Research Report

Assessing the Impact of Minimum Pricing for Alcohol on the Wider Population of Drinkers – Baseline

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Assessing the Impact of Minimum Pricing for Alcohol on the Wider Population of Drinkers - Baseline

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Glossary

Acronym/keyword	Definition
APB	Area Planning Boards
APOSM	Advisory Panel on Substance Misuse
AUDIT	Alcohol Use Disorders Identification Test
HMPPS	Her Majesty's Prisons and Probation Service
MHH	Moderate, Hazardous, Harmful drinkers
MPA	Minimum Pricing for Alcohol – used to refer to the policy of setting a minimum price for alcohol
MUP	Minimum Unit Price – the level set per unit which is used to calculate the minimum price for alcohol. In Scotland, the policy itself is also routinely referred to as MUP.
NHS	National Health Service
NPS	Novel/New Psychoactive Substances (see also Spice)
PAG	Project Advisory Group
OTC	Over-the-counter medication
REA	Rapid Evidence Assessment
RTD	Spirit-based 'ready-to-drink' beverages
SARG	Sheffield Alcohol Research Group
Spice	Common name for particular type/s of NPS (i.e. synthetic cannabinoids).

There are several acronyms that are used within single paragraphs/passages – but nowhere else in the report. They have a specificity to the point made and are not general to the whole report. These are not listed here but are each given a full title at the first time of use.

1. Introduction

In May 2018, Welsh Government issued a specification for an evaluation that would assess the process and impact of the introduction of a minimum price for alcohol (MPA) in Wales. The contract was split into four 'lots': (1) a contribution analysis, (2) work with retailers, (3) qualitative work with services and service users, and (4) an assessment of impact on the wider population of drinkers.

Three of the contracts (Lots 1, 3 and 4) were awarded to a consortium of researchers based at the University of South Wales, Glyndwr University Wrexham and Figure 8 Consultancy[1]. Lot 2 was awarded to the National Centre for Social Research. This report focuses on the assessment of impact on the wider population of drinkers and presents findings from research conducted prior to the implementation of MPA in Wales. The findings provide an important baseline that can be used to monitor the impact of MPA on the wider population of drinkers in Wales post-implementation of the legislation.

Primary baseline data on alcohol consumption and drinking-related behaviours, as well as on attitudes towards the legislation, were gathered from drinkers across Wales using an online questionnaire survey and through in-depth qualitative interviews.

Aims and objectives

The aim of this component of the evaluation is to assess the impact of the minimum price for alcohol legislation on the wider population of moderate, hazardous and harmful drinkers[2] (henceforth MHH drinkers) over a five-year period. The study is longitudinal in design and has three key reporting points: baseline/pre-implementation, 18 months post-implementation and 42 months post-implementation[3].

The primary objectives are:

1. To assess the attitudes of MHH drinkers towards the legislation
2. To assess the changes that MHH drinkers make in response to the legislation (e.g. changes in their use of alcohol and other drugs, changes in purchasing patterns, changes in their lifestyles)
3. To assess the impact of the legislation on the lives of MHH drinkers (e.g. employment, financial circumstances, health, relationships)
4. To undertake an analysis of household expenditure patterns, to assess the potential displacement of spending.

[1] Lot 1 is led by Glyndwr University, Lot 3 is led by Figure 8 Consultancy and Lot 4 is led by University of South Wales.
[2] Definitions of these terms are presented later in this chapter.
[3] In response to the COVID-19 pandemic and lockdown, the evaluation team was commissioned by Welsh Government to undertake an additional wave of interviews with the longitudinal study sample, 9-months post-implementation, in the Autumn of 2020.

Report structure

This report is the first of three that will be produced in relation to this project[4]. It is divided into three key parts. The first provides contextual information as well as a review of the literature and an overview of the methods used to conduct the baseline research. The second presents the results of the primary research and is structured around six key themes. The third summarises the results, discusses the findings in light of the literature and recommends a series of actions to guide the research over the remaining study period.

The content of the individual chapters is summarised as follows:

Chapter 2 helps to put the research in context by examining what minimum pricing is and why it was introduced in Wales. It provides a timeline of events to show how the policy evolved from early debates through to implementation on 2nd March 2020.

Chapter 3 presents the results of a review of the literature on the impact of minimum pricing policies. The review updates a more comprehensive review (see Holloway et al, 2019) and focuses on the impact of MPA on the wider population of drinkers rather than on a specific subset of drinkers in treatment.

Chapter 4 describes the methods used to gather the primary data and includes an explanation of the choices made and an overview of the procedures undertaken to gather the data.

Chapter 5 provides a summary of the characteristics of the samples of drinkers who completed the online survey and who took part in an in-depth interview.

Chapters 6 to 8 present findings from the primary research undertaken by the research team.

Chapter 6 focuses on awareness and understanding of MPA among drinkers. It also reviews the attitudes of drinkers towards the introduction of MPA in Wales and examines the reasons underlying these views.

Chapter 7 moves on to consider if and how drinkers are planning to prepare for MPA. The chapter focuses on pre-implementation activities and leaves post-implementation actions for consideration in Chapter 8, which focuses on the impact of MPA on people's drinking patterns and use of other substances. Chapter 9 investigates the potential impact of MPA on drinkers' lives more generally focusing on social and health issues.

In light of the potential impact of MPA, Chapter 10 moves on to investigate the type of support that drinkers might need to mitigate any potential negative outcomes.

Chapter 11 summarises the findings and reflects on them in light of the literature reviewed in Chapter 3. The report ends with some Concluding Comments followed

[4] Reports will also be produced 18 months and 42 months post implementation of the legislation.

by a short section in which we outline our Next Steps for the evaluation of the impact of MPA on the wider population of drinkers in Wales.

Language (labels and descriptors)

Throughout this report, the term ‘drinkers’ is used to denote anyone who has consumed alcohol in the last year, no matter the quantity consumed.

The language around alcohol harms can be confusing as it is not always clear what the terms mean (Alcohol Change UK, no date). Labels such as ‘problem drinking’, ‘alcoholic’, ‘dependent drinker’, and ‘harmful drinker’ are commonly used within the literature yet they are not always used consistently.

There are also different ways of measuring the levels of risk associated with drinking (Alcohol Change UK, undated). Some measures of risk are based wholly on the number of units that drinkers consume each week while other measures (e.g. the Alcohol Use Disorder Identification Test – AUDIT) assess consumption patterns and feelings about drinking too. Confusion arises when the different methods of measuring risk use similar language even though they are measuring different things.

The AUDIT measures a drinker’s risk of alcohol-related harm based on their answers to 10 questions[5]. The AUDIT uses the terms lower risk (0-7), increasing risk (8-15) and higher risk (16+) to categorise drinkers on the basis of their scores. A score of 20+ on the AUDIT is sometimes categorised separately as ‘possible dependence’[6].

Consistent with other researchers, in this report the terms moderate, hazardous and harmful drinking are defined on the basis of AUDIT scores[7]. A moderate drinker is therefore someone scoring 0-7 on the AUDIT and considered to be at a low risk of alcohol-related harm. A hazardous drinker includes drinkers scoring between 8 and 15 on the AUDIT and deemed to be at increasing risk of harm. Harmful drinkers includes people scoring 16 or more and assessed to be at a high risk of alcohol-related harm.

[5] Each question is allocated a score of 0 to 4. The maximum possible score is 40.
[6] Alcohol Screening Tool
[7] AUDIT scores were calculated for all research participants including survey respondents and interviewees.

2. Background and context

This chapter sets the context for the report by briefly defining minimum pricing for alcohol and outlining where in the world, and in what form, minimum pricing policies currently operate[8]. The chapter then moves on to consider the UK context of MPA and to map out the history and development of minimum pricing for alcohol policy and legislation in Wales. The chapter ends with a summary of the provisions of the new legislation and situates this report within that context.

Minimum pricing for alcohol policies

Minimum pricing for alcohol involves setting a minimum price below which alcohol cannot legally be sold or supplied. Minimum pricing for alcohol policies of one form or another are in place in a few countries around the world, including:

- Canada (in British Columbia and Saskatchewan provinces)
- Australia (in the Northern Territory)
- USA (in Connecticut, Kansas and Ohio)
- Russia
- Scotland
- Moldova
- Belarus
- Ukraine, and
- Uzbekistan

Common to all policies is the goal of reducing alcohol-related harm. However, not all minimum pricing for alcohol polices are the same. Some countries have adopted policies that are based on a minimum price per unit of all types of alcohol (e.g. Canada, Australia, and Scotland). Other models are quite different. Uzbekistan prohibits the sale of alcohol for a price less than the production cost[9], while Belarus, Russia, Ukraine and Moldova have different levels of minimum pricing for different types of alcohol (i.e. beer, wine, and spirits).

The UK context of minimum pricing for alcohol

Calls for the introduction of minimum pricing for alcohol have a fairly long history in the UK. In 2008, the Chief Medical Officer for England recommended setting a minimum price of 50p per unit asserting that this would target binge drinking and leave moderate drinkers comparatively unaffected[10]. In 2012, the Coalition Government's Alcohol Strategy included a commitment to introduce minimum pricing and levels of 40p to 50p per unit were discussed. However, the commitment was

[8] More comprehensive contextual information about Minimum Pricing for Alcohol, including the international context, are presented in Holloway et al. (2019) *Research into the Potential for Substance Switching Following the Introduction of Minimum Pricing for Alcohol.* Accessed on 19 June 2020 at: Holloway et al. (2019)

[9] World Health Organisation - European status report on alcohol and health 2014 - pricing policies

[10] 150 years of the annual report of the Chief Medical Officer

retracted following a consultation and the government, instead, introduced a ban on sales below production cost price in May 2014 (Brennan, 2014; Woodhouse, 2020). In March 2020, the Government stated that there were 'no plans for the introduction of MPA in England' although it would continue to monitor the progress of MPA in Scotland (Woodhouse, 2020) as per the recommendation of a House of Lords Committee in 2017[11].

In Scotland, alcohol licensing is a devolved matter. After a five-year legal case with industry representatives, minimum unit pricing (at the level of 50p per unit) came into force on 1 May 2018 as part of The Alcohol (Minimum Pricing) Scotland Act 2012. In Wales, the Public Health (Minimum Price for Alcohol)(Wales) Act 2018 enabled the introduction of minimum pricing for alcohol on public health grounds, an area within the National Assembly[12] for Wales's legislative competence[13].

At the time of writing (July 2020), Scotland and Wales are the only two countries in the world that have nationwide policies of minimum unit pricing that apply to all types of alcohol.

Timeline of key events in the evolution of MPA in Wales

Welsh Government has long been clear that a pricing intervention must be a key component of any strategy seeking to reduce alcohol-related harm[14]. The first public consultation on the idea was launched in 2014 as part of the Public Health Bill White Paper[15]. The proposal of introducing a minimum unit price was presented within the theme of 'improving health over the life course' and linked to the concept of 'prudent health care':

> *… introducing Minimum Unit Pricing for alcohol would be entirely in accordance with prudent healthcare principles. It involves taking proportionate and preventative action to protect public health in order to avoid longer term health, societal and economic costs, as there is indisputable evidence that the price of alcohol influences consumption.* (Welsh Government, 2014: p. 31)

In 2014, Welsh Government commissioned their Advisory Panel on Substance Misuse (APOSM)[16] and a group of researchers from the University of Sheffield's Alcohol Research Group (SARG) to explore the potential impact of a range of alcohol pricing policies as a method of reducing alcohol-related harms[17]. Both groups concluded that the introduction of a minimum unit pricing policy for alcohol in Wales would be an effective mechanism through which to reduce alcohol-related harm.

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[11] House of Lords Select Committee on the Licensing Act 2003, The Licensing Act 2003: post-legislative scrutiny, HL Paper 146, 4 April 2017, para 86

[12] On 6 May 2020, the National Assembly for Wales changed its name to Senedd Cymru – the Welsh Parliament.

[13] UK Parliament Research Briefing

[14] Welsh Government Consultation - Summary of responses

[15] Welsh Government Public consultation 2014

[16] APoSM was disbanded in 2019.

[17] In 2017, SARG were commissioned to undertake an updated analysis of the potential impact of a range of alcohol pricing policies.

A Public Health (Minimum Price for Alcohol)(Wales) Bill was subsequently drafted and included provisions to introduce a minimum price for the sale and supply of alcohol in Wales and to make it an offence for alcohol to be sold or supplied below that price. In common with the Public Health (Wales) Act 2017, the Bill sought to build on commitments in the Welsh Government's Programme for Government Taking Wales Forward and responded to important public health challenges in Wales. The approach taken in the Bill also complemented the Wellbeing of Future Generations (Wales) Act 2015[18], which seeks to improve the social, economic, environmental and cultural well-being of Wales.

Consultation on the draft Bill in 2015 found considerable support for the introduction of MPA and on 23rd October 2017, the Bill was presented to the National Assembly[19] of Wales by the Minister for Social Services and Public Health[20],[21]. While the introduction of MPA signified a 'firm commitment to further improving and protecting the health of the population of Wales' as a whole, its primary aim was 'to protect the health of harmful and hazardous drinkers who consumed larger amounts of low-cost and high-alcohol products'[22]. After passing through three stages of debate and consideration, the Bill was agreed by the National Assembly on 19 June 2018 and received Royal Assent on 9 August 2018.

Setting the minimum price per unit

The SARG had modelled a number of different minimum prices per unit (from 35-70p) but had focused on 50p per unit given its dominant place in discussions at that time and its subsequent introduction in Scotland (Meng et al, 2014; Angus et al, 2018). The group identified a negative correlation (or an inverse relationship) between price and demand for alcohol. In other words, the higher the minimum price, the lower the demand. The modelling suggested that reductions in a range of alcohol-related harms would follow any given reduction in consumption including those of:

- attributable deaths (decrease of 8.5 percent at 50p);
- work-based absences (1.9 per cent at 50p); and
- crime (up to three per cent at 50p).

Based on the analysis undertaken by SARG and on the wider evidence base (laid out in detail in the Explanatory Memorandum), Welsh Government opted to choose 50p per unit as the preferred level of the minimum unit price. It was noted:

> *Taking into account a range of factors, the Welsh Government considers a 50p minimum unit price would be a proportionate response to tackling the health risks of excessive alcohol consumption and strikes a reasonable*

[18] Wellbeing of Future Generations (Wales) Act 2015
[19] The National Assembly is now known as Senedd Cymru – Welsh Parliament.
[20] UK Parliament
[21] At that time, the Minister for Social Services and Public Health was Rebecca Evans. Shortly after its introduction, the responsibility for the Bill passed to the Minister for Health and Social Services
[22] Welsh Government

> *balance between the anticipated public health and social benefits and intervention in the market. (*Welsh Government, 2018: p.8)[23]

Ahead of laying the regulations before the National Assembly, the Welsh Government issued a 12-week consultation (28 September to 21 December 2018) on the preferred level of a 50p minimum unit price[24]. On the basis of the consultation Welsh Government concluded that a 50p (£0.50) MUP would be a proportionate response to tackling alcohol-related harm. The Minister for Health and Social Services (Vaughan Gething) subsequently issued a Written Statement about the intent to lay draft regulations for the National Assembly for Wales, with a view to introducing minimum pricing for alcohol later in 2019[25].

Laying the regulations

In accordance with the Technical Standards and Regulations Directive 2015/1535/EU, the Welsh Government referred the draft regulations to the EU Commission. This was followed by a three-month standstill period, during which the Welsh Government could not lay the draft regulations. On 22 May 2019, notification was received that an EU Member State (Portugal) had submitted a detailed opinion in respect of the draft regulations[26]. Portugal warned that the plans would have direct implications on the free trade rules of the EU market and was concerned that Portuguese wines would become less competitive in the market:

> *There are Portuguese operators who export wines to Wales whose consumer price is lower than the minimum price, therefore the application of a minimum unit price means that many of these wines will suffer an increase in price, which will make them less competitive in that market.* (BBC News, 2019)

The effect of Portugal's objection was that the standstill period had to be extended by an additional three months to 21 August 2019.

The Public Health (Minimum Price for Alcohol) (Minimum Unit Price) (Wales) Regulations 2019 were eventually laid on 15 October 2019 and specified a minimum price of 50p per unit. These were agreed by the National Assembly for Wales on the 12 November 2019.

The Public Health (Minimum Price for Alcohol) (Wales) Act 2018 (the Act) came into force on 2nd March 2020. The Act gives effect to the Welsh Government's determination to provide a legislative basis for addressing some of the long-standing and specific health concerns around the effects of excess alcohol consumption in Wales. The ultimate aim of the Act is to tackle alcohol-related harm, including alcohol-related hospital admissions and alcohol-related deaths, by reducing consumption amongst hazardous and harmful drinkers, who tend to consume greater quantities of low-cost and high-alcohol content products.
The Act includes:

[23] Welsh Government Consultation on MPA
[24] Welsh Government Consultation on MPA
[25] Welsh Government Written Statement on MPA
[26] Welsh Government Written Statement on MPA

- The formula for calculating the applicable minimum price for alcohol using the percentage strength of the alcohol, its volume and the Minimum Unit Price (MUP);
- Powers for Welsh Ministers to make subordinate legislation to specify the MUP;
- The establishment of a local authority-led enforcement regime and powers to bring prosecutions;
- Powers of entry for authorised officers of a local authority, an offence of obstructing an authorised officer and the power to issue fixed penalty notices;
- Placing a duty on the Welsh Ministers to lay before the National Assembly and then publish a report on the operation and effect of the legislation at the end of a five-year review period; and
- That the minimum pricing will be repealed at the end of a six-year period, unless regulations are made by the Welsh Ministers providing for its continuation.

Evaluation of Minimum Pricing for Alcohol in Wales

In accordance with the Act, Welsh Government has commissioned an evaluation of the operation and effect of the legislation over a five-year period. This report forms part of that evaluation and provides baseline data relating to alcohol consumption and related behaviours among moderate, hazardous and harmful drinkers within the general population of people living in Wales. The report is based on data collected in the months prior to the implementation of MPA on 2nd March 2020 when the COVID-19 pandemic was beginning to emerge within the UK. However, none of the substantive lockdown measures had been imposed at that time meaning that the data presented reflect pre-COVID and pre-MPA drinking and expenditure patterns.

3. Literature review

Since the publication of our report investigating the potential for substance switching and other unintended consequences of introducing a minimum price for alcohol in Wales (Holloway et al., 2019)[27], several important studies have emerged that shed further light on the likely impact of MPA. In this chapter we describe the methods used to identify these new papers and provide an overview of their findings. The aim of the chapter is to update our earlier review to show the current state of knowledge on the topic. We begin with a brief summary of the original review and then move on to present the results of the updated one.

Summary of original review

Holloway et al. (2019) conducted systematic searches of two bibliographic databases[28] to identify publications focusing on the link between alcohol pricing and substance switching[29]. The review covered switching in terms of (a) switching from one type of alcohol to another type of alcohol, and (b) switching from alcohol to another type of substance. Given the small number of eligible studies identified, the review was extended to include substance switching behaviour more generally rather than specifically as a result of alcohol pricing policies.

The review found only a small amount of tentative evidence suggesting that switching to more harmful substances (either licit or illicit) would occur as a result of increased alcohol prices. Furthermore, most of the evidence gathered was from studies conducted in distinct social and cultural locations, making inferences difficult to apply in the Welsh context.

Echoing the calls of other researchers, the original review concluded that more research was needed to strengthen the evidence base and confirm the likelihood and nature of substance switching as a result of increased alcohol prices (Vandenberg & Sharma, 2016; Araya & Paraje, 2018; Hobday et al, 2016; Sharma et al, 2017).

Search strategy and selected studies

A full overview of the original methodological approach can be found in Holloway et al. (2019). The review in this report followed a similar approach, whereby literature sources were identified through searches in the bibliographic database, Applied Social Sciences Index and Abstracts (ASSIA). The database is known to include studies on alcohol and interventions - including pricing policies - used to reduce alcohol consumption and subsequent harm. 'Hand' searches using Google and

[27] The 'Switching Study' included a full literature review on this topic covering studies up to and including 2018. Holloway et al. (2019).
[28] Applied Social Sciences Index of Abstracts (ASSIA) and the Web of Science.
[29] The review formed part of a broader project investigating the possibility of substance switching as a result of introducing a minimum price for alcohol in Wales. The literature review in Holloway et al. (2019) therefore focused on that particular issue.

Google Scholar were also performed to identify grey literature and studies that may not have been identified via database searches. A Boolean search using a range of keywords was conducted to identify relevant literature. The criteria for inclusion were purposely narrow and included any studies with a focus on the impact of alcohol pricing policies or price changes (increase or decrease) worldwide. Studies must have been accessible to the research team during the data gathering period and published in English. Only studies published after 2017 were included due to the recent publication of a related systematic review (Holloway et al., 2019).

Results

The initial search of ASSIA identified 10 studies of potential relevance. The abstracts of these studies were reviewed and those publications that appeared to match the eligibility criteria were obtained. This led to a provisional selection of four studies that were considered potentially suitable. Three studies were also identified using Google/Google Scholar. The characteristics of the seven included studies are summarised in Table 3.1.

Table 3.1 Characteristics of included studies

Author(s)	Country	Study Design	Focus
1. Jiang et al (2020)	Australia	Modelling	Modelled effects of a range of alcohol pricing policies on alcohol consumption in subpopulation groups
2. Sherk et al (2018)	Canada	Time-series analysis	Effect on emergency department visits of raised alcohol minimum prices
3. O'Donnell et al (2019)	Scotland	Interrupted time-series analysis	Immediate impact of MPA on household alcohol purchases
4. Stead et al (2020)	Scotland	Observational	Impact of MPA on small retailers' experiences
5. NHS Scotland (2020)	Scotland	Cross-sectional	Impact of MPA on CYP's drinking behaviours
6. Ford et al (2020)	Scotland	Cross-sectional	Practitioner views of the impact of MPA on protecting CYP from parents' and carers' harm
7. Coomber et al (2020)	Australia	Cross-sectional	Impact of MPA in achieving objectives, including reductions in alcohol consumption, negative outcomes associated with consumption, and minimal impact on moderate consumers

Overview of each included study

A recent study by Jiang et al. (2020) modelled the effects of different alcohol pricing policies on different populations in Australia, including: moderate, hazardous and harmful; younger, middle aged and older; and lower, middle and higher income drinkers. The findings found that following the modelling of the impact of various alcohol pricing policies, including an MPA of $1.00, $1.20 and $1.50 ASD, average consumption would fall by 5.8%, 10.7% and 14.9% respectively across all drinkers. Across 'type' of drinker (harmful, hazardous and moderate), the modelling projections found that introducing MPA at $1.30 and $1.50 ASD would achieve a 10% reduction in drinking (14.2% and 22.1% respectively). Similarly, the same pricing policies would reduce consumption by 12.7% and 19% respectively among households with lower incomes. Interestingly, younger (16-34) drinkers were less sensitive to MPAs of $1.00, $1.30 and $1.50 than middle and older adults. The findings were broadly in line with similar modelling studies from the UK (Holmes et al., 2014), leading the authors to similarly conclude that the introduction of MPA is likely to lead to the most significant reductions in alcohol consumption among low-income and hazardous and harmful level drinkers.

Sherk, Stockwell, and Callaghan (2018) investigated the impact of raised alcohol minimum prices in Saskatchewan, Canada, on emergency department visits. This was related to four alcohol-related injury categories, including: minor vehicle collisions; assaults; falls; and total alcohol related-injuries. The study found a lagged effect of the intervention on alcohol-related admissions into emergency departments, including a 40% reduction in motor vehicle collisions 6 months after the introduction of MPA. Based on these findings, the authors concluded that Saskatchewan's application of MPA is broadly associated with reductions in emergency department admissions. This corresponds with prior research conducted in the state, which found MPA to be associated with reduced alcohol consumption (Stockwell et al., 2012) and alcohol-related crime (Stockwell et al., 2017).

In May 2018, Scotland implemented Minimum Unit Pricing (MUP), set at 50p per unit of alcohol. Study protocols for a series of empirical evaluations have since been produced to assess the impact of the legislation. The protocol for a mixed-method natural experiment was published in early 2020 (Beeston et al, 2020) while a protocol for a natural experiment evaluating the possible intended and unintended consequences of MUP was published the year before (Katikireddi et al., 2019).

Early findings of the immediate impact of the introduction of MUP on household alcohol purchases, however, were reported by O'Donnell et al. (2019) in an interrupted time-series analysis of data from 2015-2018. Household data found that the introduction of legislation resulted in a 7.6% reduction in purchases of alcohol, equating to a total reduction of 41 UK units per adult per household per year. This is not dissimilar to the 8.4% reduction in total volume of pure alcohol sales in Saskatchewan, Canada, reported by Stockwell et al. (2012). The findings led the authors of the Scottish study to conclude that the introduction of MUP in Scotland appears to be productive in reducing the quantity of alcohol purchased by households across the nation.

Further studies from Scotland include an observational evaluation of the impact of MUP on small retailers (e.g. small, single stores owned and operated by an individual or family, or affiliated to a larger retail group (e.g. Nisa, Premier)) (Stead et al., 2020). The study sought to assess and understand small retailer's experiences following the implementation of MUP, and its impact of pricing, product range and consumption. The study was based on a range of data collection methods, including: electronic point of sale data; pricing for 2000 products sold by 200 small retailers across Scotland; interviews and observations across 20 stores; and an analysis of retail trade press to gather information on pricing, promotional activity and experiences of MUP. The data were collected between August 2017 and January 2019, capturing 9 months before and after MUP was implemented. Overall, there was adherence to the policy across small retailers, with alcohol products previously sold below 50p now increasing to prices in line with the legislation. Further, interview data with small retailers uncovered a range of varying perceptions regarding sales. Indeed, responses were mixed in terms of whether sales had increased or declined, although purchasing patterns were felt as being impacted, with a perception that customers were purchasing lower strength and smaller products, or those perceived to be of better value now that prices across products had aligned.

Overall, the findings presented data to suggest that the implementation of MUP in the small retail sector has been done so as proposed, and has resulted in intended impacts on alcohol products sold under 50p per unit in small retail shops. No adverse impacts on small retailers were identified, and products previously sold under 50p per unit ceased to be sold within stores. There were also observed changes in customer buying, with reports of customers moving from higher to lower strength products or to beverages sold in smaller containers. Overall, small retailers felt that the legislation had resulted in greater profit margins and an ability to compete with supermarkets in terms of alcohol sales.

Two more studies from Scotland have assessed the impact of MUP on protecting children and young people (CYP) from harm. This has been explored through studies investigating the impact of MPA on CYPs (13 – 17) drinking behaviour (NHS Health Scotland, 2020), and the impact of MPA on protecting CYP from parents' and carers' harmful alcohol consumption, (Ford, Myers, Burns, & Beeston, 2020). In terms of the former, the study looked at how MUP was impacting CYP's own alcohol consumption and related behaviour (NHS Health Scotland, 2020). The study was based on individual, paired and small group interviews with 50 CYP who drank alcohol prior to the introduction of the legislation, and continued to do so after the introduction of MUP.

The study found evidence to suggest that many of the alcohol products favoured by CYP were already above the 50p per unit threshold prior to the introduction of MUP. As such, there was little change in the CYPs alcohol consumption, nor were there any observed changes in related behaviours: participants continued to purchase alcohol in the same way (through asking strangers, using fake IDs, or from parents) and there was no mention of theft in response to unaffordable alcohol. Although there was some mention of changes in what CYP drank, these changes were mostly due to external factors, such as getting older, changes in taste and tolerance, and new friendship groups. Finally, no harms were reported, and there was no evidence to suggest that MUP had either increased or reduced exposure to any harms.

Subsequently, the authors concluded that MUP did not impact on participants' alcohol consumption or related behaviour either positively or negatively.

The second study – an investigation of practitioner views' on the impact of MUP on protecting CYP from parents' and carers' harm - suggested that, due to a combination of factors including: (1) the complexity and hardship experienced by the people practitioners work with, (2) the limited amount of time MUP had been in operation in Scotland for, and (3) a reluctance among some CYP to disclose any harm they may be experiencing at home, disentangling the specific impact and effects of MUP on parent and carer drinking and subsequent harm was difficult: indeed, there were limited examples within the data set of how MUP had impacted drinking and subsequent harm within these families. The study was based on eight focus groups and one interview with staff working in services that support children following the introduction of MUP. Despite the difficulty in identifying harms, the study did detect the need for appropriate support for families experiencing alcohol-related harms. This included interventions that address the root causes of harmful drinking, such as whole family approaches.

Finally, a comprehensive report investigating the introduction of a MPA of $1.30ASD in the Northern Territory (NT), Australia (Coomber et al., 2020) resulted in significant declines in: total alcohol wholesale supply per capita; alcohol-related assault offences; protective custody episodes; alcohol-related ambulance attendances; alcohol-related emergency department (ED) presentations; 'Sobering Up' Shelter admissions; alcohol-related road traffic crashes (resulting in injury or fatality); and, the number of child protection notifications, protection orders, and out-of-home care cases. No significant changes were identified in relation to the number of tourists and their expenditure, and the number of liquor licences across the NT. The report also found, despite concerns regarding substance switching prior to the implementation of the legislation, no reliable evidence of substitution, nor signs of increased drug use. The wide range of positive findings arising from the legislation led the authors to suggest that the available data presented strong evidence of the beneficial impact of MPA.

Summary of the updated review

The seven recent studies investigating the impact of pricing policies, including MPA, provide evidence that increasing alcohol prices generally resulted in favourable outcomes, including decreases in: emergency department visits (Sherk et al., 2018), alcohol consumption, alcohol-related assault, alcohol-related road traffic accidents, and child protection notifications (Coomber et al., 2020). Moreover, there is recent evidence from Scotland to suggest that MUP is being implemented across small retailers as intended (Stead et al., 2020) and was having no detrimental effect on CYP's alcohol consumption or related behaviour (NHS Health Scotland, 2020). Household expenditure on alcohol had also declined post-intervention (O'Donnell et al., 2019). However, any impact of MUP on protecting CYP from parents' and carers' harm was tentative, due to a combination of methodological and external factors that made it difficult to accredit any impacts solely to the implementation of MUP (Ford et al., 2020). Finally, a modelling study of the effects of alcohol pricing policies, including MPA, on alcohol consumption in subpopulations in Australia predicted that

increasing alcohol prices (either as a result of taxation or hypothetical price increases) would result in decreases in general population alcohol consumption, particularly among low-income and hazardous and harmful level drinkers. This finding is generally consistent with a well-established body of literature, including systematic reviews and meta-analyses, evidencing the impact of increased prices on reductions in alcohol consumption (Elder et al., 2010; Fogarty, 2010; Sharma, Sinha, & Vandenberg, 2017; Wagenaar, Salois, & Komro, 2009).

In light of the reviewed recent evidence, there is observational and cross-sectional evidence to suggest that the introduction of MUP in Scotland is being implemented as intended, with no detrimental effect on small retailers (Stead et al., 2020) nor on the drinking behaviours of CYP (NHS Health Scotland, 2020). Evidence from Australia (Coomber et al., 2020) and Canada (Sherk et al., 2018) similarly present favourable findings in terms of reducing alcohol consumption and related harms. Despite the emerging and generally positive data that is developing, there is still a need to conduct further research on this topic, particularly in Wales where there is a need to: (1) apply and re-test principle lessons from research conducted in Scotland (O'Donnell et al, 2019; Ford et al., 2020; Stead et al, 2020), and (2) add to the existing body of research on MPA that has been conducted in distinct social and cultural locations (Coomber et al., 2020; Jiang et al., 2020).

Other relevant research

The literature reviewed in this chapter was identified using specific search criteria to identify studies investigating the impact of alcohol pricing policies on consumption and purchasing patterns within the general population. Given this fairly strict criteria, the 'Switching Study' by Holloway et al. (2019)[30], of which the original literature review formed a part, was not eligible for inclusion. This was partly because the study focused on predictions of behaviour subsequent to the introduction of MPA and not actual behaviour following a price change, but also because the research was based on service users and service providers and not on drinkers recruited from within the general population. Despite these differences, we believe that the study is a useful one with which to draw comparisons with the findings presented in this report. Both studies are based on samples living/working in Wales and both provide baseline measures of alcohol-related behaviours prior to the implementation of MPA. We have therefore summarised the findings in the paragraphs below and routinely reflect back on them throughout the report.

The 9-month project gathered the thoughts and perceptions of substance misuse treatment providers as well as drinkers who were in contact with these treatment services using semi-structured interviews and online questionnaire surveys.

The potential for substance switching was thought to be an unlikely consequence of introducing MPA in Wales. For the majority of drinkers, alcohol was understood to be a clear drug of choice and crossing over to drugs and especially towards the margins of legal/illegal activity, was just not an option. It was therefore predicted that for most drinkers the only switching or change in use would be alcohol related. In other

[30] The same group of researchers conducting this aspect of the evaluation.

words, it was anticipated that drinkers might switch the type of alcohol they consume or change their purchasing behaviour.

There was, however, a suggestion that switching between substances would be more likely among certain groups, notably street drinkers and those with prior experience of drug use. If switching away from alcohol was to occur, it was predicted that this would most likely be to prescription medications such as benzodiazepines that mimic the effects of alcohol, followed by cannabis and synthetic cannabinoids, with only a few suggesting a switch to cocaine or opiate use.

Generally speaking, providers and drinkers were pessimistic about the potential for MPA to reduce alcohol consumption. For low-medium risk drinkers, the feeling was that any increase in expenditure would be absorbed into existing budgets and that no significant adaptation or change in behaviour would be warranted. However, a different scenario was anticipated for high-risk, dependent drinkers, and a range of potential coping mechanisms, often extensions of existing behaviour, were predicted. These included, in no particular order:

- Switching to stronger forms of alcohol, which are likely to become similar in price once MPA is introduced (e.g. switching from cider to spirits).
- Brewing alcohol (including spirits) at home
- Purchasing counterfeit alcohol, in much the same way that counterfeit cigarettes are purchased (e.g. under the counter).
- Committing acquisitive crime to obtain alcohol directly or fund the purchase of alcohol.
- Re-budgeting of existing household resources to free up money to spend on alcohol (i.e. spending less on food, clothes, rent and bills).
- Borrowing money from family and friends to fund the purchase of alcohol.
- Borrowing money to buy alcohol through ‘tabs’ from pubs and shops.
- Obtaining supplies of alcohol from England (or other countries not currently implementing minimum pricing policies) either by road or online.

There was concern that many of these coping strategies would result in negative consequences not only for drinkers but also for their families, friends and the communities in which they live. The potential harm to children arising from a shift in household expenditure away from food, clothing and housing costs to alcohol was a particular fear as too were the personal and social consequences that an increase in acquisitive crime might bring.

To help prepare for the introduction of MPA and minimise these potential problems, it was thought important that carefully worded and widely publicised messages, on a variety of platforms, be issued across Wales. Dissemination of findings was thought to be critical in helping key stakeholder groups prepare for a potential increase in demand for their services (e.g. GPs, substance misuse services, A&E, police).

Early warning of the price change was also thought to be essential for drinkers as this would give them the opportunity to consider, and perhaps implement, long-term coping strategies, such as cutting down or entering treatment, prior to the introduction of MPA.

Summary

This chapter has presented the results of a review of the literature on the impact of alcohol pricing policies on consumption. The review updates an earlier, more in-depth, review that formed part of the 'Switching Study' undertaken by Holloway et al. (2019). The chapter includes a summary of the original review and then moves on to detail the search strategy employed in the updated review (i.e. systematic searches of two bibliographic databases) as well as the results of those searches. Eight eligible studies were identified and their results were summarised individually and then collectively. While the conclusions of the updated review are largely positive in finding that alcohol pricing policies can help to reduce alcohol-related harm, the review identified the need for further research on the topic, particularly in a wider range of social and cultural locations. Given the focus on Wales and on gathering baseline data pre-implementation of MPA, the chapter also included a summary of the 'Switching Study'.

4. Methods

In this chapter the methods that were used to gather the baseline data pre-implementation of MPA are described. Firstly, the aims and objectives are restated to help provide context and then the research design and strategy that underpin this research project as a whole are discussed. Following this, the methods of data collection are considered and a description of how in practice the baseline data, upon which this report is based, were gathered is provided. The chapter ends with a section that provides information about the methods of data analysis that were undertaken.

Aims and objectives

The specification for the contract for the research stated that the main aim of the study was to explore the impact of the minimum price for alcohol legislation on the wider population of drinkers in Wales. The specification also listed four research objectives:

1. To assess the attitudes of MHH drinkers towards the legislation
2. To assess the changes that MHH drinkers make in response to the legislation (e.g. changes in their use of alcohol and other drugs, changes in purchasing patterns, changes in their lifestyles)
3. To assess the impact of the legislation on the lives of MHH drinkers (e.g. relationships, employment, health, financial circumstances)
4. To undertake an analysis of household expenditure patterns, to assess the potential displacement of spending.

It also listed five more practical objectives that related to the timing of the research and the production of baseline, interim and final reports.

1. To undertake baseline work prior to implementation.
2. To produce a report for publication on the findings of the baseline work.
3. To undertake follow-up studies at 18 months and 42 months[31].
4. To produce an interim report after two years.
5. To produce a final report.

The project was designed with these research and practical objectives in mind.

Research design and strategy

The *research design* is the blueprint or masterplan for conducting a study. It is the structure or approach that describes how, when and where data are to be collected and analysed (Bryman, 2016). In light of the research objectives, the proposed

[31] To investigate the potentially confounding effect of COVID-19 and lockdown on drinking patterns in the period shortly after MPA was introduced, Welsh Government commissioned the evaluation team to undertake an additional wave of interviews with the longitudinal study sample in the Autumn of 2020 (9-months post implementation of MPA).

timelines for project completion and legislation implementation, the study has two components, both of which involve the collection of data at more than one point in time: (1) a longitudinal interview study and (2) repeat cross-sectional surveys.

The longitudinal interview study will involve repeat qualitative interviews with a sample of moderate, hazardous and harmful drinkers at three points in time. The first wave of interviews was conducted in early 2020 before the implementation of MPA on 2nd March 2020. The second and third waves will be conducted 18 months and 42 months post implementation of MPA[32].

A longitudinal research design is particularly useful for capturing social changes and shifts in people's life courses and in their thoughts, feelings and behaviours (Bryman, 2016). The main disadvantage, however, is that it can sometimes be difficult to maintain contact with sample members over long study periods. Given the possibility of attrition, we propose to replace any 'lost' participants with new participants from the same sampling sources (i.e. National Survey for Wales (NSW), universities, third sector organisations or the online survey), to ensure that the sample remains consistent in terms of size and composition over the study period. The design of the longitudinal study is therefore a mixture of a cohort design and a panel design.

In addition to the longitudinal interview study, the project also includes repeat cross-sectional surveys with samples of MHH drinkers. The first survey was launched in the period prior to implementation of MPA (i.e. before 2 March 2020) to provide baseline data that can be used to measure change over time[33]. This survey will be repeated at two further points in time (at 18 months and 42 months post implementation). Repeated cross-sectional designs are not able to address the direction of cause and effect because each sample is a fresh one that may include new respondents. However, they are useful in their ability to chart broader changes over time among large samples (Bryman, 2016).

The *research strategy* is the general orientation to the conduct of research, in other words whether the study is quantitative or qualitative in focus (Bryman 2016). To achieve the objectives, a mixed methods strategy has been adopted which will guide the collection of both qualitative and quantitative data relating to the impact of MPA. A mixed methods approach is valuable in that the limitations in one approach can be offset by the strengths of the other. For example, a qualitative approach is particularly useful for helping researchers understand how others interpret the world and for seeing things through others' eyes (Wincup, 2017). Quantitative research, meanwhile, enables researchers to count and measure the extent of phenomena and is useful for obtaining the views of large groups of people (Bryman, 2016).

Consistent with Welsh Government strategies and guidance (Welsh Government, 2014), we are working closely with participants (service users in particular) to ensure that our research plans are appropriate, to check that our data collection tools are user-friendly, to help access relevant respondents and to guide our interpretation of

[32] The additional wave of interviews that was commissioned by Welsh Government during the COVID-19 pandemic will be conducted 9 months post-implementation of MPA.
[33] The survey was opened on 15th October 2019 and closed on 29th February 2020. The survey was closed between 23rd November 2019 and 13th December 2019 in the run up to the General Election.

the collected data. To assist with this process, we are working with the Project Advisory Group (PAG) that was created to support our work investigating the possible unintended consequences of introducing a minimum price for alcohol in Wales (Holloway et al, 2019)[34]. The PAG includes relevant stakeholders, including service users, and meets/communicates at regular intervals to discuss MPA research-related issues (e.g. draft data collection tools, recruitment and preliminary findings).

Methods of data collection

As noted above, this study is a longitudinal one, which involves collecting data using the same methods at three points in time. This report presents findings from the first data collection point, prior to the implementation of MPA. Subsequent reports will use this data as a baseline against which behaviours measured at 9 months, 18 months and 42 months post-implementation of MPA can be compared[35].

In the sections below the methods and procedures that were used to gather baseline data for this study are outlined. First, the longitudinal interview study and the use of qualitative interviews to gather in-depth information from a sample of drinkers are discussed. The cross-sectional study and the use of an online questionnaire survey completed by drinkers living in Wales are then considered.

Repeated qualitative interviews (i.e. the Longitudinal Interview Study)

Qualitative interviews were conducted with a sample of drinkers who all agreed to participate in two further interviews post-implementation of the legislation. Participation was encouraged with the use of incentives (Boys et al, 2003). Interviewees were given a £10 Argos[36] voucher for taking part in the first interview and advised that they would receive further £10 vouchers for taking part in the two subsequent interviews and a bonus £10 for taking part in all three.

The interviews assessed a range of issues including drinkers': awareness of and attitudes towards MPA, preparation and planning for the introduction of MPA, the potential impact of MPA on their drinking and use of other substances, the broader impact on their health and social lives, and current household expenditure and spending patterns.

The interview schedule was designed for a semi-structured interview based on themes to be covered and interviewer prompts to assist in guiding the conversation. The specific interview questions were derived from the research objectives set out in the specification and the current research evidence base (and gaps therein). Of particular importance at baseline was the need to investigate with participants their

[34] Holloway et al. (2019) Research into the potential for substance switching following the introduction of minimum pricing for alcohol in Wales.
[35] As noted above, in response to the COVID-19 pandemic, the evaluation team was commissioned to undertake an additional wave of interviews approximately 9-months post-implementation of the legislation.
[36] Argos was chosen as alcohol cannot be purchased from this retailer.

predictions of how MPA would affect their drinking patterns (e.g. would they change type or brand or even substance) and their lives more generally (e.g. relationships, health, housing, finances, etc).

In practice, the interviews were 'flexible but controlled' (Burgess, 1984) and based on an open rather than rigid structure, which can often regulate, subdue and structure the responses of participants (Bryman, 2016). We also adopted an iterative approach, whereby the results of early interviews guided the structure and content of later ones.

Sampling strategy for the longitudinal interview study
Participants in the longitudinal interview study were recruited using four methods: (1) through the National Survey for Wales, (2) through third sector organisations providing housing support in the South Wales area, (3) advertisements within two Welsh universities, and (4) the online questionnaire survey. The numbers of interviewees recruited through each method are presented in Table 4.1. Further details of how these methods were used are described in the sections below.

Table 4.1 Sampling sources

	N	%
National Survey for Wales	21	51%
Third sector organisations	10	24%
Universities	6	15%
MPA Pre-implementation Survey	4	10%
TOTAL	**41**	**100%**

1. National Survey for Wales (NSW)

The possibility of sampling from the re-contact sample within the National Survey for Wales[37] was included in the specification for the research. With Welsh Government assistance, this method was therefore pursued as a source of moderate, hazardous and harmful drinkers. In practice, recruiting interviewees through the NSW was a staged process. First, we obtained a list of names and phone numbers for all those people who (a) had taken part in the NSW, (b) had agreed to be re-contacted for research purposes and (c) had identified themselves as alcohol drinkers when completing the NSW. Second, we stratified the sample by type of drinker (using answers to questions about alcohol consumption within the NSW) to ensure that our sample of interviewees included similar numbers of moderate, hazardous and harmful drinkers. This would enable us to examine the impact of MPA on different kinds of drinker. Third, we randomly selected (using the Statistical Package for the Social Sciences (SPSS)) 10 people from within each of these three categories and invited them (by telephone) to take part in our longitudinal interview study.

Unfortunately, we were not able to make contact with all 30 of the randomly selected NSW participants. Some did not answer our calls while others turned out to be

[37] Further details about the National Survey for Wales can be found in the Appendix.

ineligible because they did not drink alcohol or because they lived outside of Wales. While most of those spoken to were willing to take part (and in many cases very keen to do so), some changed their mind before an interview date could be set. Replacement interviewees were therefore needed to help us reach our target of recruiting 30 drinkers from the NSW sample.

Replacements were selected by manually scrolling through the NSW lists to identify people with similar characteristics to the person they were replacing. This involved selecting someone who was: the same type of drinker (i.e. moderate, hazardous or harmful), living in the same Local Authority Area, the same sex and the same age (or as close as possible in age) to the original randomly selected person.

In total, we attempted to contact 49 NSW participants. This included 21 who took part in an interview and 28 who, for the reasons listed below, did not:

1. They did not answer our calls or respond to our messages (n=14).
2. They changed their mind prior to completing the interview (n=10).
3. Their phone number did not work (n=1)
4. They were no longer an alcohol drinker (n=1).
5. They were no longer living in Wales (n=1).
6. They were unavailable to take part (n=1)

2. Third sector organisations

Recruitment was also undertaken through third sector organisations that provide support and accommodation to homeless people in the South Wales area. Recruitment from these sources was based on convenience sampling with the kind help of staff working within those organisations. In practice, this usually involved one member of the evaluation team spending time in a busy city-centre hostel waiting for potential, eligible interviewees to turn up. Seven interviewees were recruited in this way. A further three interviews were arranged by staff working with people living in supported accommodation in a different South Wales city. Two of these interviews were conducted face-to-face and one over the telephone.

3. University advertisements

University students were identified as a group of people who it was thought would be affected by the introduction of MPA more than most. We therefore sought to recruit a sample of 10 students for inclusion in the longitudinal study. As university campuses are not included as households in the NSW, it was agreed that a different sampling method would be needed. In practice, this was done through advertisements and announcements placed by members of the evaluation team on the intranet within their respective institutions (one in North Wales and one in South Wales). We were able to recruit three students in this way, although it should be noted that several more were willing but for various personal reasons were unable to complete the interview before the data collection period ended[38].

[38] While we only recruited three students in this way, our final sample of interviewees did in fact include eight students in full-time education, as three were recruited through the online survey and two through the NSW sampling frame.

4. Online survey respondents

Our pre-implementation survey respondents were also used as a source of interviewees. At the end of the online survey (see below for further details), all respondents were asked if they would be willing to take part in our longitudinal study. Forty-six respondents expressed an interest in taking part and a sample of 10 was randomly selected (using SPSS) and sent an email providing them with further information about the study and asking them to contact us by a specified date. It was assumed that those who did not reply to our email had changed their mind and no longer wished to take part. They were subsequently replaced by another person from the list. In total, four interviewees were recruited through this method. Six more had been arranged and/or invited to take part but the data collection period ended before the interviews could take place.

Procedure

The first round of baseline interviews were conducted between 10th January and 28th February 2020 shortly before MPA was implemented on 2nd March 2020[39]. Prior to the interview, all interviewees were asked to complete a short, structured survey to provide information about their demographic characteristics, drinking preferences and patterns, and household expenditure. Completing the survey prior to the interview was useful in that it reduced the time burden on interviewees and also gave them the opportunity to think carefully about their answers. For those interviewees living in less stable accommodation, completing the survey prior to the interview was not an option. In these cases, the survey was completed by the interviewer in collaboration with the interviewee at the start of the interview.

The interviews were conducted in English (no one opted to be interviewed in Welsh) and most were conducted over the phone. Only those interviews involving people living on the street, in hostels, or in supported accommodation were conducted face-to-face and these were all conducted in the premises of third sector organisations with staff nearby. Telephone interviews have a number of advantages: they are less resource intensive than face-to-face interviewing; respondents are less likely to have to cancel at the last minute, and if they do, it is not such a major disruption as it is easily rescheduled; telephone interviews may also enable the respondent to feel more comfortable regarding maintaining confidentiality.

As mentioned above, the interviews were flexible, yet controlled, conversational in style, and led by an open-ended structure based on questions and 'themes' generated by the evaluation team. The benefit of this approach is that it provides a more insightful account of the interviewee's perceptions and experiences, and allows for unexpected, often 'unusual' data to emerge that may not have appeared through more structured, quantitative techniques.

The interviews lasted for an average of 29 minutes, ranging from 14 minutes to 70 minutes. All interviews were digitally recorded with the interviewees' permission and transcribed expertly and securely by Transcriptum Limited[40].

[39] The second round of interviews will take place roughly 18 months after the law has been implemented and the third round will take place approximately 24 months later (i.e. 42 months after the law has been introduced).

[40] Transcriptum Limited was formerly Avonlea Services.

Data analysis
The baseline transcripts were downloaded from Transcriptum Limited and a database of all anonymized transcripts was set up using the NVivo package for qualitative data analysis, which allows for analysis of interview data involving multiple researchers. A thematic analysis was conducted, and a thematic framework grounded in the data was developed (Glaser & Strauss, 1967; Braun & Clarke, 2006).
The data coding and framework were quality assured by two different team members checking each other's coding and/or leading on separate coding. This process helped to ensure that the final extracted themes were not just the personal interpretation of one team member but borne out of the data.

In line with Neale and West's (2014) recommendation, the research team have avoided quantifying the qualitative findings except in a small number of cases where it was deemed particularly important to do so. Instead, a form of semi-quantification has been adopted using terms such as 'a few', 'several', 'some', 'many' and 'most' in order to achieve maximum transparency with regard to the numbers of people giving particular responses or types of response (Neale et al, 2015).

Online survey questionnaire (i.e. repeated cross-sectional surveys)

While qualitative interviews are extremely valuable for gathering in-depth data from participants, they are limited in several respects. Interviews are often time-consuming and it can be expensive to transcribe lengthy recordings. As a result, sample sizes are often small, which limits the generalizability of research findings. To help address and combat these key limitations, this project also includes online[41] questionnaire surveys, which will be repeated at three points in time (i.e. baseline/pre-implementation, and 18 months and 42 months post-implementation).

Although online surveys are useful, particularly in that they are a cheap and convenient way of gathering data from large samples of respondents, they are not without their limitations. As noted by Wright (2005), in any online, internet community there are 'undoubtedly some individuals who are more likely than others to complete an online survey'. Self-selection bias and the recruitment of an unrepresentative sample threatens the external validity of findings by making it difficult to generalise the study findings to the wider population. This is a particular problem for researchers conducting probability research but less of a concern for those conducting non-probability research and who are not seeking to estimate population parameters (Wright, 2005).

Sampling strategy
Convenience sampling was used to recruit drinkers living in Wales to complete the baseline online survey. In practice, this involved advertising the survey online as widely as possible using our networks of contacts (see Procedure below for further details). The goal was to recruit different kinds of drinker (moderate, hazardous and harmful), aged 18 or over who were not currently receiving professional support for alcohol problems[42].

[41] The questionnaire was conducted online due to budgetary constraints and the high costs involved in conducting questionnaires by post, telephone or face-to-face .
[42] MHH drinkers engaged with services are being targeted separately in a separate contract.

Design
The online questionnaire survey was developed in Online Surveys[43] and was made available in English and Welsh. The questionnaire comprised a combination of closed questions (e.g. on current alcohol and drug use) and open-ended questions (e.g. perceptions and experiences of MPA) in order to capture more nuanced data on issues of particular interest.

The survey questionnaire was organised into sections that corresponded with the research objectives. It included sections on: demographics, alcohol use, drug use, awareness of MPA, attitudes to MPA, preparation for MPA, anticipated consequences and impact of MPA on their lives (e.g. on their drug and alcohol use, health, relationships, household expenditure) and the lives of those around them[44].

Participation in the surveys was voluntary and the surveys were anonymous (no identifying information was requested and no IP addresses were recorded). The survey questionnaires were designed so that respondents were able to skip questions that they did not wish to answer and exit the survey at any point if they no longer wished to participate. Respondents were provided with detailed information about the project at the start of the survey and advised that submitting their responses would be taken as evidence that they had consented to take part. They were also advised that after clicking 'finish' at the end of the survey, their responses would be submitted and withdrawal from the study would no longer be possible.

After clicking 'finish' at the end of the survey, participants were redirected to an entirely new and independent survey where they were given the opportunity to express an interest in taking part in the longitudinal cohort study and/or enter the prize draw by providing us with their contact details (i.e. an email address). Participants were advised that there would be no way of linking their MPA survey responses to their contact details.

Procedure
A link to the baseline questionnaire survey was distributed widely through our networks of contacts[45], on our university web pages and through the evaluation team's own social media pages and accounts (i.e. Facebook and Twitter). To encourage completion of the surveys and maximise the response rate, participants were offered the opportunity to enter a free prize draw to win Argos shopping vouchers. The survey went live on 15th October 2019 but was closed between 23rd November 2019 and 13th December in the run up to the General Election. It was re-opened again after the election and closed on 1st March 2020 to ensure that responses were all in relation to activities prior to implementation of MPA.

Data analysis
The baseline survey data were exported from Online Surveys directly into SPSS. The dataset was carefully reviewed and ineligible respondents were removed (i.e.

[43] Online Surveys website
[44] The pre-implementation and post-implementation surveys will be broadly the same in terms of topic areas covered. The latter, however, will differ in that they will explore changes (and motivations for any changes) in drinking and related behaviours post-implementation of MPA.
[45] For example, Alcohol Change Cymru tweeted links to the survey on our behalf.

respondents living outside of Wales). The survey responses were analysed using SPSS, Excel and Word to facilitate the analysis of the extensive amount of data collected. Online Surveys' own analysis tool was also used to support the analysis and presentation of results.

Closed questions that generated quantitative data were analysed using SPSS and Excel. These results are presented numerically using percentages and frequencies. Qualitative data generated from the open-ended questions were analysed using more traditional qualitative techniques (e.g. identifying key themes and searching for quotations to illustrate them) using the search functions within SPSS, Excel and Word. As with the qualitative interview data, quantifying the qualitative survey results has been avoided except in a few cases where it was deemed particularly important to do so (Neale et al, 2015).

Summary

To achieve the research objectives outlined in the specification and other documentation, a longitudinal study comprising two parts was designed: (1) a longitudinal cohort interview study, and (2) a repeat cross-sectional survey study. Baseline interviews were conducted with a sample of drinkers recruited using four methods including the National Survey for Wales. To provide information from a large sample, an online questionnaire survey was disseminated widely across Wales using our networks of contacts (including our Project Advisory Group) and through social media. Incentives in the form of Argos shopping vouchers were used to help maximise response rates in the survey and to recruit interviewees for the longitudinal study. The baseline data were analysed using appropriate software, which included SPSS for quantitative data and NVivo for qualitative data.

The findings presented in the following chapters are based on data collected through interviews and questionnaires completed prior to the implementation of MPA in March 2020. The study therefore provides a useful baseline with which to monitor changes post-implementation. However, the study also gathered information about people's attitudes towards, and perceptions of, a piece of legislation that had not yet been implemented. It also asked people to comment on the potential impact of MPA on their drinking patterns and on their lives more generally. The main problem with this aspect of the research, like that of the 'Switching Study' (see Holloway et al., 2019), is that the views expressed are only predictions of what **might** happen rather than what **will** happen. It is possible that actual behaviour post-implementation will not follow these predictions. While this is clearly a limitation of the study it is important to bear in mind that the longitudinal design of this project, and the two subsequent reporting points, means that we will be able to monitor if these predictions are borne out by events.

5. Samples

This chapter summarises the characteristics of the samples of drinkers who took part in this first stage of the evaluation of the impact of MPA on the wider population of drinkers (i.e. the pre-implementation, baseline study). The chapter has two broad aims. First, it aims to provide the reader with sufficient detail to understand that the sample was a diverse one that represents a range of different kinds of people from across Wales who are aged 18 or over and who drink alcohol. Second, it presents data relating to drinking patterns and related behaviours as well as household expenditure, which can be used as a baseline against which any potential changes can be measured post-implementation. For clarity, the characteristics of the longitudinal interview sample and the cross-sectional survey sample are presented separately below.

Longitudinal interview sample

Forty-one drinkers, recruited using four methods, consented to take part in the longitudinal interview study and took part in the baseline interview prior to the implementation of MPA[46]. The characteristics of interviewees are presented in text form below. Accompanying tables with frequencies and percentages can be found in the Appendix.

The first section focuses on the type of drinkers that are included in the interview sample. Through the remainder of the chapter, where relevant, any differences in the characteristics of the three types of drinker will be examined.

Drinking patterns

AUDIT scores

The sample was fairly evenly split in terms of their AUDIT score with one-third of the sample scoring low risk, another third as increasing risk and the remaining third as either high risk or possible dependence (see Table A6). Moderate, hazardous and harmful drinkers were therefore equally represented in the interview study. While the difference was not statistically significant, due to low cell sizes, interviewees recruited through the hostel and related organisations were more likely than other interviewees to score highly on the AUDIT and be categorised as harmful drinkers (see Table 5.1)

Table 5.1 Type of drinker by source of interviewee

Source	Moderate	Hazardous	Harmful	TOTAL
NSW	10	7	4	21
Survey	1	2	1	4
Hostel	-	-	7	7
Student	2	4	-	6
TOTAL	13	13	12	38

Notes: In three cases it was not possible to calculate the AUDIT score and define the type of drinker.

[46] Further details of the sampling process are presented in Chapter 4.

All but one interviewee indicated that they drank at least some alcohol at home and more than half of the sample said that they drank most or all of their alcohol at home (n=20). While the numbers are small and the differences not significant[47], moderate drinkers were more likely than hazardous and harmful drinkers to consume most or all of their alcohol at home (9 of 13] compared with 5 of 13] and 5 of 11] respectively).

Of those who drank alcohol at home, most bought their alcohol in person from either a supermarket (n=23) or from an off licence or convenience store (n=11). Supermarkets were the source of choice for all three types of drinker. However, harmful and hazardous drinkers were more likely than moderate drinkers to purchase alcohol from an off licence or convenience store (4 of 12] and 3 of 13] compared with 1 of 13], respectively).

Drinking location

The interviews were conducted in the months prior to the introduction of MPA on 2 March 2020 (and before the COVID-19 pandemic). The interviewees were therefore able to tell us where they had consumed alcohol in the last month including places outside of their homes[48] (see Table A7). The most popular places to consume alcohol were at home (n=34), followed by pubs (n=22), restaurants (n=17) and other people's homes (n=16). Consumption outdoors in public places was reported by nearly one-quarter (n=10) of the sample, all but one of whom were classified as a harmful drinker and part of the 'hostel' sample. Comparatively few people reported drinking in night clubs/bars (n=6) or at events (n=4). A few interviewees (n=7) reported drinking in 'other' locations, which included hostels and social clubs.

Frequency of alcohol consumption

Interviewees were questioned about how often they consumed different kinds of alcohol (see Table A8). All but one interviewee reported drinking beer/cider/lager[49]. Wine and spirits/liqueurs were also common (n=33). Other alcoholic drinks were less popular, although nearly one-quarter (n=10) reported drinking sherry/martini. Alcopops and low alcoholic drinks were rarely consumed by the interviewees (n=5).

In terms of frequency of consumption, more than half (n=24) of the interviewees drank beer/cider/lager on at least a weekly basis (including 11 who drank it on a daily or almost daily basis). Frequent consumption of spirits/liqueurs and wine was reported by 13 and 10 interviewees, respectively (see Table A8).

As might be expected, the harmful drinkers in the interview sample were more likely than the hazardous and moderate drinkers to consume beer, wine and spirits on a daily or almost daily basis.

[47] Even when the location types were collapsed into two groups (50% or less of their alcohol consumed at home compared with >50% of alcohol consumed at home).

[48] During the COVID-19 lockdown, public venues with 'on' licences (e.g. pubs, clubs and restaurants) were all closed in Wales for several months.

[49] This included 'strong' forms of beer/cider/lager as well as 'normal strength' forms. The two categories were combined as respondents' answers included both strong and normal strength beer/cider/lager in their answers.

Demographic characteristics of interviewees

Sex, age, ethnic group, marital status

The interview sample included 24 men and 17 women[50] (see Table A2). No significant gender differences were identified among the different types of drinker, although there was a slightly higher proportion of women in the harmful category (n=6/12) than in the hazardous and moderate categories (n=5/13 for both groups).

The sample was diverse in terms of age group with roughly half of the sample aged 45 or over and half under the age of 45. Again, no significant age differences were found among the different types of drinker, although moderate drinkers were a little more likely to be older than the hazardous and harmful drinkers (n=8/13 compared with n=6/13 and n=5/12, respectively).

Like the general population of Wales[51], the sample was not at all diverse in terms of ethnic group as nearly all (n=38) of the interviewees described themselves as 'White – English, Welsh, Scottish, Northern Irish, British', while the remainder (n=3) described themselves as 'White – Other'.

Three-fifths of the sample (n=25) were in some kind of relationship at the time of the baseline interview while nearly one-quarter (n=11) were single. The remainder were either separated, divorced or widowed (n=5 combined). While the difference was not statistically reliable due to small cell sizes, moderate and hazardous drinkers were far more likely than harmful drinkers to be in a relationship at the time of the interview (11/13, 10/13 and 4/12, respectively).

The majority of interviewees lived in households without children. However, one-quarter of the interviewees lived in a household with at least one child under the age of 18 (n=10), including one interviewee living with three children and four interviewees living with two children. Equal numbers of moderate and hazardous drinkers (n=5) reported living in households with children under the age of 18. However, none of the harmful drinkers were doing so.

Education, employment and training

The sample of interviewees included people with a mixture of different types of educational attainment ranging from people with no qualifications (n=2) through to people with Level 7 (postgraduate) qualifications (n=4) (see Table A3). Half of the sample had qualifications at Level 3 or below while the other half had qualifications at Level 4 or above. Moderate drinkers were varied in terms of their educational attainment and included people with entry level qualifications through to people with Level 7, post-graduate degrees. Hazardous drinkers all reported at least Level 3 qualifications, with most having Level 6 or above (n=7). A few harmful drinkers reported Level 6 qualifications (n=3), but most reported Level 3 or below (n=8).

[50] Men were more likely than women to be recruited through the NSW (14 compared with 7) and through third sector organisations (7 compared with 3). While the numbers are small, more women than men were recruited through the online survey (3 compared with 1) and through the two universities (4 compared with 2).

[51] According to StatsWales, 6% of the population of Wales are classified as Black, Asian and Minority Ethnicity.

In terms of employment status, the sample included a mixture of different types of people ranging from people who were unemployed and not looking for work (n=7) through to full-time students (n=8), people working full-time (n=9) and people who had retired from work (n=7) (see Table A3). Moderate and hazardous drinkers were much more likely than harmful drinkers to report being in full or part-time employment (54% and 38% compared with 17%). Half of all harmful drinkers were unemployed and not looking for work (n=6).

Financial status

The financial status of interviewees was also varied and included people earning less than £5,200[52] through to people earning more than £52,000 per year (see Table A4). A little over one-quarter of interviewees (n=10) were on benefits at the time of the interview including six in receipt of Universal Credit and four in receipt of Employment Support Allowance[53]. Harmful drinkers were more likely than moderate and hazardous drinkers to report being in receipt of benefits at the time of interview (6/12 compared with 0/13 and 1/13, respectively[54]). In fact, no moderate drinkers[55] and just one hazardous drinker reported that they were currently in receipt of benefits.

When asked how well they were managing in financial terms, just over half said that they were managing either quite well or very well while just over one-quarter indicated that they were not managing well. All of those who reported that they were not managing at all well were harmful drinkers and all of those who were not managing well were either hazardous or harmful drinkers.

Geographical area

The sample was recruited from a wide range of Local Authority areas across Wales and included people living in six of the seven Health Board areas of Wales[56] (see Table A5). Some of the LA areas were represented more than others. For example, roughly one-quarter (n=11) of the sample were resident in Cardiff while only one interviewee was resident in each of the Torfaen, Caerphilly, Flintshire and Conwy areas. The over-representation of Cardiff is explained largely by the inclusion of seven individuals recruited from a city centre hostel. Without these seven interviewees, the areas become more evenly represented.

The sample was fairly evenly split in terms of the proportion of interviewees living in urban and rural areas (n=16 compared with n=17) (see Table A5). The remaining eight interviewees described their local area as suburban. Harmful drinkers were far more likely than moderate and hazardous drinkers to be living in urban areas at the time of interview (9/12 compared with 3/13 and 1/13, respectively). Moderate drinkers, by contrast, were far more likely than hazardous and harmful drinkers to be living in rural areas (9/13 compared with 5/13 and 3/12, respectively).

[52] Interviewees reporting less than £5,200 were all homeless and recruited through the city centre hostel.
[53] In response to this question on benefits, a further three interviewees, all in the 65-74 age bracket, reported that they were receiving a state pension.
[54] Three drinkers were excluded from this analysis due to lack of AUDIT data.
[55] It should be noted that 2 moderate drinkers ticked the 'prefer not to say' answer to this question.
[56] The only area not represented in the study is Abertawe Bro Morgannwg University Health Board.

The sample of interviewees included people living in a range of different types of accommodation including: home owners with mortgages (n=10), home owners without mortgages (n=9), private renters (n=8), people living with family and friends (n=4), people living in hostels or supported accommodation (n=8), social/council renters (n=1), and one person who was street homeless. All of those who were street homeless or living in a hostel or other supported accommodation at the time of interview were categorised as harmful drinkers. Moderate and hazardous drinkers were more likely to be home owners either with or without a mortgage (8/13 and 7/13, respectively).

Previous research has predicted that people living in hostels and on the street are more likely than other drinkers to be adversely affected by MPA (Holloway et al, 2019). The inclusion of people living in such precarious circumstances is therefore important to any evaluation of MPA.

Quality of life

Four questions tapping different aspects of quality of life were included in the pre-interview survey[57]. The majority of interviewees expressed high levels of satisfaction with their lives (n=29) and the same number felt that the things that they did in life were worthwhile (n=29) (see Table A9). When asked how happy they were yesterday, nearly two-thirds (n=26) expressed high scores and roughly one-half (n=19) indicated that they had low levels of anxiety yesterday. However, while many of the interviewees appeared to have a good quality of life (based on these four measures), a sizeable minority were far less fortunate. Indeed, five interviewees reported low levels of satisfaction, and seven did not think the things they did were worthwhile. Furthermore, four interviewees indicated that they were not happy yesterday and roughly half described having medium (n=8) or high (n=12) levels of anxiety yesterday.

Analysis of variations by type of drinker showed that for each quality of life measure, harmful drinkers were more likely than moderate and hazardous drinkers to score poorly. The differences were particularly stark in terms of the question asking them if they felt that the things they do in life are worthwhile. More than half (7/12) of harmful drinkers indicated low levels of agreement with this statement compared with no moderate or hazardous drinkers. A similar pattern was found in terms of life satisfaction with 5 out of 12 harmful drinkers reporting low levels of satisfaction compare with none of the other two groups.

Household expenditure

An important part of this part of the minimum pricing evaluation is to examine the impact of MPA on household budgets and explore whether drinkers change their spending patterns as a result of increased prices of alcohol. Interviewees were therefore asked to provide details of how much money, on average, they spent on different household costs each week prior to the introduction of MPA (see Table

[57] The quality of life measures were based on those used in the National Measuring Wellbeing Programme - Quality of Life in the UK 2018.

A10). This information provides a useful baseline with which to compare expenditure in the years post implementation of the legislation.
Perhaps unsurprisingly, interviewees reported spending most money on housing each week (on average, £120.69, ranging from £5-£500, standard deviation of £109.08). This was followed by household bills (£81.41) and food from shops (£57.38). Expenditure on alcohol from shops, on average, was £36.55 per week, which was second only to housing in terms of the wide range of variation among the interviewees (£1 to £359 per week).

No significant differences emerged between the three types of drinker (MHH) in terms of total weekly expenditure, although harmful drinkers reported considerably lower costs than hazardous and harmful drinkers (£254 compared with £409 and £422, respectively). Unsurprisingly, perhaps, harmful drinkers spent significantly[58] more money than hazardous and moderate drinkers on alcohol each week (£73 compared with £13 and £10, respectively).

Summary of interviewees

In this section the characteristics of the longitudinal interview sample have been presented. The aim was to give readers an indication of the type of people that will be followed over the course of the evaluation period. Usefully, the sample includes a wide range of different types of people including: men and women, old and young people, street homeless and home owners, high income earners and low income earners as well as similar numbers of moderate, hazardous and harmful drinkers. The benefit of having such a diverse sample is that it provides an opportunity to examine the impact of MPA among different kinds of people[59].

Further analysis of the sample identified important variations among the three different types of drinker who were categorised as moderate, hazardous or harmful based on their AUDIT scores. While there were similar proportions of men and women in each category of drinker there were key differences in terms of key characteristics including: employment, educational attainment, household income, household expenditure, marital status, housing status and quality of life. Harmful drinkers were more likely than other drinkers to: be unemployed, have achieved lower level qualifications, earn less money, spend more money each week on alcohol, be single, live in unstable accommodation, and to have a low quality of life.

Cross-sectional questionnaire survey sample

One-hundred and seventy-nine drinkers completed the baseline cross-sectional questionnaire survey. As noted in Chapter 4, the survey respondents were recruited through our networks of contacts and through social media. Although the goal of 250 respondents was not reached (even with the use of incentives)[60], the resulting sample might still be considered a large sample for a lengthy questionnaire that

[58] ANOVA test, f=4.343, df = 2, p=0.22.

[59] Given the absence of any minority ethnic groups from the sample, it will not be possible to examine variation by ethnic group. This is an important limitation that we were unable to address due to the fact that information about ethnic group was not available for us to use in the sampling frame.

[60] It is also important to note that there was a period of interruption during the fieldwork phase of the research when the survey had to be closed in the run-up to the general election.

sought detailed, qualitative information about what, for some, might be a sensitive issue. Indeed, one survey respondent commented:

> *'This is quite a detailed study - might be asking a lot to get people to fill in (given current attention spans and so on)'* (Survey respondent, 163. Male, low risk, self-employed)

The characteristics of the survey respondents are presented in text form below. Accompanying tables can be found in the Appendix.

Demographic characteristics

Sex, age, ethnic group, marital status

Most of the survey respondents were female (75%) and one-quarter were male (24%) (see Table A11). One respondent described themselves as 'other'. The over-representation of women in the survey sample is important and needs to be borne in mind when drawing conclusions based on the findings.

Like the interview sample, the survey sample was diverse in terms of age with more than one-fifth (23%) of respondents aged 45 or older, one-fifth (20%) aged 35 to 44, more than one-quarter (28%) aged 25 to 34, and nearly one-third (31%) aged between 18 and 24 (see Table A11).

Unlike the interview sample, the survey sample included respondents from a range of ethnic groups (see Table A11). However, the sample cannot be considered particularly diverse in ethnic group terms as the majority (88%) defined themselves as White – English, Scottish, Welsh, Northern Irish, British. Nevertheless, the sample did include a small number of respondents from ethnic minority groups including: White – Irish, White – Gypsy or Irish Traveller, White – Other, Mixed – White and Black Caribbean, Mixed – White and Black African and Black African.

Two-thirds of the sample (67%) were in some kind of relationship at the time of completing the baseline survey while more than one-quarter (29%) were single (see Table A11). The remainder were either separated, divorced, widowed (5%) or preferred not to divulge their marital status (1%). Roughly three-fifths of survey respondents lived in a household with no children (61%) while the remaining 39 per cent lived in households with either one or two children including eight per cent who lived in households with at least three children (see Table A11).

Education, employment and training

The survey sample included people with a mixture of different types of educational attainment. This ranged from people with entry level qualifications (3%) through to people with Level 8 (doctoral level) qualifications (3%) (see Table A12). Nearly half of the sample had qualifications at Level 4 or below (47%), which included 32 per cent with Level 3 qualifications. Nearly one-fifth (19%) of the sample had graduate level qualifications at Level 7 or above.

In terms of employment status, again, the sample was mixed and included people who were in full-time paid work (29%) as well as people who were retired (2%), unemployed and not looking for work (2%) and people who were looking after the

home and family (1%). While the sample is varied in terms of employment status it is important to note that the sample was heavily weighted in favour of students and people in full-time education (49%). This over-weighting of students may be the result of the successful advertising of the survey within our academic institutions and through our academic networks on social media. As with the over-representation of women, the large number of students in the sample means that generalisations from the survey findings must be made with caution[61].

Financial status

The financial status of our survey respondents was varied and included people earning less than £5,199 per year (11%) as well as people earning over £52,000 (13%) (see Table A13). Perhaps unsurprisingly, unemployed people were more likely than those in other 'employment' categories to report earning the lowest levels of income. However, students in full-time education and part-time workers also reported far lower levels of income than those in full-time employment and self-employment.

Most people were not receiving benefits at the time of completing the survey although 17 per cent were in receipt of benefits including six per cent who were receiving Universal Credit. When asked how well they were managing financially, most of the respondents indicated that they were managing quite well (50%) or very well (10%). Just over one-fifth expressed a neutral answer while 12 per cent indicated that they were not managing well and six per cent not managing at all well.

Geographical area

Survey respondents were resident in a range of locations across Wales at the time of completing the baseline survey (see Table A14). Nineteen of the 22 Local Authority areas in Wales were represented in the survey with the largest proportions being resident in Wrexham (29%), Rhondda Cynon Taf (RCT) (14%) and Cardiff (13%). This distribution reflects the fact that nearly half of the respondents were students recruited through two universities (one based in Wrexham and one in RCT with an additional campus in Cardiff). While not all Local Authority areas were represented, all seven of the Health Board areas were represented in the study.

The sample was fairly evenly split in terms of the type of area in which they lived (see Table A14). Nearly half of respondents lived in rural areas (47%) while the remainder lived in either urban (27%) or suburban areas (26%). In terms of housing status, the sample of respondents was mixed and included people living in their own homes without mortgages (7%), people living in hostels or supported accommodation (6%) and one person who was street homeless. The most commonly reported status was 'home owner – with mortgage' (28%) followed by 'renting – private' (23%) and 'renting – social/council' (16%).

Drinking patterns

AUDIT scores

[61] The implications of (and our plan for responding to) the over-representation of women and students in the survey sample for the evaluation are discussed in Chapter 12.

Unlike the sample of interviewees which had an even distribution of drinker type, moderate drinkers were more heavily represented among survey respondents. On the basis of their AUDIT scores, roughly half of the sample (52%) fell into the 'lower risk' category and could be considered 'moderate' drinkers (Table A15). More than one-third (36%) were measured to be at 'increasing risk' or as 'hazardous' drinkers, and the remainder (12%) were in the 'higher risk' category and considered 'harmful' drinkers.

Drinking at home

Given that the survey was completed prior to the COVID-19 lockdown, respondents were able to reflect on the different locations in which they usually consumed alcohol. When asked roughly how much of their total alcohol consumption was consumed at home, the responses were mixed. Few respondents drank *all* of their alcohol at home (6%) and few drank *none* of their alcohol at home (14%). Most respondents drank either most of it (32%) or some of it at home (32%).

Those who consumed at least some alcohol at home were asked where they usually purchased their alcohol. Three-quarters reported buying their alcohol in person from a supermarket. The next most common source was an off licence or convenience store (15%) followed by supermarkets online (6%). Few respondents bought their alcohol abroad/duty free, from a petrol station, delivery service or via other online sources (e.g. Amazon).

Drinking location

As noted above, the survey questionnaires were completed prior to the introduction of MPA and before the COVID-19 pandemic resulted in a period of lockdown. Therefore, when asked about the locations where they had consumed alcohol in the last month, respondents' answers included locations outside of their homes (see Table A16). The most commonly reported location was 'at home', which was reported by 62 per cent of respondents. This was followed by 'in pubs' (55%), 'in restaurants' (43%), 'at other people's homes' (36%), 'in nightclubs/bars' (30%) and 'at events' (22%). Only a small number of people reported drinking outside in a public place (5%).

Frequency of alcohol consumption

Interviewees were questioned about how often they consumed different kinds of alcohol (see Table A17a). The most commonly consumed type of alcohol was beer/cider/lager[62] followed by wine and spirits (most often vodka but also gin, whisky, rum, and bourbon), which were consumed by approximately 80 per cent of respondents. Wine was also popular among the survey respondents (73%). Other types of alcohol were far less popular and were consumed by less than one-quarter of the sample.

In terms of frequency of consumption, only a small proportion of respondents reported being daily or almost daily drinkers of any type of alcohol. Irregular consumption (i.e. on a less than monthly basis) was more common than monthly, weekly or daily/almost daily consumption for all types of drink (see Table A17b).

[62] This included 'strong' forms of beer/cider/lager as well as 'normal strength' forms. The two categories were combined as respondents' answers included both strong and normal strength beer/cider/lager in their answers.

Weekly or more frequent consumption was most commonly reported among those drinking wine (34%) and beer/cider/lager (32%).

Consumption of illegal drugs

To create a baseline with which to explore any potential mass switching post-implementation of MPA, questions on illegal drug use were included in the pre-implementation survey. The baseline results are presented in Table A18.

While current illegal drug use was not common among survey respondents, the sample did include many people with histories of using a range of different drug types. Indeed, a history of cannabis use was reported by just under half of all survey respondents (46%). In most cases, this had been more than one year ago (27%) rather than more recently. Just over one-fifth of respondents had a history of cocaine powder use (22%) while use of ecstasy and amphetamines were reported by just under one-fifth of respondents (17%). Ketamine, nitrous oxide, magic mushrooms and LSD had been used by just over 10 per cent of respondents. Use of other illegal substances was rare and reported by less than one-tenth of survey respondents.

Treatment history

While this project focuses on the wider population of drinkers in Wales, our recruitment methods meant that it was still possible for drinkers currently in treatment to complete the online survey. When asked about their treatment histories, three respondents indicated that they were currently receiving treatment for alcohol problems (see Table A19). None reported histories of drug treatment, although seven had received drug treatment at some point in the past.

Quality of life

Four questions tapping different aspects of quality of life[63] were included in the survey (see Table A20). The majority of interviewees expressed high levels of satisfaction with their lives and a similar proportion felt that the things that they did in life were worthwhile. When asked how happy they were yesterday, nearly two-thirds expressed high scores and roughly one-half indicated that they had felt anxious yesterday. However, while many of the interviewees appeared to have a good quality of life (based on these four measures), a sizeable minority were far less fortunate. Indeed, 12 per cent had low levels of satisfaction, and a similar proportion (11%) did not think the things they did were worthwhile. Furthermore, one-fifth of respondents indicated that they were not happy yesterday and more than a half described having medium (28%) or high (33%) levels of anxiety yesterday.

Household expenditure

An important part of the evaluation is to examine the impact of MPA on household budgets. Survey respondents were therefore asked to provide details of how much money they spent on different household costs each week prior to the introduction of

[63] The same measures were used for assessing quality of life among the interviewees and were based on the Measuring National Wellbeing Programme.

MPA (see Table A21a and A21b). This information provides a baseline with which to compare expenditure in the years post implementation of the legislation[64]. Perhaps understandably, interviewees reported spending most money on housing each week (mean of £112.40, ranging from £0-£1000, standard deviation £147.51). This was followed by expenditure on household bills (£70.93) and food (£53.92). Among those who spent money on alcohol, weekly expenditure ranged, on average, from £1 to £200 (standard deviation of £10.67).

Summary of survey responses

In this section the characteristics of the cross-sectional survey sample have been presented. The aim was to generate baseline information about drinking patterns, alcohol-related behaviours and household expenditure that can be used to measure change post-implementation of MPA. Usefully, the sample includes a wide range of different kinds of drinker from across all Health Board Areas of Wales. While the sample might be considered varied in a number of ways (e.g. marital status, employment status, educational attainment and household income), it must be noted that the distribution of respondents across the categories was not always even. For example, women and students were more heavily represented than their counterparts as too were moderate (lower risk) drinkers. The over-representation of these groups means that any generalisations based on the survey findings must be made with caution. Importantly, the sample includes people with histories of illegal drug use, although most of these were cannabis users rather than users of other illegal substances.

Summary

In this chapter detailed information about the characteristics of the longitudinal interview sample and the cross-sectional survey sample have been provided. The key points to take away from this chapter are that both samples include drinkers from across different parts of Wales who vary in terms of their socio-demographic characteristics, drinking patterns, perceived quality of life, illegal drug use, and household income and expenditure. The main limitations, however, are that minority ethnic groups are not well represented in either sample and that some groups are more heavily represented in the survey sample than others. While this chapter has focused on the quantitative data provided by the interviewees and survey respondents, the next few chapters focus on the qualitative data provided by both samples. Inevitably, the interviews yielded more detailed data than the surveys but the results chapters draw on both sources wherever possible.

Throughout the results chapters, each quotation has been labelled to help readers understand where the evidence came from (i.e. interview or survey) and the type of person who provided the information. For the interviewees, we have recorded their unique ID code along with their sex and risk level based on their AUDIT scores. A similar approach was taken for the survey respondents although we also recorded

[64] Given the cross-sectional nature of the repeat surveys, any comparison of expenditure must be treated with caution and only an indication of levels of expenditure among the general population of drinkers in Wales.

their employment status to help distinguish between the responses of students (who make up half the survey sample) and people in other forms of employment. Including this kind of information is good practice within the field of qualitative research as it helps to create a link between the evidence and the source (Mack et al. 2011).

6. Awareness, understanding and attitudes towards MPA

In this chapter the interview and survey data are drawn on to examine drinkers' awareness and understanding of the plan to introduce MPA in Wales. The chapter also considers drinkers' attitudes towards the legislation and examines the underlying reasons given for their particular views.

While these important issues have already been investigated among drinkers in Wales in a previous study (see Holloway et al., 2019), the material presented in this report differs in two important respects. First, it is based on the views of a sample of drinkers recruited from within the general population in Wales rather than on the views of a 'treatment' sample or a sample of professionals working within the field, which may be quite different. Second, it draws on information collected in the months shortly before MPA was implemented. It therefore documents levels of awareness, understanding and attitudes towards MPA at a time much nearer to the date of implementation (when one might reasonably assume that awareness of MPA would be greater) than the previous study, which was conducted more than a year before (when levels of awareness were found to be limited).

Awareness and understanding of MPA

A range of replies emerged in response to interviewees' and survey respondents' awareness and understanding of MPA.

Survey respondents were fairly evenly split in terms of prevalence of awareness with just over half (52%, n=93) stating that they were aware of MPA and just under half saying that they were not (48%, n=86). By contrast, awareness of MPA was comparatively high among the interview sample with most indicating that they knew of its existence.

For both interviewees and survey respondents, awareness had been obtained largely through adverts and shows on the television and radio.

> *'I think it was on the radio or the television'* (Interviewee 001, male, lower risk)

> *'It was just coming up on… I listen to Radio 4 so it's all very factual that isn't it and they were on about they'd brought it into Scotland and it would be coming into Wales; I think it's in March or something?'* (Interviewee 010, male, possible dependence)

Survey respondents also mentioned other sources including: online (17%), news/newspapers (10%), at university and in lectures (10%), through friends (8%), and social media (5%).

While **awareness** was generally fairly high, the majority of survey respondents and interviewees had minimal in-depth **understanding** of the upcoming legislation. When asked to describe what they knew, their answers were often vague with little evidence of any detailed understanding of what the new legislation would involve in practice.

'So I couldn't reel off any figures or anything like that but I understand it's following on from something similar to Scotland whereby they introduced a minimum price for units of alcohol' (Interviewee 003, female, higher risk)

'So, I knew it had taken place in Scotland, and I was kind of aware in Wales, but obviously speaking to you guys has made me more aware of that situation' (Interviewee 029, male, increasing risk)

Most of the survey respondents who had heard of the plan were aware that it would involve an increase in the price of alcohol. Some knew little more than this openly admitting that they did not know the specific details (e.g. 'just the idea of it'; 'nothing specific'; 'only of its existence'; 'not a lot – the Welsh Government want to introduce a minimum price'). A small number of respondents were aware that the minimum price was set at 50p (13%, n=12) and a similar proportion believed that the plan was linked to MUP in Scotland (18%, n=17).

While many survey respondents were only able to describe the plan in very general terms (e.g. 'plan to introduce a minimum cost per unit'; 'minimum pricing for alcohol') a small proportion (9%, n=8) demonstrated an understanding of the potential impact on particular drinks (e.g. 'bottle of cider is going to be about triple the price'; 'to stem binge drinking on high alcohol content drinks'; 'to cut down on the large scale drinking of cheap drinks'). It was more common (17%, n=16) for respondents to comment on the aim of MPA (e.g. '… address rising alcohol misuse and dependency'; 'to reduce alcohol-related health effects'). Overall, awareness of MPA was partial and understanding of the details of MPA was mixed.

Many reported that the interview was the first time that they had heard of the legislation, and reacted with what appeared to be surprise during the interview, when details were relayed to them:

'I: So since then have you looked it up at all; do you know anything about it?
R: No I haven't actually.
I: So shall I briefly explain what is going to happen?
R: Yes please. (Interviewee 004, female, possible dependence)

'Not in Wales. I'd heard of the plans in Scotland, but it came as a bit of a shock we were going to have it in Wales as well.' (Interviewee 019, male, increasing risk)

'I: … Before taking part in this interview were you aware of the plan for minimum pricing to be introduced in Wales?
R: No.
I: So you've not heard anything about it anywhere?
R: No.' (Interviewee 013, male, increasing risk)

Among the interviewees, those who had any more detailed understanding of MPA tended to refer to the types of drink that would be affected and to its perceived aim of reducing different kinds of alcohol-related harm.

'So, from what I can gather is, there's going to be a set price per unit. You know, your cheap ciders and whatever, in terms of the price per unit, that's going to make that sort of alcohol more expensive, so it's used as a sort of deterrent, maybe for younger people or people who do have drink problems. That is my general gist of it, yeah.' (Interviewee 029, male, increasing risk)

'*Obviously, bringing a minimum pricing of alcohol. I believe it's 50p per unit, so that means obviously, like a bottle of vodka, that's going to go up in price to obviously stop and combat... I believe it said, obviously, crime to do with alcohol and the repeat offenders, and NHS wait times. I believe that's what it said.'* (Interviewee 031, male, lower risk)

'Mainly what I know about it is the stronger the alcohol the more expensive it's going to become sort of thing, and I'm pretty sure that there's going to be a standard set minimum price for all alcohol, so you're not going to be able to get the big bottles of cheap cider…' (Interviewee 046, female, increasing risk)

Overall, awareness of MPA was greater among the interviewees than survey respondents. This may well be a methodological issue and linked to the fact that interviewees had, for ethical reasons, received information about MPA prior to taking part in the interview. Across the two samples, only a small number of drinkers indicated any in-depth understanding, and most descriptions were vague.

Attitudes towards MPA

After questions relating to awareness and understanding of MPA, the interviewees and survey respondents were asked to express their general attitudes towards the introduction of MPA and the reasons behind their views.

The survey respondents were asked to indicate on a scale from one to five, how strongly they agreed with the plan to introduce MPA in Wales (see Table 6.1). The responses were mixed. Roughly half were in agreement with the plan with 30 per cent expressing moderate agreement and 20 per cent expressing strong agreement. Just over one-fifth gave a neutral answer (21%) while the remaining respondents disagreed with the plan either moderately (15%) or strongly (15%).

Table 6.1 To what extent do you agree with the plan to introduce MPA in Wales?

	N	%
Strongly agree	35	20%
Moderately agree	53	30%
Neither agree nor disagree	38	21%
Moderately disagree	27	15%
Strongly disagree	26	15%
TOTAL	179	100%

The interviewees were generally more positive about MPA than the survey respondents. Only a few interviewees were unable to describe any potential benefits or positive impacts. Importantly, those few interviewees who espoused generally negative views towards the legislation were predominantly 'harmful' and 'hazardous' drinkers who felt that they would be disproportionately affected by the legislation. Some of these more dependent drinkers perceived MPA to be a 'tax' (which it is not) that would unfairly affect them financially:

> *'I: So what do you think about that as an idea?*
> *R: I don't like it.*
> *I: Why don't you like it?*
> *R: Because it's going to cost me more isn't it?'* (Interviewee 004, female, possible dependence)

Some interviewees and survey respondents were opposed to the legislation because they felt that it would lead to an increase in crime, especially theft in response to unaffordable alcohol.

> *'Theft's going to go up. Assaults. Street robberies. People will always find a way of feeding that habit.'* (Interviewee 025. Male, possible dependence)

> *'Not a very good idea because people are going to go out robbing more. And it is only affecting the poor and not affecting the rich. This is not fair!'* (Survey respondent, 171. Male, possible dependence, retired)

Negative views were also expressed by drinkers who themselves were unlikely to be impacted by the legislation. These drinkers were concerned that the legislation would have a disproportionate impact on vulnerable populations.

> *'Yes, I'm just trying to think, just because I always hate when the less fortunate people of society or the working class are taxed for what they do, and you know it's… I did a lot of sociology and psychology and things and it's like… you know it's harsh I think; it's harsh.'* (Interviewee 044, female, increasing risk).

> *'It's going to make poor people poorer.'* (Survey respondent, 172. Male, possible dependence, unemployed but not looking for work)
> *'If people want to drink they will do it irrespective of the cost. All this scheme does is punish those who can least afford it.'* (Survey respondent, 117. Male, low risk, employed full-time)

In addition, some negative views were underpinned by frustration with perceived interference by the state and displeasure with being told what they can and cannot do in relation to alcohol use.

> *'Nanny state. Adversely affects poorer people'.* (Survey respondent, 139. Male, increasing risk, employed full-time)

'From a purely libertarian point of view, the government should not be dictating to people whether or not they can alter their minds through chemical means. I would also add, for people on or below the poverty line who wish to have a drink, they are being priced out of being able to have a good drink if they choose.' (Survey respondent, 56. Male, increasing risk, self-employed)

Those survey respondents who expressed neutral views on MPA generally expressed one of two views: (1) they did not think that it would affect them, or (2) they did not think it would make a difference to people's drinking habits:

'Can't see it making a difference. People will drink regardless. More effort needs to be put into education on the effects on alcohol, how to live a balanced healthy life.' (Survey respondent, 90. Male, low risk, employed full-time)

'I do not drink very cheap alcohol so I do not see how it would affect me. I would be disappointed if it drove up the price of my preferred drinks.' (Survey respondent, 5. Male, low risk, employed full-time)

Those interviewees and survey respondents who supported the introduction of MPA were in broad agreement that the legislation would reduce drinking and hence reduce alcohol-related harms, including alcohol-related crime:

'I reckon it's a brilliant idea personally, because obviously living in Pontypridd, you see a lot of antisocial behaviour and crime happening with people that are alcoholics. With my shop, it's right in the centre of Pontypridd, and we get a lot of people who are intoxicated coming into the shop to commit crimes and shoplift.' (Interviewee 031, male, lower risk)

Some recognised that it had worked elsewhere and were hopeful that the same positive results would be felt in Wales.

'It seems to have reduced the number of people buying alcohol in Scotland.' (Survey respondent, 67. Female, low risk, employed part-time)

Others were optimistic that MPA would be particularly useful in reducing consumption among young people.

'It needs to be more expensive so that young people can't afford to buy so much and then maybe I can go to sleep without the constant noise of people yelling outside.' (Survey respondent, 81. Female, low risk, student)

'Giving Alcohol a minimum price could potentially prevent children under the age of 18 from being able to obtain it as they may not be able to afford it this way. It could potentially save many people from abusing alcohol or excessive drinking.' (Survey respondent, 147. Female, increasing risk, employed part-time)

'It's priced at £3.59 for three litres, which is seven and a half per cent alcohol. So, under the new legislation, the minimum price for that would be £11.25, or something like that. So, that is a very significant hike, and that... I think the

prospect of a 12-year-old girl drinking three litres of seven and a half per cent cider… I think I'd struggle to deal with that. So, I think a child drinking that is going to be paralytic. That's not healthy. This new legislation will stop that, without a doubt. I mean, I'm not saying children won't continue to drink alcohol. I'm sure they will, but they won't be able to drink as much. That's bound to have a very positive effect.' (Interviewee 027, male, lower risk)

'I suppose it might be a deterrent for people who haven't already got a dependency if it's harder for them to buy alcohol cheaply. And especially thinking about teenagers I suppose.' (Interviewee 030, female, lower risk)

A small number of drinkers acknowledged the potential cost savings to society through reduced pressure on the NHS.

'Because buying drink should be a treat and not a habit. This should then reduce pressures on the NHS and third party companies' (Survey respondent, 2. Female, low risk, employed full-time)

'It can be deemed as a good idea. It's going to save money for the NHS. That money in turn can be used on other stuff.' (Interviewee 029, male, increasing risk)

'So, we know that if the minimum unit price was 70p, for example, you might be looking, in the target cohort, at something like a 30 per cent reduction in consumption. So, the public health benefits do seem to be there, and there is scope when the review is done for that to be increased later.' (Interviewee 027, male, lower risk)

'So, yeah, it'll make a big impact on them. Obviously, NHS waiting times, because people are being admitted to hospital for alcohol poisoning and stuff like that […] Probably, obviously, there will be less strain on rehab services, because obviously if it does work, there's going to be less people going into rehab for alcohol-related issues. So, there might be more money to be funded elsewhere into the NHS or the police, or stuff like that.' (Interviewee 031, male, lower risk)

'Yeah. I mean, you see a lot, obviously, whether it's drink-related problems with hospital A&E, and just out in towns in general with people being injured falling over, or violence, whatever it is, and a lot of that seems to be alcohol-related. I appreciate it's probably different in nightclubs, where people are paying more anyway, but certainly for shops and things I think it's a good idea.' (Interviewee 033, male, lower risk)

While some of those expressing positive views were influenced by the potential benefits to society, many drinkers seemed to be in support of MPA because they would not be affected personally by the increase in price. This was usually either because they could absorb the price increase into their existing household budgets or because they did not drink enough for it to affect them. One interviewee's response was characteristic of those whose consumption would go untouched by any changes in price:

'If I had to pay a couple of quid extra, maybe it would help me drink a little bit less, I suppose. So, yeah, it's not a huge concern for me, because I don't drink enough or rely on alcohol enough to be worried about it. If I have to pay a little bit more, so be it.' (Interviewee 029, male, increasing risk)

Summary

On the whole, most interviewees and about half of the survey respondents were supportive of the legislation, primarily for its potential social and health benefits. Its potential for reducing binge drinking among young people was flagged up by several respondents. Support for the legislation was less likely among dependent drinkers many of whom felt that the legislation would disproportionally affect them. Some of the more moderate, lower risk drinkers also recognised the potential unfairness and negative impact on vulnerable populations and expressed less positive attitudes towards the legislation as a result. Negative views among drinkers were also linked to the potential increase in crime that might occur if drinkers can no longer afford to pay for their alcohol. The broad pattern of findings presented in this chapter is similar to that reported by Holloway et al. (2019). Indeed, service users and providers expressed similar concerns about the potential impact of MPA on vulnerable groups, and levels of awareness of MPA were no greater among those interviewed shortly before the legislation was implemented than among those interviewed more than a year before.

7. Preparing and planning for MPA

This chapter examines what drinkers were planning to do in preparation for the introduction of MPA in March 2020. The chapter draws on both the interview and survey data to investigate the issues. The focus here is on actions and activities that the drinkers were planning to perform prior to the implementation of MPA. Actions that they anticipated taking post-implementation (i.e. responses to MPA) are examined later in the report in the chapter that focuses on the potential impact of MPA on drinkers' lives. Given that awareness was patchy and understanding of the legislation was limited, generally speaking the research participants had little to say about preparation and planning.

Preparing for MPA

When asked whether they were planning to take any measures to prepare for the introduction of MPA in Wales, the majority of survey respondents (84%) indicated that they would not. Only a small minority (16%) said that they would and this usually involved stockpiling cheap supplies prior to implementation of the legislation.

Like the survey respondents, most of the interviewees (across all types of drinker) reported that they would not be doing anything to prepare for the upcoming introduction of MPA in Wales. This was often because they had only learned about the possible implications of the policy as a result of taking part in the interview[65], which was conducted shortly before the date of MPA implementation. For these individuals there was literally not enough time left to do any preparatory work. The interviewee below, a dependent drinker, expressed his shock at the news of how quickly the policy would be introduced:

> *'I: So, do you think you'll do anything to prepare for minimum pricing now knowing it's coming in next week, on the 2nd [of March]?*
> *R: I can't believe that; it's so quick!*
> *I: I know, and you didn't know about it?*
> *R: No, I said yesterday to [key worker]: 'I can't f**king believe that.'*
> *I: Do you think there needs to be more information?*
> *R: Yeah, they could have f**king told us a lot earlier; all of a sudden - bang it's going up!'* (Interviewee 040, male, possible dependence)

Other drinkers (again, across all types of drinkers) reported that they would not be doing any personal preparation because they did not think that MPA would affect them. This was either because:

(a) they did not drink enough for it to affect them:

[65] The Welsh Government sent a direct mail out to retailers in November and December 2019, followed up with trade press and work with trade bodies to make sure it was all covered before the introduction date in March. On 17th February 2020 Welsh Government launched a national communications campaign to make the publicand those affected by the change aware of the new legislation. The campaign included advertisements on social media, radio and online.

'I don't drink enough to consider the cost implications.' (Survey respondent, 8. Male, increasing risk, employed full-time)
'It's something I've heard about, but it's not something I've given a great deal of thought, because it really won't have that much impact on me, I suppose. If we were talking about the price of petrol going up 30p a litre, and I'm working in Port Talbot and I live in Barry, that's something that would concern me, you know, because that's relevant to me.' (Interviewee 029, male, increasing risk)

'I: Do you think you'll do anything to prepare for minimum pricing?
R: No, probably not. I mean if I was one of these ones who was regularly drinking, I'd probably stock up a little, but I'm not going to go out now and think, 'Okay. I'd better stock up before the date on my particular gin.' No, not at all.' (Interviewee 008, female, lower risk)

(b) they could afford to pay for the increase in price and were not concerned about the additional costs:

'I will find money if I would like to buy some alcohol' (Survey respondent, 7. Female, low risk, student)

'I will continue buying alcohol as I want and the new minimum price probably won't change anything for me. Also, I usually buy my alcohol when visiting friends in England anyway.' (Survey respondent, 66. Male, low risk, employed full-time)

'I: So, do you think you'll do anything to prepare for the minimum price coming in?
R: No, I don't think so. I think it will just be a case of when I'm next shopping in the supermarket or at the shop I'll just notice that things cost more but I'm not sort of thinking now 'right I need to start putting away extra savings' or anything to prepare myself for it..' (Interviewee 003, female, higher risk)

'I: But if it's 50p a unit, is that going to affect you?
R: Well if it's 50p more then it's going to.
I: But 50p a unit…
R: I know I can afford to pay it.' (Interviewee 042, male, possible dependence)

Or (c) their drink(s) of choice already cost more than 50p per unit:

'I choose alcohol that is already priced over the likely minimum pricing, and do not buy in excess' (Survey respondent, 148. Male, low risk, employed full-time)

'I don't drink strong cheap alcohol' (Survey respondent, 90. Male, low risk, employed full-time)

Among those who said that they would be taking action to prepare for MPA, the most common measure described was a short-term solution that involved stockpiling

cheap alcohol prior to the introduction of MPA. This solution was mentioned by two-fifths of those survey respondents who were planning to take action (41%). Comments on stockpiling included: 'stock now while the alcohol will be cheaper' and 'may stock up on spirits whilst they are cheaper'.
Similarly, a small minority of interviewees, all of whom were dependent drinkers, suggested that now, having heard about and understood the plan to introduce MPA, they would stockpile some drinks that might become more expensive afterwards.

> *'R: Yeah they could have f**king told us a lot earlier; all of a sudden - bang it's going up!*
> *I: So if you'd have known about it earlier what might you have done?*
> *R: Stocked up; I don't know, stocked up.'* (Interviewee 040, male, possible dependence)

> *'I guess if you're drinking a vodka that's particularly cheap, and maybe you're drinking a lot of volume of it, then maybe it would be worth getting quite a few before that date'* (Interviewee 020, female, lower risk)

Interestingly, a couple of high-risk drinkers firmly rejected the idea of stockpiling drinks because they believed they would end up drinking everything they have bought very quickly.

> *'I: Do you think you'll do anything to prepare for minimum pricing knowing it's now 2 March?*
> *R: No. What do you mean, get a load of bottles in ready? No, absolutely not. I don't do that, because then I might be tempted to drink them. No, I won't do that.'* (Interviewee 017, male, higher risk)

> *'I: So knowing that the price is going to be going up with some things with the minimum price coming in, will you do anything to prepare for it?*
> *R: Well I won't go out and buy loads of it.*
> *I: No?*
> *R: No well I'd probably drink it all and kill myself in a week.*
> *I: Okay so it's a self-protection by not doing that?*
> *R: Yes because people buy drink over Christmas and there's no way I could do that. I just try and keep myself away from it.'* (Interviewee 011, male, possible dependence)

Other preparatory actions mentioned by some of the survey respondents included saving money (e.g. 'save money') and changing what they drink (e.g. 'I might change what I drink to prepare for the change'). One interviewee (a dependent drinker who consumed several bottles of vodka each day) said that she would physically move to England, where she could continue to buy alcoholic drinks for the same amount of money as she was doing now:

> *R: But I'm going to Bristol.*
> *I: You're going to where?*
> *R: Bristol.*
> *I: Bristol. Okay. What's there?*

R: Because of... They're not changing it [the price of alcohol] there.' (Interviewee 039, female, possible dependence)

Only a small number of drinkers described longer-term, potentially healthier solutions such as cutting down or stopping drinking altogether.

> *'I will try and cut down so it's not so much a shock to the system'* (Survey respondent 169. Female, possible dependence, unemployed but not looking for work)

> *'I: So, you don't think it's a good idea. Are there any good things about it?*
> *R: It does make me want to decrease before it happens, just in case.*
> *I: Does it? Yeah? So, will you talk to somebody about that?*
> *R: I've spoken to XXX about it, yeah.'* (Interviewee 039, female, possible dependence)

In response to the survey question on preparing for MPA, one further survey respondent stated that he was going to try and stop drinking altogether. However, this drinker asserted that stopping drinking was not about MPA specifically but was because he had grown tired of being addicted. Perhaps in this case, MPA was the additional nudge factor that was needed to trigger positive change.

> *'I'm going to try and stop drinking. It's not about MPA. I'm fed up of being addicted to alcohol.'* (Survey respondent 172. Male, possible dependence, unemployed but not looking for work)

Summary

Generally speaking, few drinkers were planning to take any action to prepare for the implementation of MPA. For many, there was not time to do anything because they had only just learned about or understood what the change in policy would mean for them. For others, no action was planned because they did not drink enough alcohol for the increase in price to affect them or because they could afford the price increase. Some drinkers were already spending more than 50p per unit on their drink of choice meaning that no action would be needed. When preparatory action was planned this was usually a short-term response that would involve stockpiling alcohol at pre-implementation prices. That said, this particular solution was feared by some dependent drinkers who anticipated being tempted into binge drinking the extra supplies very quickly. Longer-term solutions were rarely mentioned by drinkers, although one interviewee was planning a move to England to avoid MPA and continue drinking at low prices. Longer-term, potentially healthier solutions such as cutting down or quitting were rarely mentioned by interviewees or survey respondents. There was some suggestion, however, that MPA might trigger positive change among drinkers who were contemplating giving up drinking.

8. Potential impact on drinking patterns and substance use

A key aim of this aspect of the evaluation is to examine the impact of MPA on people's drinking patterns as well as on their lives more generally. The focus of this chapter is the first of these two themes and what drinkers believed would happen to them following the implementation of MPA is examined. The chapter is divided in two main sections. It begins with a focus on the potential impact on drinking patterns and behaviours and then it moves on to consider the possible effect on the use of other substances including illegal drugs.

Inevitably, given that the research was conducted prior to the implementation of MPA, the chapter is based on predictions of future behaviour and anticipated actions. Follow-up interviews and repeat surveys 18 months and 42 months post-implementation will enable the veracity, and subsequently the longevity, of the predictions made to be examined[66].

It is important to note that while drinkers were encouraged to focus on the personal impact of MPA on their own lives, there was a tendency for some to reflect on the potential impact on other drinkers too. This chapter draws on all of this data and endeavours to clearly distinguish between comments relating to perceived personal impact and the potential impact of MPA on other drinkers.

Potential impact on drinking patterns

An important part of the survey and interviews was to investigate whether drinkers thought that MPA would have an impact on their drinking and related behaviours. On the whole, most survey respondents (around two-thirds) thought that it was unlikely or very unlikely that MPA would impact on their drinking in terms of: quantity, type, brand, funding arrangements, purchasing location and location of consumption (see Table 8.1). The explanations given for this were linked largely to the fact that respondents (a) did not drink enough for it to affect them, (b) they did not drink the beverages most likely to be affected by MPA or (c) because they could afford any price increase. Quotations illustrating these points are incorporated into the discussion below.

While the differences are fairly small, the behaviour thought most likely to be impacted by MPA was the location where they would purchase alcohol (23%) and the least likely was the location where they would consume alcohol (11%). Unfortunately, few respondents explained their answers to these questions. However, in relation to location, one commented that they would be 'more likely to get drunk at home before going out' and another suggested that they would purchase alcohol from a 'supermarket rather than an off-licence'.

[66] In response to the COVID-19 pandemic, an additional wave of interviews with the longitudinal study sample, 9 months post-implementation of MPA, was commissioned by Welsh Government.

Table 8.1 Predicted changes in drinking-related behaviour post MPA (survey respondents)

	Very likely	Likely	Neither	Unlikely	Very unlikely	TOTAL
Quantity you drink	10% (7)	8% (14)	13% (23)	36% (64)	34% (61)	179 (100%)
Type you drink	7% (13)	12% (21)	17% (30)	28% (50)	36% (65)	179 (100%)
Brand you drink	10% (17)	11% (19)	13% (24)	30% (53)	37% (66)	179 (100%)
How you fund	6% (11)	7% (13)	14% (25)	30% (54)	43% (76)	179 (100%)
Where you purchase	7% (12)	16% (29)	12% (22)	28% (49)	37% (66)	178 (100%)
Where you consume	3% (6)	8% (14)	13% (23)	28% (49)	48% (86)	178 (100%)

Notes: Some missing cases.

Potential impact on quantity of alcohol consumed

Many of the interviewees also reported that the introduction of MPA in Wales would not have much, if any, impact on their own or other individuals' drinking behaviour. However, there were some significant differences in terms of the reasons why they thought so. Some of the survey respondents provided similar responses and these are incorporated, where relevant, into the discussion below.

First, a wide consensus existed among drinkers (of all types) that the introduction of MPA would not have any significant effect on the drinking behaviour of those who were alcohol dependent. Overwhelmingly, interviewees believed that these individuals would continue drinking regardless of any price changes resulting from the new legislation. Some interviewees and survey respondents described this from their own personal perspective:

> *'I: In your current position what are you going to do?*
> *R: I'm going to keep drinking.*
> *I: Okay. The minimum pricing for you is not going to change anything.*
> *R: Probably not. I'll figure a way out.*
> *I: It's not going to make you think, 'Oh I'll stop now'?*
> *R: It's not going to stop anyone.'* (Interviewee 025, male, possible dependence)

> *'Well, it's hitting your budget obviously but I mean if I didn't drink obviously I would see the money there, what's left like but I just have to drink every day.'* (Interviewee 040, male, possible dependence)

Others reflected on what they thought other drinkers would do:

> *'Well, I think, as you will know, the target for this… because we're talking about high-strength, low-cost alcohol, we know that the harmful and hazardous... Well, hazardous drinkers in particular drink a higher proportion*

of lower-cost alcohol than more expensive alcohol, and we know that that cohort who are living in poverty and in deprivation are more likely to be accessing that alcohol, because their income is lower. Then, the chances are that their consumption will be more price-sensitive. The only difficulty, I think, around that is if they are alcohol dependent. They will be either unwilling or unable to reduce their consumption, and what they will do then is continue to drink what they were drinking previously.' (Interviewee 027, male, lower risk)

'Like I said, obviously with the price going up, that will be a deterrent for some people, but some people are hooked on alcohol and will just buy it regardless.' (Interviewee 029, male, increasing risk)

'… and if you're a drinker anyway, a heavy drinker, it's... that price is not going to deter people from drinking. It's as simple as that.' (Interviewee 045, female, possible dependence)

Second, most of the moderate, low-medium risk drinkers reported that their drinking behaviour would not change as a result of MPA legislation because the drinks they were drinking were already sold above 50p/unit:

'I: But do you think it's going to impact on your drinking?
R: No, not at all. I would class myself as a... Granted, I drink too much. Put my hand up. But I am a social drinker.
I: Okay. So, you'll just carry on, and you can... The price won't affect you.
R: No. I only drink in the club. I pay £3 for my pint of Stella. Stella's what, how many units to a Stella? There's three, so that would be £1.50, so it's not going to affect me one bit.' (Interviewee 026, male, increasing risk)

'No, it's going to be below that. I'm even thinking now, occasionally I have a can of... It's some lager which is only about one unit, but that's about £1.50, £1.60, so it's hardly going to affect that at the lowest values. The types of whisky and vodka I drink tend to be probably what you would call top shelf, things like Żubrówka.' (Interviewee 019, male, increasing risk)

'I'm pretty sure it isn't going to have an impact on me to be honest, just because I do mainly… if I do have a drink it's out in a restaurant with a meal or what I'd buy in anyway… you know, like you said earlier, it's probably above the minimum pricing anyway. I don't tend to buy like cheap spirits or, you know, I don't drink stuff like that.' (Interviewee 036, female, lower risk)

'The alcohols you mentioned weren't the type that I drink' (Survey respondent, 124. Female, low risk, unemployed but looking for work)

'I don't drink own brand lagers/ciders/stout and I like good red wine which is normally over £7-8 per bottle' (Survey respondent, 56. Male, increasing risk, self-employed)

Third, some drinkers (across all types of drinkers) reported that they would be able to afford any price increase produced by the MPA in Wales. This was because they

were not drinking enough to have their budget affected by it and/or they were earning enough money to cope with any increase in price:

> *'So, yeah, it's not a huge concern for me, because I don't drink enough or rely on alcohol enough to be worried about it. If I have to pay a little bit more, so be it.'* (Interviewee 029, male, increasing risk)

> *'Yes because I only buy it fortnightly I don't think it's too much of an extortionate increase that would stop me.'* (Interviewee 004, female, possible dependence)

> *'I would not have thought so because I don't drink seriously a great deal, but I suppose… I'd say no for me personally.'* (Interviewee 005, male, lower risk)

> *'Again I do not drink large amounts so like to buy quality over quantity'* (Survey respondent, 126. Female, increasing risk, student)

> *'No, I'm not driven by price when purchasing beer'* (Survey respondent, 110. Male, increasing risk, employed full-time)

Finally, some drinkers anticipated that the increased prices of alcohol resulting from MPA would encourage them to cut down their drinking after the legislation comes into effect. As such, MPA would act as a 'trigger' for reducing consumption:

> *'Say, for instance, like you said, four cans cost £4 and they'd gone up to £8, I probably wouldn't pay that, so I probably wouldn't consume alcohol unless it was a special occasion like someone's birthday, or Christmas, or something like that.'* (Interviewee 031, male, lower risk)

> *'I think for us, it will probably stay the same, albeit if the gin and tonics become too expensive then we'll just think twice about buying it, and think, 'No, I just won't buy as much,' and just buy less, I'd imagine.'* (Interviewee 033, male, lower risk)

> *'Yeah. It could have more of an effect on… I don't know, yeah… if you're in that situation and you haven't got the funds, it probably would just be 'Well, I just won't buy it then'. Or 'I'll drink less'.'* (Interviewee 034, male, increasing risk)

The potential for decreasing consumption was also mentioned by people who consumed alcohol at harmful (potentially dependent) levels:

> *'I: No, okay. What about you? What's it going to do to your drinking? Will the minimum pricing change what you do?*
> *R: I'll still have a drink but I'll just have to cut it down. I myself will not be turning to drugs.*
> *I: No, but would you... do you think it will cut your drinking down then? Do you think you are going to…?*
> *R: Yeah, it probably will cut my drinking down.'* (Interviewee 045, female, possible dependence)

'I: What will happen to your drinking?
R: Well my drinking might decrease slightly but that will only be because I can't fund it' (Interviewee 010, male, possible dependence)

Potential impact on type of alcohol consumed

In addition to investigating the impact of MPA on quantities consumed, drinkers were also probed about the potential for MPA to trigger a switch in the type of alcohol consumed (e.g. from cider to whisky). Survey respondents were asked to comment on the likelihood that they would switch type and brand (see Table 8.1) and the majority indicated that this was unlikely or very unlikely. Of the small proportion that did anticipate switching (7% for type and 10% for brand), the descriptions were varied. Some indicated that they would switch to spirits while others indicated that they would switch away from spirits and strong alcoholic drinks to other cheaper types and 'lower quality' brands of alcohol.

'Spirits will become similar in price to cider. I will switch to spirits.' (Survey respondent, 172. Male, possible dependence, unemployed but not looking for work)

'I tend to only buy spirits when they are on offer, and if it is unlikely that they will be priced at under 20pounds I am less likely to buy them/will buy less often.
This won't affect me for lagers/ciders but will definitely impact my buying decisions with spirits/wine/higher value drinks' (Survey respondent, 123. Female, increasing risk, employed full-time)

'I will likely stray away from higher ABV items due to cost' (Survey respondent, 132. Female, increasing risk, student)

'Again buy lower quality products' (Survey respondent, 126. Female, increasing risk, student)

'Not White Cider' (Survey respondent 169. Female, possible dependence, unemployed but not looking for work)

Many of the moderate drinkers that we interviewed predicted that harmful and hazardous drinkers may switch to other alcoholic drinks if the price of cheap alcoholic beverages aligned with that of other stronger beverages post-implementation. This prediction was based on the situation in Scotland, where traditionally cheap, strong beverages such as white cider were understood to have fallen into line with the price of fortified wines. As such, sales of [a fortified wine] were reported to have increased substantially post-implementation[67]. Many moderate drinkers predicted something similar may occur in Wales:

'With vodka as well because I've been reading about the Scottish minimum pricing and the thing that really hit them up in Scotland was stuff like [Brand

[67] Scottish Sun - Buckfast sales increase after MUP

of cider] which is the really strong cider and stuff like that. But I was talking to people from Scotland and they said they did [fortified wine] now so all they've done is go [fortified wine] now which is fifteen per cent proof.' (Interviewee 013, male, increasing risk)

Although many interviewees indicated that switching alcoholic beverages was likely to occur, most descriptions of this occurring were in relation to other (dependent) drinkers rather than to themselves. Yet there was some qualitative evidence among dependent drinkers to suggest this may occur. Indeed, this form of switching was the most commonly cited method when participants spoke about their own future switching behaviour:

I: So maybe you wouldn't switch to the spirits again?
R: No I don't really want to, but if it's cheaper then I've got no choice.' (Interviewee 040, male, possible dependence)

R: I might switch to spirits if they are the same price as the cider.' (Interviewee 010, male, possible dependence)

Some moderate drinkers suggested that they may also be more inclined to switch brands or type of beverage in response to a minimum price for alcohol. However, these drinkers tended to make a distinction between themselves and those dependent on alcohol, suggesting that any switching that may occur would not necessarily be harmful.

'I: Would you carry on drinking?
R: Yeah. Probably.
I: You wouldn't be like 'Okay I'm not drinking tonight because it's gone up'.
R: Oh God no. I wouldn't buy that, I wouldn't buy the vodka if it was like £14 quid; I would instead maybe buy a good, cheap bottle of wine.
I: So you would look for the next cheapest alternative? Is that right?
R: Yeah.
I: So it wouldn't affect your drinking. But you might look for something else?
R: Yeah, exactly.' (Interviewee 032, female, increasing risk)

Students also predicted that MPA would impact on their choice of drink as they would look to obtain the 'best bang for their buck':

'*R: [I]f it's going to cost that much more then I'd rather not have that and I would switch.*
I: To what would you think?
R: Back to gin probably, a gin and tonic because it's sort of in my mind as more sort of cost-effective, you know it's not jumping up much more than it is now. So yes, that's probably what I would do.' (Interviewee 044, female, increasing risk)

'I'd probably try to go for the highest amount of alcohol for like the cheapest.' (Interviewee 032, female, increasing risk).

Potential impact on other substance use

The survey questionnaire asked respondents to state how likely they thought MPA would result in changes to their use of illegal drugs, prescription drugs, over-the-counter medication, non-alcoholic beverage, food, non-beverage alcohol (e.g. hand sanitizers) and any other substance (see Table 8.2). On the whole, very few respondents anticipated that MPA would lead them to switch substance. For all substances, the majority of survey respondents indicated that they were either unlikely or very unlikely to change their patterns of use following the introduction of MPA. The explanations given for their survey answers were few and far between but where possible have been drawn upon in the discussion below.

Table 8.2 Predicted changes in the use of other substances post MPA

	Very likely	Likely	Neither	Unlikely	Very unlikely	TOTAL
Illegal drugs	7% (11)	4% (7)	11% (18)	7% (12)	72% (122)	100% (170)
Drugs prescribed to you	2% (3)	3% (5)	10% (17)	9% (16)	76% (132)	100% (173)
Drugs prescribed to others	2% (3)	2% (4)	11% (18)	9% (16)	76% (131)	100% (172)
Over-the-counter drugs	1% (2)	3% (6)	9% (16)	12% (20)	75% (130)	100% (174)
Non-alcoholic beverages	2% (3)	6% (10)	12% (20	12% (20)	70% (121)	100% (174)
Food	4% (6)	6% (11)	10% (18)	10% (18)	69% (120)	100% (173)
Non-beverage alcohol	2% (3)	3% (5)	11% (19)	12% (20)	73% (127)	100% (174)
Any other substances	1% (1)	2% (3)	12% (21)	9% (15)	77% (131)	100% (171)

Notes: Some missing cases.

Potential impact on illegal drug use

Most drinkers indicated that they were unlikely to switch to illegal drugs following the introduction of MPA. This was often because they had no history of using them and had no intention to start doing so after the implementation of minimum pricing for alcohol.

> *'I am never going to take any illegal drug'* (Survey respondent, 25. Female, low risk, looking after home and/or family)
>
> *'Do not use illegal drugs'* (Survey respondent, 35. Female, low risk, student)
>
> *'So what impact do you think minimum pricing will have on your use of illegal drugs?*
> *R: None whatsoever.*
> *I: Because?*
> *R: I don't use any.*
> *I: You don't think you'd start using them?*
> *R: I think I'm far too old now.*

I: So if the price of alcohol goes up and makes it more expensive than drugs you can't see yourself starting to use drugs?
R: No.' (Interviewee 002, female, lower risk)

'I: Do you currently use any illegal substances like cannabis or anything?
R: No I never have.
I: I know you don't use any illegal drugs but could you foresee the possibility of switching from alcohol to illegal drugs to get a particular feeling?
R: No.
I: Not given what you've just said.
R: No it never appealed or quite frankly never been offered to me which my mother doesn't believe; I genuinely have never been offered any drugs, I wouldn't even know where to get them.' (Interviewee 003, female, higher risk)

While most interviewees did not anticipate switching themselves, some did suggest that those who were dependent on alcohol may choose to switch substances following the introduction of MPA.

'*I don't smoke or I don't take drugs, then it wouldn't necessarily bother me but obviously for some people if you've got an addictive personality, maybe it would'* (Interviewee 020, female, lower risk)

The dependent drinkers we interviewed had mixed views as to how MPA would influence their use of illegal drugs. A clear consensus existed among those without a previous history of drug use that they would not switch to drugs as a result of an increase in the price of alcohol:

'I: So I'm thinking that the price for you is maybe not going to change a huge amount so do you think it would impact on your use of other substances, other illegal drugs?
R: No.' (Interviewee 011, female, possible dependence)

'I: Okay. Do you think that it would have any impact on your use of illegal drugs for example? I know you don't currently use them but might you consider using them if alcohol becomes more expensive?
R: I don't think so because I'm quite anti-drugs anyway so because I've been at university for three years, if I was going to then I would have before now.' (Interviewee 004, male, possible dependence)

However, among those dependent drinkers who had a history of illegal drug use, the views about switching to drugs as a result of MPA were mixed. Most of them reported that they had no intention to switch from alcohol to drugs:

'I: So what about if the price of alcohol goes up would you start thinking about using drugs again?
R: No, no, I don't want them in my life no more.
I: No?
R: No.' (Interviewee 040, male, possible dependence)

'So you don't think it's going to change your drinking, will it change your use of other drugs?
R: I don't touch… I'm not really a massive drug person.
I: So the price of alcohol going up isn't going to make you look for something else?
R: I don't think I'd turn to anything else, no.' (Interviewee 042, male, possible dependence)

'I: What about you? What's it going to do to your drinking? Will the minimum pricing change what you do?
R: I'll still have a drink but I'll just have to cut it down. I myself will not be turning to drugs.' (Interviewee 045, female, possible dependence)

R: *I don't think I'd turn to anything else, no. I won't turn to crack cocaine or coke; it's too expensive* (Interviewee 042, male, possible dependence)

Another dependent drinker with a history of drug use reported she was not clear about what she would do in terms of her drug use after the introduction of MPA:

'I: What impact do you think it's going to have on you in your use of illegal drugs? So, you currently drink cider and a bit of vodka and you do a bit of Crack, are you going to shift your money around a bit to buy more of Crack? Or less Crack, or more alcohol?
R: No, with drinking less it's going to save me more money isn't it and it'll probably help me get off the drink.
I: Will you spend that on drugs?
R: Maybe, I can say 'yes' and I can't say 'no.'
I: We'll wait and see.
R: So it's a maybe.' (Interviewee 023, female, possible dependence)

Several others reported that they would indeed consider switching to illegal drugs. When asked what substance they were more likely to substitute alcohol with, participants explained that their choice would be based on a combination between price and desired effects (preferably similar to alcohol):

'I: What about use of drugs? Will that change your use of drugs? Would you use more of...?
R: I'm not addicted to drugs. I just use drugs now and then.
I: But would you switch from alcohol to drugs if it was cheaper?
R: Yeah, of course I would, yeah if it was cheaper. Yeah, of course I would.
I: So, what would you switch to, if...?
*R: Spice. That's the cheapest thing. But spice is f**ked up.'* (Interviewee 039, female, possible dependence)

'I: What might you switch to?
R: Whatever comes up.
I: Again, is it just what's cheapest?
R: Yes.
I: You're looking for a particular kind of effect?
R: To mellow me out.

I: Okay. So, it wouldn't be cocaine, for example?
R: It could be anything.
I: It could be anything. Just something to change…
R: How my head is.
I: How your head is. It could be anything at all. If you had to say what it might be, what drug do you think is most likely?
R: Probably the weed to start with.' (Interviewee 025, male, possible dependence)

'I: Will it have any impact on your use of illegal drugs?
R: Possibly yes; I might start using some of the drugs because they'll be cheaper.
I: Any particular types?
R: I don't know; cannabis or I might even turn to heroin; I don't know.' (Interviewee 010, male, possible dependence)

Finally, one dependent drinker who was also using cannabis reported that MPA would not have any effect on his use of any of these substances. He reported he would continue using both alcohol and cannabis in the same way as before the price change:

'I: Would it impact on your use of illegal drugs? So, would you substitute alcohol for something else?
R: I like smoking cannabis and having a drink, yeah.
I: But if alcohol became too expensive, would you stop that and start using heroin or crack, or more cannabis? No?[68]
R: No. To be honest with you, no.
I: Why wouldn't you do that?
R: I balance it between the both.
I: Why do you do that?
R: Because I like both of them.' (Interviewee 037, male, possible dependence)

The potential for switching to cannabis was also mentioned by a few survey respondents. For one, this was linked to escalation of current use but for the other it was linked to the onset of cannabis use.

'I might start using cannabis because there's no minimum price on it' (Survey respondent, 172. Male, possible dependence, unemployed but not looking for work)

'May use more cannabis' (Survey respondent, 122. Female, increasing risk, retired)

On the whole, however, with just a small number of exceptions (e.g. one survey respondent who suggested 'I might use more crack cocaine' and one interviewee who said he might 'turn to heroin'), most drinkers were unlikely to switch to 'harder'

[68] Earlier in the interview, this respondent described previously using all sorts of substances including heroin and crack, hence the probe for use of these substances here.

substances such as crack or heroin and generally maintained a preference for alcohol. This was despite many non-harmful drinkers predicting that some drinkers would. If switching was to occur, it was most likely among those with a history of drug use and in relation to drugs that were cheaper and had similar effects to alcohol.

Potential impact on use of other substances

Survey respondents were specifically probed to comment on the potential impact on their use of a range of other substances including drugs prescribed by a doctor and drugs that had been prescribed to someone else by a doctor. As shown in Table 8.2, few respondents anticipated that MPA would alter their use of these substances. Only a few respondents explained their predictions, but when they did, the main reason given was because they did not use other people's medication and did not anticipate starting as a result of MPA. Interestingly, two respondents commented vaguely on why they thought their use of other people's medication would increase. One referred to the use of medication diverted from family members without explaining why. The other indicated that they 'might have to buy more street valium'.

The potential for switching to Valium was also mentioned by one interviewee who described how Valium would help them cope when withdrawing from alcohol:

> *'If you are addicted to alcohol it doesn't matter what other substances you take, you still withdraw from alcohol so unless you take Valium or diazepam then you've still got to withdraw from alcohol. Probably the most sensible thing to do would be to turn to Valium because that will stop me from being addicted to alcohol.*
> *I: So street Valium or prescribed?*
> *R: Well they'd only prescribe you Valium if you are on detox in hospital so it would be street Valium yes.'* (Interviewee 025, male, possible dependence)

For drugs prescribed legitimately by a doctor, the main reasons given by survey respondents for not changing their pattern of use were either because they did not think that their prescriptions would be affected by MPA (e.g. 'prescriptions are free', 'won't be affected by the introduction of the minimum pricing for alcohol', 'I will still need insulin') or because they did not receive any prescription medication (e.g. 'I don't take any') and did not anticipate starting as a result of MPA.

For the remaining substances, very few explanations were given by survey respondents. When a change in behaviour was thought likely or very likely, a few interesting responses were given. For over-the-counter medication (e.g. 'pain killers maybe'), for non-alcoholic beverages (e.g. 'drink a lot of soft drinks when I cannot get hold of alcohol'), for food (e.g. 'eat more when I drink less'), and for non-beverage alcohol (e.g. 'people who can no longer afford alcohol will use such things in its stead').

Summary

Minimum pricing for alcohol has been introduced in Wales in order to help protect the health of hazardous and harmful drinkers who consume large amounts of strong, cheap alcohol. This chapter examined what drinkers (including hazardous and harmful drinkers) anticipated would happen to their drinking patterns post-implementation of the legislation. The chapter also considered what would happen to drinkers' use of other substances including illegal drugs. As also found by Holloway et al. (2019), drug switching was considered unlikely among the drinkers in this study. In line with previous research, switching to illegal drugs (usually cannabis and rarely harder drugs) was only a possibility for those with histories of using them. Most drinkers thought it unlikely that their drinking patterns would change as a result of MPA. For dependent drinkers the lack of change was driven by the physical need to keep on drinking to avoid withdrawal, seizure and potentially death. For other drinkers it was because they could afford the additional costs or because they did not drink enough for it to affect them. While the predictions were largely negative in the sense of limited prospects for change, a small number of drinkers (including dependent drinkers) thought that MPA might trigger a reduction in their drinking.

9. Potential social and health consequences

Moving on from the potential impact of MPA on patterns of drinking and substance use, this chapter examines the potential social and health consequences of introducing a minimum price for alcohol in Wales. The chapter is divided into two main parts. The first focuses on the potential social impact of MPA on drinkers including possible effects on: offending, finances, relationships, employment, and housing. The second part of the chapter explores the potential impact of MPA on drinkers' physical and mental health.

Like the previous chapter, this chapter is based on drinkers' predictions of what they think will happen once MPA is implemented rather than on actual events. Furthermore, the chapter examines both what drinkers anticipate will happen to themselves personally as well as to other drinkers.

Likelihood of social and health impact

To investigate the potential social and health impact of MPA on drinkers' lives, survey respondents were asked to state how likely they thought it was that MPA would affect them personally on a range of health and social issues. The figures in Table 9.1 clearly show that for each issue, most drinkers thought that it was **very** unlikely that MPA would result in any change. For most issues, less than 10 percent of respondents thought that MPA would affect them. However, for Finances, the figure was slightly higher at 15 percent.

Table 9.1 Predicted changes in other aspects of their lives post MPA

	Very likely	Likely	Neither	Unlikely	Very unlikely	TOTAL
Family members	2% (4)	3% (6)	11% (20	9% (16)	74% (132)	100% (178)
Friends	1% (2)	7% (13)	12% (21)	7% (13)	73% (129)	100% (178)
Physical health	3% (6)	5% (8)	8% (14)	9% (16)	75% (132)	100% (176)
Mental health	4% (7)	4% (7)	11% (19)	10% (18)	71% (127)	100% (178)
Employment	1% (1)	1% (1)	10% (18)	10% (17)	79% (141)	100% (178)
Finances	5% (9)	10% (17)	10% (18)	9% (15)	67% (118)	100% (177)
Housing/living	1% (2)	-	14% (24)	9% (16)	76% (136)	100% (178)
Offending	2% (4)	2% (3)	11% (20)	9% (15)	76% (135)	100% (177)

Notes: Some missing cases.

Explanations for why respondents thought that MPA would change their lives were rarely provided but included some interesting points. These comments are drawn upon where appropriate in the sections below.

While most survey respondents did not anticipate that MPA would have any kind of effect (positive or negative) on their lives, the interviewees had a different view. In fact, the majority of interviewees felt that the legislation would result in negative health and social effects for drinkers, especially dependent drinkers.

Potential social impact

While research participants recognised a range of potential social consequences of MPA, one of the most frequently mentioned was related to crime and offending behaviour. For the most part, this issue was discussed in fairly negative terms with most describing a potential increase in offending.

Acquisitive crime

Most survey respondents did not anticipate a change in their offending behaviour as a result of MPA. However, a small proportion thought a change was likely and in those cases where explanations were provided, the anticipated change was not for the better.

> *'Less money to pay for more therefore using more illegal actions to get the money for it'* (Survey respondent, 119. Male, low risk, student)

> *'I may need to go out robbing to fund my drinking'* (Survey respondent, 170. Female, possible dependence, unemployed but not looking for work)

Similarly, interviewees (including all types of drinkers) overwhelmingly, anticipated that one of the most likely social impacts of MPA was an increase in crimes committed by dependent drinkers, who as a consequence of the price changes would need to find new ways of acquiring money.

Most low-medium risk drinkers (who were not dependent drinkers themselves) raised clear concerns that the price increases introduced by MPA policy would lead those who have an alcohol addiction into committing more acquisitive crimes such as shoplifting, theft, burglaries, but also, in a few cases, violence. Others anticipated a general increase in crime, without specifying which types of crimes in particular would see an increase:

> *'I mean crime rate I'm thinking as well. If people can't afford to feed their habit, in some respects like with heroin, because that's such an expensive thing, people do tend to look for other means of getting money as opposed to what they may get in employment. So I think that's a concern.'* (Interviewee 044, female, increasing risk)

> *'[I] guess it would be the same with drugs and whatever people want to do. If they are that addicted to something and the price then triples then maybe they'll go to a supermarket and steal it anyway. So maybe there will be more thefts or house burglaries, you know whatever people do to get their kicks really isn't it?'* (Interviewee 020, female, lower risk)

'I'm not dependent on alcohol, so I'm not sure. But I'm thinking that the theft of alcohol from shops and then the potential impact on shopkeepers, maybe increased violence, these things should be taken into consideration.' (Interviewee 029, male, increasing risk)

'If someone wants to buy something, they'll find a way. Like I said, it could increase crime because people might be stealing more because alcohol's gone up.' (Interviewee 031, male, lower risk)

Participants who were themselves dependent on alcohol reported that an increase in price due to the introduction of MPA in Wales would not stop them from drinking. Instead, because of the strength of their dependence, which was often likened to heroin addiction, they admitted they would commit acquisitive crimes to help them cope with the price change:

'I: Do you think it'll stop people from drinking?
*R: Obviously not, because they're gonna f****** nick it… they'll just take it out of the shop. … Just going to take the bottles out of ASDA. It's going to take the shop out of ASDA. When you want it, you'll get what you want.*
I: So, people who need it will just take it?
R: Yeah. You rob, because... Heroin's like, you rob your own Nan on stuff like that. You'd rob family, friends, you don't care. Alcohol's a similar drug. When you need it, you do go to that extent to get it… Well, they're going to burgle, not just steal off the shelves; they're going to burgle houses and all that. You will get that situation, because it's still a drug like any of the others. It's still an addictive drug.' (Interviewee 037, male, possible dependence)

'I: What will happen to your drinking?
R: […] it will just mean I'll start shoplifting alcohol and stuff like that' (Interviewee 010, male, possible dependence)

'R: I think you'll see shoplifting going up.
I: So, people will steal it?
R: That's the way I think it will go. They're going to go out and drink because they're alcoholics, and then they'll shoplift from the shops.
I: Would you steal it? Would you steal alcohol?
R: I have done in the past, and I would do, yeah.' (Interviewee 039, female, possible dependence)

Other types of crime

Apart from an increase in acquisitive crime, some participants also anticipated a rise in under-the-counter sales of alcohol at a price below the legal limit, something that happened previously with the sale of tobacco, after its increase in price. Some drinkers reflected on their own experience of this in the past:

*'R: I'll just go to the P** shop then.*
I: But he'll have to sell it at that.

R: No he won't; he's alright. … he sells cans for 99p and I give him a pound a can every time…' (Interviewee 040, male, possible dependence)

Others reflected on what they thought would happen based on what sounded like a more indirect understanding of how things had worked in the past.

'You hear it, you see it in the news, of this black market in cigarettes and things like that, where alcohol may become more available underground, so to speak, so it can be bought that way.' (Interviewee 033, male, lower risk)

'I: So, do you think this is a good thing, then? That they're increasing the price?
*R: It's f**king... I don't know. I don't know, because if you increase the alcohol, they're going to sell it under the counter.'* (Interviewee 038, male, possible dependence)

A few other participants (particularly dependent drinkers), also emphasised that sales of counterfeit alcohol could grow, again in the same way as it happened with cigarettes, when their price went up. These drinkers reported that they could easily source this type of alcohol if they needed to:

*'I know which shop to go to it's just it's quicker the P*** shop where I go down, so I'll just walk on a bit further and I can get it there; there's drink there and they keep it all upstairs so good luck to them like'* (Interviewee 040, male, possible dependence)

In fact, one of them was already doing so:

*'I do think that they're going to start serving them like... It's like cigarettes, when they started selling cigarettes under the till. Some of them will start serving alcohol under the till. So, yeah, I would buy it, yeah… They'll already sell you fake cigarettes, so I just…under the counter, selling the fake booze, like they already do in the *** shop in Grangetown, and it's f**king poisonous. But they're selling it. I drank it the other day.'* (Interviewee 039, female, possible dependence)

Other drinkers were aware that this practice had happened with tobacco and anticipated that it would also happen with alcohol.

'I'll be honest with you, they've put the prices up now; a couple of things have gone up. One thing, people are going to start like they do with tobacco, they're going to be round the corners selling cheap booze right? Which isn't a good thing because a couple of years back with vodka it was making them all go blind, but if they want to drink they'll go round the corner won't they and buy it.' (Interviewee 045, female, possible dependence)

'I think that people will always find a way to purchase alcohol if they need it, beware of black market, counterfeit products becoming more commonplace.' (Survey respondent, 91. Female, low risk, employed)

On a more positive note, one survey respondent anticipated that if MPA resulted in a reduction in alcohol use then this may result in a decrease in certain types of alcohol-related crime, namely violent crime.

> *'If there is less alcohol consumption it may stop alcohol induced crime such as GBH'* (Survey respondent, 134. Female, increasing risk, student)

Finances and accommodation

Another key social impact considered in both the survey and interviews was the potential impact of MPA on drinkers' finances. As noted above, survey respondents indicated that finances were more likely than other issues to be affected by MPA (see Table 8.3). Few explanations were given, but some identified that the increase in price would result in their finances being stretched while others indicated that it might help them to save money, presumably because they were not buying as much alcohol.

> '*I will be struggling more because alcohol will cost more and I will still need to drink'* (Survey respondent, 170. Female, possible dependence, unemployed but not looking for work)

> *'I'll probably have saved a few pennies*' (Survey respondent, 160. Female, increasing risk, student).

Among the interviewees there was a general consensus that alcohol dependent drinkers may re-budget existing resources (e.g. food, gas/electricity bills, rent) to cope with increased alcohol prices:

> *'The only difficulty, I think, around that is if they are alcohol dependent. They will be either unwilling or unable to reduce their consumption, and what they will do then is continue to drink what they were drinking previously, but they will then have less money left to feed themselves, clothe themselves, heat their homes. But the impact on the other people in their family, particularly vulnerable children, could be difficult.'* (Interviewee 034, male, increasing risk)

> *'Again, with some of the job I do, I know with Universal Credit that the money now goes directly to the client, and then they're responsible for paying their rent, et cetera. But I think ultimately, if you can't afford it, then most probably in terms of housing I think it will be beneficial. I think people will pay their rent more on time. It depends. If you really want to drink, then if it's £11 is that going to be a deterrent? Maybe not. So, it could work two ways. It could either be, 'I can't afford it, so therefore I end up with more money,' or, 'I really need a drink, it's £11, I won't pay my rent.' So, it can work both ways, I guess.'* (Interviewee 029, male, increasing risk)

> *'For me, in my situation, personally no. Potentially for some people, then if they're heavily dependent on alcohol then they might have to really think hard about where their money goes, whether they're spending more money*

on alcohol, which is having a negative impact on their food, or monthly bills, that kind of thing.' (Interviewee 033, male, lower risk)

'I think the only negatives really are for the real sort of people that are really addicted to alcohol who would, you know, not buy food or not pay bills or whatever in order to pay the increased price.' (Interviewee 036, female, lower risk)

Two dependent drinkers also commented on the financial implications from a more personal perspective. Both predicted that the increase in the price of alcohol would impact on their ability to pay for their accommodation and result in eviction and homelessness:

'R: It will just mean that I'm spending twice as much money on alcohol as what I am now and I'm already spending all my money on alcohol so I don't see how I can spend twice as much on alcohol.
I: So you'll spend less on other things?
R: Yes.
I: So you'll spend less on food and other things? I think you said before you won't be able to pay your service charge fee or room?
R: For my accommodation yes.
I: And what might be the consequence of that?
R: I'll just be evicted.'
(Interviewee 010, male, possible dependence)

'I'll get into debt and I won't pay my rent and then will get evicted and be living on the streets so yes it's a very negative thing to me.' (Interviewee 011, female, possible dependence)

Some interviewees felt that disregarding essentials could have a number of consequences for the care of children and vulnerable populations, particularly among low-income populations. One implication was the diversion of money from food to subsidise less affordable alcohol. This was cited as a common procedure among drinkers in the past when alcohol had become difficult to afford, and cited as a possible future coping strategy in response to MPA. Participants were concerned that foregoing these essentials would lead to increased health concerns (if food is neglected) and broader social consequences (for childcare). Some spoke of this in relation to other drinkers.

'… I think, around that is if they are alcohol dependent. They will be either unwilling or unable to reduce their consumption, and what they will do then is continue to drink what they were drinking previously, but they will then have less money left to feed themselves, clothe themselves, heat their homes. But the impact on the other people in their family, particularly vulnerable children, could be difficult.' (Interviewee 027, male, lower risk)

'Yeah, well if you've got a dependency issue and you're forced to make that choice, I think a lot of the time the dependency might win. If it's a low-income family with an alcoholic living within it who's in charge of the benefits, or in charge of the money coming in, then choices might be made that have

a negative effect on the members of that family, whether that's not stocking food, paying the bills, do you know what I mean? ' (Interviewee 034, male, increasing risk)

One interviewee discussed the issue from his own personal experience and perspective:

'Well I think it's just going to take food out of children's mouths because if you are an alcoholic you need the drink and by boosting up the price isn't going to stop you from buying it. It's just going to mean that you are not going to spend the money on other necessities like your children's clothes and children's food and your own food and your own clothes and stuff. You are still going to buy the alcohol; you are just not going to buy the other stuff that you usually buy.' (Interviewee 010, male, possible dependence)

There was a general consensus among interviewees that despite the potential benefits occurring from MPA, those from low-income or vulnerable populations may experience and be subject to the most significant harms and implications stemming from MPA.

'I think the only negatives really are for the real sort of people that are really addicted to alcohol who would, you know, not buy food or not pay bills or whatever in order to pay the increased price.' (Interviewee 018, male, lower risk)

'Well, I think it will make people think about what they actually are paying before they spend their money, but it depends on the individual, like we were discussing about people who perhaps are on very low incomes, or homeless. There is going to be a large amount of people who are going to be affected by it, but there are also going to be even more that are not going to be affected by it' (Interviewee 008, female, lower risk)

'Yes I think so; it never occurred to me but of course a lot of homeless people do move from city to city, particularly if one city suddenly decides to get tough on the homeless and starts clearing them out of doorways and things, then they move on. Bristol is not that far away.' (Interviewee 021, male, increasing risk)

While the potential for eviction and homelessness was noted by a few interviewees, few survey respondents thought that MPA would have an impact on their living arrangements. Unfortunately, those who thought it would, failed to provide an explanation of how and/or why they thought this would happen.

Relationships

Previous research with service users and service providers suggested that one possible unintended consequence of MPA could be a negative impact on relationships with family and friends, perhaps as a result of increased financial strain (Holloway et al, 2019). Questions were therefore included in the survey and

interviews to explore the views of drinkers within the wider population of people in Wales.

While most survey respondents did not anticipate any impact on their relationships, a small number did. Among the few who provided explanations, there was concern about an increase in arguments (e.g. 'argue a lot') and one respondent made a worrying prediction about the future of her relationship with her boyfriend:

> *'My boyfriend will leave me for a woman who can provide alcohol for him. He needs four cans of beer every second day, and it will not change after the increase of price of alcohol.'* (Survey respondent, 43. Female, increasing risk, student)

A few dependent drinkers admitted during their interviews that the introduction of MPA and the subsequent increase in the price of alcohol would put an additional strain on their personal relationships, many of which had already deteriorated due to their alcohol dependence:

> *'I: What about the impact of minimum pricing on relationships with others?*
> *R: That will have an impact on my relationship yes.*
> *I: Could you explain?*
> *R: My partner drinks as well.*
> *I: What do you think might happen there then?*
> *R: Just that we are going to be arguing over money more.'* (Interviewee 010, male, possible dependence)

> *'a breakdown in relationships I think is going to happen as well, because people are going to be more stressed and when they are stressed relationships go wrong.'* (Interviewee 004, male, possible dependence)

> *R: Well, my mum doesn't like me drinking… When I do drink, they're not happy with that and then when I don't drink, they're not happy with that because I fit, and it scares them.'* (Interviewee 039, female, possible dependence)

While most focused on the impact of MPA on family relationships, some considered the wider social implications. One survey respondent highlighted the potential negative impact on relationships with friends, flagging up that they would be 'less social' as a result and would see less of their friends 'because our relationships are built on alcohol'.

However, it was not all doom and gloom. One survey respondent flagged up that MPA might have a positive impact on family members who might be 'more present without the use of alcohol'. Nevertheless, this positive outlook was rare and indicated that drinkers found it difficult to identify potential benefits of MPA in terms of relationships.

Potential health impact

As well as significant social implications, interviewees also alluded to a number of health implications that could arise in response to the legislation. Some felt that if dependent drinkers switch to potentially more harmful spirits from lager or ciders, this would lead to significant negative health consequences.

One participant reported that he would potentially switch to spirits and suggested that move could be a dangerous one for those who were not used to consuming stronger types of alcohol:

> *'R: Well if I'm wanting a drink I'd just swap to shorts because that gets me drunker quicker. I mean fifteen pounds a bottle of vodka, which will have a lot more of an effect on me than just over four pints in my local pub. But potentially I think if people went on shorts rather than beer it will do them a lot more damage I think …'* (Interviewee 013, male, increasing risk)

One dependent drinker predicted that he would have to switch to spirits because of the increase in price. However, he was reluctant to do so because of the negative health consequences that he had experienced in the past.

> *'I: So if the price of alcohol goes up, if your cider goes up and makes it similar in price to spirits, would you switch to spirits?*
> *R: Probably yeah; probably.*
> *I: Because?*
> *R: Because it's stronger.*
> *I: You want the stronger?*
> *R: Yeah but I don't want to get back to where I used to be, shaking every morning and I've done well but it's been hard, believe me it's been hard.*
> *I: So maybe you wouldn't switch to the spirits again?*
> *R: No I don't really want to, but if it's cheaper then I've got no choice.'* (Interviewee 040, male, possible dependence)

Further, there was concern among some drinkers that a switch to 'counterfeit' alcohol may also occur, and result in physical harm to drinkers. One interviewee used an example from Russia to reinforce this point:

> *'Yeah. The only other thing which just went to mind which could be a concern is, you've got... Maybe not so much over in this country, but you've got bootleggers who... I think it's quite a big thing in Russia. I think I read somewhere before about bootlegged vodka being made, and it made about 30 people seriously ill off the back of it. With criminal gangs, they see an opportunity to make money and if they can sell vodka for half the price that you can buy it in the supermarket then there's always going to be the potential that somebody's going to be interested in that.'* (Interviewee 018, male, lower risk)

For drinkers unable to reduce or stop consumption following the introduction of MPA, there was particular concern that there would be an increase in alcohol withdrawals,

including seizures, should an alcohol dependent person be unable to afford, and obtain, alcohol.

> *'I: What do you think might happen then to people that can't afford to...? R: Well, I just think things like, you know, theft is probably going to up or people are going to end up having like withdrawal problems and not having... you know, a way to deal with it, especially if it's... I don't know, like homeless people or...'* (Interviewee 036, female, lower risk)

> *R: Well, my mum doesn't like me drinking, but then she doesn't like me seizuring in the corner. I'll be down, like I'll be seizuring in his van. So, it's like, I can't win. I either drink or I don't. When I do drink, they're not happy with that and then when I don't drink, they're not happy with that because I fit, and it scares them.'* (Interviewee 039, female, possible dependence)
> *'I will be going into withdrawal'* (Survey respondent, 170. Female, possible dependence, unemployed but not looking for work)

There was consensus among all drinker types on this topic and a concern that it may lead to an immediate burden on medical services following the introduction of MPA:

> *'But I mean, in the long run, yes, it's probably going to be good for everyone - including dependent drinkers, but in the sort of short-term I just… now you've told me about it, I do have a few concerns about how, you know, some people are going to manage with that, and like we were saying, the knock-on effects on the NHS and people needing extra support.'* (Interviewee 036, female, lower risk)

> *'People are going to use more drugs if you drink less, commit more crime for the sake of... You use more drugs, commit more crime, cost the NHS more money, you're all f***ed.'* (Interviewee 038, male, possible dependence)

> *'I think the government are making a mistake in doing this because they think it's going to solve a lot of problems, but it's going to create another dozen. Especially with the reduced numbers in police force, ambulance service. A friend of mine got taken to hospital yesterday. The ambulance was well over an hour because he's picked up six spiceheads. Two of them I knew, and they go and rob for their stuff. So don't tell me it's gonna work, because it's not.'* (Interviewee 025, male, possible dependence)

> *'I know from the NHS that it would be very difficult. As we know, funding has dropped for everybody. A lot of voluntary bodies now are not as well funded as they were in the past, and will they be able to cope with that extra demand? I don't know. It depends if there's funding to put into it extra to counterbalance the extra costs, and maybe that might be a good use of the extra 50p.'* (Interviewee 019, male, increasing risk)

Some interviewees recognised the potential seriousness of alcohol withdrawal, and thought that the legislation may increase the number of individuals suffering significant harm, including death. One interviewee described this in very stark, personal terms:

'Yeah, but I know that it's very dangerous to for an alcoholic that we remove the alcohol. If that were to happen there would be a lot of deaths of people that can't afford it and that's why I am curious to know whether shoplifting would increase for these groups.' (Interviewee 046, female, increasing risk)

'Yeah, they could die from not drinking.' (Interviewee 037, male, possible dependence)

*'If I don't drink I'll seizure and die' (*Survey respondent, 172. Male, possible dependence, unemployed but not looking for work)

While most comments about health focused on physical health, the potential impact on mental health was also recognised. One survey respondent noted 'I will be more depressed', while another noted they would be 'a bit upset' if they were unable to have their regular glass of wine 'after a hard week'. That said, the potential for positive consequences was also noted (e.g. 'help lose weight if you're drinking less')

Summary

In this chapter the interview and survey data have been drawn on to examine the potential health and social impact of MPA on drinkers. There was a broad consensus among survey respondents and interviewees that harmful or dependent drinkers were the most likely to be affected by MPA in terms of both their health and social issues. Of particular concern was the potential for an increase in acquisitive crime among those drinkers who were unable to afford to pay for their usual supplies. The potential for re-budgeting household finances to free up money to pay for alcohol was also identified as a method of generating money for alcohol. This was a matter of some concern given the potential consequences for vulnerable children. In extreme cases the possibility of eviction and homelessness was predicted among drinkers who would have to choose to buy alcohol rather than paying rent.

The potential impact on relationships was also recognised by drinkers, some of whom predicted that arguments and break-ups would be the consequence of the increased strain that MPA would bring, particularly on dependent drinkers. That said, the potential for MPA to bring people together and make drinkers 'more present' was also acknowledged. For the most part, the potential health consequences were largely seen as negative. Comments on this important issue, again, mainly related to dependent drinkers[69] who it was anticipated would experience physical harm either as a result of withdrawing from alcohol or from using counterfeit alcohol as a cheaper alternative.

[69] As noted earlier in the report, dependent drinkers form only a small proportion of the drinking population and are not the main target group for the legislation.

10. Preparation and support

The results presented in this report so far have focused on what drinkers thought would happen to them (and other drinkers) once MPA was introduced in Wales. In this chapter attention is shifted towards what support drinkers thought would be necessary to help people prepare for and cope with the consequences of introducing MPA in Wales. The focus in this chapter is on the interview data as questions on 'support' were not specifically included in the survey[70]. The chapter begins with a section that examines issues relating to 'preparation' and then moves on to consider issues relating to 'support'.

Preparing for MPA

There was a wide consensus among interviewees (across all types of drinkers) that more needed to be done to raise awareness about what introducing MPA would mean in practical terms. Of particular importance was the need for clarity on how much drinks would cost under the new system and wider publicity regarding the date of implementation.

> *'I think the shops could probably do with putting a few posters up saying the alcohol price is going to go up by x amount and this will affect these drinks, just so people are aware of it for when it hits next month but other than that there's not much they can do because obviously there's still going to be a desire for people. Obviously, people are still going to go and buy alcohol and spend x amount of money on it regardless, but I think they probably could do with telling people how the pricing is going to change. They might have been doing that; I could have just missed it, but I've been out and about recently and haven't seen anything about it just yet.'* (Interviewee 014, male, increasing risk)

Some of the more high-risk drinkers were critical of the fact that they had not been notified earlier about the details of a policy, which could potentially have a significant impact on their lives. They argued that more time was needed to help them adjust to the new regulations:

> *'I: So, you think people need time to adjust, and to think about what they're going to do?*
> *R: Yeah, definitely. We launch new products in my company, yeah? We give people plenty of time notice of what's coming, what are we going to do. We prep them, get them ready, and then bang, and that's how we do it, yeah? Okay, I'm a manufacturer, yeah? Totally different to what you're doing, yeah? But people don't like change. You need to make them aware.'* (Interviewee 029, male, increasing risk)

Interviewees stressed that the raising of awareness should be done via a multitude of channels, especially media outlets (i.e. TV, radio, newspapers and social media):

[70] The survey did, however, include a question at the end inviting respondents to use a free text box to tell us about any other issues that they thought were important about MPA.

'I suppose every aspect of the media should be used as the next step.' (Interviewee 005, male, lower risk)

This comes because of a widely reported lack of knowledge about the MPA policy, even among interviewees who claimed they were staying up to date with the latest news from Wales:

'I am quite interested in news social media, yeah? So, in other words, I will read a lot of social media. I'm very interested in the news, be it BBC News, be it news on the phone, yeah? Okay? So, I'm up to date with my news, current events, very much a proud Welshman. So, I am aware of what goes on in Welsh politics, in Welsh life, in Welsh sport, okay? If I'm not aware of this coming in on 2 March, then it's not being advertised enough.' (Interviewee 026, male, increasing risk)

However, some lower-risk interviewees were cautious about the potential benefits of media campaigns (internet-based ones in particular) in raising awareness of MPA. Their main concern was that some dependent drinkers have a reduced presence online and would therefore not be exposed to any internet-based campaigns:

'I suppose there's always social media isn't there as well; a lot of people get their information via that these days, don't they? Then again if somebody's got a real serious alcohol dependency, I don't know how much they would be online.' (Interviewee 030, female, lower risk)

[There should be] 'a lot more advertising about it, because when I'd first seen it, it was like, 'Oh yeah, follow this link,' and not all people have access to internet and computers, so they might not be able to see what it means. They should say, 'This is what's happening,' like in the papers and on billboards, so people actually know what's going on, because a lot of the time, like I said, people don't have access to this sort of thing so they don't know until it actually happens, and then the frustration gets taken out on shop owners and the people who work in shops.' (Interviewee 031, male, lower risk)

Several interviewees suggested that actions aiming to raise awareness about the introduction of MPA should be targeted at locations where the individuals most likely to be affected by it have access on a regular basis, such as hospitals, surgeries and the drinks aisles in supermarkets and shops:

'I suppose doctors surgeries is always a good place and hospitals and things because you might get people there if they do have a very serious alcohol dependency; I imagine they might have medical issues as well so that might be one way… Just with the information it might be worth having things like a fact sheet or something up in supermarkets, in the alcohol aisle but I don't know how happy supermarkets would be about that but that's obviously then targeting the people that are buying the alcohol so they'd be able to get the information that way.' (Interviewee 030, female, lower risk)

The consensus of opinion that more work needed to be done to raise awareness of the introduction of MPA among drinkers, mirrors the views of service users and service providers reported by Holloway et al. (2019). This was despite the fact that these interviews were all conducted in the two months prior to implementation of the legislation (between 10th January 2020 and 28th February 2020) a period during which (a) media articles and social media posts about MPA were beginning to emerge[71], and (b) the Welsh Government launched its own media campaign designed to raise awareness about MPA among the general population[72].

Supporting drinkers

There was widespread agreement among interviewees that support (along with additional funding for services) would be needed to help drinkers prepare for and cope with the introduction of MPA. It was thought that dependent drinkers would be in particular need of support given that they were most likely to be affected by the legislation.

While there was consensus in the call for more support, interviewees were less consistent when it came to the specific type of support that they thought should be provided. Several interviewees suggested that some general or generic support should be offered, without going into more detail about what that should entail:

> *'I: So, do you think they need any support, or you think they don't need support?*
> *R: I think they'll need support, yeah.*
> *I: What do you think that ought to look like?*
> *R: I don't know. You're the specialist, not me.'* (Interviewee 026, male, increasing risk)

> *'I feel like some issues might come from it and a lot of the time services aren't really… don't deal well with things like this just because like, of not being funded enough and things like that. So, I feel like that probably needs to be looked at and something needs to be put into place for the most vulnerable people who will be affected by it.'* (Interviewee 032, female, increasing risk)

Other interviewees suggested specific areas of support, including:

(a) more staff for alcohol detoxification services and a reduction in waiting times for these services:

> *'It needs better access to support; it's quite hard to get support so maybe they can use some of the money from the increased price to pay for more support workers so that there is more support and facilities to detox people rather than how it is now. It's like a two or three month waiting list to go into*

[71] One of the first social media posts on the topic of MPA was a tweet by Aneurin Bevan University Health Board on 18th January 2020, which focused on the impact of MPA on the costs of different types of alcohol. Aneurin Bevan UHB Twitter post.
[72] BBC News 17 February 2020 – Welsh Minimum Alcohol Pricing Campaign Starts

a medical detox which is not good.' (Interviewee 010, male, possible dependence)

'R: I want to cut down, but I think it's all a bit sudden. There's no plan behind it. It's like, 'Oh, you've got to cut down, because we're going to charge more for the alcohol.' There's no point when I'm dead.
I: So, you think there needs to be more support in place to get people into treatment quickly?
R: Yeah, because it takes years. Everyone knows. Years to get into rehab. They're expecting us to suddenly stop drinking. Doesn't work like that.' (Interviewee 039, female, possible dependence)

(a) improving signposting to available support:

'if people are aware of those who are dependent on it, then trying to offer them and let them know about the help that's out there, so that they aren't feeling so vulnerable and alone. Yeah, I think a lot of it is just sort of giving them advice and showing them where they can go to get the support that they need to be able to change, especially if they are on low income and drink-dependent and then they could end up homeless, sort of thing' (Interviewee 046, female, increasing risk)

'They sell people alcohol, but I feel like if they had a couple of posters up with just like a helpline or somewhere where you could just talk to people. I think people are... you know, some people would use it.' (Interviewee 032, female, increasing risk)

'But yes, so I think we need to raise awareness of help that is out there for them, including psycho, social and detoxing. I mean alcoholics can't just stop, they need to wean themselves off; it's not something that everyone is aware of, which is why some people can die from just stopping drinking. You know, if we are going to penalise these people with the tax that we are putting on there, we should be offering something else. I mean overall, I know the more money that we put into substance misuse and alcohol addiction, the more money we save in other areas. So yes, I think they should have everything available to them.' (Interviewee 044, female, increasing risk)

(b) reducing the waiting time for GP appointments:

'I think the speed at which you see your GP, the speed at which you get referred to the support organisations, will need to be sped up. I have friends that have been alcoholics, or are alcoholics, and the support they've got has been invaluable, you know? I have friends that have drunk a hell of a lot, and the doctors basically said that they should under no circumstances completely stop. In terms of going complete cold turkey, it's really dangerous. So, I'm just thinking the speed at which doctors see people, the speed at which the referrals are taking place will need to be increased.' (Interviewee 029, male, increasing risk)

(c) offering help with developing budgeting skills:

> *'There could be things put in place, like, classes that they could go to, to help them budget their money more, help them prioritise it. Instead of paying £12 for a bottle of vodka or whatever, they could use that money to save then for a mortgage, you know? But then, say for instance they put £200 into savings, that gives them £50 then to indulge in alcohol if that's what they want to do. I think classes could help people finance their monies better.'* (Interviewee 031, male, lower risk)

> *'Some alcohol, some people are potentially going to be priced out of alcohol, and not be able to afford that, really. Potentially some financial guidance as well as to how to budget better in terms of affording alcohol.'* (Interviewee 033, male, lower risk)

> *'I think they should get, a lot of them need help with benefits and things like that so, potentially financial help; I'm just thinking of people who are in homes potentially.'* (Interviewee 044, female, increasing risk)

(d) increasing outreach support:

> *'R: Yeah, there could be more help out there for people, I suppose, if they need it.*
> *I: And what would that help look like?*
> *R: I don't know. Someone to tell them, I don't know, that sort of help. If you've seen someone vulnerable or who looks like they're spiralling out of control, try and help them, I suppose.*
> *I: So, outreach, going out...*
> *R: Yeah, something like that.'* (Interviewee 037, male, possible dependence)

(e) increasing ambulance and hospital staff numbers:

> *'I mean if people are going to move to Skunk or some sort of synthetic cannabinoids then you might need more ambulances and more trained staff but without knowing that is going to happen it would be very difficult to put these sorts of things in place.'* (Interviewee 021, male, increasing risk)

(f) Finally, some argued for a wraparound, holistic type of support, which covers a multitude of aspects that need to be addressed at the same time:

> *'If there was wraparound care to go along with the programme that you were also putting more funding into… I don't know, alcohol and drug admission centres around Wales and more shelters, or more money for the charities that do work with alcoholism, I think as a plan, it probably works well because if you're supporting the people that are already disadvantaged and that are already struggling with alcoholism, to then put a preventative measure in for the next generation coming through would seem sensible. If it is just a bit of a knee-jerk reaction to say 'Well, there's people drinking too much, let's make drink more expensive', I think you'll probably just see the negatives of that.'* (Interviewee 034, male, increasing risk)

'Housing. I don't know, social security. Yeah, and then more therapeutic interventions and just adequate support. Yeah, and not just oh, here you go. You can sleep in this hostel or halfway house or something. People really need help. They just need to get back on track.' (Interviewee 007, female, increasing risk)

'The ideal of course is what I said earlier which is to tackle the root problem of the drinkers and look at it from a society point of view and look at the homeless, look at people who might have a roof over their head but are drinking regularly to excess because they can't see any future and if you can address these sort of social problems then yes you could put something in place.' (Interviewee 021, male, increasing risk)

Not all interviewees agreed that specific support should be put in place to prepare drinkers for the introduction of MPA. Among a small minority of lower-risk drinkers there was a perception that support for individuals with alcohol-related problems is already available and easily accessible. According to these participants, all that needed to be done is for the dependent drinkers who need that support to make the decision to seek it:

'Well, I think there's already a lot of support out there. It's people needing to want that support, and to try and get the help for it. Like I say, I don't think the majority of... It's not me personally. I think this is going to affect the alcoholics, which again, there's already heaps of support out there, but the people need to want it. Like I say, I think there's plenty of help out there, but like I say, it's trying to get people to want the help, and to encourage them to go for help.' (Interviewee 001, male, lower risk)

'[I] don't really think there's much they could do, really. Those who drink, if they drink a large amount, there's plenty of support there anyway, but it's just whether or not that person chooses to seek that support which is there.' (Interviewee 018, male, lower risk)

Summary

In this chapter attention was shifted away from the potential impact of MPA and focused on what drinkers thought would be needed to help drinkers prepare and cope with the legislation. Among our interviewees, the consensus of opinion was that more support (and funding) was needed to help drinkers, particularly dependent drinkers, cope with the price increase. Of particular importance was the need to raise awareness of the forthcoming legislation to provide clarity over what it would mean in practice and more widespread information about when it was going to be implemented. In terms of support, interviewees flagged up a number of specific initiatives that they thought might be helpful including the need to reduce waiting times for treatment, the need for more staff, improvements in signposting and support with budgeting. However, some drinkers recognised that support already existed in some parts of Wales and that the main issue was getting dependent drinkers to access that support.

11. Discussion

This report has presented findings from the first of three waves of research being conducted as part of a 5-year evaluation of the impact of MPA on the wider population of drinkers in Wales. The report focuses on data collected through semi-structured interviews with a sample of 41 drinkers and an online questionnaire survey that was completed by 179 drinkers from across Wales shortly before the legislation was implemented on 2nd March 2020. The report presents important baseline information that can be used to monitor change at 18 months and 42 months post-implementation (waves 2 and 3, respectively)[73].

The pre-implementation research presented in this report focused largely on obtaining baseline measures of alcohol consumption and related behaviours. However, the study also examined awareness and understanding of MPA as well as attitudes towards it. Drinkers' views on how they might prepare for the price increase and the type of support that might be needed were also investigated.

In this concluding chapter we summarise the findings and reflect on them in light of the literature reviewed in Chapter 3, which builds upon and extends our earlier systematic review (see Holloway et al. 2019).

Before doing this, it is important to note that the data presented in this report were gathered prior to the implementation of MPA and include predictions of what drinkers think will happen post-implementation rather than actual future scenarios. The benefit of conducting a longitudinal study (with second and third waves of data collection post-implementation) is that it provides an opportunity to assess the validity and longevity of these predictions once the legislation has been enforced.

It is also important to note that while similar issues were investigated in an earlier study (see Holloway et al. 2019), this research differs in terms of (a) its target population (i.e. the general population rather than service users and service providers) and (b) its proximity to implementation (i.e. data were collected shortly before implementation rather than a year before). The report therefore provides an additional vantage point from which to examine awareness of and attitudes towards MPA as well as its potential impact.

Finally, while the sample of interviewees and survey respondents were diverse in many respects (including drinking patterns, illegal drug use, employment status, household income, geographical location and quality of life), it must be noted that minority ethnic groups were not well represented in either the interviews or survey, and university students and women were over-represented in the cross-sectional survey. Caution must therefore be taken when generalising the results beyond those represented within the research.

[73] An additional wave of interviews was commissioned by Welsh Government in response to the COVID-19 pandemic. The findings from these interviews will provide the first opportunity to examine changes in drinking patterns and related behaviours post-implementation of MPA.

Awareness, understanding and attitudes

Levels of awareness and understanding of MPA were mixed with interviewees demonstrating considerably more awareness than survey respondents (perhaps as a result of pre-interview preparation). Generally speaking, however, few participants had any in-depth understanding and most descriptions provided were vague. This lack of awareness was not wholly surprising given similarly low levels of awareness reported prior to implementation of minimum pricing policies in previous studies both in Wales and Scotland (Holloway et al., 2019, O'May et al., 2016). However, given that this research was conducted months (and in some cases weeks and days) before the legislation was due to be implemented, at a time when media reports about MPA were emerging and the Welsh Government's own media campaign was launched, the inference might be that the messages were just not being heard.

In terms of agreement with the principle of MPA, survey respondents were divided in their views with roughly half in support, one-quarter opposed and the remainder 'on the fence'. Interviewees were more positive than the survey respondents with most recognising the potential health and social benefits as well as cost savings for society more generally. Its potential for reducing binge drinking among young people was flagged up by several respondents.

In line with previous research, there was broad agreement among drinkers (including harmful and hazardous drinkers themselves) of a perception that MPA would have a disproportionate effect on dependent drinkers who consume cheap, strong alcohol (O'May et al., 2016, Holloway et al. 2019). Of particular concern was the potential for an increase in acquisitive crime among those with limited resources to fund their continued alcohol consumption.

Preparation and planning for MPA

Few drinkers were planning to do anything to prepare for the introduction of MPA. For some this was because they had only just learned about it and there was not enough time in which to do any preparatory work because the legislation was about to be implemented. For others, this was because they did not feel any need to prepare because they did not think that it would affect them.

Among the few who were planning to take action, most were opting for a short-term solution that involved stockpiling. However, some were fearful of this for fear of consuming stockpiled supplies in one big binge. Few other measures were mentioned but reference was made to saving money, changing their drink of choice in preparation for the increase in price and one dependent drinker described an extreme measure that would involve her moving to England to avoid the price increase. Rarely were more healthy plans mentioned, although some thought that MPA might be a nudge factor for those contemplating change.

Holloway et al. (2019) found that preparation and planning was also low on the agenda among drinkers receiving professional support for alcohol-related problems. Interestingly, short-term solutions such as stockpiling cheap alcohol were favoured

by drinkers even when there was far more time in which to develop longer-term, healthier plans for cutting down or stopping (Holloway et al., 2019).

Potential impact on drinking patterns and use of other substances

In Chapter 8 we examined the potential impact of MPA on drinking patterns and the use of other substances including illegal drugs. Given that the primary aim of introducing a minimum price for alcohol in Wales is to help protect the health of hazardous and harmful drinkers and reduce alcohol-related harm, the findings are of particular importance for any evaluation of the impact of MPA.

In line with previous research, most drinkers thought it unlikely that their drinking patterns would change as a result of MPA (Holloway et al., 2019). For dependent drinkers the lack of change was driven by the physical need to keep on drinking to avoid withdrawal, seizure and potentially death. For other drinkers it was because they could afford the additional costs or because they did not drink enough for it to affect them.

While the predictions were largely negative in the sense of limited prospects for change, a small number of drinkers (including dependent drinkers) thought that MPA might trigger a reduction in their drinking. Research from other countries suggests that these more positive predictions of reductions in consumption may be realistic. In Scotland, where MUP was introduced in May 2018, researchers identified a 7.4 per cent reduction in purchases (O'Donnell et al., 2019) while the volume of pure alcohol sales in a province in Canada reduced by 8.4 per cent following the introduction of minimum pricing for alcohol (Stockwell et al, 2012).

Few drinkers anticipated switching type or brand of alcohol, although some predicted a switch to spirits. Dependent drinkers were thought the most likely to switch to stronger forms of alcohol and some of the dependent drinkers in our samples agreed that this might be something that they would consider doing. Some moderate drinkers also anticipated switching type of alcohol, including students who described the importance of getting the best value for money. Research in other countries suggests that the potential for switching type of alcohol may well be borne out by events. Muller et al. (2010), for example, found in Germany that an increase in the price of alcopops was associated with an increase in consumption of spirits and a switch to drinks more commonly associated with riskier drinking patterns.

Few drinkers thought that there would be changes in their use of other substances. Drug switching was considered unlikely among the drinkers in this study. In line with previous research, switching to illegal drugs (usually cannabis and rarely harder drugs) was only considered a possibility for those with histories of using them (Miller and Droste, 2013; Peters and Hughes 2010, Holloway et al. 2019).

Interestingly, even among those with a history of illegal drug use, there was a general reluctance for switching away from alcohol to drugs. Perhaps, then, dependent drinkers in the wider population are less likely than those receiving professional support for alcohol-related problems, to switch to illegal drugs (see Holloway et al., 2019). The longitudinal nature of the evaluation of MPA in Wales and the inclusion of this research focusing on the wider population as well as on service

users (the subject of a separate contract forming part of the overall evaluation), will enable us to explore any differences and see if this is, indeed, the case.

Those who did anticipate a switch to drugs, described a potential to switch to drugs with a similar effect to alcohol. With just a couple of exceptions there was no intention to switch to harder drugs even though many thought that dependent drinkers would do this.

Social and health consequences

Most drinkers thought it was unlikely that MPA would have an impact on their health or social lives. Crime, however, was one of the most frequently anticipated social consequences, which many drinkers thought would be committed by dependent drinkers who would need to fund their continued use of alcohol. Similar predictions were reported by service users and service providers in Wales (Holloway et al. 2019). However, evidence from other countries suggests that income-generating crime was rarely committed by drinkers when faced with an increase in price of alcohol (Faulkner et al. 2015; Erickson et al, 2018). Furthermore, research by Coomber et al. (2020) in Australia identified significant declines in a range of outcomes including crime.

In addition to acquisitive crime, other types of crime including under-the-counter sales and use of counterfeit alcohol were also mentioned as possible consequences of introducing MPA. Few studies have investigated these possibilities, but research from Thailand suggests that switching to illicit alcohol will be minimal and limited to areas where there is a history of alcohol production (Chaiyasong et al. 2011).

In terms of social consequences, the financial implications for dependent drinkers were widely acknowledged. Of particular concern was the potential for some drinkers (and their families) to forego essentials in order to pay for alcohol. The possibility that children would end up going without food and clothing was a real worry for some drinkers. The threat of eviction and homelessness as a result of not paying rent was also a matter of anxiety for some. Research from other countries suggests that such concerns may be realistic given that re-budgeting of resources was a commonly used strategy used by drinkers to help them cope with price increases (Erickson et al., 2018; Faulkner et al., 2015)

Preparation and support

The consensus of opinion was that more support (and funding) was needed to help drinkers, particularly dependent drinkers, cope with the price increase. Of particular importance was the need to raise awareness of the forthcoming legislation to provide clarity over what it would mean in practice and more widespread information about when it was going to be implemented. Similar findings and recommendations were reported by O'May et al. (2016) in Scotland and Holloway et al (2019) in Wales.

In terms of support, interviewees flagged up a number of specific initiatives that they thought might be helpful including the need to reduce waiting times for treatment, the need for more staff, improvements in signposting and support with budgeting. However, some drinkers recognised that support already existed in some parts of

Wales and that the main issue was getting dependent drinkers to access that support.

Concluding comments

This study has provided a comprehensive baseline picture of alcohol consumption and related behaviours among two samples of drinkers recruited from within the general population of Wales. The research differs to previous research in its focus on drinkers not currently engaged in treatment for alcohol-related problems and in its close proximity in time to the introduction of MPA. Nevertheless, despite these differences, many similarities have emerged in terms of awareness of and attitudes towards MPA and its potential impact on drinking patterns and related behaviours. The next wave of the research (to be conducted 18 months post-implementation) will enable us to examine changes in consumption patterns and to see if drinkers' predictions are borne out by events[74].

For the most part, drinkers anticipated that MPA would have little effect on their drinking behaviours. This view was shared by all different types of drinker including those that the legislation specifically targets (i.e. hazardous and harmful drinkers). There was, however, general agreement among the research participants that MPA would have disproportionate effects on one particular type of drinker, namely those who were dependent on cheap, strong alcohol. The need for additional support to be put in place to help these drinkers cope with the potential consequences was widely proposed.

Negative views of the new policy were expressed by some drinkers and included criticisms of the government for being too focused on financial issues and for not taking more radical action to reduce harm.

> *'It is clearly another half-baked government scheme with little thought towards scientific insight of addiction..... just more old ideas about money matters most.'* (Survey respondent, 141. Male, low risk, employed part-time)

> *'If alcohol causes so many deaths and misery for so many people, and puts unnecessary strain on an already under funded NHS system then why are people still able to buy it?? Makes no sense to me, same with tobacco… IF THE GOVERNMENT REALLY CARED ABOUT OUR HEALTH THEN WHY ARE THESE ADDICTIONS ALLOWED TO BE IN OUR SOCIETY!'* (Survey respondent, 38. Male, low risk, student)

However, there was also recognition that MPA was underpinned by a desire to improve the health of the population, particularly hazardous and harmful drinkers. One survey respondent summed this up well acknowledging the complexity of the issue and the need for governments to take difficult and unpopular decisions for the greater good.

[74] In response to the COVID-19 pandemic, an additional wave of interviews with the longitudinal study sample, 9 months post-implementation of MPA, was commissioned by Welsh Government.

'It's a complex issue. But sometimes a responsible government has to act to force change in its society, because change, however unpopular, will not happen on its own. To our good health!' (Survey respondent, 173. Female, low risk, looking after home and/or family)

Next steps

This report is the first of three reports planned for the assessment of impact of MPA on the wider population of drinkers. The second report will focus on data collected 18 months post-implementation of the legislation and the third report will present findings based on data collected 42 months post-implementation[75]. Both of these follow-up reports will draw upon the data presented in this report in order to assess and monitor changes in alcohol consumption patterns and related behaviours, including alcohol-purchasing patterns, over time.

In both the second and third wave of the research, the plan is to conduct repeat interviews with our interview sample (replacing any drop-outs with similar types of drinker[76]) and to repeat the cross-sectional survey with drinkers across Wales. Conducting repeat interviews with a sample of drinkers will enable us to monitor the direct impact of MPA on drinkers' lives. This element of the evaluation is critical for assessing the effectiveness of MPA in achieving its aims. Conducting repeat cross-sectional surveys is less useful as a tool for measuring effectiveness because each sample is a fresh one that may include new respondents. However, as Bryman (2016) notes, cross-sectional designs are nevertheless useful, particularly in their ability to chart broader changes in behaviour over time among larger samples.

It was noted earlier in the report that the use of a non-probability sampling strategy resulted in the recruitment of a survey sample that was over-represented by women and students. Planning ahead for waves 2 and 3 of the evaluation (18 and 42 months post-implementation) we propose to address this limitation in two ways. First, we will carefully monitor the characteristics of survey respondents throughout the data collection period and employ a flexible but targeted campaign to generate interest and encourage participation among any under-represented sub-groups. The goal will be to obtain responses from as representative a sample as possible. Second, where sample sizes permit, we will examine variations between different groups (e.g. men compared with women; students compared with people in employment) in terms of changes in drinking patterns and associated behaviours post implementation of MPA. Breaking down the analyses in this way will enable us to control for the over-representation of any particular sub-group.

Moving forward, it is important to note that within a week of implementation of MPA (02/03/2020), Wales, like many other countries around the world, experienced

[75] In response to the COVID-19 pandemic and lockdown, Welsh Government commissioned the evaluation team to undertake an additional wave of interviews with the longitudinal study sample in the autumn of 2020. It is anticipated that a report presenting findings from these interviews will be written and published online in the spring of 2021.

[76] Any drop-outs will be replaced with new interviewees who are matched as far as possible in terms of: (1) the type of drinker [moderate, hazardous or harmful], (2) the area they live, (3) their sex, and (4) their age.

changing behavioural patterns in (panic) shopping and alcohol use, and within three weeks was in a full lockdown of strict physical distancing. While ‘on’ licenced premises were closed, premises with ‘off’ licences (i.e. shops) were given permission to continue operating as ‘essential businesses’ (Reynolds and Wilkinson, 2020). In this context, it is important to acknowledge that it is likely to take some time to establish if the predictions presented in this report are borne out by events.

It is also important to recognise that any assessment of the impact of MPA on patterns of alcohol consumption in Wales will need to take into account the confounding and competing effects of drinkers’ responses to the global COVID-19 pandemic. To this end, Welsh Government has commissioned the evaluation team to conduct an additional wave of post-implementation interviews in the autumn of 2020. The results will shed light on drinking patterns post-implementation of MPA and help to disentangle the effects of MPA from those of COVID-19 and any other related factors.

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Appendix

Appendix 1 National Survey for Wales

The NSW runs annually and involves 45 minute face-to-face interviews with a randomly-selected sample of people aged 16 and over across Wales. Each year, a sample of addresses is selected at random from the Royal Mail's list of addresses. Survey interviews then take place face-to-face with one randomly-selected adult in each selected household (Welsh Government, no date)[77]. The NSW includes an extensive set of questions on alcohol consumption and therefore presents a useful opportunity for identifying a sample of moderate, hazardous and harmful drinkers (who have agreed to be recontacted) for the purpose of this research.

However, it is important to recognise that while the NSW includes a very large sample (n=>11,000) it does not include important groups of people who research has shown are likely to be moderate, hazardous and harmful drinkers. For example, it excludes people aged under 16 as well as people living in communal establishments (e.g. care homes, prisoners, hostels, student halls) and homeless people living on the street.

[77] Welsh Government (no date) Design and Methodology - National Survey for Wales

Appendix 2 Interview schedule

Introduction and preamble

My name is … and I am part of a team of researchers that have been commissioned by Welsh Government to evaluate the impact of Minimum Pricing for Alcohol in Wales. Thank you for agreeing to be interviewed. Please can I check that you have read the privacy notice and information sheet and also that you consent to being interviewed? The interview will take approximately 30 minutes and will begin with a series of closed questions where you will be asked to pick from a list of answers. This will then be followed by some open questions where you will be asked to tell us about yourself, your drinking and use of other substances and what you think about MPA. Please try to answer as fully as possible. After the interview I will email you a £10 Argos voucher and ask you to confirm by email that you've received it. Is this ok?

Do remember that your participation is entirely voluntary and that you are free to skip any questions or stop the interview at any point. Your identity will be kept confidential and your responses will be anonymised in any reports or articles that we write. Please can I check that you are still happy for me to record the interview on this digital recorder? Do be careful not to mention any names while the recorder is on, but don't worry if you do as we will delete them from the written transcript as soon as it has been transcribed. Thanks again for helping us with this important project.

Survey questions

Before we start the interview, we would like ask you a few questions about yourself (e.g. your sex, age, ethnic group), your lifestyle, your weekly household expenditure, your drinking patterns and your use of other substances including illegal drugs. We will ask you similar questions when we interview you again 18 months and 42 months after MPA has been introduced. This information is really important as it will enable us to examine any changes in your use of alcohol and associated behaviours. Please remember that the information you provide about this will be treated confidentially and that your responses will be anonymised in any publications.

[administer survey questions: pages 1-18, questions 1-28 inclusive.]

Background

Please could you tell me a bit about yourself, including where you come from, who you live with and what you do?

Alcohol use

Please tell me about your current use of alcohol. What do you like to drink? How often do you drink? Where do you tend to drink?

When did you first start drinking alcohol?

Where do you tend to buy alcohol from?

Have you ever had any treatment for alcohol problems? If so, please can you tell me about when this was and what help you got?

If not, do you think you've ever needed any treatment or support for alcohol problems? If yes, why didn't you seek help?

Drug use

Please tell me about your current use of illegal drugs (including prescription drugs not prescribed to you). What do you like to use? How often do you use them? Where do you tend to use them?

When did you first start using illegal drugs? What drug did you first use?

Where do you tend to buy illegal drugs from?

Have you ever had any treatment for drug problems? If so, please can you tell me about when this was and what help you got?

If not, do you think you've ever needed any treatment or support for drug problems? If yes, why didn't you seek help?

Awareness, understanding and attitudes towards MPA

Before taking part in this interview, were you aware of the plan to introduce MPA in Wales? If so, how did you hear about it? Please could you explain briefly what you thought the plan involved?

[After this, give details of what the plan is]

Now that you know about the plan, what do you think about it? Is it a good/bad idea? Please explain why you think this.

Potential impact of MPA

What impact do you think MPA will have on your drinking?

What impact do you think MPA will have on your use of illegal drugs?

What impact do you think MPA will have on your relationships with others?

What impact do you think MPA will have on your financial circumstances? [probe re household expenditure]

What impact do you think MPA will have on other aspects of your life? [health, offending, work, housing]

Preparation for MPA

Do you think you'll do anything to prepare for MPA? [probe for details]

Support for MPA

What support, if any, do you feel should be provided to drinkers to help them prepare for the price increases? [probe for issues such as health, housing, substance misuse treatment, financial advice, etc]

Anything else?

Is there anything else that you would like to tell us about MPA or alcohol consumption?

Thank you very much for your time.

[Ask for email address for e-voucher; establish willingness and consent for repeat interview.]

Appendix 3 Questionnaire topic guide

1. Preamble and information sheet
2. A few questions about you (gender, ethnic group, Local Authority area, type of area, age, marital status, number of children under 17, qualifications, employment, household income, housing status,
3. A few questions about your household expenditure (alcohol from shops/online, alcohol in restaurants/pubs, cigarettes, illegal drugs, food, clothing, other groceries, household bills, transport, other)
4. A few questions about your quality of life (satisfaction, worthwhile, happy, anxious)
5. A few questions on your usual use of alcohol (how often, how many units, impact on your life)
6. A few more questions on your use of alcohol (frequency of consuming different types of alcohol, location of consumption, location of purchase)
7. A few questions on your use of other drugs (illegal drugs, prescription drugs not prescribed to you)
8. A few questions on substance misuse treatment (alcohol or drug treatment ever or currently)
9. A few questions on your understanding of MPA (awareness, understanding)
10. A few more questions on MPA (attitudes)
11. A few questions about the potential impact of MPA on you (quantity, type, brand, funding arrangements, purchasing location, consumption location)
12. A few questions on preparing for MPA (preparation and planning)
13. A few questions on the impact of MPA on your use of other substances (illegal drugs, prescription drugs, over-the-counter medication, non-alcohol beverages, food, non-beverage alcohol, other)
14. Support for drinkers (is support needed for drinkers, type of support needed)
15. A few final questions on the potential impact on other aspects of drinkers' lives (relationships with family, relationships with friends, physical health, mental health, employment, financial circumstances, housing/living arrangements, offending behaviour)
16. Anything else that you would like to tell us about MPA.

Appendix 4 Longitudinal interview sample – tables

Tables A1-A10 Characteristics of the longitudinal interview sample

Table A1 Sampling sources

	N
National Survey for Wales	21
Third sector organisations	10
Universities	6
MPA Pre-implementation Survey	4
TOTAL	**41**

Table A2 Demographic characteristics of the longitudinal interview sample

	N
Sex	
Female	17
Male	24
Age	
75+	1
65-74	5
55-64	4
45-54	11
35-44	6
25-34	8
20-24	6
Ethnic group	
White – E/W/S/NI/B	38
White – other	3
Marital status	
Separated	1
Divorced	3
Widowed	1
In a relationship	6
Single	11
Cohabiting/living together	3
Married	16
Number of children under 18 living in your household	
Three or more	1
Two	4
One	5
None	31

Table A3 Education, Employment and Training of the longitudinal interview sample

	N
Highest qualification	
Level 7	4
Level 6	12
Level 5	3
Level 4	1
Level 3	8
Level 2	7
Level 1	1
Entry level	1
No qualifications	2
Employment status	
Other	2
Pupil/student/FT education	8
Retired	7
Looking after home/family	1
Unemployed but not looking	7
Unemployed but looking	2
Employed part-time (<30h)	5
Employed full-time (30+h)	9

Table A4 Financial status of the longitudinal interview sample

	N
Are you currently receiving any state benefits	
Universal credit	6
Other benefits	6
No	27
Prefer not to say	2
Household income	
I prefer not to say	4
£52,000 pa or more	5
£36,400-£51,999	1
£26,000-£36,399	9
£20,800-£25,999	1
£15,600-£20,799	6
£10,400-£15,599	4
£5,200-£10,399	7
Up to £5,199	3
Managing financially	
Not managing at all well	5
Not managing well	6
Neither managing/not managing	7
Managing quite well	19
Managing very well	4
TOTAL	41

Notes: Some missing cases.

Table A5 Location and housing status of the longitudinal interview sample

	N
Local Authority/Health Board Area	
Wrexham – BCUHB	5
Vale of Glamorgan – CVUHB	2
Torfaen – ABUHB	1
Rhondda Cynon Taf – CTHB	5
Powys – PTHB	4
Newport – ABUHB	4
Monmouthshire –ABUHB	2
Flintshire – BCUHB	1
Conwy – BCUHB	1
Ceredigion - HDHB	2
Carmarthenshire - HDHB	2
Cardiff – CVUHB	11
Caerphilly - ABUHB	1
Area type	
Rural	17
Suburban	8
Urban	16
Housing status	
Street homeless	1
Hostel/other supported	8
Living with family/friends	4
Renting (social, council)	1
Renting (private)	8
Home owner (mortgage)	10
Home owner (no mortgage)	9

Notes: ABUHB – Aneurin Bevan University Health Board; Betsi Cadwaladr University Health Board; CTHB – Cwm Taf Health Board; CVUHTB – Cardiff and Vale University Health Board; HDUHB – Hywel Dda Health Board; PTHB – Powys Teaching Health Board;

Table A6 Alcohol consumption among the longitudinal interview sample

	N
AUDIT Score	
Lower risk	13
Increasing risk	13
Higher risk	3
Possible dependence	9
Roughly how much of the alcohol you consume is consumed at home?	
None of it	1
Some of it	10
About half of it	9
Most of it	17
All of it	3
Where do you usually buy the drinks that you consume at home?	
Other	1
From a delivery service	1
Off licence/convenience store	11
Supermarket online	2
Supermarket in person	26

Table A7 Alcohol consumption among the longitudinal interview sample

	N
Where have you consumed alcoholic drinks in the last month	
At home	34
At other people's homes	16
In pubs	22
In restaurants	17
In nightclubs/bars	6
At events	4
Outside in a public place	10
Other	7

Table A8 Frequency of alcohol consumption among the longitudinal interview sample

	Daily or almost daily	Weekly	Monthly	Less than monthly	Never/missing	TOTAL
Beer/cider/lager	11	13	8	8	1	41
Spirits or liqueurs	5	8	7	13	8	41
Sherry or martini	-	1	5	4	31	41
Wine	4	6	12	11	15	41
Alcopops	-	-	1	4	36	41
Low alcohol	-	-	2	3	36	41

Notes: Normal and strong beers were listed in both categories and hence have been merged. The most frequent rate of use was selected for inclusion in the variable.

Table A9 Quality of life measures among the longitudinal interview sample

	N
How satisfied are you with your life?	
Low (0-3)	5
Medium (4-6)	5
Higher (7-10)	29
How worthwhile are the things you do?	
Low (0-3)	7
Medium (4-6)	3
Higher (7-10)	29
How happy were you yesterday?	
Low (0-3)	4
Medium (4-6)	9
Higher (7-10)	26
How anxious were you yesterday?	
Low (0-3)	19
Medium (4-6)	8
Higher (7-10)	12

Table A10 Weekly household expenditure among the longitudinal interview sample

	N	Mean	Range	SD
Housing	25	£120.69	£5-£500	£109.08
Household bills	26	£81.41	£10-£250	£56.91
Food shops	36	£57.38	£7-£150	£38.98
Children	8	£54.38	£4-£250	£85.13
Other	21	£50.12	£3-£175	£49.51
Loans	16	£44.67	£2-£100	£30.72
Transport	29	£42.10	£8-£204	£50.19
Drugs	5	£39.00	£10-£100	£35.78
Alcohol from shops	37	£36.55	£1-£357	£63.42
Food out	25	£18.39	£3-£50	£14.06
Alcohol out	23	£17.91	£1-£80	£19.38
Cigarettes	14	£15.04	£6-£30	£6.58
Clothing	28	£13.44	£3-£50	£10.40
Non-food groceries	34	£9.38	£1-£30	£7.19
TOTAL	40	£348.69	£80-£1020	£239.73

Appendix 5 Cross-sectional survey sample – tables

Tables A11-A21 Characteristics of the cross-sectional survey sample

Table A11 Demographic characteristics of the cross-sectional survey sample

	N	%
Sex		
Female	135	75%
Male	43	24%
Other	1	1%
Age		
75+	1	1%
65-74	3	2%
55-64	8	5%
45-54	26	15%
35-44	35	20%
25-34	50	28%
20-24	40	23%
18-19	15	8%
Ethnic group		
White – E/W/S/NI/B	157	88%
White – Irish	2	1%
White – Gypsy or Irish Traveller	1	1%
White – Other	15	8%
Mixed – White and Black Caribbean	1	1%
Mixed – White and Black African	1	1%
Black - African	1	1%
Marital status		
Married	46	26%
In a civil partnership	1	1%
Cohabiting/living together	28	16%
Single	52	29%
In a relationship	42	24%
Widowed	2	1%
Divorced	3	2%
Separated	3	2%
Prefer not to say	2	1%
Number of children under 18 living in your household		
None	109	61%
1	27	15%
2	29	16%
3 or more	14	8%

Table A12 Education, Employment and Training of the cross-sectional survey sample

	N	%
Highest qualification		
Entry level	5	3%
Level 1	1	1%
Level 2	8	5%
Level 3	57	32%
Level 4	11	6%
Level 5	22	12%
Level 6	40	22%
Level 7	29	16%
Level 8	6	3%
Employment status		
Employed full-time (30+h)	52	29%
Employed part-time (<30h)	16	9%
Self-employed	5	3%
Unemployed but looking for a job	6	3%
Unemployed but not looking	4	2%
Looking after home/family	2	1%
Retired	4	2%
Pupil/student/FT education	87	49%
Other	3	2%

Table A13 Financial status of the cross-sectional survey sample

	N	%
Are you currently receiving any state benefits		
Universal credit	10	6%
Other benefits	20	11%
No	143	80%
Prefer not to say	6	3%
Household income (annual)		
Up to £5,199	19	11%
£5,200-£10,399	22	12%
£10,400-£15,599	18	10%
£15,600-£20,799	16	9%
£20,800-£25,999	13	7%
£26,000-£36,399	19	11%
£36,400-£51,999	31	17%
£52,000 pa or more	23	13%
I prefer not to say	18	10%
Managing financially		
Managing very well	17	10%
Managing quite well	92	51%
Neither managing/not managing	37	21%
Not managing well	22	12%
Not managing at all well	11	6%
TOTAL		

Notes: Some missing cases.

Table A14 Location and housing status of the cross-sectional survey sample

	N	%
Local Authority/Health Board Area		
Blaenau Gwent - ABUHB	3	2%
Bridgend - CTHB	8	5%
Caerphilly - ABUHB	8	5%
Cardiff – CVUHB	23	13%
Carmarthenshire - HDHB	1	1%
Ceredigion - HDHB		
Conwy – BCUHB	2	1%
Denbighshire – BCUHB	6	3%
Flintshire – BCUHB	13	7%
Gwynedd – BCUHB	1	1%
Isle of Anglesey/Ynys Mon - BCUHB		
Merthyr Tydfil - CTHB	2	1%
Monmouthshire –ABUHB	1	1%
Neath Port Talbot - ABMUHB	2	1%
Newport – ABUHB	12	7%
Pembrokeshire - HDHB	7	4%
Powys – PTHB	6	3%
Rhondda Cynon Taf – CTHB	24	14%
Swansea - ABMUHB		
Torfaen – ABUHB	2	1%
Vale of Glamorgan – CVUHB	5	3%
Wrexham – BCUHB	52	29%
Area type		
Urban	48	27%
Suburban	46	26%
Rural	84	47%
Housing status		
Home owner (mortgage)	50	28%
Home owner (no mortgage)	13	7%
Renting (private)	41	23%
Renting (social, council)	28	16%
Living with family/friends	34	19%
Hostel/other supported	11	6%
Street homeless	1	1%

Notes: ABMUHB - Abertawe Bro Morgannwg University Health Board; ABUHB – Aneurin Bevan University Health Board; Betsi Cadwaladr University Health Board; CTHB – Cwm Taf Health Board; CVUHTB – Cardiff and Vale University Health Board; HDUHB – Hywel Dda Health Board; PTHB – Powys Teaching Health Board;

Table A15 Alcohol consumption among the cross-sectional survey sample

	N	%
AUDIT Score		
Lower risk	92	52%
Increasing risk	64	36%
Higher risk	10	6%
Possible dependence	11	6%
Roughly how much of the alcohol you consume is consumed at home?		
All of it	11	6%
Most of it	58	32%
About half of it	27	15%
Some of it	58	32%
None of it	25	14%
Where do you usually buy the drinks that you consume at home?		
Supermarket in person	134	75%
Supermarket online	11	6%
Off licence/convenience store	26	15%
Abroad/from a duty-free	2	1%
Petrol station	1	1%
From a delivery service	2	1%
Other	1	1%

Table A16 Alcohol consumption among the cross-sectional survey sample

	N	%
Where have you consumed alcoholic drinks in the last month		
At home	110	62%
At other people's homes	64	36%
In pubs	99	55%
In restaurants	76	43%
In nightclubs/bars	53	30%
At events	39	22%
Outside in a public place	9	5%
Other	8	5%

Table A17a Frequency of alcohol consumption among the survey sample

	Daily or almost daily	Weekly	Monthly	Less than monthly	Never/missing	TOTAL
Beer/cider/lager	6% (10)	20% (36)	26% (47)	30% (53)	19% (33)	100% (179)
Spirits or liqueurs	4% (7)	12% (22)	31% (56)	35% (63)	18% (31)	100% (179)
Sherry or martini	1% (2)	-	2% (4)	7% (13)	90% (160)	100% (179)
Wine	5% (9)	20% (35)	20% (35)	29% (52)	27% (48)	100% (179)
Alcopops	1% (2)	3% (5)	6% (10)	13% (23)	78% (139)	100% (179)
Low alcohol	1% (1)	2% (3)	6% (10)	12% (21)	80% (144)	100% (179)

Notes: Normal and strong beers were listed in both categories and hence have been merged. The most frequent rate of use was selected for inclusion in the variable.

Table A17b Frequency of alcohol consumption among the survey sample

	Daily or almost daily	Weekly	Monthly	Less than monthly	TOTAL
Beer/cider/lager	7% (10)	25% (36)	32% (47)	36% (53)	100% (146)
Spirits or liqueurs	5% (7)	15% (22)	38% (56)	43% (63)	100% (148)
Sherry or martini	11% (2)	-	21% (4)	68% (13)	100% (19)
Wine	7% (9)	27% (35)	27% (35)	40% (52)	100% (131)
Alcopops	5% (2)	13% (5)	25% (10)	58% (23)	100% (40)
Low alcohol	3% (1)	9% (3)	29% (10)	60% (21)	100% (35)

Notes: Normal and strong beers were listed in both categories and hence have been merged. The most frequent rate of use was selected for inclusion in the variable.

Table A18 Frequency of illegal drug use among the cross-sectional survey sample

	Last 7 days	Last 30 days	Last 12 months	> 12 months	Never used	Missing	TOTAL
Cannabis	7% (12)	4% (7)	7% (13)	27% (49)	54% (97)	1% (1)	100% (179)
Ecstasy	1% (2)	1% (1)	3% (6)	13% (23)	82% (146)	1% (1)	100% (179)
LSD	-	1% (2)	-	9% (16)	89% (160)	1% (1)	100% (179)
Magic Mushrooms	-	2% (3)	2% (3)	11% (19)	86% (153)	1% (1)	100% (179)
Amphetamines	-	1% (2)	3% (6)	14% (24)	82% (145)	1% (2)	100% (179)
Methamphetamine	-	-	1% (1)	-	99% (177)	1% (1)	100% (179)
Cocaine powder	2% (3)	3% (6)	7% (12)	10% (18)	78% (139)	1% (1)	100% (179)
Crack cocaine	1% (2)	1% (1)	1% (1)	2% (3)	96% (171)	1% (1)	100% (179)
Heroin	-	1% (1)	1% (1)	1% (2)	96% (172)	2% (3)	100% (179)
Tranquillisers	1% (2)	1% (2)	2% (3)	4% (7)	92% (164)	1% (1)	100% (179)
Anabolic steroids	-	1% (1)	-	-	98% (176)	2% (3)	100% (179)
NS-IPEDS	-	1% (1)	-	1% (1)	98% (175)	1% (2)	100% (179)
Ketamine	-	2% (4)	3% (5)	9% (15)	86% (153)	1% (2)	100% (179)
Mephedrone	-	-	1% (1)	5% (9)	93% (167)	1% (2)	100% (179)
GBL/GHB	-	-	1% (1)	1% (2)	97% (174)	1% (2)	100% (179)
Synthetic cannabinoids	1% (2)	-	1% (1)		96% (172)	2% (3)	100% (179)
BZP	-	-	-	-	99% (177)	1% (2)	100% (179)
Salvia	-	-	-	2% (4)	96% (172)	2% (3)	100% (179)
Khat	1% (1)	-	-	-	98% (175)	2% (3)	100% (179)
Nitrous oxide	1% (1)	1% (2)	2% (4)	10% (17)	86% (153)	1% (2)	100% (179)

Notes: Normal and strong beers were listed in both categories and hence have been merged. The most frequent rate of use was selected for inclusion in the variable.

Table A19 Drug/alcohol treatment history among the cross-sectional survey sample

	N	%
Ever received treatment for alcohol problems	7	4%
Ever received treatment for drug problems	3	2%
Not ever received treatment for either	169	94%
Currently receiving treatment for alcohol problems	3	2%
Currently receiving treatment for drug problems	0	0%
Not currently receiving treatment for either	176	98%

Table A20 Quality of life measures among the cross-sectional survey sample

	N	%
How satisfied are you with your life?		
Low (0-3)	21	12%
Medium (4-6)	64	36%
Higher (7-10)	92	52%
How worthwhile are the things you do?		
Low (0-3)	19	11%
Medium (4-6)	44	25%
Higher (7-10)	114	64%
How happy were you yesterday?		
Low (0-3)	35	20%
Medium (4-6)	58	33%
Higher (7-10)	84	48%
How anxious were you yesterday?		
Low (0-3)	69	39%
Medium (4-6)	49	28%
Higher (7-10)	59	33%

Table A21a Weekly household expenditure (including zeros)

	N	Mean	Range	SD
Housing	179	£112.40	£0-£1000	£147.51
Household bills	179	£70.93	£0-£1000	£113.04
Food shops	179	£53.92	£0-£400	£47.05
Children	179	£18.86	£0-£360	£50.39
Other	179	£28.09	£0-£500	£55.47
Loans	179	£37.24	£0-£750	£78.69
Transport	179	£28.10	£0-£200	£28.53
Drugs	179	£15.13	£0-£400	£49.46
Alcohol from shops	179	£13.23	£0-£200	£26.87
Food out	179	£17.62	£0-£200	£24.63
Alcohol out	179	£8.47	£0-£70	£10.49
Cigarettes	179	£5.51	£0-£100	£14.02
Clothing	179	£13.87	£0-£100	£16.46
Non-food groceries	179	£10.77	£0-£100	£11.28
TOTAL	179	£434.15	£0-£2580	£370.32

Table A21b Weekly household expenditure (excluding zeros)

	N	Mean	Range	SD
Housing	137	£146.85	£10-£1000	£152.91
Household bills	129	£98.42	£8-£1000	£122.65
Food shops	167	£57.80	£3-£400	£46.35
Children	49	£68.91	£4-£360	£76.77
Other	114	£44.11	£3-£500	£64.30
Loans	83	£80.30	£4-£750	£99.70
Transport	153	£32.88	£3-£200	£28.19
Drugs	29	£93.38	£10-£400	£89.34
Alcohol from shops	136	£17.41	£1-£200	£29.64
Food out	152	£20.75	£1-£200	£25.50
Alcohol out	127	£11.94	£1-£70	£10.67
Cigarettes	41	£24.05	£5-£100	£20.45
Clothing	138	£17.99	£1-£100	£16.66
Non-food groceries	163	£11.83	£1-£100	£11.28
TOTAL	173	£449.21	£35-£2580	£367.58