**Table 2 Methodological issues encountered and recommendations.**

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| **Task** | **Issue** | **Our approach** | **Implication for study process and project costing – Recommendation(s)** |
| Recruiting within busy clinical setting | Alcohol treatment (detoxification) inpatient clinics, offered restrictive time-slots to recruit/interview patients due to the large number of timetabled therapy sessions.  Opportunities for recruiting in general hospitals were dictated by hospital routines (protected mealtimes, visiting hours etc.). Day-patients were easier to access as less occupied with formal activities, similarly outpatients usually more willing to participate while waiting for their appointment. | Research Assistants (RAs) were employed who had previous experience of working within NHS settings and met with key staff before data collection. | Costing must include RA time to permit development of good working relationship with site staff, (particularly crucial for longitudinal study).  Participant appointment times were dictated totally by clinical routine. RA had to manage their own timetable, remaining flexible to clinical priorities. Recruitment was often sporadic and RA downtime was inevitable. On some occasions recruitment was not possible. |
| Issues for the conduct of the interview (face-to-face) | (i) Privacy issues in multi-bed wards.  (ii) Interview space was at a premium and interviews could be interrupted.  (iii) Accurate recording of drinks data.  (iv) data collection during the festive period | (i) RAs created as private an environment as possible. Some things were communicated non-verbally e.g. pointing, writing. Some participants provided answers by writing on their hands.  (ii) RAs were proactive and flexible.  (iii) Interviews were not time limited. RAs sensitively challenged ambiguities and discretely used participant’s expenditure claims, to cross check alcohol intakes.  RAs were provided with a regularly updated, extensive list of common drink brands. Changes to drink Alcohol By Volume % (ABV%) did occur during the timescale of the project.    (iv) We suspended data collection during the festive period due to seasonal effects on alcohol sales and changes in NHS clinic times etc. | (i) RAs must use their experience and be sensitive to the context and to the participant.  (ii) Essential to build in time for RA inactivity.  (iii) RA training should include extensive discussion of common beverage types, containers sizes and, importantly expected typical prices. Mock interviews were beneficial.  Continually check retailers and manufacturers websites to ensure that drinks data is current.    (iv) Implications for RA downtime. |
| Recruitment at baseline | Duplicate interviews e.g. a patient admitted due to an alcohol induced medical emergency (an inpatient) could be recruited a second time by a different interviewer when subsequently given a referral to a detoxification service. | Addressed at the cleaning of the database before progression to follow-up. | Quality of administrative support was crucial to permit identification of interview duplication and data entry errors. Essential they follow identical training to RAs in relation to current drink types and prices etc. |
| Requesting sufficient contact details to arrange follow-up interviews. | (i) No fixed address, temporary or emergency accommodation (homeless hostels), reliant on informal arrangements with friends or family.  (ii) Reluctance to provide details of a secondary contact (e.g. close friend, relative, support worker). | (i) We recorded as much personal contact information as possible, some gave a support worker’s number, others suggested contact via their NHS treatment centre.  (ii) Assurance was given that this would be used as a last resort and there would be no mention of the nature of the study or discussion of personal information. | (i) Links could be made with treatment centres for re-contacting patients which may have a cost implication and must be considered prior to submission to the Ethical Approval Committee. This would not aid re-contacting of participants not receiving treatment. |
| Contacting for follow-up interviews | (i) Frequently, mobile phones were switched off or rang out.  (ii) Telephone numbers unavailable/participants had changed contact details.  (iii) Attrition  (iv) Contact details for participants who die during the course of the study. | (i) Unanswered calls were immediately followed by discrete text messages. Mobile phone voice messages were avoided as charges can be applied to collect them. Up to three calls followed by text messages were made before trying alternative approach, usually letter.  (ii)Where phone contact failed, participants were sent letters, reply forms and envelopes plus full contact details of the RA so they could indicate willingness to continue participation and provide new contact details if relevant.  A maximum of 3 letters were posted (in line with our ethical approval) and if still no response, we called/wrote to their secondary contact where available.  Some participants additionally provided an email addresses.  (iii) A project update communication including a reply form and envelope for updated contact details, was posted to all participants before the first follow-up interviews began.  Following the completion of the baseline interview and before any attempt to re-interview participants was made, RAs noted anything which could be addressed which might decrease the risk of loss to follow-up; e.g. considering mobility or anxiety e.g. travelling alone.  (iv) Established link with NHS Central Records (Scotland) to receive concurrent notifications and so minimise risk of causing distress. | (i) Project costs should anticipate expense of multiple calls/texts and postal/stationery costs for further contact attempts, in addition to administrative time.  (ii) It is recommended that as much contact information as possible is recorded at original interview.  These measure incurred a significant cost. Email provided a cheap method of contact but not available to all participants.  (iii) Special consideration may be required for some participants such as extra transport costs (taxis, additional accompanying person).  (iv) We recommend that this link is established. When considering ethical permission, researchers should anticipate what information is needed for identifying participants to link with death records. |
| Conduct of second interview (face-to-face) | (i) Convenience of locations for interview.    (ii)Participant did not attend (DNA)  (iii) RA safety | (i) Choice offered: some original recruitment sites, research clinics and community substance misuse premises. Distribution of postcodes from baseline sample influenced choices  (ii) Reminder text or call made day before the interview. All DNAs were contacted by text and/or call at the time and later followed up.  (iii) Rarely, additional safety considerations were required e.g. due to aggressive behaviour. Consequently telephone interview was conducted. In one instance, arrangements were made for a male member of the research team to be present at interview. | (i) Maintain rapport with staff at original recruitment sites plus capitalise on these networks to build links with other clinics and treatment centres. Additional sites involved greater travel and time costs for RAs.  (ii) This again had implications for RA time and occupied clinic space unnecessarily.  (iii) In addition to normal health and safety procedures, personal alarms were purchased. |
| Follow-up interviews by telephone  (interviews 3 & 4) | (i) Requirement to improve participant retention.  (ii) (Similar to face-to-face interviews, DNA was an issue and our approach was as described above).  (iii) Judging if participants were under the influence of alcohol difficult. Participants could report drinking or use of illicit substances.  (iv) A small number of participants were distressed when contacted by phone.  (v) Confirming the identity of the person answering the phone call.  (vi) Some participants clearly not alone when an interview was arranged. This could influence their attitude towards the researcher and their responses to the questionnaire. | (i) Interviews 3 & 4 were changed from face-to-face to telephone only, reducing the time and effort of participants required to travel to interview locations.  (iii) RAs used their discretion whether or not to initiate or continue an interview.  (iv) Distressed participants not interviewed. RAs offered assistance in the form of suitable contact numbers (treatment clinics, helplines etc.). RAs contacted services on a participant’s behalf.  (v) Security questions were always asked. If RA was sceptical the interview did not take place.  (vi) RAs requested that interview be rearranged. | (i) Reduced participant expenses and improved efficiency of RA time.  (ii) Cost and time implications from repeated phone calls must be factored in.  (iii) RAs who have experience of the setting is important. Time must be allowed for failed interviews and attempts to re-interview.  (iv) RAs must have appropriate contact details and be prepared to contact services directly (including emergency). |
| Payments to participants | (i) Travel costs for face-to-face follow-up interviews  (ii) Financial incentive to address attrition. | (i) Public transport costs were reimbursed. Additional costs (taxis) for those who would find accessing public transport difficult or additional fares for those requiring travel companions.  (ii) £10.00 vouchers. The voucher took the form of a card activated once the RA informed the study administrator. This method avoided the RAs carrying money on their person. | (i) Implications for project costing.  (ii) Had all participants completed all interviews the total cost of the vouchers would have been £25,760. |