for support regarding excessive alcohol consumption that might be related to workload or other organisational/environmental issues.	
10. Change the narrative that predominantly associates issues of alcohol with discipline and dismissal. For example, organisations can do this by a) Spotlighting stories that demonstrate positive examples of the supportive and health focussed role of the workplace. b) Harnessing opportunities to raise awareness of alcohol workplace policies, and more specifically the support options that are available to employees	

10.2 Recommendations for Research

The recommendations for research are as follows:

- More empirical research needs to be undertaken on hangovers, and the culture of its normalisation in the workplace context. This will enable a better understanding around potential ways to manage hangovers in workplaces.
- The current case study focussed on two public sector organisations in England. Considering that context differs across organisations, cities, countries, and continents, it is recommended that future research is

undertaken in other settings to build on and expand the knowledge around the health-promoting potential of AWPs.

- The literature review chapter highlighted that between 20% to 40% of workplaces do not have AWPs in place. It was not within the scope of the current PhD study to investigate why this might be so, however it is recommended that future research explores this further.
- It will be useful for future research to evaluate implementation of the '10 Point Checklist' that was proposed in the recommendations for practice.

10.3 Recommendations for Policy

The recommendations for policy are as follows:

- The literature review identified that alcohol workplace policies has been a neglected area and almost absent in UK national alcohol strategies. With the refreshed efforts of the draft WHO Global Action Plan for Alcohol 2022-2030, the current study recommends that UK national and local policy make more explicit mention of alcohol in workplaces; the role that workplaces can play in alcohol health promotion and harm reduction for employees; and encourages organisations to adopt more health promoting AWPs.
- The '10 Point Checklist' (see table 5) can be used to enhance existing policy development approaches in workplaces. This can help to ensure more visibility of, and commitment to the provision and support for alcohol health promotion in the workplace, and in the AWPs.

10.4 Concluding Remarks

Reflecting on the original inspiration for pursuing the PhD study, I recall working in a role that required me to contribute towards the development of an alcohol policy that would support employee health. When that did not

happen, despite all my attempts to engage the individuals that would normally be involved in the policy development process, it left me with an incurable curiosity to understand why that one task on my Gannt Chart was so challenging to complete. I am reminded about my initial assumptions that developing health-promoting alcohol policies in the workplace would mainly involve inserting content that demonstrates a commitment to supporting employee health. Furthermore, I believed that having a policy on alcohol would mean employees align with the policy's ascribed goals. This PhD study has shown me that AWPs and practices are much more complex than I had originally envisaged. The study brings into sharp focus the various entanglements of social, cultural, politico-economic, and workplace/environmental factors that influence alcohol problem framing, and consequent management of problems in a work context.

The PhD study achieved its aim to explore the extent to which AWPs and practices are underpinned by health promotion principles. It concludes (in agreement with existing literature) that AWPs can be health-promoting, and that the organisations show current good practice and a tremendous amount of support for employees who might be dependent on alcohol. However, when looking at the AWPs and practices through the lens of health promotion theory, the study advances understanding of how the health-promoting potential is limited by the areas of misalignment and persistent tensions between treatment versus prevention, and discipline versus treatment. The health-promoting potential is also limited by lack of explicit recognition (in the policies) that alcohol problems are on a continuum; and disinvestment in proactive preventative approaches that can support employees who may be consuming alcohol at ‘increasing’ and ‘higher risk’ levels. This represents a missed opportunity to address alcohol problems that are on the continuum but not identified as ‘alcohol dependence’. In addition, the study concludes that AWPs and a less permissive drinking culture may have had the unintended consequence of hindering early help-seeking because employees fear disciplinary action if they are to divulge any struggles with alcohol. There is a

need for workplaces to address all the above areas (for example, by using the ‘10 Point Checklist’) in order to enhance the potential for their AWPs and practices to contribute towards alcohol health promotion and prevention of more severe alcohol problems in employees. This would also ensure workplaces are taking a more proactive and upstream approach to employee alcohol health promotion.

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Appendix 1: Summary of Literature Review Studies

Author/s	Year Published	Country	Study Design/ Methods	Setting/Industry	Sample Size	Study Aim/s	Main Outcomes
Howie and Carter	1992	Scotland	Survey	Not stated	72 Organisations	To survey the implementation of alcohol and smoking policies in the workplace	Low AWP uptake, and little interest in developing these
Ames et al.	1992	USA	Case Study (Survey Questionnaires & Ethnographic Interviews)	Assembly Plant in large US Corporation	50 Interviews 984 survey questionnaires (Sample included union staff, management, health and safety representatives, human resources, labour relations medical department staff)	To explore obstacles to effective alcohol policy in the workplace	Weak policy, under controlled drinking, Dual policy dilemma, Ambivalent nature of alcohol policy & organisational mechanisms
Braddick	1993	Scotland	No explicit design stated (Data collected through a letter sent to organisations)	Health boards	13 Health Boards (participants included area personnel officers)	To investigate AWPs and their potential to meet NHS Scotland's target of working towards a 20% reduction in the proportion of those drinking above safe limits by the year 2000	Study concludes AWP in Scottish Health Boards are not exemplars. Policy lacks information on drinking on premises, education of employees & managers. Unlikely to meet the target for reducing excessive drinking if AWPs are not enhanced

Godfrey et al.	1993	England	Mixed Methods (Survey & Interviews)	Energy, Transport, Communication, Manufacturing, Retail, Engineering, Construction, Catering, Banking, Business & Finance, Public Administration, Education, Medical & Veterinary Services	Telephone Survey with 189 Organisations, Interviews with 25 Organisations	To assess scope for improving estimates of workplace alcohol-related costs. To identify type of information that organisations require to influence their decisions on adopting AWP	Health education on alcohol not fully assimilated in workplaces. Emphasis on treatment for dependence. Not convinced that other policies (apart from disciplinary ones) are effective.
Powell *	1994	England	Mixed Methods (Postal Survey & Interviews)	Agriculture, Energy, Water Supply And Construction, Manufacturing & Service Industries	373 Postal Surveys 34 Organisations Interviewed	To identify factors most likely to lead to the implementation of AWP by employers. To examine the types of policy adopted and the process by which these were initiated and implemented	30% of workplaces had policies but majority were "disciplinary codes" Lesser number (13 organisations) had health orientated AWP.
Baggott & Powell *	1994	England	Mixed Methods (Postal Survey & Interviews)	Agriculture, Energy, Water Supply, Construction, Manufacturing & Service Industries	373 Postal Surveys 34 Organisations Interviewed	To identify factors influencing AWP adoption by employers. To examine the process by which AWPs are designed and initiated	Most AWPs were disciplinary in nature. Implementation strategies were poor and staff training on recognition of alcohol problems was absent

Zhang et al.	1999	USA	Desk based Study (using data from national survey)	Agriculture, Forestry, Fishing, Hunting, Mining, Manufacturing, Construction, Wholesale & Retail Trade, Finance, Insurance, Real Restate, Professional, Scientific, Arts, Entertainment, Recreation, Accommodation, Food Service, Public Administration, Management, Administrative, Waste Management, Transport, Information & Communication, Education, Health, and Social Care,	7055 participants (from the year 1994 data) 7957 participants (from the year 1997 data) All full-time workers aged 18-49years old	To explore associations between workplace programmes /policies & employee use. To describe the nature of drug & alcohol use & show prevalence of workplace programmes (including policy) for reducing consumption	Workers reporting lack of workplace policy on drugs and alcohol were twice as likely ($p < 0.05$) to report heavy alcohol use than workers who reported policy presence
Eriksson et al.	2004	Sweden	Qualitative (Interviews, Focus Groups & Documentary Analysis	Public & private companies (Industry types not stated)	54 telephone interviews in 16 companies, 6 Focus Groups,	To explore interest in alcohol & drug prevention in the workplace, including policies & programmes on prevention at work.	Study concludes there is little overall interest in prevention (related to alcohol) in the workplace, and policies are vague, open to interpretation and have insufficient detail

					Document Analysis of 121 policies/ programmes		necessary to support preventative health action.
Wickizier et al.	2004	USA	Pre-Post Quasi-Experimental Design with Non-Equivalent Comparison Group	Mining, Agriculture, Fishing, Forestry, Manufacturing, Transportation, Wholesale & Trade, Finance, Insurance, Real Estate, Service	261 companies in the drug free workplace programme (intervention group) assessed against 20,500 (non-intervention group)	To assess/evaluate the impact of a publicly sponsored drug-free program on reducing occupational injuries	Programme had a statistically significant ($p< 0.05$) but selective industry specific impact on reducing occupational injury. Programme was significantly associated ($p< 0.05$) with reduction in incidence of serious injuries that required 4 or more days off work particularly in construction services and manufacturing
Pidd et al.	2006	Australia	Survey	Building / Construction	300 participants (1st year apprentices)	To assess associations between alcohol & other drug policies (& workplace factors) with drug & alcohol consumption/use patterns	Apprentices reporting presence of AWP were more likely to report lower consumption than those who reported policy absence. Alcohol or drug policies significantly associated with consumption patterns (with less likelihood to drink during work hours)
Larson et al.	2007	USA	Desk based research using 2002, 2003 & 2004 national survey dataset	Agriculture, Forestry, Fishing, Hunting, Mining, Manufacturing, Construction,	115 million (full time workers aged 18-64 years).	To describe nature of drug & alcohol use & show prevalence of workplace programmes (including	Across most demographic comparisons, those meeting criteria for alcohol dependence were less likely (than those who did not meet the criteria) to

				Wholesale & Retail Trade, Finance, Insurance, Real Restate, Professional, Scientific, Arts, Entertainment, Recreation, Accommodation, Food Service, Public Administration, Management, Administrative, Waste Management, Transport, Information & Communication, Education, Health, and Social Care,	Secondary analysis of national survey on drug use & health	policy) for reducing consumption. To explore associations between workplace programmes /policies & employee consumption	report working for an employer who had educational programmes, written policies & employee assistance programmes.
Brown	2008	Australia	Survey	Agriculture	147 participants	To explore employee perceptions & attitudes on the effectiveness of alcohol and drug policies	Comprehensive policies which include preventative measures are perceived as being most influential in changing drinking behaviour
Harkins et al.	2008	England	Mixed methods (Telephone Surveys & Interviews)	Education, Health, Industrial, Leisure & Hospitality, Office, Retail Shops, Service, Transport, Charities,	302 Telephone Surveys 10 interviews	To investigate the impact of alcohol on the workplace, & how companies manage this	Two thirds (66.8%) of companies have an alcohol policy and 62.3% provide at least one form of support. These companies are more likely to be larger and more

				Social Housing & Translation		To examine AWPs	established. Companies with policies are more likely to be those in the health sector compared with the leisure and hospitality sector.
Koeppe	2010	Austria, Belgium, Czech Republic, Germany, Greece, Hungary, Ireland, Lithuania, Norway, Portugal, Slovenia, Spain, Sweden, Finland, France, Italy, Luxembourg, Poland &, Slovakia, Slovenia, UK	Case Studies	Motoring, Service, Drinks Industry, Oil Refinery, Council, Administration, Production, Trade Sector, Government Agencies	23 Case studies (across 13 European countries)	To report on workplace policy and programme impact on harm reduction and share good practice case studies.	Report concludes there are a range of alcohol policy & programme benefits such as reduced sickness absence and increased productivity

Moore et al.	2012	USA	Mixed Methods (Interviews & Telephone Surveys)	Bar Chain	67 Interviews 1294 telephone surveys	Explores the relationship between comprehension of workplace alcohol policy, policy compliance & consequences of policy violation	Policy deterred drinking in most workers during work hours (but not out of hours). AWP violation was associated with hazardous drinking and greater likelihood for hazardous drinkers to experience problems at work.
Rodriguez-Jareno et al.	2013	Belgium, Catalonia, Croatia, Estonia, Finland, Germany, Greece, Ireland, Italy, Poland, Portugal, Romania, Scotland	Case Studies (Surveys & Interviews)	Manufacturing, Transport & Storage, Water Supply Sewage & Waste Management, Chemical Industry, Alcohol Breweries & Drinks Businesses, Health & Social Work, Armed & Uniformed Services, Electricity Gas Steam & Air Conditioning Supply, Gas/Fuel Industry	**Country level** 12 countries at case study gathering phase 11 countries at pilot intervention stage. **Company level** 24 companies at case study phase; and 55 companies in the pilot phase. **Employee level** 5623 employee & 55 employer baseline surveys.	To prepare & disseminate a toolkit & policy recommendation for workplaces to reduce alcohol-related harm	Report concludes that policy is regarded as the most cost-effective single intervention acting as a deterrent to drinking, clarifying procedures for disciplinary action and support. Basic interventions (including policy) had greater impact on workers alcohol consumption regardless of whether they were risky drinkers or not. Comprehensive interventions (including alcohol policy) had greater impact on increasing employee help-seeking.

					3810 employee and 54 employer interviews at follow up.		
Bush and Lapari	2014	USA	Desk based study (using data from national survey)	Agriculture, Forestry, Fishing, Hunting, Mining, Manufacturing, Construction, Wholesale & Retail Trade, Finance, Insurance, Real Restate, Professional, Scientific, Arts, Entertainment, Recreation, Accommodation, Food Service, Public Administration, Management, Administrative, Waste Management, Transport, Information & Communication, Education, Health, and Social Care,	123, 100 participants (from 2003 -2007 annual data) compared with 111,500 participants (using 2008-2012 annual data)	To analyse survey data on substance use & health to present a variety of estimates of full-time workers who are employed by companies that provide workplace policy & programs on drug & alcohol	Report concludes heavy drinkers are less likely to report working for employers that have workplace policies when compared to those who drank less. Younger workers (18-25yrs) are less likely to work for an employer with alcohol or drug policies & less likely to be aware of policies
Cheng and Cheng	2016	Taiwan	Qualitative Interviews	Construction	22 Construction workers (16 outsourced workers, 3	To examine construction workers drinking & workplace alcohol	Outsourcing complicates the implementation

					subcontractors and 3 worksite supervisors)	management policies in the context of outsourcing.	of AWP and affects workers' drinking behaviour Policy has limited influence or effect when contextual factors such as outsourcing, size of company (smaller firms), subcontractors' own behaviour & attitudes to alcohol, precarious work conditions and low wages are considered
Pidd et al.	2016	Australia	Desk based study (using data from national survey)	Mining, Utilities, Public Administration & Safety, Transport, Postal and Warehousing, Information Media and Telecommunications, Education, Health and Social Care, Manufacturing, Financial and Insurance Service, Arts and Recreation, Construction, Accommodation, Food Services, Wholesale	13,590 participants (Secondary analysis of data from the 2010 National Drug Strategy Household Survey)	To explore the prevalence & impact of alcohol & drug policy in Australian workplaces (using a nationally representative dataset)	AWPs are associated with significantly decreased odds of high-risk drinking (OR: 0.61). Use & use with assistance policies showed even greater odds of reduced high-risk drinking (OR: 0.64 & OR: 0.43 respectively)

				Trade, Administrative Support, Scientific and Technical Services, Agriculture, Forestry & Fishing, Rental, Hiring and Real Estate			
Pidd et al.	2018	Australia	Cluster Nonrandomised Controlled Trial	Manufacturing	284 participants 4 sites (2 intervention, 2 comparison)	To examine 4 strategies to reduce workplace alcohol-related harm – using a holistic approach	No significant intervention effect for reducing risky drinking. Unexpected finding of intervention group having higher AUDIT-C scores (riskier drinking) than the control group at T3. There was however increased awareness with the intervention group only.
Orlowski et al.	2021	Israel & USA	Survey	Hospitality	788 working college students	To examine the moderating effect of formal social control through workplace alcohol policies	Study concludes individuals whose workplace had formal AWP in place were 0.13 times less likely to drink alcohol at work. Results also indicate the presence of a formal policy does

							not completely mitigate workplace drinking

*Papers by Powell (1994) and Baggott and Powell (1994) are based on the same study data.

Appendix 2:Ethical Approval Letter

Lancaster University

Applicant: Lolita Alfred
Supervisor: Mark Limmer
Department: Health Research
FHMREC Reference: FHMREC16053

14 March 2017

Dear Lolita

Re: Healthy Alcohol Policy Development and Implementation in the Workplace

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 592838
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

[redacted]

Dr Diane Hopkins
Research Integrity and Governance Officer, Secretary to FHMREC.

Appendix 3: Recruitment Flyer

Seeking Volunteers for a Research Study on Alcohol and the Workplace

- Are you employed by the University or the NHS?
- Does your role involve supervision or line management of others?
- Have you ever been involved in any aspect of the development, implementation or review of workplace policies?
- Do you have an interest in alcohol health improvement?

If your answer is YES to any of the above questions, you may be eligible to take part in the study. To find out more about the study, please contact Lolita Alfred via phone: XXXXX or email: l.alfred@lancaster.ac.uk

Appendix 4: Participant Information Sheet

Participant Information Sheet

Title of study: Healthy Alcohol Policy Development and Implementation in the Workplace

What is this study about?
This study will explore staff views, stories, and experiences of alcohol in the workplace as well as factors that influence healthy alcohol workplace policy development and implementation.

Who is organising this research?
This study has been designed by Lolita Alfred who is a PhD student with Lancaster University.

Has the study been reviewed?
Yes, this study has received approval from the ethics committees of the NHS and Lancaster University Faculty of Health and Medicine. It has also been approved by the internal ethics committee/research and development department in your organisation. If you wish to raise any concerns about the study, please to contact the research supervisor on the details below:

Dr Mark Limmer

Furness Building, Lancaster University, Bailrigg, Lancaster LA1 4YG

Email: m.limmer@lancaster.ac.uk

Tel: 01524 593015

Do I have to take part in this study?
No, participation is completely voluntary. If you are interested, you will have a 2 week deciding period during which you can seek further clarification about the study before making a decision.

What will be required of me?
If you choose to participate, you will be asked to email or phone Lolita Alfred to indicate your interest, and then an interview date and time will be negotiated based around your availability. You will be required to sign a consent form to indicate you are happy to participate. The interview will last approximately one hour.

Will my information be confidential?
Yes, your contributions will be kept confidential. Your real name and that of your organisation will not be used in any reports or publications of the study findings. There are some limits to confidentiality, for example if you share something in the interview

that suggests you or someone else may be at significant risk of harm. In this instance, the researcher will need to break confidentiality and consult the research supervisor on this. The researcher will let you know if confidentiality will need to be broken.

Are there any risks of participating?
We do not foresee any risks, however, should you feel upset or affected by the interview in any way, please feel free to access support from The Samaritans, which is a free and confidential service. They can be contacted via phone on 08457909090, or via email on jo@samaritans.org. Alternatively you may access your organization's occupational health or staff wellbeing service.

What are the potential benefits of taking part?
Your contributions will generate valuable knowledge and understanding of employee and employer perspectives about alcohol in the workplace, and/or the extent to which the alcohol policies and approaches to development and implementation are underpinned by health promotion.

Am I allowed to withdraw my participation?
Yes, you can withdraw your information from the study at any point until a deadline of 2 weeks after your interview. If you choose to withdraw, you do not have to give any reason why.

How do I withdraw?
You can do this by contacting Lolita Alfred via email or telephone using the contact details provided at the end of this information sheet.

What will happen to the results of the study?
The findings will be written up and submitted as a thesis for a PhD course. They may also be presented at conferences, seminars and published in academic or professional journals. A brief 2 page summary of the study results can be provided to you upon completion of the study. The information generated from this study will be anonymised and stored on a secure server for 10 years (post completion of the PhD programme) in line with the Lancaster University Research Data Management policy.

What do I do now?
Please take time to consider this information, and if you would like to participate in the study, please express your interest by email to Lolita on l.alfred@lancaster.ac.uk or by phone on XXXXXXX

Thank you for taking time to read this information

Appendix 5: Consent Form

Study Title: Healthy Alcohol Policy Development and Implementation in the Workplace

Before you consent to participating, please take time to read the participant information sheet and then initial each box below if you agree. If you have any queries before signing the consent form please speak to the researcher, Lolita Alfred.

		Please initial each box below
1.	I have read and understood the information sheet for the above study. I have had the opportunity to consider the information and ask questions about it	☐
2.	I understand that participation is entirely voluntary and I have the right to withdraw my information at any point until 2 weeks after my interview. I do not have to give a reason for withdrawal	☐
3.	I consent to my anonymised quotes being used for future reports, publications, or presentations by the researcher	☐
4.	I understand that confidentiality will be maintained at all times. The only exception is if I provide information that reveals risk of harm to me or to others. In this case I understand that the researcher will breach confidentiality and discuss with the research supervisor	☐
5.	I am aware that my name, and the name and exact location of my organization will not appear in any reports, publications, or presentations	☐
6.	I understand that information transcribed will be stored on a password protected computer and anonymised to ensure my contributions are pseudo- anonymous	☐
7.	I understand that the audio recording of my interview will be kept until the research project has been examined	☐
8.	I agree to take part in this study	☐

Name/Signature of Participant……...Date……

Name/Signature of Researcher……...Date……

Appendix 6: Interview Schedule

Interview Schedule - Updated following first 2 interviews

Introduction (rapport building & re-hashing study purpose)

- Rapport building, thanking participants for participating
- Purpose of the study
- Clarification of any questions participants may have
- Participant's rights, such as the right to stop or take a break at any point.
- Checking consent again before commencing - record on audio and on paper (or electronically)

Main Interview

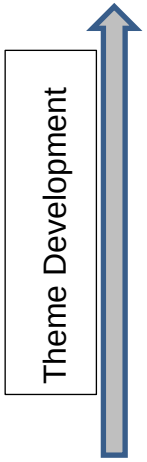
Mainly open-ended questions and some closed questions in the following areas

- Participants role, length of time working in organization and organization/department/service area descriptions **(all participants) (context)**
- Participant stories on alcohol in/and the workplace **(all participants) (WHO & EST)**
    - Prompts- organization drinking culture, hangovers,
- Perspectives on alcohol as a policy area in the workplace and what that looks like **(all participants) (WHO & EST)**
- Involvement in policy development or implementation **(all participants) (WHO & EST)**
- The organization policy development process **(policy makers & managers) (WHO & EST)**
- Approaches to alcohol policy implementation **(all participants) (WHO & EST)**
- Views/comments/stories on whether they have seen policy used/implemented, how and in what circumstances **(all participants) (WHO & EST)**
- Experiences/views on potential or actual barriers or levers to development or implementation of alcohol workplace policies **(all participants) (WHO & EST)**
- Views on what the elements of an alcohol workplace policy might be/are **(all participants) (WHO & EST)**
    - Prompts - structure, content, focus, views on what are the important or ideal aspects
- Alcohol health promotion approaches **(all participants) (WHO & EST)**
    - Prompts- support, intervention, priorities

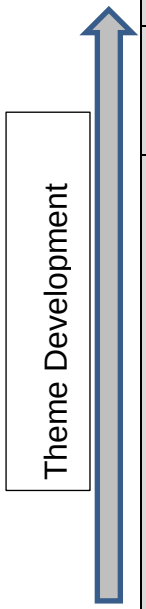
Conclusion

- Thanking participants for their insights
- Offering 2-page summary of findings at project completion
- Follow up email to formally thank participants for their time

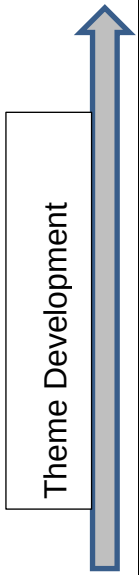
Appendix 7: Theme Development



Theme 1	**MISALIGNED VOICES**	
Subthemes/ Categories	***Differential Framing of Risk***	***The Policy vs The Reality***
Codes	Risk defined by behavioural outcomes Risk defined by frequency of problems Othering- comparing own drinking tendencies to others Sensible drinking open to interpretation Comparison of stories from the 'bad past' vs 'good present' Public health vs workplace definition of a problem Binary framing of alcohol problems at work	Parallel processes in operation - formal policy vs the informal reality The explicit and the implicit messages within policy- employees Identifying vs proving a problem Perceptions of alcohol workplace policy being for discipline/problems rather than support Policy rules vs common sense rules Knowing vs doing Battle between treatment/ prevention, proactive/reactive Individual/personal values vs policy/organisational values The relationship with colleagues - harder to follow formal policy process. Supporting customers vs supporting colleagues



Theme 2	**THE GREY AREAS**	
Subthemes/Categories	What About Hangovers	The Missed Opportunities to Promote Health
Codes	Younger age associated with more hangovers at work With maturity comes greater responsibility & less hangovers Hangovers are on a spectrum Lack of policy steer regarding hangovers Normalisation of hangovers	Missed opportunity to involve workers with lived experience of alcohol problems at work Inaccessible policies Maximising opportunities for health promotion Lack of data to inform workplace response to alcohol prevention/health promotion Moving past static policy and towards engaging and responsive policy Unintended consequences of policy driving drink problems underground



Theme 3	**THE WIDER DETERMINANTS, MEANINGS & PURPOSE OF ALCOHOL**	
Subthemes/Categories	***Personal and Socio-Cultural Meaning***	***Environmental and Politico-Economic Considerations***
Codes	Alcohol as an important part of team cohesion & work related social functions Individual right to make own choices Celebratory function of alcohol Exclusive practices	Influence of the working environment & workplace culture Workload pressures Organisational Change and constant state of flux Societal change over time Move from permissive to less permissive drinking culture Law Politics 'unmaking' of workplace progress Professional body expectations Organisation priorities Passionate leadership Commissioning/funding

Appendix 8: Critique Checklist for a Case Study Report

Completed Checklist for a Case Study Report (taken from Stake, 1995)

1. Is this report easy to read?	Very	So-so	Hard
2. Does it fit together, each sentence contributing to the whole?	Very	So-so	Misfit
3. Does the report have a conceptual structure (i.e. themes or issues?)	Yes	A little	None
4. Are its issues developed in a serious and scholarly way?	Yes	A bit	None
5. Is the case adequately defined?	Yes	So-so	Poorly
6. Is there a sense of story to the presentation?	Strong	Some	None
7. Is the reader provided some vicarious experience?	Yes	A bit	None
8. Have quotations been used effectively?	Yes	A bit	No
9. Are headings, figures, artefacts, appendixes, and indexes effectively used?	Very	So-so	No
10. Was it edited well, then again with a last-minute Polish	Shiny	Nicks	Rough
11. Has the writer made sound assertions, neither over nor under interpreting?	Yes	So-so	No
12. Has adequate attention been paid to various contexts?	Yes	A little	Done
13. Were sufficient raw data presented?	Loads	So-so	Weak
14. Were data sources well-chosen and in sufficient number?	Strong	Some	Weak
15. Do observations and interpretations appear to have been triangulated?	Yes	A bit	No
16. Is the role and point of view of the researcher nicely apparent?	Nicely	A bit	None
17. Is the nature of the intended audience apparent?	Yes	Some	No
18. Is empathy shown for all sides?	Yes	A bit	No
19. Are personal intentions examined?	Yes	A bit	No
20. Does it appear individuals were put at risk?	Yes	A bit	No