

Minimum Unit Pricing (MUP) for alcohol evaluation

The impact of MUP on protecting children and young people from parents' and carers' harmful alcohol consumption: A study of practitioners' views

Jane Ford, Fiona Myers, John Burns, Clare Beeston

2020



Other formats may be available from:



Acknowledgements

The authors would like to thank all the study participants; the Alcohol and Drugs Partnership leads; the Child Protection Committee Chairs; the members of the study's Evaluation Advisory Group; and the NHS Health Scotland MUP Evaluation Project Team.

The Evaluation Advisory Group (EAG) membership and terms of reference are available online here:

www.healthscotland.scot/health-topics/alcohol/evaluation-of-minimum-unit-pricing-mup/overview-of-evaluation-of-mup/governance-of-evaluation-of-mup/mesas-governance-board-overview/evaluation-advisory-groups-eag

Declaration of Interests

Members of the Children and Young People EAG provided comment on the draft of this report. This group includes members from academic organisations, statutory and third sector organisations that work with and provide services for families affected by harmful drinking, the Scottish Youth Parliament, Scottish Government, and NHS Health Scotland. All comments were advisory only. Decision making on the content of the report rested with the research team led by NHS Health Scotland (now Public Health Scotland), which is funded by the Scottish Government. Membership of the EAG can be found on the **MUP evaluation website**

Published by Public Health Scotland
1 South Gyle Crescent
Edinburgh EH12 9EB
© Public Health Scotland 2020
All rights reserved.

Established on 1 April 2020,
Public Health Scotland is Scotland's
national public agency for improving
and protecting the health and
wellbeing of Scotland's people.



Contents

Abbreviations	3
Glossary.....	4
1. Introduction	6
1.1 Minimum unit pricing.....	6
1.2 The evaluation of minimum unit pricing	7
1.3 Protecting children and young persons from harm from others' alcohol consumption.....	7
1.4 Relevant research and policy context.....	8
1.5 Aim and research question.....	11
2. Design and methods	12
2.1 Study design.....	12
2.2 Methods.....	12
2.3 Introducing the study findings.....	16
3. Participants' awareness of, and attitudes towards, MUP	19
3.1 Participants' awareness of MUP.....	19
3.2 Service user awareness of MUP	19
3.3 Public awareness of MUP	20
3.4 Views on MUP as a mechanism for addressing alcohol-related harms	21
4. Participants' perceptions of the impacts of increased alcohol price on service user harmful alcohol use and related behaviours	23
4.1. Perceived influences on harmful alcohol use.....	23
4.2. Perceived impact of increasing the price of alcohol/MUP on different 'types' of drinking.....	25
4.3 Participants' perceptions of behavioural responses to increasing the price of alcohol/MUP	28
5. Harms experienced by children and young people related to parent/carer harmful alcohol use	33
5.1 Children and young people's responses to parental/carer harmful drinking	33
5.2 Types of adult harmful drinking and the impact of MUP on harms to children and young people	35
5.3 Potential harms to children and young people from parental/carer harmful drinking.....	36
6. Additional issues	48
6.1 Young people's own alcohol and drug use	48

6.2 Service provision for families affected by harmful alcohol consumption ...	52
6.3 Gender and alcohol	58
7. Discussion.....	60
7.1 Principal findings	60
7.2 Strengths and limitations of the study	63
7.3 Interpretations	64
7.4 Evidence from other studies in the evaluation portfolio.....	66
7.5 Conclusions.....	67
Appendix 1: MUP for alcohol evaluation theory of change	69
Appendix 2: Focus group topic guide	70
A. Introductions and initial exploration of the issues	70
B. Questions specific to MUP	70
C. Understanding the factors that may be contributing to any perceived impacts	72
D. Understanding any changes in service environment.....	73
E. Anything else?	73
Appendix 3: Participant information sheet	75
Participant information sheet (14 November 2018)	75
Appendix 4: Consent form.....	84
Participant consent form.....	84
Appendix 5: Analytical framework (v6)	87
Participant awareness/views of MUP	87
Children's experience of harm from parental/carer/sibling alcohol consumption	87
Perceived impacts of MUP on children's experiences of harm from parental/carer/sibling alcohol consumption and related behaviours.....	88
Evidence of impact.....	88
Family contexts	88
Adult alcohol consumption.....	89
Local services.....	91
Gender differences	91
Young people's alcohol consumption	92
Drugs.....	92
Miscellaneous.....	92
References.....	94

Abbreviations

ADPs	Alcohol and Drug Partnerships
AUDIT	Alcohol-Use Disorder Identifier Test
CAPSM	Children Affected by Parental Substance Misuse
CPC	Child Protection Committee
EAG	Evaluation Advisory Group
FAS	Fetal Alcohol Syndrome
FG	Focus Group
GIRFEC	Getting it Right for Every Child
GOPR	Getting our Priorities Right
MUP	Minimum Unit Pricing
PPU	Pence per unit
RDG	Research Development Group

Glossary

Cycle of addiction: A model for understanding the pathways people may take toward recovery for alcohol use. It comprises six stages including pre-contemplation, contemplation, preparation, action, maintenance, lapse (and potential relapse).*

Dependence/dependency: See ‘possible dependence’ below.

Detoxification/detoxify: Process of withdrawing from alcohol. May be undertaken prior to treatment for harmful alcohol use.

Diazepam: A benzodiazepine, used to treat anxiety, alcohol withdrawal symptoms and muscle spasms (brand name Valium).

Dunt: A hit from using a substance (slang).

Harmful alcohol consumption: A quantity or pattern of alcohol consumption that results in adverse events such as physical or psychological harm.

Hazardous alcohol consumption: A quantity or pattern of alcohol consumption that places individuals at risk for adverse health events.

Kinship carer: A carer who is known to a child, usually a member of their extended family or a close family friend.

Legal high: New psychoactive substances (NPS), designed to produce the same, or similar, effects to drugs such as cannabis, cocaine and ecstasy, structurally different enough to avoid being controlled under the Misuse of Drugs Act.†

* See, for example, <https://adfam.org.uk/help-for-families/understanding-the-issues/understanding-addiction> (Accessed 2 March 2020)

† See, for example, <http://knowthescore.info/drugs-a-z/legal-highs/> (Accessed 2 March 2020)

On tick: Obtained on credit.

Poly drug use: Use of combined psychoactive substances to achieve a particular effect.

Possible dependence/dependency: Alcohol dependency has been defined as ‘a cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. They will also give alcohol a higher priority than other activities and obligations.’* The term ‘possible dependence/dependency’ is used by the authors throughout the report to reflect that a formal assessment or clinical diagnosis is not known or discussed during the focus groups.

Universal Credit: A UK Government social security benefit paid monthly (or in Scotland, fortnightly) to people out of work or on low incomes. It replaces a number of pre-existing benefits, including Jobseeker’s Allowance, Income Support and Housing Benefit. It is paid in arrears, so can take up to five weeks before the first payment is made. Universal Credit is gradually being rolled out across Scotland.

Vallies/street Valium/street blues: ‘Street Valium’ is the name used to describe either seepage from the treatment system (where prescribed diazepam is sold on by the person to whom it was prescribed) or, as is more commonly understood, benzodiazepines such as etizolam and alprazolam (Xanax) which are widely available in Scotland and have increasingly been implicated in drug-related deaths (DRDs) since 2014. Many of the drugs available are counterfeit products containing high strengths of active substances.

* www.nice.org.uk/guidance/ph24/chapter/8-Glossary (accessed 9 December 2019).

1. Introduction

1.1 Minimum unit pricing

Minimum unit pricing (MUP) was proposed as part of a comprehensive suite of interventions in the Scottish Government's alcohol strategy 'Changing Scotland's Relationship with Alcohol: A Framework for Action'¹ which aimed to reduce Scotland's high rate of alcohol-related harm. The necessary legislation² was passed by the Scottish Parliament in 2012. This allows the setting of a minimum price based on the alcoholic strength of products below which alcohol cannot be sold in licensed premises. It applies to both the on-trade (places that sell alcohol for consumption on the premises, such as pubs, restaurants and clubs) and the off-trade (supermarkets, off-licences, convenience stores and any shop that sells alcohol for consumption off the premises).

The legislation was seen as being both a whole-population approach to reducing alcohol consumption in Scotland, and also a targeted approach, specifically aimed at reducing harmful drinking.

MUP was subject to a legal challenge, which ended when the UK Supreme Court confirmed that MUP is lawful.³ Secondary legislation was then passed that set the level of minimum price at 50 pence per unit (ppu) of alcohol and MUP was implemented on 1 May 2018.

The MUP legislation will expire before the end of a six-year period of implementation unless the Scottish Parliament makes provision for it to continue. The legislation also requires a review report on the operation and effects of MUP to be put before the Scottish Parliament as soon as possible after the end of the fifth year of implementation. This review report is required to assess the impact of MUP on alcohol licence holders and producers, and

on the five licensing objectives* set out in the Licensing (Scotland) Act 2005.⁴ The review report is also required to assess differential impact by age, gender, socioeconomic and drinking status where possible.

1.2 The evaluation of minimum unit pricing

The Scottish Government has tasked Public Health Scotland (formerly NHS Health Scotland) with leading the independent evaluation of MUP that will form the basis of the review report.

The overarching questions for the evaluation of MUP are:

- 1** To what extent has implementing MUP in Scotland contributed to reducing alcohol-related health and social harms?
- 2** Are some people and businesses more affected (positively or negatively) than others?

The evaluation is taking a theory-based approach. A theory of change for MUP has been developed (see [Appendix 1](#)). A mixed methods portfolio of studies managed by Public Health Scotland (formerly NHS Health Scotland) has been established to gather evidence on the chain of outcomes in the theory of change. Other separately funded studies, resourced by research grant or other funding, will complement this portfolio. A description of the evaluation as a whole can be found in the evaluation protocol.⁵

1.3 Protecting children and young persons from harm from others' alcohol consumption

This study forms part of a strand of work looking at the impact of MUP on children and young people. A separate study exploring the impacts of MUP on

* The licensing objectives cover crime and disorder, public safety, public nuisance, public health, and protecting children and young persons from harm.

the harms children and young people may experience directly through their own drinking or related behaviour was published in January 2020.⁶ This current study looks at the impact of MUP on protecting children and young people from harms experienced as a result of others' alcohol consumption.

There are four mechanisms whereby MUP may impact on children and young people's experience of 'harm from others':

- 1 Changes in alcohol consumption and related behaviour of those living with, or in close contact with the children and young people. This may include, for example, parents, carers, siblings and grandparents.
- 2 Changes in family disposable income as a result of either increased or reduced expenditure on alcohol.
- 3 Changes in harmful drinking in public spaces, the impact on feelings of safety and children's behaviour in response to this.
- 4 Changes in alcohol consumption in women of child bearing age, impacting on the extent of Fetal Alcohol Syndrome (FAS) and related problems.

This study focuses specifically on the impact of MUP on children and young people's experience of harm via the first two of these mechanisms. These are the direct effects of a family/household member's alcohol consumption and the indirect effects on household income.

1.4 Relevant research and policy context

This section sets out a brief overview of the policy and research context that is relevant to the current study.

The impact of parental drinking can be very diverse and in some cases can have significant negative consequences for children and young people.

'Parental substance misuse' (which covers both alcohol and drugs use) was

recorded as a cause for concern in 36.8% of child protection case conferences in Scotland in 2017/18.⁷

Children may experience a range of harms as a result of a parent's or carer's alcohol consumption.^{8 9} They are more likely to have poor attendance and lower educational attainment. Home life can be severely disrupted with missed mealtimes and disturbed sleeping patterns. Some children, particularly older children, may take on greater caring responsibilities for their parents or younger siblings.^{8 10} In some cases they may become victims or witnesses of violence. Ultimately some children and young people may also become looked after or accommodated. These types of harms have been linked to the increased risk of a range of poorer health and social outcomes throughout the lifecourse.¹¹ These individuals are more likely to display behavioural, educational and mental health problems.^{8 12 13}

Where a parent is in recovery this can be a positive journey for the family. However, some children can have fears that a parent who is seeking to reduce their alcohol consumption might relapse. It can also, at times, create a fragile and unstable environment which can be a particularly difficult time for these children due to the emotional stress this places on them.¹⁴

There is also evidence for the association between parental and offspring drinking, although causality is not certain.¹⁵ This includes a potential link between parental drinking and the concurrent or subsequent modelling of drinking by some children and young people.¹⁶ However, this potential for parental influence on young people's own drinking is complex and can be mediated by a range of factors including the influence of peers as well as a positive relationship with a parent who does not drink at harmful levels.^{16 17}

Minimum unit pricing (MUP) is operating within a complex societal and policy context. Supporting and improving the lives of children has been central to Scottish Government policy in recent years, such as Getting it Right for Every Child (GIRFEC)¹⁸ and other developments and areas of legislation that

support families and design approaches that ensure children get the help they need when they need it.^{19 20 21}

Within this policy context there has been a clear commitment to supporting children and families affected by parental alcohol and drug use, with a focus on the recovery of the whole family.^{22 23} Both the Scottish Government's alcohol and drug treatment strategy, Rights, Respect and Recovery¹³ and Alcohol Framework 2018²⁴ set out actions aimed at supporting children, young people and families affected by alcohol and drug use. These include encouraging a whole-family approach. This involves services working together to provide tailored support both for adults who are on their recovery journey and for children. These, among other key policies, have the potential to interact with MUP and impact on the experiences of children and young people.

There are a range of additional factors that will influence the potential impact of MUP, including welfare reform, wider socioeconomic trends, cultural changes and changes to service provision. There is, for instance, a highly complex relationship between alcohol and poverty and the subsequent health harms people experience.^{25 26} Harmful alcohol use, as one among many factors, can be both a cause and a consequence of poverty.²⁷ Within this context the impact of welfare reforms on household income may have implications for alcohol consumption within families.

Trying to understand the potential protective role of MUP within families' research is made more difficult by the parallel changes in welfare provision. The phased introduction of Universal Credit over the same period has introduced substantial changes to the way that benefits are calculated and delivered which impacts significantly on the household finances of many of the families that are the focus of this study. This includes the five-week delay before the receipt of the first payment, the impact of sanctions, if these are applied, and the need to budget to meet housing costs. This further emphasises the need to understand the experiences of families within this wider context.

1.5 Aim and research question

The primary aim of this study is to contribute to an understanding of the potential role of MUP in protecting children and young people from harms caused by parents' or carers' alcohol consumption, in the context of the families within which they live. Drawing on the views of practitioners working with families affected by harmful alcohol use, it provides qualitative insights into the mechanisms of any potential change. The study aimed to answer the research question:

'Has MUP affected parental/carer harmful alcohol consumption and related behaviours, with implications for the harms experienced by children and young people? If so, in what ways?'

2. Design and methods

2.1 Study design

A qualitative approach was considered the most appropriate to meet the study aims.²⁸ This approach enabled a more in-depth discussion with practitioners, in order to gain an understanding of their perceptions of any changes in alcohol consumption and related behaviours of parents/carers in the families with whom they work, post MUP. It also allowed an exploration of how any changes are perceived to have impacted on the children and young people, and what might have led to these changes.

2.2 Methods

2.2.1 Data collection methods

The study involved focus groups with practitioners working with families, children and young people affected by parent/carer harmful alcohol use. Previous research has concluded that focus groups are an appropriate methodology for conducting sensitive areas of research.^{29 30}

A topic guide ([Appendix 2](#)) was developed. It included questions on participants' perceptions of the potential harms experienced by children and young people affected by parent/carer harmful alcohol use, any potential changes participants had observed since the introduction of MUP, and what factors might have contributed to any changes.

Focus groups were conducted by one or two researchers and, with participants' consent, audio-taped. In one area, where only one person felt able to participate, a telephone interview was conducted. Data collection for the focus groups and interview took place over the period January–April 2019.

2.2.2 Sampling and recruitment

The study employed purposive sampling to identify participants from organisations working with families affected by harmful alcohol use.* With the help of Alcohol and Drug Partnerships (ADP) staff, services from different parts of the country were identified to ensure a mixture of geographical areas, with varying and mixed levels of socioeconomic deprivation, were included. The research team then provided senior staff in the identified services with a study information sheet to give to potential participants ([Appendix 3](#)). Written consent was obtained from participants prior to the focus groups taking place ([Appendix 4](#)).

The proposal was to include around ten to twelve focus groups, each comprising six to eight participants. In practice, recruitment proved more difficult than anticipated. One area declined due to a lack of staff capacity, two did not respond, and it was not possible to recruit participants in one area. In some areas the lack of whole-family support or family inclusive practice meant that it was difficult to identify relevant staff to invite to participate. Some teams approached were reluctant to participate because they felt they were not sufficiently aware of the impacts of MUP in their work at the time of fieldwork, or that it was too soon to see emerging impacts.

The final sample comprised eight focus groups and one interview: a total of 42 participants. Six focus groups comprised a mixture of health, social work and third sector participants. One focus group comprised local level third sector participants only, and one included staff from a national third sector organisation. Some participants worked within services that focused primarily on the needs of children and young people, some on adults and a few took a

* Organisations that included workers and volunteers who were themselves family members and carers affected by another's drinking were excluded from the recruitment process. This was to ensure individuals were not placed in a situation where they would be asked to answer questions about a context that directly affects them and the children and young people in their family or they cared for at home.

whole-family approach. Some provided a generic service for people referred for a variety of reasons not just or primarily because of alcohol issues. This included, for example, services working with particular vulnerable groups. Others provided support specifically for alcohol use or for both alcohol and drug use. The specific composition of individual participants' caseloads is, however, not known.

Where practicable, focus groups were conducted with people from organisations, teams or practitioner groups that already worked together professionally on a regular basis as it was felt this would encourage discussion.

The ADP areas from which participants were recruited included rural, urban and mixed areas. Some managers had quite a wide geographical remit. As a result it was not possible to analyse any differences by type of area, although where a specific issue relating to the geography of an area was raised in a group this is highlighted in the report.

Focus groups lasted 45 to 90 minutes and were arranged to take place at a time and in a venue convenient for participants. The impacts of parent or carer harmful alcohol consumption on children and young people is a sensitive and potentially distressing subject. Participants were able to take time out from the focus group at any time, and time was provided at the end of the focus group to debrief if needed. One focus group used the time to discuss, more informally, some of the issues raised.

The participants in the study may, to some extent, be from services that are atypical of other alcohol-related services and other services supporting children and young people. Further, the families the participants worked with were those already known to services, and do not necessarily reflect the experiences of all families affected by others' alcohol use. Individuals who come into contact with alcohol-related services have reached a point where a number of these factors bring them to treatment.³¹

2.2.3 Data analysis

Data were transcribed verbatim by a private transcription service, quality checked for accuracy and anonymised.

All the focus group and interview data were coded, summarised and analysed using NVivo (version 12), a qualitative data management package. The ‘Framework’ method³² was used to enable the identification of themes relevant to the study. Initially three transcripts were coded independently by two team members and a subset of this by the third team member. These were compared and used to develop the analytical framework ([Appendix 5](#)). This framework was independently used to summarise data from three focus groups. The summaries were compared and agreement reached on how the team would continue to apply this process to the complete analysis.^{33 *}

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, terms such as ‘a few’, ‘several’ or ‘many’ have been used to indicate patterns within the data, but without implying generalisability beyond the study population.³⁴

2.2.4 Ethics

The NHS West of Scotland Research Ethics Service advised that as the proposed study design involved recruiting participants in their professional role, there was no requirement for NHS Research Ethical Review. The study protocol,³⁵ however, received a favourable opinion from NHS Health

* The methodological difficulties associated with combining interview and focus group data are acknowledged. It was, however, felt that the study would benefit from including this participant. This was discussed and agreed with the Evaluation Advisory Group for the study.

Scotland's Research Development Group (RDG)* in November 2018. The RDG requested that before recruiting in an area the topic guide be shared with the Child Protection Committee (CPC) chairs to ensure that the questions to be asked were in line with existing local multi-agency protocols. No CPC chairs that were contacted had any objections to the research questions being asked or raised any concerns about breaching local guidelines or confidentiality of families within services.

To ensure confidentiality, participants were asked not to discuss the details of individual or identifiable families. The participant information sheet ([Appendix 3](#)) emphasised the importance of not disclosing information, or drawing on examples, that could potentially identify families or family members.

2.2.5 Data protection, storage and management

As a public body, Public Health Scotland has legal responsibilities to comply with data protection legislation in the processing of personal data.

To ensure confidentiality, all hard copy material is stored in locked cabinets and electronic information is stored in dedicated secure password protected files on a secure NHS server. Research material is only accessible to project staff and support staff, who are subject to NHS information governance protocols. Personal data is securely destroyed following dissemination of the study findings.

2.3 Introducing the study findings

The following chapters present the findings from the analysis of the focus group and interview data:

- Chapter 3: Participants' awareness of, and attitudes towards, MUP

* The RDG provides research ethics guidance and approval for studies that do not require approval from an external research ethics committee.

- Chapter 4: Participants' perceptions of the impacts of increased alcohol price on service user harmful alcohol use and related behaviours
- Chapter 5: Harms experienced by children and young people related to parent/carer harmful alcohol use
- Chapter 6: Additional issues

The first two chapters are included to set the context for the rest of the findings.

Although the study was initially designed to understand the impact of parental, carer and sibling alcohol consumption on harms to children and young people, there was very little reference to sibling consumption during focus group discussions. Most of the analysis therefore relates primarily to parental and carer consumption.

Where quotes from participants have been included, and to assist with continuity and comprehension, they have been labelled according to the focus group (FG1–FG9) they are part of. To ensure the anonymity of the one interviewee, this data has also been labelled as a focus group.

A note on language

In the course of the focus groups, participants used a variety of terms to describe different types of drinking patterns, such as 'hazardous and harmful', 'addicted', 'dependent' or 'heavy drinkers'. These terms have been used here to reflect the language used by participants, but they may not be based on a formal assessment of levels of consumption nor necessarily overlap with definitions used in guidance.*

* See, for example, NICE (2010), Alcohol-use Disorders: prevention (PH 24) National Institute for Clinical Excellence, www.nice.org.uk/guidance/ph24/chapter/8-Glossary (accessed 9 December 2019). This defines 'harmful drinking' (high-risk drinking) as a pattern of alcohol consumption that is causing mental or physical damage. 'Alcohol

The term ‘possible dependence/dependency’ is used by the authors throughout the report to reflect that a formal assessment or clinical diagnosis is not known or discussed during the focus groups.*

dependence’ is defined as ‘a cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. They will also give alcohol a higher priority than other activities and obligations.’

* www.nice.org.uk/guidance/ph24/chapter/8-Glossary (accessed 9 December 2019).

3. Participants' awareness of, and attitudes towards, MUP

To understand the context for the subsequent discussions, focus group participants were asked at the outset to indicate the extent of their awareness of MUP, and their perception of the level of awareness among those with whom they worked and the wider population. Participants were also invited to discuss their views on increasing the price of alcohol, in general, and on MUP in particular, as mechanisms to reduce alcohol-related harms.

3.1 Participants' awareness of MUP

The ways in which participants became informed about the policy varied. These included, for example, an Alcohol and Drugs Partnership (ADP) providing information on MUP for services to share with staff and service users, or discussions within services, including at team meetings. One participant, however, suggested that their own understanding came largely from media coverage and they were not aware of much discussion within their work context.

3.2 Service user awareness of MUP

In relation to service users, participants in several focus groups described their own role in making families aware of MUP. More generally, the view was that any awareness was of a change in price, rather than specifically of MUP as a new policy. Service users that participants referred to as 'hazardous and harmful drinkers' were described as being unaware of MUP until they went to purchase alcohol, and then became angry about the cost. Participants noted that the increase in price was helping some parents/carers to reflect on what they are drinking and purchasing, and for some individuals has helped them to reduce consumption.

Among service users described as ‘dependent drinkers’, participants noted that families were not necessarily commenting on the increased price, or how it was affecting them. Some service users, however, were reportedly saying that they were aware of the price increase but that they did not expect it to affect their consumption (see [section 4.2](#)).

‘I haven’t even been asking about MUP but people have spontaneously said, I mean, “the price that’s not going to make any difference”, but actually we just don’t know.’ (FG5)

3.3 Public awareness of MUP

The high profile given to the issue in the media and on social media (for example Twitter) was noted by a number of participants. One participant hoped that the level of public debate might generate its own positive outcomes, serving to nudge the general population to reflect on alcohol consumption and health:

‘I was hoping that minimum unit pricing would act as a sort of nudge that would encourage people to reflect, to think, not necessarily because of the direct financial consequences, but because of the profile of the topic. Here was a great example of a potentially controversial issue being debated in public [...] So that raised the issue of alcohol consumption, wellbeing, health and safety in the general public’s eye, perhaps raising it with people who had never really thought of it too much before, either because it wasn’t really an issue for them, or because it was an issue, but they’d never actually considered that.’ (FG9)

Reflecting on public awareness in general, participants cited examples suggesting that, as with service users, people were aware of an increase in the price of alcohol, if not the policy itself. Participants in one focus group, for example, who held information sessions in supermarkets and community centres, were aware of people looking for advice on reducing their alcohol consumption, mentioning cost as a reason. Awareness of MUP was, though,

felt to be higher among young people. Participants in a number of focus groups described discussions they had had with young people who were working through the implications of MUP for their own alcohol purchasing patterns and consumption (see [section 6.1](#)).

3.4 Views on MUP as a mechanism for addressing alcohol-related harms

As a policy, participants reflected that they could see the value of MUP as a whole population approach. They could envisage, for example, how MUP could have a preventative role, stopping young people from drinking alcohol as a habit, even if this was tempered by a view that young people would still be able to obtain alcohol (see [section 6.1](#)).

Whether, and how effective, MUP could be as a mechanism for reducing alcohol consumption was, however, felt to be influenced by the nature of alcohol use, the wider context of alcohol marketing, public attitudes toward alcohol, and the potential for price increases to become normalised.

Very broadly, participants distinguished between people drinking harmfully but not considered to be possible dependent consumers of alcohol ('high level' drinkers, 'hazardous and harmful', 'binge drinkers'), and those they described as 'dependent' or 'addicted'. Participants could see the potential benefits of MUP in encouraging adults drinking at harmful levels to reflect on and potentially reduce their consumption (see [section 4.2.1](#)). The consistent view, however, was that increasing the price of alcohol would have little positive impact on consumption for those considered to be 'alcohol dependent'.

'[...] if they're in addiction, family members generally are saying that they're going to keep drinking [...] And I think that's the challenge for us like whole population wise we know it reduces drinking and it will reduce harm but actually there are individual cases like that. Then, I suppose, there are other drinkers that they like to drink until their money's gone.'

(FG5)

The perceived continued availability of cheap alcohol, together with the ubiquity of alcohol advertising (see [section 4.1](#)) were also seen by participants as potentially working against the positive intentions of MUP.

'I don't see it myself and think, "oh my God, the price of alcohol is really expensive". I actually see special offers, you know. I'm not sure it's had any real impact, to be honest.' (FG8)

From the perspective of some participants, alcohol advertising was felt to promote greater social acceptability of alcohol consumption. This was thought to result in misleading people and confusing children in families where a parent may be drinking, about what is, and what is not appropriate.

'So there's a normal level of alcohol marketing absolutely everywhere all of the time so actually if a kid is thinking, well, actually, you know, their mum drinks as well so how's that...you know, that's the same but different. It must be confusing for kids, yes.' (FG5)

It was also suggested that over time people adjust or adapt to changing prices, particularly when other costs are also increasing. Participants could anticipate price increases becoming normalised in future.

'Do you not think as well though it takes a very short time for that to become the norm? So that happened then, and now everything else just adjusts to make way for it. So actually the impact of it...you know, it's just like everything else goes up in price. So...how long is it actually going to have an impact other than when it's first...it first comes out? 'Cause people make small adjustments, don't they, to everything else.' (FG2)

4. Participants' perceptions of the impacts of increased alcohol price on service user harmful alcohol use and related behaviours

Participants shared their perceptions of the individual and societal factors that may contribute to harmful alcohol use, and the implications of increasing the price of alcohol, including through MUP, on people drinking at different levels and living with possible dependence on alcohol. This chapter sets the context for the discussion in Chapter 5 on how MUP may affect the harms experienced by children and young people.

4.1. Perceived influences on harmful alcohol use

Some participants reflected on the influences of MUP on alcohol consumption at a population level. For instance, several focus groups drew attention to the perceived 'weird dichotomy' between public policies aimed at reducing alcohol consumption and promoting healthy living and the 'glorification' of alcohol in advertising and product packaging (FG7). As a result of the extensiveness of alcohol promotion, adults, children and young people were felt to be constantly targeted or surrounded by alcohol.

At an individual level, factors that participants described as influential on why someone may drink at harmful levels included: to deal with bereavement or physical pain; as a way of self-medicating to cope with mental health issues; or to give themselves the sense that they are (socially) invisible.

'And she says, I'm invisible when I drink. You know, nobody can see me and I can't see them.' (FG2)

Participants also made reference to the impact of trauma, including childhood trauma, on why people become dependent upon alcohol.

'But in so many families when it becomes out of control, they're using alcohol as a means to manage trauma. And often, trauma based from

childhood. And it doesn't matter how much you put up the (price of) alcohol, they're going to look for something to manage what they are trying to make sense [...] and then that just has a knock-on effect to children.' (FG7)

Poverty and deprivation were also seen by participants as contributing to harmful alcohol use as a way of coping with challenging life circumstances.

'And when you're living in a country as well, that there is a lot of deprivation and poverty, that alcohol and drugs is something people turn to manage that, and block it out.' (FG7)

In the context of these individual and wider influences, from the perspective of the participants, some perceived MUP as something of a 'blunt instrument' (FG2), potentially placing strain on household finances but not addressing the underlying causes of harmful drinking:

'And there is the aspect of we're penalising people financially when probably a hundred per cent of people using alcohol problematically is because of underlying psychological reasons, which minimum unit pricing won't effect change in.' (FG6)

As another participant commented, while they were hopeful that MUP would lead to a reduction in individual alcohol consumption, they acknowledged that the underlying reasons behind why people drink harmfully would not be addressed, and therefore would still need additional support.

MUP was also seen as potentially 'discriminatory' (FG8) impacting more on families in poverty than middle-class families who may be more able to absorb the costs.

'I seem to think they're a bit more of, like functioning, like a functioning – I don't like saying it – alcoholic. They can get through daily life, even work, pay their bills on time. But like I'm saying, they could go home and have a bottle of wine every night. So is that just as big a problem as someone

who binges at the weekend, and who has a bottle, like, has a drink every morning just to get through the day. I think it's...people can be very judgemental of classes, and social status.' (FG8)

4.2. Perceived impact of increasing the price of alcohol/MUP on different 'types' of drinking

Participants across the focus groups believed that increasing prices would impact differently, depending on where people were in the 'cycle of addiction' (FG7).

4.2.1 Perceptions of the impact of increasing the price of alcohol/MUP on harmful, 'non-dependent' drinking

Participants suggested that, among those people variously described as 'non-dependent' drinkers, 'binge drinkers' and those able to stick to a previously set budget for alcohol, the increase in price could possibly encourage people to reflect on, and prioritise, what they were spending, and perhaps reduce their consumption.

'[...] 'cause I think the people who are non-dependent drinkers, the price point is influencing decisions that are made and I think there is a reduction in alcohol consumption. And I think you don't have that same I suppose, kind of, pressure or urge to...you know, you've got ten pounds in your purse. Are you going to buy alcohol or are you going to feed your family? I think that's...you know, not such a, kind of...an issue if you are a non-dependent drinker. It's perhaps easier to, kind of, make what we would consider to be the right choice, a pro-social choice, whatever...however you want to describe that.' (FG4)

One participant, for example, reported that people attending a counselling service for people drinking at hazardous and harmful levels were saying that they were drinking less as a result of MUP:

'And the early indications from those who are working directly within the organisation are that people feel quite angry and annoyed that their alcohol costs them more, but that's having the impact of making them think about how much they're drinking and what they're purchasing and the choices that they're making [...] so the, kind of, sense that we have is that that initial, kind of, annoyance, irritation dissipates and it's been really helpful and is having the impact of reducing consumption, which I think is really helpful.' (FG4)

Another described a person who had received treatment and support which had enabled them to reflect on the costs of their drinking, and modify their consumption, in the context of increasing prices:

'So with support from our service, (the person) gradually got better at managing (their) mental health, and has gone to see, you know, addictions psychologist, and is now better able to think, no I'm not going to have a drink. And in actual fact, I really can't afford a drink. And hiking up the prices, I think, did put (them) off that.' (FG8)

4.2.2 The perceived impact of increasing the price of alcohol/MUP on possible dependent drinking

For people described by participants as 'dependent', 'addicted', 'in addiction' or with a 'strong addiction' the view was that increasing the price of alcohol was unlikely to affect their consumption, with implications for household income and the potential impact on the family.

'I think for the folk that we're working with, that becomes harder if alcohol or whatever substance is your focus, and that...that's more of a focus than actually looking after your kids, managing them as well as you can, I don't think pricing has a huge impact.' (FG2)

Participants felt that for some people, the 'addiction' takes priority, whatever the price, with people cutting budgets in other areas, including for nutritional food, or fuel, or a child's activities, in order to pay for alcohol.

'A lot of the families [...] they're going to drink whatever because they're in an addiction and so money will be cut from other areas, so like school trips. I know one family, their son can't go to football club any more and things so it does impact on them.' (FG5)

Another participant reflected:

'Depends on the dependency then, doesn't it. Like, the more dependent you are on a substance then obviously that comes first. That comes before your children and your...everything in your world.' (FG3)

Participants suggested that people who were not living with possible dependence on alcohol may be able to recognise they can no longer afford to drink. Those they perceived to have a possible dependency on alcohol, however, may be less likely to make the connection between the price of alcohol, their level of consumption and increasing financial strain. As a participant remarked, they had never had a service user say '...oh I'm drinking less because of the unit pricing changing.' (FG7)

Participants acknowledged that this could also reflect the multiple sources of financial pressure these families may already be experiencing including, for example, welfare benefit changes and the increasing costs of food and other goods. In these circumstances the price of alcohol may be just one increase among others.

'[...] Because every cost, like, fuel cost and everything, it just seems to creep up and creep up. So are you going to notice with alcohol, necessarily?' (FG7)

'I mean there's just so much going on for families that actually price is only one issue and probably at the minute with the price point for MUP it is a minor issue... Welfare reform is the most damaging probably.' (FG5)

4.3 Participants' perceptions of behavioural responses to increasing the price of alcohol/MUP

4.3.1 MUP and harmful alcohol consumption and purchasing patterns

When participants refer to MUP as having no impact, they seem to be referring specifically to individuals living with possible alcohol dependence. The perception was that for this group of people MUP was not able to address the perceived dependency. Participants reflected that while some of this group of people may change their consumption patterns (changing what they drink, for example), others, were not felt to have made a change in either the amount or type of alcohol.

'A parent that used to drink a bottle...it was a bottle of vodka a day. (They're) still drinking a bottle of vodka a day. Do you know, that's...doesn't seem to have made any difference to...I don't know how much that's gone up by, but it doesn't seem to have made any difference to (person). They're still using the same brand'. (FG1)

In part, participants also felt that this may be contingent on what alcohol people consume and whether or not it had been impacted by MUP. Participants suggested that people who would normally drink vodka or beers will not have been so affected by MUP.

'So if people are drinking vodka...it's not much of a change in price for them really.' (FG1)

Where and how people purchase alcohol may also dilute the effects of an increase in price, and therefore limit its potential impact on consumption. People may, for example, purchase alcohol on credit from local stores. This could mean that they are less immediately aware of MUP, even if it results in them working up significant debts.

'...Some of the families I've worked with in the past, they go to the corner shop and get it on tick. And then they get their giro or their benefit in and

then they...that's the first bill they pay back so they know that they'll get tick the next time... So they don't actually need money per se. So then it becomes, like, well what is the minimum...what's the minimum price? What does that mean?... You know, it doesn't really affect me as such.'

(FG2)

For people living in rural areas, options about where they can purchase alcohol may be limited. In a context where a shopkeeper was perceived to be able to charge whatever price they chose for alcohol, this could mean that they are already paying for alcohol at a higher price and therefore be less affected by MUP.

Participants perceived that some people may respond to increasing prices by changing what they drink in order to sustain their consumption. This might be through, for example, switching to cheaper brands of a similar product. Focus group participants in one area also described recently receiving referrals where a parent was using miniatures instead of bottles. Participants did however caution that it was unclear whether this was specifically due to changes in price, or the ease with which miniatures could be hidden. Participants thought another response may be for people to switch from bottles or cans of strong ciders to spirits, such as vodka.

'So they might buy...instead of a three-litre bottle of Frosty Jack's, they might buy a bottle of vodka 'cause it's almost the same price.' (FG2)

The possibility of people switching from strong white cider to vodka was raised in a number of focus groups. Several participants viewed this as potentially reducing the overall volume of alcohol consumed by individuals, even if the strength of what was consumed was greater. This was seen as beneficial if the person was getting the 'same kicks for fewer units' of alcohol (FG2). There was however some concern that substitution, or a greater speed of consumption, may result in someone having a lower tolerance for a different type of alcohol, or reduce their control. Some participants felt these changes had the potential to result in aggressive behaviour.

'Cause obviously dependent on each individual person but, like, I know there's a few service users that we had support and who were okay drinking their ciders and stuff 'cause it had been years' worth of drinking. But now when they're changing on to the things like vodka and things, it's having a different effect on their aggression and things like that.' (FG4)

Participants also suggested that some people were changing their purchasing patterns, in order to continue consuming the same amount of alcohol. For example, they felt that people may purchase alcohol from supermarkets because it was considered to be cheaper than in local shops in rural localities in particular. This may include families bulk purchasing alcohol from supermarkets at times when they had money available to do so.

'They were telling us, people buying in bulk because it's cheaper. But it's only if they've got the wherewithal to buy in bulk. And I know some families as well, get home deliveries from Asda and Tesco's. Whereas, before, they didn't... So for one family in particular, there's been a shift in their buying, and getting a home delivery from Asda. And that's one of the things we talked about is, so what do you buy first – I buy my alcohol, before I buy anything else. (FG7)*

4.3.2 Drug use and alcohol price

A number of participants noted that poly drug use was prevalent among their service users, describing high referral rates where many were related to alcohol and drug use, including prescription drugs. A number of participants also described seeing increased trends in drug use among families and young people (see also [section 6.1](#)), but were unable to say whether and how this

* Note: It is assumed that this refers to alcohol still being comparatively cheaper in supermarkets than in local shops, even when taking into account MUP. Discounting for multi-buy purchase of alcohol is illegal in Scotland (see Section 2 of the Alcohol etc (Scotland) Act 2010).

could be related to MUP. Participants could not identify a clear link between MUP and the use of other drugs, but there were some concerns expressed that MUP might exacerbate existing problems for individuals within the context of poverty, welfare changes and what people can afford to buy, and their desire to use substances to cope with/escape from their lives. Some participants felt the increased use of drugs they saw was not a new (post-MUP) trend but was related to the established existence of poly drug use among service users. Another group suggested that the use of street drugs (such as street Valium, cannabis) reflected a cultural or generational shift. One participant said they had not had reports of adults (parents) within their alcohol treatment service switching to drugs since the introduction of MUP as they stayed with their current choice of substance.

Other participants discussed being aware of parents and young people using drugs but questioned the role of MUP within this choice. Insofar as the price of alcohol may be a factor for some individuals it was only one of a range of factors reflective of the complexities of the lives of families with experience of substance use. Participants felt that within these contexts MUP may have created a situation where people would seek self-medication through means other than alcohol. Participants in one focus group, for example, suggested that for the people they work with, the substance (alcohol and/or drugs) of choice will change depending on relative price and that people will get whatever is cheaper and is going to ‘give you the best dunt’ (FG2).

4.3.3 Use of street benzodiazepines (Valium)

A particular concern expressed by participants in a number of the focus groups related to the rise in people using ‘street Valium.’* The tablets have been increasing in availability and reducing in price in recent years.

* ‘Street Valium’ is the name used to describe either seepage from the treatment system (where prescribed diazepam is sold on by the person to whom it was prescribed) or, as is more commonly understood, benzodiazepines such as etizolam

'Well that's it, when vallies are going for 50 pence a vallie, would you not, you know, and it's easily accessible, this is what people are saying. Why would I go out and spend eight quid on a case of beer when I can get vallies for 50 pence.' (FG2)

Some participants reported that individuals have used street Valium to attempt to self-detoxify from alcohol, and that this has increased a risk to health and life. While they were not able to say whether this was linked to MUP, one participant noted:

'There has been a few referrals recently that has been for alcohol and street Valium, and it's been a knot of people saying that they're trying to detox themselves off of it, rather than them going to services [...]' (FG6)

Participants also expressed concern about potential for harm from illegally made counterfeit benzodiazepine products as individuals were often unaware of the higher strength of these products and subsequent risks involved.

An example was given of a family where this was an issue and resulted in criminal charges for possession of drugs, '[...] but it was to try and withdraw from alcohol, that's when their street Valium consumption started.' (FG6)

Participants also referred to the impact that parental/carer drug use can have on children and young people in the home. They considered that many of the issues are the same as those experienced when living with parental alcohol use described in Chapter 5. Additional drug-related issues raised specifically about young people are presented in [section 6.1.6](#).

and alprazolam (Xanax) which are widely available in Scotland and have increasingly been implicated in drug-related deaths (DRDs) since 2014. Many of the drugs available are counterfeit products containing high strengths of active substances.

5. Harms experienced by children and young people related to parent/carer harmful alcohol use

This chapter focuses on participants' perceptions of the direct and indirect impacts on harms experienced by children and young people as a result of parent/carer harmful alcohol use.

In addition to describing the impact of parental/carer drinking on harms experienced by children and young people, participants were also asked to describe any perceived changes in the experiences of families they worked with that had occurred since MUP was implemented. Participants were, however, cautious about saying whether these harms to children and young people had or were occurring as a direct result of MUP or even the extent to which MUP was a contributory factor. This was in part because they did not feel they yet had the evidence on which to base any claims. As discussed below, this may be because the children themselves can be reluctant to talk about the harms they may be experiencing. But it was also because participants perceived that a number of other factors were felt to contribute to children's experiences of harm, making it difficult to unpick the specific impacts of MUP or the ways in which increases in the price of alcohol may contribute.

5.1 Children and young people's responses to parental/carer harmful drinking

Participants thought that it was difficult to know from children and young people what harms they may be experiencing and if anything had changed at home following the introduction of MUP in relation to parents'/carers' alcohol consumption. This was because, even from an early age, children and young people are reluctant to disclose sensitive information and were described as often being quite guarded about what they say to protect their family. This was thought to put pressure on children.

'And I would say the children and young people are very protective of their parents and carers, and kinship carers, and they don't want to have to disclose to anybody that their parent or carer has relapsed, or, you know, it's difficult for them, puts them in that position. Then you're also going to get cases where the parents and carers actually specifically tell the children not to mention any kind of relapse as well, or ongoing addiction certainly; so that can be difficult for the children because it's a lot for them to hold in.' (FG6)

The concern was also expressed around older children who cover up issues and, in doing so, may become invisible to services.

'I think once children reach primary six/primary seven and certainly second year, they become invisible because they're no longer seen to have the same vulnerabilities that young children have. We're no longer anxious that they're going to injure themselves in the home environment 'cause their parents are not keeping themselves safe. And they become, I think, much more adept at covering up. Children are really afraid of what might happen if they tell. They're afraid of being taken away or removed from their parents. So they will, kind of, cover up. They become much better at fending for themselves, getting themselves to school on time...' (FG4)

Participants provided examples of children and young people removing alcohol in an attempt to protect their parents, with one reflecting on the potential risks to the young person of doing this:

'And I had one young person that said, I know when my mum's had eight cans of, whatever it is, Superlager, if she has one more she'll be flat out. So this child said, eight cans was enough, but any more than that, she had to remove them and put them down the sink. And I was thinking, oh gosh, you know, at 11 years old, to put alcohol down the sink. Quite risky, as well, for a young person.' (FG7)

Participants also described children not being aware of harmful alcohol use in the family until they were older.

‘One of the young people that I work with, her mum, they’re very middle class and the mum’s a teacher and she didn’t know until she was about 15 that her mum drank. She just said, “I would go to Brownies and come back and I’d have a different mum.” She just thought at night time her mum was horrible and so lack of knowledge and talking about it and like now she’s like, “I can’t believe I was so old before I knew but I just remember hating coming back from any activity because she was totally different.”’(FG5)

5.2 Types of adult harmful drinking and the impact of MUP on harms to children and young people

Based on their wealth of experience of working with families affected by harmful alcohol use, participants described what they saw as the potential implications of any increase in alcohol price, in terms both of the potential for change, and the nature of the harms children may experience as a result. Few participants described specific instances where they felt MUP had directly impacted, positively or negatively, on children’s experiences of harms.

As noted in [section 4.2](#), in families where parents may be drinking to levels that participants described as hazardous or harmful, but not experiencing possible dependence, it was suggested that MUP was, for some service users, acting as a catalyst for reducing their drinking, with potentially beneficial implications for children. However, it was acknowledged that they did not have evidence to indicate whether any reduction in harms to children was in fact happening.

Where parents/carers were perceived to be experiencing possible dependence on alcohol, participants felt that MUP would make very little positive difference to the situation for children and young people in these families. Participants in several focus groups made the point that for these

children the harms were already present, and that the children themselves were still seeing it as a normal way of living, particularly where families are already impacted by poverty.

5.3 Potential harms to children and young people from parental/carer harmful drinking

5.3.1 Living in unstable environments

Participants described the chaotic lives, instability and uncertainty experienced by some children and young people within families affected by harmful drinking and the resulting behavioural problems they can experience.

'Because when you've got a parent that's, you know, using alcohol excessively, or has a dependency to alcohol, there is, you know, there is things [going] on in the family that you kind of see a pattern in all families. So then, parents are less motivated, and they suffer depression, and you know, all these things that go along with drinking too much alcohol [...] And then, a child living in that situation can also either have behavioural issues themselves because they're looking for attention, or they're becoming quite isolated, and you know, withdrawn from other people as well.' (FG7)

'And the kind of volatility as well within the home environment as well so when someone's intoxicated or in withdrawal, that unpredictability as well. And sometimes again that can lead to young people acting out behaviours because the only kind of attention they get is negative attention, but at least it's attention, kind of thing, as well; so it's not always a...you know, children's behaviour can very much go from being quite stable to all of a sudden it's like they're acting out, because of what they're being exposed to on a daily basis as well.' (FG6)

Participants also described how circumstances and behaviours related to challenging home lives can become normalised by younger children.

‘[...] He was eight. And he said, it’s okay for my mum to drink. It’s okay for my mum to get drunk ’cause that’s what people do at the weekend. That’s what people do at Christmas. And it was very, sort of, normalised within the family.’ (FG2)

‘And I think for children and young people as well, like who do they talk to so...? And also there’s a bit of normalising it so you don’t realise it’s not normal apart from, then you’re like, hang on, I don’t really want to bring anybody home or, you know, things like that but also, yes, things can get quite extreme before there is any intervention.’ (FG5)

Participants also described normalisation of the challenging contexts of children’s lives related to other drugs, gang culture, domestic abuse, and alcohol-related bereavement.

Referring to this context of unstable environments, participants discussed the importance of attending school as being a protective factor for some children and young people, providing them with some respite from the challenges of chaotic home lives. For this reason the holiday periods can be more difficult for some of these youngsters.

5.3.2 Psychological distress

Participants in all focus groups described the damaging behavioural and psychological effect that parent/carer drinking can have on children and young people. For instance, parental harmful alcohol use can, in some cases, result in a child being neglected and becoming psychologically withdrawn.

Participants described how living with parental/carer harmful drinking can result in constant stress for some children and young people such as worrying if they are going to be fed or have enough money to be able to get to school. Other participants described the stress for some children who worry when they have to leave their parents, for example to go to school:

'Also worrying about what kind of state the parents are going to be in when they return, if they are going to school. And...about the children not going to school because they're concerned about their parents, so withdrawing from what would be seen as kind of supports for them, and escape for them as well.' (FG6)

One focus group discussed how children are affected by the binge cycles that their parents are going through, whether the parent is suffering from and has support for mental health issues, and also where they are in their cycle of recovery. Participants described how this means that at times the children are upbeat because their parent is stopping consuming alcohol, but then their parent relapses and for the child 'the whole world collapses about them' (FG7).

Participants discussed other psychological impacts on children such as fearfulness and hypervigilance resulting from having to deal with or manage parental alcohol consumption.

'So they're hypervigilant about, you know, mum's...or dad's got a drink. What are they drinking? So even if it looks like a cup of coffee, they're smelling that. They're looking for bottles of alcohol.' (FG2)

5.3.3 Social isolation

Participants described varying degrees of social isolation experienced by children as a result of harmful drinking by parents/carers. For instance, if alcohol is prioritised within the available household budget then participants reported that children can miss out on activities such as clubs and after-school care (see [section 4.2.2](#)). This can also impact the scope for further respite from the type of chaotic circumstances described previously, particularly during school holidays.

'[...] whereas summer holidays, any other holidays, the family don't have the money that's required for kids to go to the movies or do the kind of

things that my son takes for granted, as well as the amount of time that the family are together. And there's a lack of, you know, they're not able to go on holidays, or things that normal people take for granted, if you like. And that again that can be when crisis time, you know, there tends to be a spike in referrals to children and families at the start of the summer holidays, or Christmas holidays and things.' (FG6)

Participants also described how children might not feel able to bring friends home because they did not know what they will be going home to, or might feel embarrassed by their parent's behaviour.

'The embarrassment I think is massive, like can't take anybody home, somebody's dad was lying on the street and was walking past with his school friends. It's the embarrassment I think for teenagers is massive.'

(FG5)

Participants considered that a parent's or carer's harmful alcohol use may not only limit their social activities but also cause disruption if the child had to be moved around and looked after by friends or family. But again participants could not say that this was definitely a consequence of the cost of alcohol or the result of a combination of the complex challenges that families may be facing. For instance, participants described situations where a parent may also be coping with severe depression and this could result in them not feeling motivated to find out about clubs for their child to attend, or able to cope with taking them along.

Participants reflected on the impact of debt, which may be related to harmful alcohol use or wider factors, on social isolation. If, for example, they can no longer visit relatives to whom families may be indebted this further increases the potential harms to children by damaging their family and support networks.

'Or even just borrowing off different family members and then that's almost isolating in a way because then they maybe want to avoid certain people so people who might be a positive influence in their life. Like if you

think of that actually, from like a child's point of view, oh, why have we stopped going to Gran's house? Because Mum owes Gran a fortune and we're not going round while we owe her money.' (FG5)

Participants perceived that at times children and young people can feel they do not have anywhere to go or anyone to talk to about their experience at home, or to help them understand what is or is not appropriate behaviour. In these instances one participant described how some sessions in school intended to support young people with discussions about alcohol and drugs can be more stressful if young people are experiencing problems at home because they can feel like their peers know about what is going on at home.

5.3.4 Physical safety and unsafe environments

Participants described some of the physical risks children and young people are exposed to as a result of family members' drinking, either by a direct impact on the child or when they witness abuse and violence in the home. One participant described a situation where they perceived that a six-year-old child they worked with did not want to visit her dad because she did not feel safe due to his drinking-related behaviour:

'...Dad would have his friends over, she would get sent to her room, and they would drink. But when she was saying drink, she didn't really understand it was alcohol, but she said, they would act funny [...] And that was the result of why she didn't want to go to his house...So, I think she probably didn't feel safe, and didn't like how he was acting.' (FG8)

A relationship between domestic abuse and alcohol in general was referred to in a number of the focus groups. While not able to identify any specific or recent changes in either the intensiveness or extensiveness of domestic abuse incidents where alcohol has featured as a direct result of MUP, participants reflected on the ways in which it could affect families, particularly in contexts of pre-existing abuse, poverty and the complexities of the lives of the families they worked with. First, a greater proportion of the family budget

may be spent on alcohol if the abusive partner is unable or unwilling to change their consumption. In contexts such as this alcohol may be another means of exerting coercive control. One case was described where a parent has to 'choose' whether to give their partner money for alcohol, or purchase items for their children. In a situation of pre-existing domestic abuse, the participant suggested that things may have got harder for the mum as she attempted to protect her children:

'I think the family in particular I'm thinking of, they've got [...] kids and she literally doesn't...finds that she chooses whether to give him a tenner for drink or for a nappy and it will always be him because otherwise he's in a really bad mood. So she's making that choice and it's probably slightly harder for her but maybe hasn't realised that that's the impact, you know, I think it's only when I'm asking, is kind of aware now, maybe [...] I mean, parents do this all the time, mums in particular are protecting their children, that's the decision...she's making all those decisions thinking this is actually keeping the children safer. It's a very rational process even if we're looking at it going, what a nightmare.' (FG5)

Second, participants suggested that people who they described as living with possible dependence on alcohol may change their consumption patterns, substituting cider with vodka or whisky, for example. Participants felt this may result in a change in behaviours, potentially increasing the risk of aggression toward family members.

'Also an idea that, you know, then it becomes quite financially difficult for somebody with an alcohol dependency, to afford their alcohol, then it can often change the dynamics in a family, and the idea of mood and emotional wellbeing. And then, a parent that has cravings, and is needing alcohol to manage their tolerance level, maybe can't afford it, to the level that they want. And the emotional sort of state in the house could become quite, you know, difficult, as well. So then, often, you know, families can then be affected by anger and aggression.' (FG7)

5.3.5 Influence of parent/carer drinking on young people's own alcohol consumption

The relationship between parental/carer alcohol use and their children's own future drinking is a complex issue mediated by a range of factors (see [section 1.4](#)).

One participant working with families affected by harmful alcohol use described the challenges faced by some of the young people referred to them who are experiencing chaotic lives 'and they just drink to knock themselves out' (FG3).

Participants in another focus group described the complexity of the role that alcohol can play in relationships within families, particularly where young people drink as a way to bond with their parents. They went on to raise concerns about the potential risk to young people, including those that are care experienced who are 'looking for that bond and they see that as the only way they can get it' (FG6).

There was a view among some participants that MUP might have an impact on protecting young people from experiencing possible dependence themselves in the future. Some participants expressed the view that if the increased price of some alcohol leads to there being less alcohol around children and young people within families, that this may have a protective effect in deterring them from starting to use alcohol themselves. However, participants went on to caution this view by raising concerns that the underlying experiences (such as trauma, mental health, experiences of poverty) which tend to lead to harmful alcohol use are not going to be impacted by price.

Within the context of the current study, participants in a number of focus groups commented that a lot of the young people that they work with who use alcohol have experienced harmful parental substance use. It was also noted that this cycle of alcohol harmful alcohol use can then continue within some families:

'We find you're working with the parents and then you know their kids...and now [participant's name] working with the kids, but I'm working with the parents though. It's...they're growing up, they're getting it. It's quite scary that you're working in the same team with parents and children.' (FG3)

5.3.6 Changing family relationships

Participants described how living with parents/carers drinking at harmful levels can change children and young people's role in the family. For example, some may take on a caring role for siblings as family life becomes more chaotic.

Participants also described how a parent can sometimes require additional support for their current substance use. At times this additional support can result in a child or children requiring alternative accommodation, or in a parent leaving the household. Participants reflected that when a mother, for instance, has to leave the family home because of their own support needs, this can be a particularly difficult experience for children and young people. As two participants (P) discussed:

'(P4) So that impact...regardless of the impact they've had from mum's alcohol prior to that, they're then not in the same family unit any longer. Which is massive.'

(P6) And they're also dealing with the loss of their mother because then they have seen her in both situations and now they're now having to deal with the loss of that as well:

(P4) And out of the nine, probably five of those families with children aren't allowed contact with their mum because their alcohol use is so chaotic.' (FG2)

This experience was described as creating emotional conflict for the child who understands a parent cannot currently care for them but they also still want to stay with their mother.

A further situation was described by one participant where the parent was drinking excessively at weekends. As this child was not with them at the weekend this was described as a bit of a protective factor. However, it was noted that harms may still be experienced by the child following this drinking episode even when not present at the time:

‘But then it’s the hangover, the comedown the next day, when they maybe get the child back and they have to try and function normally for the child. And children sense when you’re not feeling a hundred per cent.’
(FG8)

Some participants described how parental harmful drinking could be a factor in family breakdown. They described the impact that this could have on the children and young people in the home. For some young people, it could be a contributing factor in them using alcohol themselves in future as a coping mechanism within their lives.

Participants spoke about the importance of the role of kinship carers in protecting children and, for some, the additional pressures that they themselves can face. Participants described some instances where a kinship carer is dealing with their own harmful alcohol use, but they do not feel able to report this or seek support themselves as they know they are an important source of support for their family. One participant highlighted the possibility of under-reporting by kinship carers, particularly:

‘...if they were the last, kind of, port of call of responsibility, as it’s seen and then the child might get taken away, so it’s that extra burden for them (...).’ (FG3)

5.3.11 The impact of financial hardship

During the focus groups, participants discussed the complex interplay of factors that they saw as influential on families’ experiences of harmful alcohol

use, and on the direct and indirect impacts this may have on children's experiences of harms.

Poverty, including in-work poverty, was one of the wider societal factors that participants identified as potentially contributing to, and increasing, the impacts of harmful alcohol use within families. Participants also expressed their concerns about how changes to the welfare system may place additional pressures on families. For instance, they discussed how delays in receiving Universal Credit, being sanctioned in the welfare system, or perhaps not being eligible for social security support may result in severe financial constraints, affecting household budgets and budgeting.

'And I've had families that have struggled with that, or haven't had payments, or have had payments stopped, because they're seemingly no longer eligible, or whatever. So I think, and they're not even families that I know of that are affected by alcohol. So that's bound to have an impact on those who are dependent as well, because then that's even less money, when it's costing more money to buy alcohol. So I think there's just been a lot of financial change anyway, which makes it difficult to pull out, is it minimum unit pricing.' (FG7)

Relating to the pressures that this financial hardship places on families, some participants described the impact on some children in a context where a parent or carer may not be receiving support for harmful alcohol use:

'Neglect towards children, and the idea that, obviously, it takes a greater financial strain on a family. And addiction is a field that people without the right support have no, almost, control over, and they will go for their addicted substance, whether it be alcohol. And neglect is something that becomes quite obvious in families, in the idea that they're maybe not getting the right food or clothing, and heating [...] because of that.' (FG7)

Another participant described how some young people end up 'sofa-surfing' because the parents are not able to cope financially (FG3).

Where families are already experiencing financial challenges, participants suggested that increasing the price of alcohol might exacerbate these, making household budgeting more difficult for some families.

'So I think...we found a few issues where alcohol dependent people obviously making choices that are already quite tough choices in the home. So we've had a few families sitting without electricity for three days to be able to fund their alcohol consumption.' (FG4)

A number of participants referred to an increase in food bank usage and/or breakfast clubs but they made the point that this could be associated with impacts on family finances as a result of welfare changes, and MUP might only be one contributory factor for some families. One focus group reported they had not seen the increase in demand for food vouchers that they had anticipated in response to MUP, although there were some views that this might be because people would not want to admit they could not feed their children because of their alcohol consumption.

Again the point was made that children going hungry was not a recent phenomenon, nor one only associated with harmful alcohol or substance use, but with the impact of poverty on families.

It was suggested that if people attending an alcohol-related service ask for a foodbank referral they would be supported by the staff within the service to access a welfare benefits check. This could also be used as an opportunity by the staff within the alcohol service to discuss what is going on with their finances, which may then bring to light the extent of someone's drinking. Participants in another group also felt that MUP had provided an opportunity to open up a discussion with families to look at the impact of drinking on family budgets and budgeting decisions.

In a number of focus groups participants raised the complex interplay between problems of debt and alcohol use. Payday loans were described as a big issue for some families they worked with who were experiencing poverty. These families are particularly vulnerable to these types of loans as they are

unable to access other types of credit, and are also less able to pay them back, so building up additional debts and increasing financial pressures. Participants also described how informal loans between people who are struggling financially impacts on the community.

'But I hear people borrow. It's the little communities of people that, you know, quite often we can work with families that are, that know other families in these little communities. And they'll be saying, oh yeah, I borrowed £50 off Bob, do you know what I mean. And it's like, but then you know that Bob might be struggling as well. And it's just this little community of people sharing money at times, as well.' (FG7)

Participants also spoke about the impact of parents/carers receiving lump-sum payments (such as payments for housing benefit or a successful appeal against a sanction). It was described how this system of payments can create additional financial pressures within some families by making effective budgeting challenging, particularly when parents are drinking at harmful levels.

'So, they've been going from getting paid fortnightly or weekly, and having to last a month (...). And I feel like when they get this money, they see this as this big pot of money that they can blow. And sometimes they do spend it within the week, and then they've left themselves short, and they're struggling the rest of the weeks.' (FG8)

Within this context of financial hardship participants reflected concerns that, in some cases, such severe financial constraints may result in some members of a family becoming involved in criminal activity. This might, for instance, be because a parent living with possible dependency resorts to stealing alcohol that they are unable to afford to buy or starts using illegal drugs as a cheaper substitute. If a parent is convicted, participants reflected that this could have a huge impact on children, particularly if the parent receives a custodial sentence.

6. Additional issues

In addition to the findings presented in the previous three chapters, the other main areas of discussion that emerged during the focus groups were:

- Young people's own alcohol and drug use
- Service provision for families affected by harmful alcohol consumption
- Gender and alcohol

Although these topics are not directly related to the research objectives of the current study, they provide rich and valuable context about the experiences of families affected by harmful alcohol use as reflected by the study participants that work closely with them.

6.1 Young people's own alcohol and drug use

During the focus groups there were discussions about alcohol use by young people and the potential impact of price changes including MUP.

A number of participants worked with young people and reflected on their experiences and perceptions of drinking behaviours and attitudes of those they worked with. These young people are currently engaged with support for families affected by harmful alcohol use and therefore have lived experience of challenging and chaotic home lives. As such, their experiences are not representative of young people more generally.

6.1.1 Perceived impacts of alcohol price on young people's own alcohol consumption

Participants in a number of focus groups reflected that some young people they work with were aware of MUP, although others were thought to be aware of price increases but less aware of the legislation. Where participants perceived a reduction in alcohol consumption among young people, they felt

that it was difficult to attribute this to MUP alone and decouple it from other factors that influence young people's drinking decisions.

One participant had spoken with the young people in their service about MUP and reported that some of their drinks of choice were unaffected by MUP but others had been, such as cheap white ciders. Participants described the mixed views on MUP among the young people using their service. While some young people had said they would switch to a different type of alcohol (such as vodka instead of cider), others had discussed how the increased cost of alcohol would make them think twice about buying alcohol.

Some participants felt that the young people they work with are still drinking worrying amounts alcohol and did not believe that the price would affect this. They also reported that the young people were very price aware and used strategies that enabled them to afford the alcohol they wanted (such as switching to different and lower-strength drinks, pooling money, using pocket money and college grants). Where participants were aware of young people switching product or drinking less they believed this was due to their age and transition to being older teenagers or adults, and was not linked to MUP.

6.1.2 Reasons for young people drinking

Participants highlighted a range of reasons that the young people they work with were drinking. This included the impacts of parental and carer alcohol use (see [section 5.3.5](#)), using alcohol to manage mental health issues, and boredom due to a lack of activities, particularly during holidays.

6.1.3 Shifting choices in alcohol types due to trends

Some young people were drinking different types of alcohol such as wine or gin instead of cheap cider. Others were drinking more expensive brand vodka as drinking cheaper vodka was thought to come with a stigma attached to it. Other drinks were identified as fashionable for young people to drink, for instance gin was described as a designer drink. However, participants were

not able to say if shifting choices of alcohol type among the young people they worked with were related to MUP. Some also noted that the shift to branded drinks came before MUP.

A number of focus group discussions highlighted concerns about the marketing of alcohol towards young people. Participants suggested that alcohol companies adapt their sales strategies in response to policy changes like MUP. This perceived marketing of alcohol and energy drinks towards young people was a source of frustration among participants. In particular one focus group discussed the design and marketing of energy drinks (such as Monster) and similar alcohol products (such as Dragon Soop), reflecting on the similarity between these products in terms of how they look and taste.

6.1.4 Where and how young people obtained alcohol

There was discussion in some focus groups around how the young people they worked with were able to obtain alcohol regardless of their age. This included from the family home, friends and from shops, with one participant commenting that they believe it is the small off-licences that are more likely to serve alcohol to under-age young people. Participants also reported examples of young people approaching vulnerable individuals to buy alcohol for them from local shops, offering them money to do this.

One participant had concerns that by asking someone older to buy alcohol for them might put the young person at risk:

‘You don’t get something for nothing, so what are they expecting in return.’ (FG7)

There were reports from a number of participants about young people getting alcohol on credit from local shops, an issue described as being quite problematic. This included a situation where a young person was able to obtain alcohol by leaving a mobile phone, which would be returned when the money was paid.

6.1.5 Young people's own drinking and related harms among young people

Participants commented that the young people they work with are drinking huge amounts. A perceived increase in the number of young people drinking vodka was also felt to have implications for their behaviour, putting them at risk of becoming vulnerable and chaotic, impacting on them and their families. However, participants did not believe this shift was as a result of MUP (see [section 6.1.3](#)).

Some participants commented on the risks that young people face from their own drinking and related behaviour. For instance, they felt that some young people were risking potential harm by drinking to get as drunk as possible for a variety of reasons (see [sections 5.3.5](#) and [6.1.2](#)), including risk to their mental health and sexual health. Participants reflected concerns that children and young people may be extremely vulnerable and be targeted by others and experience abuse while they are drinking.

Other concerns raised by participants included young people missing school due to their levels of alcohol consumption. It was also suggested that young people may resort to stealing alcohol, although they commented that this was not a new phenomenon.

6.1.6 Young people and drugs

Perceived shifts in patterns of drug use in families that participants worked with were happening for a range of reasons (see [section 4.3.2](#)). Additional reasons for this perceived shift from alcohol to drugs in young people were the age restriction and cost of alcohol, and drugs being readily available in places such as at the school gate. Participants also reflected young people's views that it is harder to hide alcohol to avoid fines for drinking in public, in contrast to drugs which can be easily hidden.

One participant said that the young people they worked with had said they were not drinking alcohol because they are not able to get access to it, but

that they described being able to easily get access to cannabis. One participant highlighted that young people in their area are able to obtain drugs without paying for them at the time, making use of credit offered by suppliers. Participants did not feel they were able to say whether MUP has had any impact on young people using drugs or if this was a shift that was happening anyway.

A particular concern raised by participants in a number of focus groups was in relation to young people being targeted for criminal behaviour such as drug dealing:

‘And the ones that are 12 upwards are dealing [...] And the problem with them is they will...’cause they’re vulnerable, these people who are targeting them will use them for drug running. And that’s what’s happening now.’ (FG3)

6.2 Service provision for families affected by harmful alcohol consumption

During the focus groups, participants were asked to describe any local service changes in response to the needs of service users as a result of MUP implementation. Although participants did not highlight any substantive changes in local service provision directly related to MUP, a number of important themes emerged during discussions:

- The structure of the service system
- Service development and change
- MUP, service provision and service demand

6.2.1 The structure of the service system

In order to deliver the Scottish Government’s strategic approach to preventing alcohol and drug-related harm, Alcohol and Drug Partnerships (ADPs) are

responsible for commissioning services to meet local needs, consistent with national strategy. These can include health board, local authority and third sector provided services.

Although not the main focus of this study, the perception among participants in a number of focus groups was that the structure of the service system locally could sometimes place barriers in the way of people getting the support they need when they need it. One participant, for example, referring to the difficulties people may have in obtaining detox commented:

‘I mean, we obviously take that multi-agency approach sort of thing, and if somebody has a high level of dependency to alcohol. I mean, I find the whole system quite difficult and challenging, and sometimes the windows of opportunity are kind of lost.’ (FG7)

Participants in a number of the focus groups referred to a perceived disconnection between children’s and adult services. A participant in one group, for example, responding to the focus of the current study, made the point that:

‘The idea of looking as to whether this makes a difference to children is really important, because quite often (...) what happens is the children get lost and get left out of this (...) I think quite often is...(...) that it’s the children that get missed out of that some place. And we need to work quite hard with the addiction services and services to think about, are there any children involved here? You know, because that’s...the focus is round about adults. And that’s quite...it’s difficult to do the next bit which is, well how’s that impacting?’ (FG2)

The perceived lack of integration between different parts of a local service system, highlighted by some participants, was felt to open up the risk of decisions being made in one part of the system resulting in indirect, and unintended consequences in another part. One focus group, for example, described how decisions made on the criteria for residential detox can extend

the period to which children and young people may be exposed to potential harms arising from parental alcohol use:

'And sometimes I think it's a shame, because I'm finding, the long term of going into a family, and a parent drinking chaotically, on and off, they're not looking at that as a level acceptable to go into detox. But actually it's a long time for a young person to be living in a situation of a parent going through these ups and downs, and highs and lows of alcohol use (...) And I think this is where it's failing on the young people, because, you know, that's, the longer somebody is living in that situation, the more damaging and detrimental that is for a young person.' (FG7)

Several focus groups described links being made with housing associations and housing liaison officers. In one area this enabled a youth worker and family support worker to work alongside the housing associations to identify support needs for families. Issues relating to alcohol or drugs might sometimes be identified among a number of problems families were experiencing. In another area, the implications of Universal Credit for housing benefits provided the context for an exchange of information between housing liaison officers and substance use workers.

Despite the range of services that might be available locally, it was suggested that young people may still not know who to go to if they have concerns.

'And I think for children or a young person there's nowhere obvious. I mean, there's no messaging really anywhere about what's appropriate and not appropriate, where to go if you've got concerns. I think for me that's a big worry that like how would...where would you go and...?'
(FG5)

Children may also not be able to get the help they need for their own mental health and well-being if their parent or carer is not able to support them to attend a service appointment because of their own substance use or mental health issues.

6.2.2 Service development and change

Although not specifically associated with MUP, participants drew attention to service changes and developments. There were, for example, descriptions of new teams being formed, new services were being set up, new arrangements being put in place, or practices changing in order to meet the needs of families experiencing harmful alcohol use.

Participants also described attempts at integrating elements of the system. In one area, for example, funding had been obtained for a Children Affected by Parental Substance Misuse (CAPSM) team to support families when a parent was undergoing home detox. Although a number of referrals had been received via the local alcohol treatment and care service, they had not so far provided anyone with the full 12 weeks of support for reasons related to the needs of the service users. In the absence of recent referrals, the group described the need to actively work to maintain the momentum of an integrated approach between adult, children and family services to ensure that children and young people within these families are identified and supported.

Another participant described how a new assessment process had very recently been introduced (but not yet used by participants) to try and achieve greater integration between services:

‘Where we’ll be having direct conversations with the children of the adults that we support to ask about the impact of the adult substance misuse directly on the child. So that’s something that actually was introduced last month.’ (FG1)

In the context of funding ceasing for a specialist children and young people’s service, participants in one area described how parental (and young people’s) harmful substance use would be picked up under GIRFEC¹⁸ arrangements. They felt that the best protection for children and young people is for their parent/carer to be receiving treatment. They believed that robust GIRFEC

procedures within substance treatment and care services in their geographical area meant they would be able to identify when a child is present in the home.

Participants in another area also described the development of an integrated service model, with assertive outreach for those people who do not attend their first appointment. The aim was to reduce the barriers adults may face in engaging or re-engaging with services. In another area two previously separate teams were combined. Although accompanied by a local reduction in funding, and requiring a period of rapid learning for some staff for whom the drug and alcohol dimensions were felt to be quite new, participants described how this had facilitated a whole-family approach.

Changing health service policies or practices regarding the availability and eligibility criteria for residential and/or home detox arose in a number of the groups. A theme was the perceived shift towards home detox. It was suggested that this may be due to a number of factors including: a possible increase in demand; comparatively lower alcohol consumption in those who were coming forward making home detox more feasible; the high cost of residential detox; changes in the criteria for suitability for home detox (potentially in response to increased demand); or a combination of factors.

6.2.3 MUP, service provision and service demand

MUP was not seen as an important driver for most of the service changes described by participants. Participants in one focus group did, however, explain how they had introduced new questions to ask callers to a helpline about whether MUP was impacting on the household budget. Participants in this focus group also indicated that, in the run-up to implementation of MUP, they had discussed how they would embed MUP in to their practice. For those families for whom participants perceived that MUP might have a challenging impact, they anticipated using this as an opportunity to discuss the implications of someone's drinking on the household budget (see [section 5.3.5](#)).

Collecting and analysing data on service use was not within the scope of the current study so it was not possible to draw conclusions about the impacts of MUP on service demand or uptake. Several participants, however, referred to what they believed was a recent increase in people (new and re-referrals) for alcohol detox. A number also described increased alcohol-related referrals to their own teams.* In one case the service was looking at introducing a brief intervention as a way of responding to the demand. Even where a recent increase was noted, participants were cautious about attributing this directly to MUP, noting that increased demand may be related to increased awareness of a service. At the same time they did not exclude the possible impact of alcohol price on help-seeking.

A similar point was made in relation to an apparent increase in referrals to an alcohol clinic, where participants thought price might be one contributory factor in people seeking help. It was acknowledged that this increase in referrals was also coincident upon a recent service change.

In one focus group participants described a sudden steep increase (compared with the previous pattern) in alcohol-related referrals for parental harmful drinking from social work to alcohol and drug treatment and care services. But even here, participants were uncertain about the reason (and timing) for these families to become known to social work services.

‘So something has changed that they’ve then come on the radar of social work. But some of these families would not have been referred to us previously because of a real sense of...from (the) school’s point of view, quite a functional family. So something has changed that they’ve then come on the radar of social work.’ (FG2)

Even within a context of service re-design, a potentially greater awareness of service need, and a possible increase in service demand, the point was made in several focus groups that there was still a high level of unmet need.

* No local service data were collected as part of this study.

'I suppose one thing to note is we're not in touch with most families and actually most families affected by addiction are probably not on anybody's radar. So a minority of people are in treatment, a minority of families reach for support so I think we need to be quite conscious of that, that actually most of this is...you know, we are the tip of the iceberg stuff and most of it's underneath.' (FG5)

This is in a context in which, as several participants noted, an increase in parental referrals might be beneficial for identifying a child or young person who might otherwise have 'fallen off the radar' (FG2).

6.3 Gender and alcohol

During the focus groups, participants described gendered patterns of alcohol consumption and help-seeking, and the implications of gender roles on the harms experienced by children and young people, and for service response. Although not specific to MUP, the comments draw attention to the potential for differential impacts based on gender. Participants from one service indicated that while most of those they worked with were men, women were more likely to approach them for support, often because of men's drinking. Contradictory views were, however, expressed about how open men and women were about their alcohol use. Some participants suggested that men's drinking was more hidden, while others felt that this was the case for women's consumption. This was mirrored in the comments of participants in one group, who suggested that parents, particularly mothers, were likely to delay help seeking (for their own drinking), and were likely to under-report their consumption.

It was suggested by participants that the expectation is that female parents are the care giver, with a responsibility to protect children from their own or the other parent's drinking. Male parents on the other hand were thought to feel less responsibility and/or their role was overlooked:

'It's just interesting [...] so you've got a mum and a dad who are not living together in the same household, but you've got dad who has contact with their children. We still see (...) It's been mum's responsibility to keep the children safe and, 'isn't it terrible that she's drinking'. It's like, well where's the dad here? What's he doing to help that situation?' (FG4)

Perhaps because of the gender roles within families, as discussed in [section 5.3.4](#), when a mother has to leave the family home because of their own harmful substance use, this can have a big impact on children and young people.

7. Discussion

The minimum unit pricing legislation was implemented on 1 May 2018. A portfolio of studies are evaluating the impact of the policy. Through focus groups and one interview with practitioners working with families affected by harmful parental/carer alcohol use, this study sought to answer the research question:

Has MUP affected parental/carer harmful alcohol consumption and related behaviours, with implications for the harms experienced by children and young people? If so, in what ways?

Specifically the study explored participants views of the nature of harms experienced by children and young people related to parent/carer harmful alcohol use, their perceptions of any recent changes within the families they worked with, and whether and how they saw these related to MUP. Eight focus groups and one individual interview were conducted with 42 participants that worked with families affected by harmful alcohol use. The data were collected just under one year following the implementation of MUP.

7.1 Principal findings

What emerged most strongly from the study was the nature and extent of the physical, psychological and social harms to which some children may be exposed as a result of harmful drinking within the family. The children and young people from the families that participants worked with often live in unstable, chaotic environments which may result in psychological distress, social isolation and exposure to physically risky or unsafe situations. The poverty experienced by many of the families, as well as the potential financial implications of harmful parental alcohol use, also make it difficult for some families to meet children's basic needs.

Although describing the range of harms some children and young people experience as a result of parent/carer harmful drinking, participants were

cautious about saying whether MUP had had a direct or indirect positive or negative impact on these harms. In part this was because they felt it was too soon after implementation to have the evidence to suggest that children's experience of harm had changed. At a family level, participants also suggested that some children and young people are reluctant to talk about what they are experiencing at home in order to protect their families. Some harms may therefore be hidden from services. It was also in part because participants felt that, in the context of the complex family lives of many of those they worked with, there were a range of other factors that were also impacting on children and young people's experiences. Poverty, in particular, was seen as a pervasive feature of many of these families' lives. This may be compounded by the roll out of Universal Credit, which other research has suggested may impact on individual and family poverty.^{36 37 38 39} This combination of factors made it difficult for participants to identify the specific effects of MUP.

Within this context, participants were, however, broadly supportive of MUP as a policy to address hazardous and harmful drinking at a population level. Participants felt that the increase in price may encourage people to reflect on, and possibly reduce their consumption, with positive implications for children and young people.

Participants, however, also suggested that MUP may have little positive impact on those who they described as having a possible dependency; for this group the view was that MUP would not be sufficient to address the perceived dependency. Contingent on whether and how someone's preferred alcohol was affected by MUP, participants suggested this could mean increasing financial strain on families who may already be experiencing financial hardship. It could also mean people changing what they consume to get a better 'return on the price', for example, switching from strong white cider to vodka. At an individual level this may have a positive effect if it means they consume fewer units of alcohol. But if the change is to a drink they have not

developed a tolerance for, it may result in an increased risk of aggression, again, with potential implications for children and young people.

Participants working in adult alcohol services were not aware of any parents/carers who only used alcohol substituting alcohol with drugs since the introduction of MUP. Other participants suggested that an increase in alcohol prices had the potential to impact on patterns of drug use by some individuals who were already using drugs. While again cautious about ascribing any changes specifically to MUP, they described how some service users may look to substances other than alcohol to self-medicate depending on the relative price.

The focus groups also generated a number of additional findings. While not the main focus of the study they provide a broader perspective on the contexts within which MUP is being implemented. Participants discussed not only parent/carer alcohol use, but also alcohol and drug use among the children and young people with whom they worked. Many of the issues raised resonate with those identified in a related study of the impact of MUP on young people's own drinking and related behaviour.⁶ Participants also reflected that one of the underlying reasons that some of these young people drink is to cope with complex situations relating to harmful parental alcohol use.

This study was not designed or intended to be an evaluation of service delivery. However, participants highlighted some important issues in relation to supporting families affected by alcohol use. Participants suggested that although efforts are being made to improve service integration, some current service configurations were perceived to act as potential barriers to individuals engaging or re-engaging with support. The criteria for accessing services, such as detox services or mental health services, were highlighted as particular issues. Participants discussed how the service system has a role to play in supporting individuals who might seek help as a result of MUP and also in mitigating any of the unintended negative impacts of MUP, particularly as these relate to the experiences of children and young people.

7.2 Strengths and limitations of the study

The main strengths of the study relate to the qualitative approach. This generated rich data on practitioners' perceptions of the impacts on children and young people of parent/carer harmful alcohol consumption. Purposive sampling was used to identify a broad range of services and professional groups to include in the study, giving a range of experiences from across services providing support to families affected by harmful alcohol use. The participants were able to draw on their experience in their respective fields to consider the potential implications of MUP on the families they work with. Even where the discussions were more general in nature, this was based on an understanding of the complex realities faced by families with lived and living experience of harmful alcohol use.

There are a number of limitations for the study that should be noted. For methodological and ethical reasons the study does not include the lived and living experiences gathered directly from children and young people. Discussions with the study Evaluation Advisory Group concluded that this would not be appropriate as children and young people may not identify as being affected by parental/carer harmful drinking or, as highlighted above, may be reluctant to discuss their experience with others.

As noted above, participants were cautious about describing the direct or indirect impacts of MUP on the families they worked with, feeling that they did not have concrete evidence on which to base their claims. Further, in order to protect the confidentiality of the families they worked with, participants were asked not to discuss individual, potentially identifiable families. As a result some responses were pitched at a more general level, or were descriptions based on their experience in practice of what they perceived could be the potential impacts of MUP.

Data collection took place 9–12 months after MUP implementation. This was to allow sufficient time for changes to become evident, and not so long that it becomes more difficult to recall or associate any perceived changes to

implementation. However, as noted above, practitioners felt it was still too soon to identify impacts following implementation. Some teams approached to take part in the study in fact chose not to participate because they did not feel they had a sense of any impact of MUP on the families they worked with and would not be able to contribute to the study. It is possible, however, that changes may have been happening that were not yet evident to frontline practitioners working with families already within services.

To some extent the participants in the study may be from services that are atypical of other alcohol-related services supporting families and/or children and young people. Those teams who agreed to take part may also differ (in their experience and/or perspectives) from those not approached or who chose not to participate. The families the participants worked with were those already known to services. As such they also do not necessarily reflect the experiences of all families affected by harmful alcohol use. Alcohol use may also be only one factor contributing to the harms children and young people may face.

7.3 Interpretations

This study has highlighted the importance of the societal, individual and family contexts within which MUP plays out, and which may in some way shape the impacts of the policy. The study was designed to gather data on participants' perceptions of the potential impact of MUP on the experience of harms to children and young people from parents' and carers' harmful alcohol use.

Drawing on their experience, study participants underlined the range of harms children and young people experience as a result of harmful parent/carer alcohol consumption. While able to consider the potential impacts of MUP on families experiencing harmful alcohol use, practitioners were, however, cautious about identifying or attributing any changes in these experiences to MUP following implementation.

What also emerged from the discussions was the complexity of the lives of the families affected by harmful alcohol use. In these contexts MUP may be just one of a number of factors contributing (positively or negatively) to children and young people's experiences within these families. In particular what the study reveals is the pervasive impacts of poverty, including child poverty in many of the families with whom participants worked. The view was that this may have been exacerbated by recent welfare changes, including the ongoing roll-out of Universal Credit. This suggests the need for a greater understanding of the potential interactions between MUP and social security reform as they impact on household income and child poverty. More practically, it underlines the need for services to ensure families receive welfare benefits, financial support and debt advice to help mitigate the financial impacts. This could also provide an opportunity to open up a discussion with families about the implications of alcohol consumption on the household's income to ensure they receive the support they need when they need it.

Although reluctant to make specific claims about the impacts of MUP, participants did consider how it might impact differently depending on the nature of harmful drinking, with implications for families. Participants felt there was scope for MUP to lead to positive change in consumption among parents/carers who were drinking to hazardous and harmful levels, but not considered to be living with a possible dependence. They could anticipate how this might have indirect positive implications for children and young people. However, participants felt there was less potential for MUP to be an effective intervention in reducing the alcohol consumption of those individuals with a possible dependence due to the enduring and complex nature of alcohol use and its underlying causes. For families experiencing possible dependent alcohol use, participants described how the increase in price may increase the risk of some harms. This may be through increased pressure on household income in order to continue to meet the costs of alcohol, or changes in behaviour if someone switches to a drink for which they have less tolerance.

This suggests both the importance of MUP being complemented with other interventions aimed at supporting parents and carers to address the factors underlying harmful drinking, and also whole-family approaches that mitigate the risks of harms to children and young people while supporting recovery. Participants highlighted the value of an integrated service response across the continuum of different types of harmful drinking, not just between children's and families' services, but between specialist substance use services, children and adult mental health services and generic services. Policy developments in recent years have aimed to address these important aspects of the service response to support families affected by harmful substance use.^{22 23} The challenges that participants raised in this study highlight the importance of appropriate responses to support families with differing alcohol-related needs. It is also important to reflect that this study was not designed as an evaluation of current service provision.

7.4 Evidence from other studies in the evaluation portfolio

Further evidence on the impact of MUP on children and young people's experience of harm may come from recently published and future studies. Specifically:

- Young people's own alcohol consumption. This qualitative study was based on interviews with 50 young people under 18 who reported drinking both before and after MUP. The study found that MUP did not impact on their acquisition, consumption or related behaviours, either positively or negatively. Many of the products favoured by the young people were, on average, already being sold above 50 pence per unit before MUP was introduced. Money and price changes were not perceived to be barriers to drinking by the participants. There were no reported changes in the extent or nature of alcohol-related harms among the young people interviewed, following the introduction of MUP.

- Harmful drinking. This study includes qualitative interviews with adult family members of those drinking at harmful levels, recruited through the community, to explore the impact of MUP on themselves and the rest of their family, if applicable. The study also includes survey interviews with people drinking at harmful levels recruited through services. These interviews explore the impact of MUP on drinking and related behaviour and also collect information on the children in the respondent's life. Finally this study will also use market research data to assess the impact of MUP on the alcohol consumption of harmful drinking at a population level, with differential analysis for those with children, if possible. This study is expected to report in 2021.
- An expenditure on food study uses market research data to assess the impact of MUP on household expenditure on, and nutritional quality of, food. Differential analysis for those households with children will be undertaken if sufficiently powered. This study is expected to report in 2021.

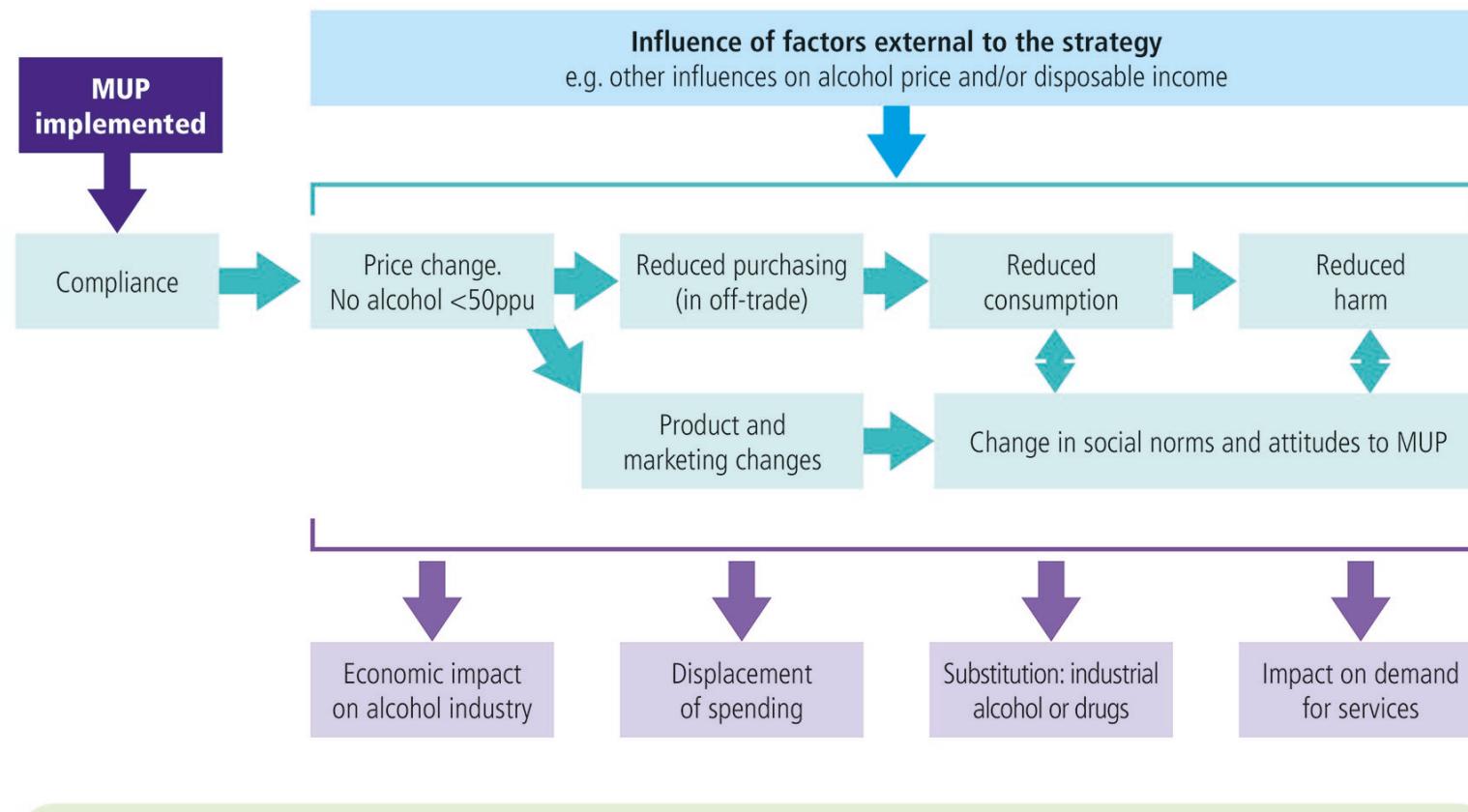
7.5 Conclusions

The aim of the study was to contribute to an understanding of the potential role of MUP in protecting children and young people from harm from parent or carer harmful alcohol use. Through in-depth discussions with practitioners with specialist expertise in alcohol-related services the study powerfully illustrates the harms that children and young people may experience as a result of parent/carer alcohol use within some families. The participants in this study were experienced practitioners that understand the complexity of the lives of the families they work with, the pressures they face from challenges relating to financial hardship, and the multitude of factors that influence alcohol consumption and related harms to children. This complexity, together with the comparatively recent implementation of MUP made it difficult for participants to identify specifically how MUP had changed children and young people's experience of harm from parents'/carers' drinking.

Participants did feel that MUP may support some of those who were drinking at hazardous and harmful levels to reflect on and possibly reduce their consumption. There were some examples of this happening, with the potential for beneficial effects for children and young people. Participants felt that MUP may have a limited positive impact on those living with a possible dependence on alcohol. The study suggests that, in addition to MUP, in order to address alcohol consumption and related behaviours and to help mitigate the risk of harms to children and young people, interventions are needed that support individuals to address their underlying reasons for harmful drinking. It will be important to consider whether such interventions for individuals living with a possible dependence on alcohol may be different to those for individuals who are considered to be drinking at harmful and hazardous levels, but not living with a possible dependence. In a context of pervasive poverty, including child poverty, the study also suggests a need for greater understanding of, and actions to address, the interactions between poverty, welfare reform and substance use.

Appendix 1: MUP for alcohol evaluation theory of change

Figure 1: MUP theory of change



Appendix 2: Focus group topic guide

A. Introductions and initial exploration of the issues

Introductions

Just to start the discussion it would be really helpful if you could each just tell us your first name and very briefly about your role and the nature of your work with children and young people affected by others' alcohol consumption. You do not need to give your name or the geographical area you work in so that this information is not recorded, however if you do this information will all be removed from the data to maintain your anonymity.

Initial exploration and orientation (include participatory methods if necessary).

- Thinking generally about alcohol price. How might it play a role in increasing harms to children associated with parental/carer/siblings drinking?
- How might it influence the level and type of harms to children and young people? For example, how might it reduce or limit these harms?
- How aware were you of the introduction of minimum unit pricing in Scotland? Did you have any sense before it was implemented how it might impact on your work with children and young people?

B. Questions specific to MUP

In this section we will be asking you about any impacts on behaviours and/or patterns of behaviours that you might have noticed among families since the increase in the price of some alcohol (due to minimum unit price) in May 2018.

(Prompt/reminder – no individual examples.)

- To what extent do you feel MUP has had any impact on alcohol consumption and related behaviour among parents/carers?
 - For example positive aspects; how or where people get alcohol from (for example criminal behaviours such as stealing alcohol); substitution with other substances.
- If so, what have the consequences of these been? This might include:
 - positive changes, such as lower amounts of alcohol consumed, less frequent drinking
 - more negative unintended consequences, such as how or where people get alcohol from (for example criminal behaviours such as stealing alcohol), less money to spend on essential goods for children, substitution to other illicit substances, increased family stress; parent/carer/sibling mental health problems; consequences associated with withdrawal; increased stress/mental health problems for children/young people.
- Thinking about your experience since May, have children/young people described any recent changes in parental/carer alcohol consumption and related behaviour?
 - This might include positive changes such as lower consumption, lower frequency of drinking.
 - Unintended consequences, such as less money to spend, substitution to other illicit substances, increased family stress; parental mental health problems; consequences associated with withdrawal; increased stress/mental health problems for children/young people.
- Based on your experience, do you feel there have been impacts on children's experiences of harms from parental/carer drinking?

- This might include positive or negative impacts.

C. Understanding the factors that may be contributing to any perceived impacts

In this section we want to understand if there are factors other than the price of alcohol that may be, independently or in interaction with MUP, impacting on children and young people in the families you work with.

- What are the main factors that you perceive may have contributed to any impacts on children/young people's experiences of harm since the increase in minimum unit price?
 - This might relate to alcohol affordability, whether and how people are accessing services, other related or parallel changes?
 - How, if at all, have these factors influenced internal family dynamics, specifically as they impact on children and young people?
 - (Consider prompts – finances, challenging housing situations, any changes in mental health, and whether families have noticed increasing price of alcohol.)
- We are aware that there have been a series of changes in the welfare system that may have affected the families you work with in a range of ways. Do you have any sense of whether and how the changing price of alcohol might have interacted with these changes in welfare? If so, in what ways? [Note = space to talk about this but need to steer participants to focus on MUP.] For example:
 - reduced welfare benefits/income increasing stress resulting in increased alcohol consumption (despite higher price)

- reduced welfare benefits and increased alcohol price reducing alcohol consumption (and any potential positive impact on employment)
- other ways?

D. Understanding any changes in service environment

Note – these questions in section D will only be used in focus groups if there is sufficient time.

- Have there been any impacts on the ways they work with parents/carers/sibling and families affected by alcohol-related harms since the introduction of minimum unit pricing?
 - For example any changes in the care of children and young people by families or changes in family relationships, and how this potentially impacts on what participants do as practitioners in response to these families.

E. Anything else?

That is all the questions that we had. Are there any other issues, other things relating to MUP and its potential impact on harms to children and young people from others' (other family members?) alcohol consumption that we haven't covered?

Final note

- Note on what happens next: reminder from the information provided about the research process – recordings will be transcribed and analysed together with data from other focus groups to produce a report identifying main themes. Hope to publish in July/August 2019.
- Thank you for your participation.

- We will be here for a few minutes more if you would like to spend some time just reflecting on the process and unwind before going back to your work.

Appendix 3: Participant information sheet

The impact of minimum unit pricing on protecting children and young people from harms from others' alcohol consumption: Practitioners' views

Participant information sheet (14 November 2018)

We would like to invite you to take part in a study exploring the impacts of increased alcohol price on protecting children and young people from harms from other family members' alcohol consumption. The study is being undertaken and funded by NHS Health Scotland, and will involve focus groups with practitioners in a number of different areas across Scotland.

As an experienced practitioner working with families affected by alcohol use your views are important and will add value to the study by helping us to understand the potential impact of alcohol price on the families you work with.

Taking part is entirely up to you, so before you decide we would like you to understand why the study is being done and what it will involve. Please read this information sheet carefully. Talk it over with others if you wish and please contact us at any time if you have any questions. If you decide to take part we will go through this information with you at the start of the focus group to give you another opportunity to ask any questions you might have.

Why is the study important?

To help reduce alcohol-related harms, the Alcohol (Minimum Pricing) Scotland Act 2012 was passed. The aim was to increase the price of low-cost, high-strength alcohol, reducing its affordability. It was hoped that this would contribute to a reduction in alcohol consumption and associated harms. Since 1 May 2018, when the legislation came into effect, the minimum unit price (MUP) of alcohol has increased to 50p.

What does MUP mean for the price of alcohol?

Calculating the minimum price = price per unit (£0.50) x strength of alcohol (ABV) x volume (litres)
The cheapest products in most drink types have increased by about £1-3, with many products staying the same. Strong white cider has increased far more – for example a 3L bottle of frosty jacks was £3.50, now needs to retail about 3x more at £11.25. This illustrates the targeted nature of MUP.



To assess the impacts of MUP, NHS Health Scotland has been asked by the Scottish Government to undertake an evaluation of the act. This will inform the review of the legislation that Ministers are required to provide to the Scottish Parliament before 2024. The evaluation consists of a number of different studies including this current study to explore the potential impacts of the increase in alcohol price on protecting children and young people from harm.

You can find out more at www.healthscotland.scot/health-topics/alcohol/evaluation-of-minimum-unit-pricing/mup-evaluation-overview

What is this study about?

NHS Health Scotland is doing this study because we want to understand the possible role that increasing the price of alcohol may have in protecting children and young people from harms from others' alcohol consumption. We are especially interested in the views of practitioners working with children, young people and families affected by parental or immediate family alcohol misuse. In particular:

- whether they feel there have (or haven't) been impacts on parent/carer or sibling alcohol consumption or other behaviours since the introduction of MUP in May 2018
- the possible factors contributing to any impacts (such as family relationships, changes in welfare)
- the potential implications for children and young people.

The study will run from October 2018 to July 2019, with most of the data collection taking place between November 2018 and February 2019. This will involve 10 to 12 focus groups with practitioners.

Why have I been invited to take part?

You have been invited to take part because the organisation for whom you work has identified you as someone who works with families, children and young people affected by alcohol use within the family. Your views and experiences from working with these families are extremely important to help us understand any potential impact of changes in alcohol price on the lives of children and young people. Others who currently work in the same team as you, or that you regularly work with to support families, may also be invited to participate in a focus group.

What does taking part in the study involve?

Taking part will involve you participating in a focus group with 6–8 other practitioners. Each focus group will take around 1.5 hours and will be held at a time and in a venue convenient for participants. Refreshments will be provided for participants as a small thank you for taking part.

The focus group will be facilitated by two NHS Health Scotland researchers. If each focus group member has consented the discussion will be recorded for confidential transcription. If recording is not possible the researchers will make detailed written notes of the discussion.

In the course of the focus group participants will be invited to discuss:

- 1 the impact of family alcohol misuse on children and young people, and the role alcohol price may play in that
- 2 whether you are aware from your work of any impacts on alcohol consumption and related behaviour since the increase in the minimum unit price of alcohol at the beginning of May 2018. In particular whether you are aware of any recent impacts on parental/carer/sibling alcohol consumption and related behaviour
- 3 the possible factors that may have contributed to any impacts
- 4 the potential implications for children and young people

If we have time in the discussion we might also ask you whether there have been any impacts on the ways you work with parents/carers/siblings and families affected by alcohol-related harm since the introduction of minimum unit pricing. We may also speak to service managers at a later date to see if there have been any impacts on the way the organisations you work for provide services.

Do I have to take part?

No, it is entirely up to you.

If you do decide to take part you will be given this information sheet to keep and will also be asked to sign a consent form to say you have read and understood this information and agree to take part in the study. You can decide not to take part, or if you change your mind about taking part you can still pull out before the start of the focus group without giving a reason.

If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible.

What should I do if I want to take part?

If you do decide to take part you will be asked to sign and return the attached consent form to Jane Ford (jane.ford3@nhs.net) in advance of the focus group. The consent form must be initialled and signed (electronic signature is acceptable). Before the start of the focus group discussion, we'll confirm if everyone participating has returned a completed consent form.

What are the possible benefits of taking part?

It is important that we understand the impacts of increasing the price of alcohol through minimum unit pricing as a new way for attempting to address alcohol-related harms. Your views will be an important contribution to developing this understanding. By sharing your knowledge and experience you will be helping us to build up a picture of the impacts on children and young people of others' alcohol consumption. This will be extremely valuable for helping to understand the potential role of alcohol price in contributing to improving the lives of children and young people, and will form an important part of the learning for future policy in Scotland.

What are the possible risks of taking part?

Reflecting on the impacts of family alcohol consumption on children and young people is a sensitive and potentially distressing subject. To help reduce any potential stress it will be possible to have short breaks in the course of the focus group. The researchers will also provide time at the end of the focus group for people to raise any concerns or issues about the research process. If you feel you need additional support following the focus group we would encourage you to discuss these with your line manager and they will be able to advise you of sources of support where necessary.

As you will appreciate it is important in a study of this kind that the confidentiality of the families you work with and the relationships of trust you have built up are not breached. All the participants will therefore be expected

to contribute to the discussion in ways that meet data protection legislation* and local information governance protocols on information sharing. Any accidental breach would be treated sensitively. Where appropriate, any inadvertent disclosure may need to be reported in accordance with the relevant disclosure process.

How will my information be kept confidential?

All information collected about and/or from you will be kept strictly confidential and will only be used for the purpose of this specific study. If you attend a focus group session, the other people in the group will know what you have said but all group participants are asked to respect each other's privacy, and the privacy and confidentiality of the families with whom they work.

With the permission of all the focus group members the discussion will be audio recorded and transcribed. The recording and transcription will only be accessible to members of the research team, Health Scotland support staff and the transcription service who will have signed a confidentiality agreement. The researchers may also make handwritten notes in the course of the meeting.

The recordings will be transcribed and analysed together with data from other focus groups to produce a report identifying the main themes that emerge from discussions. To ensure anonymity identifiers will be removed from the transcripts. No individuals will be identified in reporting of the study. We may use some direct quotes from what you say in the study reports, presentations

* General Data Protection Regulation 2018 <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/> (accessed 10 September 2018).

Data Protection Act 2018

www.legislation.gov.uk/ukpga/2018/12/contents/enacted/data.htm (accessed 10 September 2018).

and publications but your identity and the organisation you work for will not be revealed.

What will happen to the information collected before and during the focus group?

All information will be securely stored. Any personally identifiable information provided on the consent form will be stored separately from the data collected in the course of the focus group.

In order to collect and use your personal information as part of this research, we must have a basis in law to do so. The basis we are using is that the research is ‘a task in the public interest’. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. Your personal data will be processed only so long as it is required for this study. We will minimise the processing of personal data wherever possible.

The audio recording will be securely destroyed on publication of the study report, in approximately one year. The transcript and any handwritten notes will be kept for up to five years from publication of the study report before being securely destroyed. Personal data will be securely destroyed following dissemination of the study findings.

We will adhere to data protection legislation. The data controller for this study is Public Health Scotland (formerly NHS Health Scotland), who is responsible for looking after your information and using it properly. For enquiries about Public Health Scotland data protection practices, you can contact Duncan Robertson, Public Health Scotland’s Senior Policy, Risk and Data Protection Officer by email at Healthscotland-dpo@nhs.net or by phone on 0131 314 5436.

What will we do with the results?

Once the study is complete we will publish the final report on the Public Health Scotland website. If you would like us to we can also provide you with a summary of the findings from the study and the links to the other studies evaluating the impacts of MUP (please indicate this on the consent form).

Has the study been approved by an ethics committee?

The study has been given a favourable opinion by NHS Health Scotland's Research and Development Group.

Contacts for further information

If you have any questions about the study or wish to withdraw from the study, please feel free to contact:

Jane Ford, Public Health Intelligence Adviser, Public Health Scotland

Tel: 0141 414 2738 or Mobile: 07500 121983

Email: jane.ford3@nhs.net

If you are unhappy with how the study has been conducted please contact:

Rebecca Sludden, Research Services, Public Health Scotland

Tel: 0141 414 2760

Email: Rebecca.Sludden@nhs.net

Should you wish to make a complaint about Public Health Scotland's collection or use of data, the UK's independent authority set up to uphold

information rights in the public interest, promoting openness by public bodies and data privacy for individuals is the Information Commissioner's Office.

This information sheet is for you to keep. Thank you for your time.

Appendix 4: Consent form

The impact of minimum unit pricing on protecting children and young people from harms from others' alcohol consumption: Practitioners' views

Participant consent form

Version 3 (14 November 2018)

Please read each of the statements below, and initial where you are happy to give consent. If you have any questions please contact Jane Ford (Telephone: 0141 414 2738; email: jane.ford3@nhs.net)

This consent form is to ensure that you understand the nature of this research and have given your consent to participate in this study. Your participation is entirely voluntary and you are free to change your mind about taking part at any time before the start of the focus group discussion.

The focus group should take around 1.5 hours and with your permission will be audio recorded to ensure the information is accurately recorded. Your information will be stored safely and securely. Anything that could identify you or your service will be changed or removed in any study reports.

Before deciding whether or not you wish to take part please read the attached information sheet, and feel free to ask us any questions you have. If you are happy to participate please complete this consent form and email to Jane Ford (Jane.Ford3@nhs.net) before the focus group. The consent form must be initialled and signed (electronic signature is acceptable).

Please initial box (do not tick):

- 1** I confirm that I have read and understood the participant information sheet dated (14 Nov 2018) for the above study. I have had the chance to ask any questions and am satisfied with the answers given.
- 2** I understand my participation is voluntary and that I am free to withdraw from the study at any time before the focus group takes place without giving a reason.
- 3** I agree to the focus group discussion being audio recorded and transcribed.
- 4** I understand that any quotes used in reports on the research will not be directly attributed to me or the organisation I work for and I agree to the use of direct anonymised quotes in research reports, presentations and publications.
- 5** I would like to be sent a copy of the findings of the study.
- 6** I agree to take part in the above study.

Name of participant

Date

Signature

Name of person taking

Date

Signature

consent

If you would like us send you a copy of the findings of the study please provide your contact details below depending on your preferred format of receiving the findings:

Appendix 5: Analytical framework (v6)

Participant awareness/views of MUP

1. Participant's awareness, understanding and views on MUP/price as a mechanism

1.1 Own awareness and understanding pre-MUP

1.2 Service awareness

1.3 Participant's attitudes towards/views on MUP

1.4 Views on/understanding price as a mechanism affecting consumption

1.5 Participant's role in raising awareness of MUP among service users

2. Perception of public awareness of MUP/attitudes towards alcohol

2.1 Public awareness of MUP

2.2 Public awareness of alcohol related harms

2.3 Social acceptability of alcohol/drinking

Children's experience of harm from parental/carer/sibling alcohol consumption

3. Children's experiences of harm from parental, carer, sibling, alcohol consumption and related behaviours (for example in children in care; descriptions of what life is like as a child where parent[s] have alcohol-use disorder, including hypervigilance, protecting the family secret, anxiety of unpredictability at home, the torn feeling of betrayal but wanting to live with parents).

3.1 Hypothetical views on impact of alcohol on children's experience of harms.

3.2 Examples of specific instances of impact of alcohol on children's experiences of harms (outwith MUP).

3.3 Examples of protective factors and measures.

Perceived impacts of MUP on children's experiences of harm from parental/carer/sibling alcohol consumption and related behaviours

4.1 No impact.

4.2 Positive experiences (i.e. reduction in harms) (actual/anticipated).

4.3 Negative experiences (i.e. increase in harms) (actual/anticipated) (e.g. could include parents prioritising spend on alcohol).

4.4 Difficulties of uncoupling impact of MUP from other policy actions (includes previous 'don't know' code').

Evidence of impact

5. Local evidence drawn on to suggest nature scale of impacts (including no impact) e.g. local child protection registers (MUP and/or alcohol).

Family contexts

6. Complexity of family contexts.

6.1 Interaction with MUP.

6.2 Complexity of family relationships – may include domestic abuse related to/exacerbated by MUP (e.g. including providing/withholding alcohol, obstructing recovery efforts, other forms of abuse described).

7. Perceived financial hardship/poverty.

7.1 Related to/exacerbated by MUP.

7.2 Related to welfare reform, universal credit, sanctions.

7.3 Other causes.

8. Effects of financial hardship on families/children.

8.1 Food/fuel poverty.

8.2 Debt.

9. Parental/carer mental health.

9.1 Relationship between parent/carer mental health and alcohol consumption.

9.2 Impact of MUP on (parent/carer) mental health.

9.3 Children's experiences of harm due to any impact of MUP on parent/carer mental health (as highlighted in 9.2).

Adult alcohol consumption

10. Perspectives on different types of drinker (general and MUP-specific).

10.1 Regular binge drinker.

10.2 Irregular binge drinker.

10.3 Problematic drinker.

10.4 Harmful drinker (includes e.g. 'functional alcoholic').

10.5 [Add others if relevant in other transcripts.]

11. Reasons for drinking.

11.1 Bereavement.

11.2 Physical pain management.

11.3 [Add others if relevant in other transcripts.]

12. Sources of alcohol (adults) – where/how obtained.

13. Perceived adult alcohol consumption in general, including changes.

13.1 Increased (volume/units/strength).

13.2 Decreased (volume/units/strength).

13.3 Drinking regimes/patterns e.g. higher strength consumed in shorter time.

13.4 Alcohol and drug use (substitution or poly use).

14. Perceived changes in adult alcohol consumption in response to MUP.

14.1 Increased (volume/units/strength).

14.2 Decreased (volume/units/strength).

14.3 Drinking regimes/patterns, such as higher strength consumed in shorter time.

14.4 Alcohol and drug use (substitution or poly use).

14.5 No change in consumption.

14.6 Not able to uncouple MUP from other policy actions.

15. Impact of MUP on alcohol-related behaviour.

15.1 Impact of MUP on different types of drinker (including no impact)

15.2 Drunken comportment (behaviours e.g. aggression due to alcohol)

16. MUP unintended consequences e.g. obtaining alcohol locally on tick

Local services

17. Local services

17.1 What the individual services deliver.

17.2 Current service configurations e.g. how child and adult services work together (or otherwise).

17.3 Changes in service demand (numbers presenting/range of needs presented).

17.4 Changes in the way services are delivered or configured.

Gender differences

18. Gender differences.

18.1 In service need and service response.

18.2 In patterns of alcohol consumption.

18.3 Implications for children/young people e.g. if mother is the parent with care who has the alcohol issue (links back to children in care).

Young people's alcohol consumption

19. Young people's own alcohol consumption.

19.1 Increased (volume/units/strength).

19.2 Decreased (volume/units/strength).

19.3 Alcohol and drug use (substitution or poly use).

19.4 Reasons for consumption (e.g. confidence, peer pressure, enjoyment etc).

19.5 Harms experienced by young people (e.g. put at risk of harm, vulnerable situations).

19.6 Shifting choices in alcohol types due to trends (e.g. Dragon Soop, MD 20/20, include marketing of products for YP).

19.7 Sources of alcohol (young people) – where/how obtained.

Drugs

20. Drugs.

20.1 Diazepam/street Valium/street blues.

20.2 Distribution of drugs.

20.3 Other drugs/other issues relating to drugs.

Miscellaneous

21. Miscellaneous issues.

22. Interview blurb.

References

- ¹ Changing Scotland's Relationship with Alcohol: A Framework for Action. Edinburgh: Scottish Government; 2009.
- ² Alcohol (Minimum Pricing) (Scotland) Act 2012 (asp 4) [cited 2018 Oct 10] Available online: www.legislation.gov.uk/asp/2012/4/contents/enacted
- ³ United Kingdom Supreme Court (UKSC 76) Scotch Whisky Association and others (Appellants) v The Lord Advocate and another (Respondents) (Scotland); 2017. Available online: www.supremecourt.uk/cases/docs/uksc-2017-0025-judgment.pdf
- ⁴ Scottish Parliament (2005) Licensing (Scotland) Act 2005, Edinburgh. Available online: www.legislation.gov.uk/asp/2005/16/contents
- ⁵ Protocol for the evaluation of Minimum Unit Pricing for alcohol. Edinburgh: NHS Health Scotland; 2019. Available online: www.healthscotland.scot/media/2581/protocol-for-the-evaluation-of-minimum-unit-pricing-for-alcohol_english_june2019.pdf
- ⁶ Minimum Unit Pricing in Scotland A qualitative study of children and young people's own drinking and related behaviour. Edinburgh: Iconic Consulting; 2020. Available online: www.healthscotland.scot/publications/minimum-unit-pricing-mup-for-alcohol-evaluation-children-and-young-people-own-drinking-and-related-behaviour
- ⁷ Children's Social Work Statistics Scotland 2017–2018. Edinburgh: Scottish Government; 2019. Available online: www.gov.scot/publications/childrens-social-work-statistics-2017-2018/
- ⁸ Gell L, Ally A, Buykx P et al. Alcohol's harms to others. Sheffield: ScHARR, University of Sheffield & Institute of Alcohol Studies; 2015.

⁹ Children and young people exposed prenatally to alcohol. Edinburgh: Scottish Intercollegiate Guideline Network; 2019. Available online: www.sign.ac.uk/sign-156-children-and-young-people-exposed-prenatally-to-alcohol.html

¹⁰ Bancroft A, Wilson S, Cunningham-Burley S et al. The effect of parental substance abuse on young people. York: Joseph Rowntree Foundation; 2004. Available at: www.jrf.org.uk/report/effect-parental-substance-abuse-young-people

¹¹ ‘Polishing the Diamonds’. Addressing Adverse Childhood Experiences in Scotland. Edinburgh: Scottish Public Health Network; 2016. Available at: www.scotphn.net/projects/adverse-childhood-experiences/introduction/

¹² Berg L, Back K, Vinnerljung B and Hjern A. Parental alcohol-related disorders and school performance in 16-year-olds-a Swedish national cohort study. *Addiction* 2016; 111(10):1795–803.

¹³ Kaplan LM, Nayak MB, Greenfield TK and Karriker-Jaffe KJ. Alcohol’s harm to children: Findings from the 2015 US National Alcohol’s Harm to Others Survey. *Journal of Pediatrics* May 2017; 184: 186–192.

¹⁴ Everyone has a story. Component 4. What the evidence tells us. Edinburgh: Corra Foundation; 2016. Available at: www.corra.scot/everyone-has-a-story-project/

¹⁵ Rossow I, Felix L, Keating P and McCambridge J. Parental drinking and adverse outcomes in children: A scoping review of cohort studies. *Drug and Alcohol Review* 2016, 35(4): 397–405. <http://doi.org/10.1111/dar.12319>

¹⁶ Velleman R. Children, young people and alcohol: how they learn and how to prevent excessive use. York: Joseph Rowntree Foundation; 2009. Available online: www.jrf.org.uk/report/children-young-people-and-alcohol-how-they-learn-and-how-prevent-excessive-use

¹⁷ Park S and Schepp K. A systematic review of research on children of alcoholics: Their inherent resilience and vulnerability. *Journal of Child and Family Studies* 2015; 24: 1222–1231.

¹⁸ Getting it Right for Every Child. Edinburgh: Scottish Government; 2012. Available online: www.gov.scot/policies/girfec/

¹⁹ Children's Hearings (Scotland) Act 2011 (asp1). Available online: www.legislation.gov.uk/asp/2011/1/contents

²⁰ Children and Young People (Scotland) Act 2014 (asp 8). Available online: www.legislation.gov.uk/asp/2014/8/contents/enacted

²¹ Child Poverty (Scotland) Act (2017) (asp 6). Available online: www.legislation.gov.uk/asp/2017/6/notes/contents

²² Getting our priorities right: good practice guidance. Edinburgh: Scottish Government; 2013. Available online: www.gov.scot/publications/getting-priorities-right/

²³ Rights, respect and recovery: alcohol and drug treatment strategy, Edinburgh: Scottish Government; 2018. Available online: www.gov.scot/publications/rights-respect-recovery/

²⁴ Alcohol Framework 2018: Preventing Harm. Edinburgh: Scottish Government; 2018. Available online: www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/

²⁵ Jones L and Sumnall H. Understanding the relationship between poverty and alcohol misuse. Liverpool: Centre for Public Health, Liverpool John Moores University; 2016.

²⁶ Katikireddi SV, Whitley E, Lewsey J et al. Socioeconomic status as an effect modifier of alcohol consumption and harm: an analysis of linked cohort data. *Lancet Public Health* 2017; 2(6): e267–e276.

-
- ²⁷ Joseph Rowntree Foundation. What is poverty? Available at: www.jrf.org.uk/our-work/what-is-poverty (Accessed 11 November 2019.)
- ²⁸ Ritchie J, Lewis J, McNaughton-Nicholls C and Ormiston R (eds). Qualitative Research Practice. Second Edition. London: Sage Publishing; 2014.
- ²⁹ Jordan J, Power J and O'Hagan M-T. Using focus groups to research sensitive issues: insights from group interviews on nursing in the Northern Ireland 'Troubles'. International Journal of Qualitative Methods, Dec 2007;6(4):1–19.
- ³⁰ Wellings K, Branigan P and Mitchell P. Culture, Discomfort, discord and discontinuity as data: using focus groups to research sensitive topics. Health and Sexuality 2000; 2(3): 255–267.
- ³¹ Best D and Laudet A. The potential of recovery capital. London: RSA project; 2010.
- ³² Gale NK, Heath G, Cameron E et al. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Medical Research Methodology 2013; 13:117. Available at www.biomedcentral.com/1471-2288/13/117
- ³³ Lambert S and Loiselle C. Combining individual interviews and focus groups to enhance data richness. Journal of Advanced Nursing 2008; 62(2): 228–37.
- ³⁴ Neale J and West R. Guidance for reporting qualitative manuscripts. Addiction 2015; 110: 549–550.
- ³⁵ MUP Study Protocol. Edinburgh: NHS Health Scotland; 2019. Available online: www.healthscotland.scot/media/2581/protocol-for-the-evaluation-of-minimum-unit-pricing-for-alcohol_english_june2019.pdf

³⁶ Cheetham M, Moffatt S, Addison M et al. Impact of Universal Credit in North East England: A qualitative study of claimants and support staff. *BMJ Open* 2019; 9:e029611. doi: 10.1136/bmjopen-2019-029611(*)

³⁷ McKechnie K. Early Warning System report on Universal Credit and childcare. CPAG Scotland Early Warning System, 2019.
<https://cpag.org.uk/policy-and-campaigns/report/early-warning-system-report-universal-credit-and-childcare-costs> (*)

³⁸ Social Security Support for Housing. SP Paper 550, 7th Report, 2019 (Session 5). Edinburgh: Scottish Parliament Social Security Committee; 2019.
<https://sp-bpr-en-prod-cdnep.azureedge.net/published/SSC/2019/6/12/Social-Security-Support-for-Housing/SSCS52019R07.pdf>

39 Wright S, Dwyer P, Jones K et al. Final findings: Universal Credit. Project Report. York: Welfare Conditionality; 2018. Available online:
<http://eprints.gla.ac.uk/166339/>

www.healthscotland.scot/MUPevaluation

 @MESAS_NHS