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Research into the potential for substance switching following the introduction of minimum pricing for alcohol in Wales

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Research into the potential for substance switching following the introduction of minimum pricing for alcohol in Wales

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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Glossary

Acronym/Key word	Definition
*There are several acronyms that are used within single paragraphs/passages – but nowhere else in the report. They have a specificity to the point made and are not general to the whole. These are not listed here but are each given a full title at the first time of use.	
APB	Area Planning Boards
APOSM	Advisory Panel on Substance Misuse
HMPPS	Her Majesty’s Prisons and Probation Service
MPA	Minimum Pricing for Alcohol
MUP	Minimum Unit Price/Pricing – the often-used shorthand for the Scottish Policy implementation
NBA	Non-Beverage Alcohol (i.e. mouthwash, aftershave, hand sanitisers)
NHS	National Health Service
NPS	Novel Psychoactive Substances (see also ‘Spice’)
PAG	Project Advisory Group
OTC	‘Over-The-Counter’ Medication
REA	Rapid Evidence Assessment
RTD	Spirit-based ‘Ready-To-Drink’ beverages
SARG	Sheffield Alcohol Research Group
Spice	Common name for particular type/s of Novel Psychoactive Substances (i.e. synthetic cannabinoids)

1. Introduction

- 1.1 This report presents the results of a study investigating the potential consequences of introducing a minimum price for alcohol in Wales with a focus on the possibility of 'substance switching'. The study was conducted by a consortium of researchers from Figure 8 Consultancy, the University of South Wales and Glyndŵr University.
- 1.2 The research gathered the views and opinions of both service providers and drinkers using a combination of qualitative interviews and online survey questionnaires (see Sections 1.7-1.10 'Language' and Chapter 5 for further detail on the use of these labels/descriptors).
- 1.3 In relation to service providers, the key objectives of the study were to explore:
- their awareness and understanding of the Public Health (Minimum Price for Alcohol) (Wales) Act 2018 legislation (from now on referred to as MPA legislation);
 - the approaches that might be used to help people prepare for the introduction of a minimum price for alcohol;
 - their perceptions of the likelihood of people switching substances; and
 - their thoughts on what additional support materials or guidance might be required.
- 1.4 In relation to drinkers, the research objectives were similar to those for the providers but also included some additional issues relevant to substance switching. The objectives for drinkers were therefore to explore:
- their awareness and understanding of the MPA legislation;
 - their perceptions of the incoming legislation;
 - how they will prepare for the change in the legislation;
 - their existing use of alternative substances;
 - whether they would be likely to switch to another substance and if so, to what and if not, why not;
 - whether they would use any strategies to cope with the change in price; and
 - what support they may require to prepare for the change.

Structure of the report

1.5 The report is divided into four key parts:

- The first provides contextual information and an overview of the research methods.
- The second presents the results of the study and is structured around five key themes.
- The third summarises the results and includes a series of recommendations.
- The fourth part is the **Annexes**, which include a series of tables and other documents relevant to the study.

1.6 The content of the individual chapters can be summarised as follows:

Chapter 2 puts the research in context looking at what minimum pricing for alcohol is in practice and where in the world it already operates. The chapter also reviews why Welsh Government has introduced a minimum price for alcohol and tracks the development of the legislation over time.

Chapter 3 presents the results of a Rapid Evidence Assessment (REA) of studies investigating any substitution/switching effects and the related coping strategies of individuals resulting from increased alcohol prices.

Chapter 4 describes the methods used in our data collection, including justifications for the choice of research tools and how in practice we gathered the data and conducted the analyses.

Chapter 5 provides a summary of the characteristics of the providers and drinkers who took part in the research, including details for the online survey as well as interviews.

Chapters 6 to 10 are the findings chapters.

Chapter 6 focuses on the possibility of drinkers switching substances because of a minimum price for alcohol being introduced. It draws on the survey and interview data to examine the likelihood of switching and the nature of any switching behaviour.

Chapter 7 draws on the survey and interview data to examine providers' and drinkers' awareness, understanding and attitudes towards the introduction of a minimum price for alcohol in Wales.

Chapter 8 examines the potential impact of minimum pricing for alcohol on drinking-related behaviours from the perspective of drinkers and providers. It considers what providers and drinkers think may happen in relation to the type of alcohol consumed, the funding arrangements, purchasing patterns and the context in which alcohol is used.

Chapter 9 considers the potential consequences of a minimum price for alcohol on other aspects of drinkers' lives. It examines providers' and drinkers' thoughts on whether and how the change in legislation will impact on drinkers' financial circumstances, health, living arrangements, relationships with family and friends, employment and offending behaviour.

Chapter 10 moves on to focus on preparation, planning and support issues. The chapter examines the work currently underway to help drinkers cope with the new legislation and reflects on what providers and drinkers think should be done in preparation for the change in price.

Chapter 11 provides a summary of the key findings and includes a list of recommendations that might be helpful to Welsh Government and support services in the period prior to and shortly after implementation of the new legislation.

Language (labels and descriptors)

- 1.7 For clarity, the research team have chosen to adopt two labels/descriptors: 'drinkers' and '(service) providers'. Detailed characteristics of these groups, for both survey and interview samples, are provided in **Chapter 5**.
- 1.8 Within the report, additional and nuanced terms are used to reflect the specifics of delineated sub-populations within these overall groups.
- 1.9 In relation to the term 'drinkers', the report acknowledges two broad types: (a) 'drinker' – referring to those in the general population whose use is categorised as moderate, hazardous or harmful, but who are not currently engaged in treatment/services; and (b) 'service user' – referring to dependent, harmful or hazardous drinkers, who are currently engaged with services.
- 1.10 In relation to the term '(service) providers', as can be seen through Chapter 5, the research team capture and refer to both specialist alcohol/drug services (e.g. Her Majesty's Prisons and Probation Service (HMPPS), third sector), and those who work regularly with alcohol and/or drug use (e.g. criminal justice, housing).

2. Background and context

2.1 This chapter sets the context for the report by looking briefly at what minimum pricing for alcohol is in practice and where in the world it exists. This is then further expanded upon within the literature review in Chapter 3. The chapter also reviews why Welsh Government opted to introduce an MPA and tracks the development of the legislation from its inception to the current time.

Why introduce a minimum price for alcohol in Wales?

2.2 Levels of alcohol-related harm and hazardous and harmful drinking remain an issue in Wales despite Welsh Government implementing a range of activities that are consistent with its current substance misuse strategy (Livingston et al, 2018). There is strong international academic evidence that increasing the price of alcohol is one of the most effective ways of controlling levels of alcohol consumption and reducing alcohol-related harm (Nelson et al, 2013b; Wagenaar, 2009). However, up until recently, pricing as a key element has been missing from the Welsh Government's approach to reducing alcohol-related harm.

2.3 In 2014, the Welsh Government commissioned the then expert Advisory Panel on Substance Misuse (APOSUM) and a group of researchers from the Sheffield Alcohol Research Group (SARG) at the University of Sheffield to explore the potential impact of a range of alcohol pricing policies as a means of reducing alcohol-related harms.

2.4 The separate analyses conducted by these two sets of experts concluded that the introduction of a minimum unit pricing policy for alcohol in Wales was one of the most effective mechanisms through which alcohol-related harm can be addressed. This was then reinforced in 2015, by the Health and Social Care Committee (National Assembly of Wales, 2015).

2.5 The SARG modelled a number of different minimum prices from 35-70p per unit (Meng et al, 2014), and this was subsequently revised in 2018 (Angus et al, 2018). Whilst a range of prices and modelling was presented, a focus on 50p per unit was given, as this remained the dominant level being discussed at the time and was subsequently introduced in Scotland. Reduction in consumption is proportionate to the price, i.e. the higher the minimum price the greater the reduction in consumption. The modelling suggested that reductions in a range of alcohol-related harms would follow any given reduction in consumption including those of:

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

2.6 In introducing the Public Health (Minimum Price for Alcohol) (Wales) Bill, the Welsh Government were clear in signalling the overall intent of the bill as a whole population measure rather than one targeting any specific sub-group (e.g. dependent drinkers)¹. The Explanatory Memorandum for the Bill states the following:

‘The ultimate objective of the Bill is to tackle alcohol-related harm, including alcohol-attributable hospital admissions and alcohol-related deaths in Wales, by reducing alcohol consumption in hazardous and harmful drinkers². In particular, the Bill is targeted at protecting the health of hazardous and harmful drinkers (including young people) who tend to consume greater quantities of low-cost and high-alcohol content products.’

Minimum pricing for alcohol in other countries

2.7 In some form or another, minimum pricing for alcohol policies are already in place in a few countries around the world, such as:

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

2.8 The Canadian and Australian policies are quite similar to the minimum pricing policy based on a price per unit proposed by the Welsh Government and notably adopted as a first whole national policy by the Scottish Government in 2018. A similar minimum pricing for alcohol policy to the one proposed by the Welsh Government is now in place in Scotland (commonly referred to as MUP). On 15th November 2017, following a five-year legal case with industry representatives, the UK Supreme

¹ This was made clear in the discussions at the [Finance committee on 7 December 2017](#) (and paras 54 – 62 discuss dependent drinkers).

² While dependent drinkers are likely to be ‘harmful’ drinkers, not all harmful drinkers are dependent drinkers.

Court confirmed that the legislation which allows Minimum Unit Pricing to be introduced in Scotland is lawful. Following a two-month consultation, a minimum unit price (MUP) of 50p was implemented in Scotland on 1st of May 2018.

- 2.9 Other models of minimum pricing for alcohol listed above are quite different. For example, Uzbekistan prohibits below-cost selling (selling for a price less than the production cost)³. This was also adopted by the UK Government, coming into effect in England and Wales on 28th May 2014 (Home Office 2017). Belarus, Russia, Ukraine and Moldova have different levels of minimum pricing depending on the type of alcohol (i.e. beer, wine, spirits)^{4,5}. It is important to note that there are no official evaluations of these policies currently available to the public.⁶
- 2.10 Perhaps the most detailed account of the context, rationale, process and intention for the Welsh Government Public Health (Minimum Pricing for Alcohol) (Wales) Bill can be found in the (June) 2018 update of the Explanatory Memorandum incorporating the Regulatory Impact Assessment and Explanatory Notes (Welsh Government, 2018). This includes exploration of purpose and background to the Bill, price and tax models across the world, proposed impact at different prices and other related discussions.

History of minimum pricing for alcohol in Wales

- 2.11 A minimum pricing for alcohol policy is not a tax. The Public Health (Minimum Price for Alcohol) (Wales) Act 2018 sets out a formula for calculating the applicable minimum price for alcohol – based on the minimum unit price (the MUP), the percentage strength of the alcohol, and its volume. Importantly, the subsequent revenue goes to the drink's producers and retailers, not the Government. The Welsh Government has actively considered whether its objectives regarding reducing alcohol-related harm could be achieved by raising the level of tax on alcohol (Welsh Government, 2018). However, partly due to the limitations of the National Assembly for Wales to pass legislation on taxation and partly due to the fact that evidence (APOSIM, 2014) suggested that taxation alone would not target hazardous and harmful drinking in the same way – and as effectively – as minimum

³ [World Health Organisation](#)

⁴ [Ministry of Finance of Ukraine](#)

⁵ [Republic of Moldova Parliament](#)

⁶ Although it should be noted that post-implementation evaluation on the Scottish MUP is beginning to materialise into the public domain. Further information: [Monitoring and Evaluating Scotland's Alcohol Strategy \(MESAS\)](#)

pricing, the Welsh Government opted for the latter. Minimum pricing for alcohol is also the strongest indicator for reductions in overall population consumption.

- 2.12 A consultation on a draft Public Health (Minimum Price for Alcohol) (Wales) Bill followed in 2015, which found considerable support for the introduction of a minimum price for alcohol. Most stakeholders recognised the crucial impact it would have on reducing existing levels of hazardous and harmful drinking in Wales and the associated health gains and impact on health inequalities this would bring.
- 2.13 The Public Health (Minimum Price for Alcohol) (Wales) Bill was introduced to the National Assembly for Wales on 23rd October 2017. It included provisions to introduce a minimum price for the sale and supply of alcohol in Wales and to make it an offence for alcohol to be sold or supplied below that price. In the Welsh Government's view, while the Bill's objective was to tackle alcohol-related harm, including alcohol-attributable hospital admissions and alcohol-related deaths in Wales, and an effective epidemiological approach at health protection, it was also likely to target those hazardous and harmful drinkers who tend to consume greater amounts of low-cost and high-alcohol content products.
- 2.14 During the scrutiny stages of the Bill, concerns were raised by Assembly Members⁷ and other stakeholders, about possible unintended consequences arising from the legislation, including the possibility of hazardous and harmful drinkers switching to other substances. However, evidence of the extent of such behaviour is scarce as there is little, and contradictory, published research available on this matter (Falkner et al, 2015; Keatley et al, 2016; Stockwell, 2017).
- 2.15 In March 2018, the Health Social Care and Sport Committee published their stage 1 report on the Public Health (Minimum Price for Alcohol) (Wales) Bill and included a recommendation to undertake research into this issue. In response, Welsh Government accepted this recommendation and issued an Invitation to Tender for research into users switching substances (C086/2018/2019) and the contract was awarded to a consortium of researchers from Figure 8 Consultancy, the University of South Wales and Glyndwr University.

⁷ [Health, Social Care and Sport Committee 23/11/2017](#)

2.16 While the new legislation is based on a whole population approach to tackling alcohol-related harm, the research was commissioned to focus on the attitudes and perceptions of those either receiving or delivering support for alcohol-related problems. The findings presented in this report must therefore be considered in this context.

3. Literature Review

Key messages

- All studies found evidence that increased alcohol prices led to decreases in alcohol consumption among their sample, and there was some evidence of substitution and/or switching occurring as a direct result of these price increases.
- All studies reported that harmful coping strategies were rarely deployed among this population when alcohol became less affordable.
- Studies suggested that individuals with previous histories of illicit drug use might be at a higher risk of substituting alcohol with illegal drugs as a result of an increase in the MUP, compared with those who do not have such past experiences.
- Any unintended consequences of the increased price legislation would likely be short term and could be counterbalanced by the introduction of preventative and anticipatory approaches among health and social care providers.
- Given the limited number of studies identified in this review, there is a need to conduct ongoing research on this topic before confirming the existence of substitution and/or switching as a result of increased alcohol prices.
- This review found only a small amount of tentative evidence to suggest that substitution or switching to more harmful substances (either licit or illicit) will occur because of increased alcohol prices.

3.1 The impact of increased alcohol prices (including taxation and minimum unit pricing) on reductions in alcohol consumption is well established, as evidenced in empirical literature (Robinson et al, 2014; Stockwell, 2012a; Stockwell, 2012c), meta-analyses (Wagenaar et al, 2009) and systematic reviews (Elder et al, 2010; Fogarty, 2010; Nelson, 2013a; Sharma et al, 2017). However, little is known about the full impact of any taxation or pricing policy, including any effects on alcohol/illicit substance substitution or switching which may occur as a direct consequence (Araya & Paraje, 2018; Sharma et al, 2017)⁸, and the coping strategies of individuals in response to less affordable alcohol (Erickson et al, 2018).

⁸ Also known as 'cross price elasticity of demand'.

- 3.2 There are suggestions that alcohol drinkers with a history of illicit drug abuse or dependence are more likely to substitute alcohol for an illegal drug when the price of alcohol increases. However, little is known about the role of dependency in the likelihood of someone switching from one substance to another in circumstances of price changes.
- 3.3 In this chapter we present the results of a rapid evidence assessment (REA) that reviews the available evidence of any substitution/switching effects and the related coping strategies of individuals resulting from increased alcohol prices. The chapter also considers the importance of previous diagnosis of substance abuse or dependence for the substitution behaviour and how the length and degree of dependence to a substance might influence someone's decision to substitute.

Methods

- 3.4 Literature sources were identified through searches in two bibliographic databases: Applied Social Sciences Index and Abstracts (ASSIA) and Web of Science. These databases were known to include studies on alcohol and psycho-active substance 'switching'. A range of Boolean searches were conducted to identify relevant literature relating to (1) alcohol and switching with reference to price, and (2) alcohol and switching in general.
- 3.5 To reduce selection bias, a range of searches were conducted using the following search algorithms⁹:
- (alcohol) AND (switch* OR substit* OR complement*)¹⁰
 - (alcohol) AND (switch* OR substit* OR complement*) AND (pric*)
 - (alcohol) AND (switch* OR substit* OR complement*) AND (pric*) AND (drug*)¹¹
- 3.6 Results up to 12th December 2018 were downloaded and saved in Endnote referencing software. The items were then screened, and duplicates removed. The abstracts of the remaining articles were then read and discussed by two members of the research team to determine their relevance to the aims of the review. Studies that clearly did not meet the inclusion criteria were removed. In any cases of dispute

⁹ Searches were specifically tailored to each database and the field tags used within them. For each example, ASSIA provides a function which allows for abstracts to be screened, while Web of Science only allows for topics to be screened. Hence, abstracts were searched in ASSIA and topics in Web of Science. Searching by title was inappropriate in both databases as it significantly reduced the number of returns.

¹⁰ Search performed only in ASSIA as the algorithm returned a large number of unsuitable items for screening within Web of Science (n=55,713). This is due to Web of Science covering a range of scientific fields.

¹¹ Search performed only in Web of Science as the algorithm returned only a small number of returns in ASSIA (n=17), all of which were duplicates of items returned in search number 2.

regarding the relevance of a study to the aims of the review, both researchers discussed the article until a consensus to include or exclude the study was reached.

Inclusion criteria

- 3.7 The initial criteria for inclusion was purposely narrow and included any studies with a focus on switching from alcohol to either another form of alcohol or another psycho-active substance as a result of price changes (including MUP/MPA). A second, broader search criteria was then applied which included any studies with a focus on switching from alcohol to either another form of alcohol or another psycho-active substance. The reasoning for this two-stage approach was due to: (1) minimal research on switching from alcohol as a result of price changes existing (as found in our initial search), and (2) our intention to explore and apply theoretical insights from switching in other areas (for example, psycho-active substances, where there is a more established body of literature) in our research. Studies must have been accessible to the research team during the data gathering period and published in English.

Results

- 3.8 The initial search of databases yielded a total of 794 studies: ASSIA (n=552) and Web of Science (n=246). Following the removal of duplicates (n=264), a total of 530 unique studies were analysed for relevance. The abstracts of these studies were reviewed and those publications that appeared to match the eligibility criteria were obtained. This led to a provisional selection of 106 studies that were considered potentially suitable.
- 3.9 The publications obtained were then examined to determine their relevance to the review. Three studies were then excluded for being a duplication (n=1), not relevant (n=1) and not published in English (n=1), leaving a total of 103 potentially relevant studies. These were then assessed for eligibility, resulting in seven being inaccessible and 73 being deemed not relevant, leaving a sample of 23 relevant studies.
- 3.10 A PRISMA flow chart detailing the search process is presented in Annex A.
- 3.11 This REA is structured into six main sections:
- The first section provides an overview of identified literature relating to switching and/or substitution because of alcohol pricing policy.

- The second summarises literature relating to the coping strategies of drinkers in response to unaffordable alcohol.
- The third section is a presentation of those studies that discuss the importance of previous diagnosis of substance abuse or dependence for substitution behaviour.
- The fourth summarises findings of studies which looked at how the length and degree of dependence to a substance might influence someone's decision to substitute.
- The penultimate part of the REA presents the literature that exemplifies types of substitution behaviour.
- The review concludes with a discussion of the key themes identified from the literature search.

Summary of studies

3.12 Ten studies were found that examined the relationship between increased alcohol prices and alcohol consumption and associated switching/substitution, including the coping strategies of individuals in response to unaffordable alcohol. The characteristics of those studies are summarised in Table 3.1 below:

Table 3.1: Characteristics of studies examining relationship between increased alcohol prices and alcohol consumption and associated switching/substitution

Study Author (s)	Country	Study design
Black et al (2011)	Scotland	Cross-sectional study
Chaiyasong et al (2011)	Thailand	Before-and-after study
Doran and DiGiusto (2011)	Australia	Before-and-after study
Erickson et al (2018)	Canada	Cross-sectional study
Falkner et al (2015)	New Zealand	Cross-sectional study
Hobday et al (2016)	Australia	Cross-sectional study
Jiang & Livingston (2015)	Australia	Time-series analysis
Muller et al (2010)	Germany	Cross-sectional study
O'May et al (2016)	Scotland	Cross-sectional study
Stockwell et al (2012)	Canada	Commentary reiterating findings from an unobtainable thesis

3.13 Thirteen further eligible studies were identified that investigated the relationship between price increases and substance use behaviour, including the importance of previous diagnosis of substance abuse or dependence for the substitution behaviour and how the length and degree of dependence to a substance might

influence someone's decision to substitute. The characteristics of those studies are summarised in Table 3.2 below:

Table 3.2: Characteristics of studies examining relationship between increased alcohol prices and alcohol consumption and associated switching/substitution

Study Author (s)	Country	Focus of study
Chandra and Chandra (2015)	India	Actual price increases and actual changes in behaviour
Chikritzhs et al (2009)	Australia	Actual price increases and actual changes in behaviour
Clements (2004)	Australia	Actual price increases and actual changes in behaviour
Csak et al (2013)	Hungary	Actual price increases and actual changes in behaviour
Degenhardt et al (2005c)	Australia	Actual price increases and actual changes in behaviour
DiNardo and Lemieux (2001)	United States	Actual price increases and actual changes in behaviour
Hall and Chikritzhs (2010)	Australia	Actual price increases and actual changes in behaviour
Jofre-Bonet and Petry (2008)	United States	Hypothetical purchasing tasks
Miller and Droste (2013)	Australia	Actual price increases and actual changes in behaviour
Peters and Hughes (2010)	United States	Actual price increases and actual changes in behaviour
Peters et al (2017)	United States	Hypothetical purchasing tasks
Petry and Bickel (1998)	United States	Hypothetical purchasing tasks
Subbaraman (2016)	Various	Review of the literature

Impact of price on alcohol consumption and substitution/switching among general population

3.14 Five of the ten studies (see Table 3.1 above) examined the impact of price increases on alcohol consumption and associated substitution/switching among the general population (Chaiyasong et al, 2011; Doran & DiGiusto, 2011; Hobday et al, 2016; Jiang & Livingston, 2015; Muller et al, 2010). All found evidence that increased alcohol prices led to decreases in alcohol consumption among their sample, and there was some evidence of substitution/switching occurring as a direct result of these price increases. However, the extent of this varied across studies

and was found to be dependent on a number of factors, including the type of beverage subject to the price increase, and the population comprising the study sample.

- 3.15 For example, a before-and-after study of increased taxation on spirit-based ready-to-drink beverages (RTDs) in Australia found that consumption of RTDs dropped whilst consumption of other alcoholic beverages increased at the general population level following the introduction of the tax (Doran & DiGiusto, 2011). However, although the increased consumption of other alcoholic beverages could be interpreted as indicating that RTD drinkers switched to purchasing spirit or wine-based RTDs or cider, the authors suggested that this could be due to a continuation of underlying trends within the general population rather than a substitution effect. These trends included: increased consumer price sensitivity due to the global financial crisis, general population preferences away from beer and spirits towards other beverages, and consumer responses to adaptive alcohol marketing and national binge drinking strategies occurring at the time of research. As such, the study concluded it was not possible to know if substitution occurred directly because of the tax.
- 3.16 These findings are not dissimilar to those of a cross-sectional study of the association between an alcopop tax and alcohol consumption among adolescents in Germany (Muller et al, 2010). The study found that whilst alcopop consumption declined after the alcopops tax was implemented, consumption of spirits among adolescents increased. The authors concluded that the tax resulted in a partial substitution of alcopops by spirits and a switch in preference to beverages associated with riskier drinking patterns. However, similar to the study of Doran and DiGiusto (2011), the authors make reference to how the observed changes in alcohol (especially alcopop) consumption may not be due only to the alcopops tax but may also reflect general cultural and social changes associated with shifts in alcohol preference.
- 3.17 There is some indication from other data, however, that alcohol price is responsible for a considerable part of substitution effects. For example, a hypothetical study of how price increases affect alcohol purchasing found that the majority of participants were reluctant to change the type and brand of drink they usually purchase at price increases of 10 per cent (Hobday et al, 2016). Price increases of 50 per cent, however, appeared to be the threshold at which participants were willing to

substitute, with two-thirds of respondents indicating a switch to a cheaper brand or different beverage type. Significantly, after economic status was considered, those living in postcodes with a lower socio-economic status were more likely to substitute for a cheaper brand or beverage type at a 10 per cent increase in price.

- 3.18 Similarly, an annual time-series analysis of responses of alcohol consumption to changes in alcohol prices and affordability in Australia between 1974 and 2012 found that, after taking into account national average weekly earnings, a 10 per cent increase in alcohol price was associated with a two per cent per capita decrease in population level alcohol consumption the following year (Jiang & Livingston, 2015). Decreases in consumption due to increases in the price of one beverage were offset by increases in the consumption of more affordable substitutes.
- 3.19 Finally, a before-and-after study of the impacts of increased taxation on distilled spirits in Thailand found that total consumption levels of distilled spirits fell by 10.3 per cent nationally following the introduction of the tax (Chaiyasong et al., 2011). However, the net total alcohol consumption was estimated to decrease only by 2.3 per cent due to substitution effects among alcoholic beverages. Increases in beer consumption (18.5 per cent) were largely responsible for these substitution effects, a finding the authors suggest may also be due to national trends in beverage preference. National estimates for switching to illegally distilled white spirits – a concern prior to the implementation of the tax - was minimal (0.8 per cent) and only common in communities with a tradition of producing illicit alcohol. In communities without any production, shifts to illegal spirits were not found. This led the authors to conclude that switching to illicit alcohol after the taxation was introduced was not a significant issue.

Coping strategies of dependent drinkers in response to increased alcohol prices

- 3.20 Five studies focused on the responses of dependent or 'ill' (including homeless) drinkers to less affordable alcohol (Black et al, 2011; Erickson et al, 2018; Falkner et al, 2015; O'May et al, 2016; Stockwell et al, 2012)¹². All studies reported that harmful coping strategies were rarely deployed among this population when alcohol became less affordable. For example, a qualitative study of 175 alcohol-dependent and unstably housed people across five Canadian cities identified the most frequent coping strategies of this population when alcohol became less affordable (Erickson

¹² Stockwell et al (2012) is a commentary reiterating findings from an unobtainable thesis on the coping responses of homeless drinkers (Williams, 2011).

et al, 2018). Coping by re-budgeting was the most commonly reported strategy, followed by going without alcohol, waiting for money and making an existing supply last longer. The latter three strategies each involved coping by reducing alcohol consumption to some degree. Although a number of participants in the total sample did report using non-beverage alcohol, stealing from 'liquor' stores and using illicit drugs ('marijuana'), these coping strategies were found to occur at a less frequent rate.

- 3.21 These findings are supported by a cross-sectional survey of 115 dependent drinkers in New Zealand which found that stealing alcohol, or the use of non-beverage alcohol, were seldom reported as strategies used in response to unaffordable alcohol (Falkner et al, 2015). In contrast, when facing the situation of having no money for alcohol, participants reported various coping strategies including forgoing essentials (i.e. utility bills, food), borrowing alcohol and going without alcohol. There were also no reports of any intent to switch to illicitly distilled alcohols, or to steal alcohol in a cross-sectional study of 377 dependent drinkers, which examined what might happen following the implementation of MUP legislation in Scotland (Black et al, 2011).
- 3.22 Finally, one further hypothetical qualitative study of 20 heavy drinkers' perspectives on the introduction of MUP in Scotland found that some participants indicated potential reductions in alcohol intake resulting from the legislation (O'May et al, 2016). However, effects on consumption and associated harms were not fully understood. This was because many participants were unaware of MUP legislation prior to being interviewed and had not had the opportunity to plan and think about possible coping strategies. Consequently, recommendations from the study included increasing awareness of changes in legislation among this group prior to its implementation. In line with other studies, it was also suggested that some unintended consequences of the legislation (i.e. an increase in demand for health and/or social care, particularly among dependent drinkers) would likely be short term, and could be counterbalanced by the introduction of preventative and anticipatory approaches among health and social care providers (Black et al, 2011; Erickson et al, 2018; Stockwell et al, 2012).

The role of previous histories of other substance abuse/dependence

- 3.23 Miller and Droste (2013) investigated the effect of proposed alcohol price changes upon a university student sample in Australia, a demographic which has an established precedent of higher risk alcohol and drug use and a high sensitivity to economic restrictions. These authors investigated participants' potential changes in alcohol consumption patterns and the possibility of switching to other drugs. Consistent with other previous similar studies (e.g. Babor et al, 2010), participants generally indicated that in the case of an increase in the unit price for alcohol, they would likely reduce their alcohol intake rather than switch to other substances. Significantly though, as the price per drink increased, so too did the number of participants who would consider ecstasy and cannabis as viable substitutes for alcohol. Also of importance is the finding that those students who had a previous history of ecstasy and cannabis use were likely to substitute for alcohol at a 'significantly lower price' compared to those who had never used either drug (\$10 vs \$13).
- 3.24 A similar finding was reported by Peters and Hughes (2010), who studied changes in substance consumption patterns following cessation of cannabis use in the United States. The authors concluded that marijuana users with a diagnosis of past alcohol abuse or dependence substituted alcohol to a much greater degree than those without this diagnosis (52 per cent vs three per cent increase in the use of alcohol following cessation).
- 3.25 The above studies suggest that individuals with previous histories of illicit drug use might be at a higher risk of substituting alcohol with illegal drugs as a result of an increase in the MUP, compared with those who do not have such past experiences.

The role of the degree of dependence

- 3.26 Degenhardt et al (2005c) investigated the impact of a reduction in drug supply on the demand for drugs. Specifically, it documented changes in drug consumption patterns among heroin users in Australia following a severe shortage of heroin in the market. It concluded that the price elasticity of heroin differs among younger and older heroin users (also reported by Bretteville-Jansen and Sutton, 1996, and Jofre-Bonet and Petry, 2008). For the older, more entrenched heroin users, substantial increases in heroin price were not enough to reduce their use of heroin, meaning that their demand for this drug was inelastic. In contrast, heroin demand was price elastic among younger and less entrenched users, who reported that their response

to the shortage was to increase their consumption of other illicit drugs available at that time (i.e. cocaine and methamphetamine).

- 3.27 Peters et al (2017) investigated changes in consumption behaviour of cannabis and tobacco using hypothetical price increases. Consistent with the experimental studies cited above (by Bretteville-Jansen and Sutton, 1996, and Jofre-Bonet and Petry, 2008), these authors also concluded that participants who had higher nicotine dependence showed less elasticity of demand than the group with lower nicotine dependence, supporting the view that changes in price might not be sufficient to motivate decreases in consumption among substance-dependent individuals.
- 3.28 The above findings are relevant for our study on the effect of the introduction of a Minimum Price for Alcohol in Wales. Extant literature suggests that dependent and non-dependent individuals may show different elasticities of demand when price changes occur. Specifically, the reviewed studies suggest that drug substitution is less likely to occur among the most entrenched drug users, whereas less problematic users might substitute more easily (especially if the individual already used the substituent drug previously).

Examples of switching behaviour

- 3.29 Two studies (both from Australia) were identified which discussed the possibility of drinkers substituting their preferred alcoholic drink with another type of alcohol because of an increase in price. Hall and Chikritzhs (2010) and Chikritzhs et al (2009) examined the effect that the introduction of the alcopops tax in Australia had on drinkers' alcohol consumption patterns (either substitution or reduction in the overall amount of alcohol consumed). Both these studies identified a substitution effect in that some drinkers substituted alcopop drinks with beer and/or spirits but concluded that the extent of substitution was lower than the overall reduction in the use of alcohol.
- 3.30 Other studies examined the possibility of switching between alcohol and other illegal drugs. One such study examined the effect of raising the minimum drinking age from 18 to 21 years in the US (DiNardo and Lemieux, 2001). Results revealed that cannabis was a substitute for alcohol, such that restricting access to alcohol resulted in an increase in marijuana use among high school seniors. These authors speculated that the observed substitution was related to similarities in the physiological effects of these substances. DiNardo and Lemieux (2001) also suggested that increased societal disapproval of alcohol use played a role in the

substitution of marijuana for alcohol. Social disapproval, particularly parental and peer disapproval, is related to decreased likelihood of substance use (Kumar et al, 2002; Nash et al, 2005).

- 3.31 Another example is Clements' (2004) study, which investigated the declining levels of cannabis prices in Australia and concluded that the lower prices for marijuana have stimulated marijuana consumption and reduced alcohol consumption. As marijuana and alcohol would appear to both satisfy a similar want of the consumer, Clements (2004) suggested that they are probably substitutes in consumption.
- 3.32 A few other studies (not necessarily involving alcohol) were identified, which discussed switching between drugs in general because of changes in price. Csak et al (2013) analysed the drug consumption patterns of injecting drug users in Hungary and they observed significant changes in their participants' drug preferences. More than half the heroin users they investigated reported substituting this substance with methylene-dioxy-pyrovalerone, a new psychoactive substance classed as a stimulant. Despite having little information on participants' reasons for this change, the authors suggested that one possible explanation could be the price and availability of methylene-dioxy-pyrovalerone compared to heroin. Research that reported an increase in cocaine and methamphetamine use among former heroin users in Australia (Degenhardt et al, 2005a; 2005b; Topp et al, 2003; Roxburgh et al, 2004) gives weight to the idea that even a substance with an opposite psychopharmacological profile can serve as a substitute during periods of shortage, when the price of the preferred substance has increased.
- 3.33 These trends showing that some heroin users substituted stimulant drugs for heroin when heroin became less available have been reported in experimental studies as well. For instance, Petry and Bickel (1998) used a sample of polydrug abusers undergoing treatment for heroin addiction and asked them to explain how they would respond to hypothetical increases in the price of the drugs they were using. These participants reported that as the price for heroin rose, heroin purchases decreased and, simultaneously, Valium and cocaine (a stimulant) purchases increased (indicating that these drugs substituted for heroin).
- 3.34 Finally, in another study, Chandra and Chandra (2015) reported that the key finding of their paper was that of a substitution effect between a form of cannabis, charas (hashish) and opium, when both these substances were legal in India, at the

beginning of the 20th century. In other words, an increase in the price of charas was associated with an increase in the use of opium.

Overview of included studies

- 3.35 The five studies investigating the impact of price increases on alcohol consumption and associated substitution/switching provide evidence that increasing alcohol prices (either as a result of taxation or hypothetical price increases) result in decreases in general population alcohol consumption. These findings are generally consistent with a well-established body of literature, including systematic reviews and meta-analysis, evidencing the impact of increased prices on reductions in alcohol consumption (Elder et al, 2010; Fogarty, 2010; Sharma et al, 2017; Wagenaar et al, 2009). The five included studies in this review, however, include further exploration of related issues of switching or substitution occurring as a direct result of increases in alcohol prices.
- 3.36 All five studies provide evidence for some substitution to more affordable alcohol occurring as a result of increased alcohol prices, although only one study noted a switch in preference to beverages associated with riskier drinking patterns (Doran & DiGiusto, 2011). Similarly, a study of the impacts of increased alcohol prices on the consumption of illegally produced alcohol – a concern prior to the tax’s implementation – uncovered only minimal evidence of this occurring, with switching to more affordable alcohol (beer) largely responsible for substitution effects (Chaiyasong et al, 2011). Nevertheless, three of the studies acknowledge that confounding factors, such as trends in general population alcohol consumption, may have influenced the change in consumption patterns evidenced in their findings (Chaiyasong et al, 2011; Doran & DiGiusto, 2011; Muller et al, 2010). They therefore urge caution when drawing conclusions from their findings¹³.

As these studies did not focus on the responses of very heavy or dependent drinkers who may respond differently to general population samples, a further section featuring studies focusing on the responses of dependent drinkers to unaffordable alcohol was also included. Five studies found that when unable to afford alcohol, only a small number of potentially harmful coping responses were

¹³ These studies are limited further by their focus on the taxation of single beverage types (such as alcopops or spirits) rather than all beverages. Therefore, these studies were unable to determine potential responses if a cheaper brand or beverage type was not available (as would be the case with minimum pricing for alcohol). This also excludes any analysis of the potential uptake of illicit substances in response to alcohol unaffordability.

deployed among this population. Switching to substitutes, using illicitly distilled alcohols, or stealing alcohol was seldom reported among dependent drinkers in studies investigating this issue. Instead, various other coping strategies - including forgoing essentials, borrowing alcohol, making an existing supply last longer and going without alcohol - were reported as occurring at a more frequent rate. Nevertheless, other unintended consequences, particularly among dependent drinkers, were identified in some studies and the introduction of preventative and anticipatory approaches among health and social care providers were therefore recommended (O'May et al, 2011; Erickson et al, 2018)

- 3.37 In light of the reviewed evidence, we found only a small amount of tentative evidence to suggest that substitution or switching to more harmful substances (either licit or illicit) will occur as a result of increased alcohol prices. This is based on inconclusive evidence of switching occurring because of increased alcohol prices from five studies, and minimal evidence of switching occurring from five studies focusing on the responses of dependent drinkers to unaffordable alcohol. Nevertheless, there is also evidence from a few other studies that people do switch from one substance to another (not necessarily alcohol) depending on price and availability and need.
- 3.38 Given the limited number of studies identified in this review, we believe there is a need to conduct further research on this topic before confirming the existence of substitution/switching as a result of increased alcohol prices.¹⁴ Indeed, the lack of research on this topic has previously been identified by other studies in this area (Hobday et al, 2016; Sharma et al, 2017; Vandenberg & Sharma, 2016), and there have been recent calls for the further exploration of the factors associated with substitution to other substances and beverages in response to pricing policy implementation (Araya & Paraje, 2018; Hobday et al, 2016; Sharma et al, 2017). Most of the evidence on this topic is also based on studies conducted in distinct social and cultural locations, making inferences difficult to apply in the Welsh context.

¹⁴ A detailed evaluation of Minimum Price for Alcohol has been designed and commissioned by the Welsh Government for the period 2019-2024, which will add further research intelligence into the question of whether substitution and/or switching takes place as a result of increased alcohol prices.

4. Methods

4.1 In this chapter the methods that were used to conduct the primary research to explore perceptions of this issue are described. Firstly, the aims and objectives are re-stated to provide context and then the research design and strategy are discussed. Following this an explanation of the choice of each method of data collection is provided with a description of how in practice the data were gathered. The chapter also includes information about methods of data analysis.

Aims and objectives

4.2 The specification for the contract stated that the main aim of the study was to explore the extent to which switching between substances may be a consequence of the introduction of a minimum price for alcohol. More specifically, the study had eleven objectives, four focusing on individuals working as providers of services to people with alcohol problems (i.e. service providers) and seven focusing on people receiving support from those services (i.e. service users). For clarity, these objectives are listed separately below.

Service providers:

1. To explore service providers' awareness of the MPA legislation and what it means.
2. To explore with service providers the approaches they will use to help people prepare for the change in the legislation and the introduction of a minimum price for alcohol.
3. To explore service providers' perceptions of the likelihood of people switching.
4. To explore with service providers possible additional support materials or guidance that may be required.

Service users:

5. To explore service users' awareness of the MPA legislation and what it means.
6. To explore with service users how they will prepare for the change in the legislation
7. To explore with service users their existing use of alternative substances.

8. To explore with service users their perceptions of the incoming legislation.
9. To explore with service users whether they would be likely to switch to another substance and if so, to what and if not why.
10. To explore with service users any coping mechanisms that might be adopted when prices rise.
11. To explore with service users the support they may require to prepare for the change.

4.3 In short, the project aimed to investigate the perception of possible consequences of introducing a minimum price for alcohol in Wales including the potential for substance switching and other unintended consequences, and to explore ways of preventing and/or responding to those consequences.

Research design and strategy

4.4 The research design is the blueprint or masterplan for conducting a study. It is the structure or approach that describes how, when and where data are to be collected and analysed (Bryman, 2016). Considering the objectives of the project, proposed timelines for project completion and legislation implementation, along with other information provided in the Specification, the research was based on a cross-sectional design whereby data relating to MPA and substance switching were collected at a point in time (rather than monitoring change over time).

4.5 The research strategy is the general orientation to the conduct of research, in other words whether the study is quantitative or qualitative in focus (Bryman, 2016). To achieve the objectives of this research on MPA and potential substance switching, a predominantly qualitative strategy was adopted, although some quantitative data were also collected (e.g. treatment history, drug use, alcohol use and expenditure on alcohol). A principally qualitative strategy enabled data to be gathered on service providers' and service users' knowledge, understanding, perceptions and attitudes of the key issues relating to minimum pricing for alcohol and its potential consequences. A qualitative approach is particularly useful for helping researchers understand how others interpret the world and for seeing things through others' eyes (Wincup, 2017). While quantitative research has many benefits (e.g. in counting and measuring the extent of phenomena), it would have limited the extent to which issues could be explored and discussed as they emerged.

- 4.6 The Research Team had hoped to use a participatory action research design as the basis for this project. This approach usually involves close collaboration between the researchers and the research participants at each stage of the research process in order to identify, evaluate and develop solutions to address social problems together (Baum et al, 2006). Such extensive service user involvement is also consistent with Welsh Government strategies and guidance (Welsh Government, 2014). However, given the short seven-month timeframe, a fully participatory design was not feasible (Livingston and Perkins, 2018).
- 4.7 Nevertheless, work was undertaken with service users and providers to ensure that the research plans were appropriate, that data collection tools were user friendly, to help access relevant respondents and to guide interpretation of the collected data.
- 4.8 To assist with this process, a Project Advisory Group (PAG) that included relevant stakeholders was established and met at regular intervals throughout the study period¹⁵.

Methods of data collection

- 4.9 A combination of interviews and online survey questionnaires were used to enable the research objectives to be met. However, before proceeding with details of what was done, it is important to provide a brief overview of the people that were included in the research. The Specification referred to the need to capture the views of two specific groups, namely service providers and service users.
- 4.10 The term ‘service provider’ was interpreted to mean people involved in the provision or delivery of support services for harmful drinkers (predominantly alcohol alone but sometimes in combination with other drug use).
- 4.11 ‘Service users’ were therefore the people who were in receipt of these services. In other words, service users were harmful or hazardous drinkers who were engaged in some form of treatment to address their drinking (and sometimes other drug use) behaviour.
- 4.12 While these two groups provided the focus of the research, it is possible that responses to the MPA legislation may vary depending on the level of drinking and on engagement with services. It was therefore thought useful to include as many

¹⁵ Members of the PAG included representatives from: Welsh Government Substance Misuse Branch, Welsh Government Knowledge and Analytical Services, Welsh Government Homelessness Branch, Alcohol Change, Gwent Drug and Alcohol Service, and the North West Recovery Community.

types of drinker as possible when studying the potential impact of minimum pricing on substance switching. Drinkers (moderate, hazardous and harmful) who were not currently engaged in treatment were therefore also included.

4.13 The research included, to varying degrees, four groups of people:

Primary focus:

1. Service providers (i.e. people involved in the delivery of alcohol support services).
2. Service users (i.e. harmful or hazardous drinkers engaged with services).

Additional perspectives:

3. Harmful drinkers not engaged with services.
4. Other drinkers not engaged with services.

4.14 The research focused on adults aged 18 and over who were either resident in Wales or involved in the delivery of alcohol services within Wales¹⁶.

Qualitative interviews

4.15 Qualitative interviews were conducted with two groups (service providers and service users).

4.16 The main aims of the service provider interviews were to: investigate issues from the perspective of those who support harmful drinkers, examine their perceptions of potential benefits and problems resulting from minimum pricing for alcohol and explore their preparation for responding to those problems and supporting drinkers.

4.17 The main aims of the interviews with service users were to establish: the perceived likelihood of any unintended consequences resulting from minimum pricing including substance switching, the nature of any consequences, the reason for these consequences, and the kind of support that might be needed to respond to any such consequences.

¹⁶ The decision to focus on adults was made largely for pragmatic reasons linked to the short study timeframe and the complexity of obtaining consent to interview vulnerable young drinkers. We nevertheless believe that children and young people are important populations that are likely to be affected by MPA and that a separate study focusing on these groups would be a worthy endeavour.

Sampling strategy

- 4.18 Interviews were conducted with 49 service users and 38 service providers (including operational management and frontline staff)¹⁷. Three interviews with service users were done in groups.
- 4.19 Convenience sampling was used to recruit interviewees from alcohol services operating across the seven Area Planning Board (APB) areas of Wales. Conducting the research across Wales meant that a voice could be given to people living in a wide variety of area types ranging from urban major conurbations to rural villages in sparse settings, thus making the research relevant to people living (and working) in the full range of area types.
- 4.20 The convenience approach was augmented with some purposeful sampling to ensure that a diversity of; sex, age range, geographical location (including areas close to the borders), drinking types and drug use profiles was captured.
- 4.21 Given the varied objectives of the study, capturing a diverse range of individuals was important. It enabled variations in potential responses to minimum pricing to be examined and both risk and protective factors that might respectively increase or decrease the likelihood of switching and other unintended consequences to be identified.
- 4.22 Interviewees were recruited with the kind help of staff based in several third-sector organisations that provide support to people with alcohol problems in Wales (e.g. Barod, Kaleidoscope).
- 4.23 Ethical approval for the project was obtained from the University of South Wales, Faculty of Business and Society's Research Committee as well as from Her Majesty's Prisons and Probation Service (HMPPS)¹⁸.
- 4.24 Securing HMPPS approval enabled service users under criminal justice supervision to be included within the sample. This decision was based on the understanding that alcohol-using offenders may have greater opportunities to engage in, and have

¹⁷ Further details of the sample's characteristics can be found in Chapter 5. Interviews were also conducted with two Welsh Government employees with responsibility for substance misuse policy whose views have been used to provide additional contextual information about the study. These two interviews have not been included in the sample totals.

¹⁸ Given the short study period, we have ruled out obtaining NHS ethical approval. In our experience (and that of our colleagues) obtaining REC and R&D approval for seven Health Board areas and completing research activities is not feasible within a seven-month period.

a predisposition towards, substance switching due to their criminal lifestyles and access to illegal substances (Bennett and Holloway, 2009).

- 4.25 Using existing networks of contacts within these organisations a variety of strategies to recruit interviewees was deployed. As expected, service providers were the most straightforward to access and their recruitment was done through email invitations distributed on our behalf by APB co-ordinators, service managers and through follow-up phone calls. Service users are often difficult to recruit into research projects and, at least to begin with, this project was no different. However, with the assistance of service managers and key workers, who spread the word about the project, a large sample of service users was recruited for interview.
- 4.26 Previous experience suggested that qualitative research recruitment often benefits from snowballing and cascading strategies (especially when recruiting for additional perspectives such as non-service users). The invitation to participate in an interview was therefore also distributed electronically through the research team's network of contacts in the field. It was also set as an option within the surveys, with information on how to make contact if they wished to take part in an interview. All contacts were encouraged to disseminate the invitation widely.
- 4.27 In addition to the formal recorded interviews, the research team was also able to gather useful insights and thoughts from a range of other individuals. This included service users who were not willing to partake in a formal interview¹⁹ and providers who were not able to allocate enough time to do so. In these cases, field notes were made after the event and shared with other members of the research team. While not included in the formal data analysis process, these notes have proved valuable and have informed the thinking and development of this report.

Design

- 4.28 The interview schedules were designed for a semi-structured interview based on themes to be covered and interviewer prompts to assist in guiding the conversation. The interviews were 'flexible but controlled' (Burgess, 1984) and based on an open rather than rigid structure, which can often regulate, subdue and structure interviewees' responses (Bryman, 2016). Separate schedules were developed for service providers and service users although common issues were explored in both.

¹⁹ In some cases, the conversations were brief and involved general 'chit-chat' about MUP/MPA with service users waiting for treatment. In other cases, the discussions were a little more formal, and in some cases involved spending up to half an hour in discussion with the informants.

An iterative approach was adopted, whereby the results of early interviews guided the structure and content of later ones.

- 4.29 The specific interview questions were derived from the research objectives set out in the specification and the current research evidence base (and gaps therein).
- 4.30 Of importance was the need to investigate the nature of any potential substance switching as well as the perceived likelihood of it occurring. Studying the nature of any switch included investigating whether people anticipated substituting alcohol entirely for another substance or whether they would complement their use of alcohol with other substances (Moore, 2010).
- 4.31 It was also important to establish whether people anticipated different kinds of switch. For example, some people may have predicted a switch from one type of alcohol to another (e.g. from wine to beer) while others may have anticipated a switch from one brand of alcohol to another. Similarly, some may have expected to switch from alcohol to other legal substances such as tobacco or prescription drugs while others may have believed they would switch from alcohol to illegal substances including illicit alcohol or illegal street drugs.
- 4.32 Other potential consequences were also investigated and included the possibility of: cross-border shopping; changes in expenditure; and acquiring additional funds through borrowing, begging or acquisitive crime.

Procedure

- 4.33 All interviews were conducted in English, except for one, which was conducted in Welsh. They took place at times and locations convenient to the interviewees. Most interviews were conducted face-to-face with just a small number of interviews (with service users and providers) being conducted by telephone.
- 4.34 Telephone interviews have a number of advantages: they are less resource intensive than face-to-face interviewing; they may also enable the respondent to feel more comfortable regarding maintaining anonymity and confidentiality; respondents are less likely to have to cancel at the last minute, and if they do, it is not such a major disruption for them or the interviewer, as it is easily rescheduled. Furthermore, for many service providers, this was sometimes the only practical way demanding work schedules allowed participation.

- 4.35 That said, face-to face in-person interviews were conducted when this was the expressed preference of the interviewee and took place in a mutually agreed location such as the premises of a service provider, where the interviewee was comfortable, and the interviewer was protected in terms of ethical governance and lone researcher safety policy.
- 4.36 Most of the interviews were conducted on a one-to-one basis. However, three group interviews were conducted with some of the service users (data examples from groups are clearly delineated as such). One-to-one interviews are useful in providing interviewees with the freedom to discuss sensitive and personal issues (Wincup, 2017). However, they can be time-consuming as well as expensive to conduct and transcribe. Group interviews are a cheaper alternative as they enable multiple voices to be captured during the same event. They are also useful in that they can sometimes help put interviewees at ease and can trigger important discussions and highlight themes that might have otherwise remained hidden. They further help individuals to formulate their own understanding through the group sharing process. The main downside of the group interview is the potential for one voice to dominate. It can also sometimes be hard for an interviewer to listen attentively to more than one interviewee at a time (Wincup, 2017). Using a combination of both individual and group interviews meant that the research team were able to offset the limitations of one approach with the strengths of the other (Bryman, 2016).
- 4.37 As mentioned above, the interviews were ‘flexible but controlled’ (Burgess, 1984), ‘conversational’ in style, and led by an open-ended structure based on questions and ‘themes’ generated by the team. The benefit of this approach was that it:
- provided a more insightful account of the interviewees’ perceptions and experiences; and
 - allowed for unexpected, often ‘unusual’ data to emerge that may not have appeared through more structured, quantitative techniques.

Such an approach was well suited to interviews with interviewees who were being asked to predict their own or others’ future actions and behaviour. The interviews lasted for an average of 30 minutes and ranged from just under 10 minutes to

nearly one hour. All interviews were digitally recorded and then transcribed expertly and securely by either Voicescrpt Ltd²⁰ or Avonlea Services Limited²¹.

Data analysis

- 4.38 The transcripts were downloaded from Voicescrpt Ltd and Avonlea Services Limited and any potentially identifying information was removed. A database of all anonymised transcripts was set up using the NVivo package for qualitative data analysis, which allows for analysis of interview data involving multiple researchers and synthesis of large datasets. A thematic analysis was conducted, and a thematic framework grounded in the data was developed and reshaped (Glaser & Strauss, 1967; Braun & Clarke, 2006). The data coding and framework were quality assured by different team members checking each other's coding and/or leading on separate coding. This process helped to ensure that the final extracted themes were not just the personal interpretation of one team member but borne out of the data.
- 4.39 In line with Neale and West's (2014) recommendation, the research team have avoided quantifying the qualitative findings except in a small number of cases where it was deemed particularly important to do so. Instead, a form of semi-quantification was adopted with a tendency to use terms such as 'a few', 'several', 'some', 'many' and 'most' in order to achieve "maximum transparency with regard to the numbers of people giving particular responses or types of response" (Neale et al, 2015).

Online survey questionnaire

- 4.40 While qualitative interviews are extremely valuable for gathering in-depth data from people, they are limited in several respects. As mentioned above, interviews are often time-consuming, and it can be expensive to transcribe lengthy recordings. As a result, sample sizes are often small, which limits the generalisability of research findings. To help address and combat these key limitations, online questionnaire surveys were used as an additional method of data collection.

Sampling strategy

- 4.41 By using online questionnaire surveys, data were gathered from a wider sample of respondents including: service providers; service users; non-service users; and also moderate and hazardous drinkers who were otherwise excluded from the research.

²⁰ [Voicescrpt](#)

²¹ [Avonlea](#)

The survey also provided interviewees with the opportunity to contribute additional, anonymous, information to the study if they so wished.

Design

- 4.42 Separate online questionnaire surveys for service providers and drinkers were developed in Online Surveys²² (formerly Bristol Online Surveys). The survey questionnaires comprised a combination of closed questions (e.g. on current alcohol and drug use) and open-ended questions (e.g. perceptions of minimum pricing for alcohol) in order to capture more nuanced data on issues of especial interest. The surveys were available in both English and Welsh.
- 4.43 The survey questionnaires were organised into sections that corresponded with the research objectives.
- 4.44 The service provider survey focused on the views of those people who work within alcohol services in Wales and included sections on: demographics, service experience, their own awareness and understanding of minimum pricing for alcohol, their own attitudes and perceptions of minimum pricing, and their perceptions of minimum pricing on substance switching.
- 4.45 The ‘drinkers’ survey focused on people who currently used alcohol either harmfully or recreationally and included sections on: demographics, alcohol use, drug use, awareness of minimum pricing, attitudes towards the policy, likelihood of drug switching, barriers to switching, how they would switch, the nature of switching and the type of support that they anticipated being needed.
- 4.46 Participation in either survey was voluntary, and the surveys were anonymous (no identifying information was requested, and no IP addresses were recorded). The survey questionnaire was designed so that respondents were able to skip questions that they did not wish to answer and exit the survey at any point if they no longer wished to participate. Respondents gave consent prior to commencing the survey and were advised that once they had clicked ‘finish’ at the end of the survey, their responses were submitted and withdrawal from the study was no longer possible.

²² [Online surveys](#)

Procedure

- 4.47 The surveys were distributed electronically to the research team's network of contacts within the field for completion and for cascading to their colleagues, to service users and to other drinkers not engaged in services. To maximise the sample size, the surveys were launched at the beginning of the data collection period. The two methods of data collection (interviews and surveys) were therefore undertaken simultaneously.
- 4.48 In practice, a link to the online 'provider' survey was sent out by email to people working in various support organisations. A link to the survey was also distributed via social media platforms (Facebook and Twitter). Using this dissemination strategy, 100 service providers were recruited to complete the survey. Most of the 'provider' respondents put considerable time and effort into their survey responses and included detailed answers to the open-ended questions. Far more qualitative data than had originally been anticipated was therefore gathered.
- 4.49 A link to the online 'drinkers' survey was distributed to people engaged in alcohol services for cascading to service users and other drinkers. A link to the survey was also distributed via the same social media platforms as the provider survey (i.e. Facebook and Twitter). Using this multi-pronged strategy of dissemination, data was gathered from 93 drinkers. Most completed the survey online but five completed hard copies (with the assistance of their support worker) and these were later entered into the online version by a member of the research team. Like the providers, many of the drinkers provided detailed responses to the questions. This resulted in a far larger dataset than had been envisaged.

Data analysis

- 4.50 The two sets of survey data were exported from Online Surveys directly into Statistical Package for the Social Sciences (SPSS). The survey responses were analysed using SPSS, Excel and Word to facilitate the analysis of the extensive amount of data collected. Online Surveys' own analysis tool was also used to support the analysis and presentation of results.
- 4.51 Closed questions that generated quantitative data were analysed using SPSS and Excel. These results are presented numerically using percentages and frequencies.

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

Summary

- 4.53 To achieve the eleven objectives outlined in the specification and other documentation, qualitative interviews with service providers and service users were conducted. Online questionnaire surveys were also used to gather further information from a wider sample of service providers and drinkers (including drinkers not engaged in services).
- 4.54 Samples (from within the community and the Criminal Justice System) were recruited using the research team's networks of contacts within the substance misuse field and with support from the Project Advisory Group.
- 4.55 The data collected were analysed using appropriate software (e.g. SPSS for the survey data and NVivo for the interview data).
- 4.56 While the chosen approach enabled the research objectives to be achieved, it is important to note that the commission and timescale of the research confined the expected study to an exploration of predictions about future behaviour. This method has the inherent limitation that the study only collected perceptions of what **might** happen, and that actual behaviour which occurs post minimum price implementation, may not follow these predictions. It could not happen, or it could be less impactful than predicted.
- 4.57 Future research investigating the impact of minimum pricing on drinking-related behaviour once it has been implemented will be needed to establish whether the predictions made are accurate.²³

²³ During the course of this study, the Welsh Government tendered and awarded (to the current research team) a subsequent contract to conduct qualitative evaluation with services and service users, post-implementation of MPA.

5. Sample characteristics

5.1 This chapter briefly summarises the characteristics of the samples of drinkers and providers who took part in the research. For clarity, the four samples have been separated to provide an overview of the characteristics of each:

- drinkers who completed the online survey²⁴;
- providers who completed the online survey;
- service users who participated in an interview; and
- providers who participated in an interview.

5.2 The main aim of the chapter is to provide the reader with sufficient detail to understand that the sample was a diverse one that represents a range of people who either drink alcohol or who provide support to people with alcohol-related problems.

Survey respondents – drinkers

5.3 In total, 93 people completed the ‘drinkers’ survey’. Most drinkers completed the survey online. However, five drinkers completed it off-line on hard copy versions with the assistance of a service provider. These hard copy versions were subsequently entered into the online survey by a member of the research team. One drinker completed the survey in Welsh and the responses were translated into English by a Welsh-speaking member of the research team prior to the analysis. Socio-demographic characteristics of drinkers who completed the survey are presented in Table B.1 in Annex B, with headline characteristics mentioned below.

5.4 Roughly half of the sample were female (51 per cent) and just under half were male (48 per cent). One respondent described themselves as “non-binary”.

5.5 The majority of drinkers (94 per cent) indicated that they were ‘White – English/ Welsh/ Scottish/ Northern Irish /British’ while the remainder were ‘White – Irish’ (two per cent), ‘White – Gypsy or Irish Traveller’ (one per cent), ‘White – Other’ (two per cent), and ‘Mixed – Other’ (one per cent).

²⁴ Whilst the research team were able to gather in-depth information about the drinkers who completed the online survey, for consistency with the other samples, only a brief overview of their characteristics are presented in this chapter. More in-depth information about this group (e.g. marital status, living arrangements, qualifications, employment status, expenditure on alcohol, type of alcohol consumed, use of other drugs, AUDIT scores, and history of substance misuse treatment) can be found in Annex B.

- 5.6 Just over half of the drinker survey respondents were aged between 45 and 74 (55 per cent) while the remainder were aged between 20 and 44 (45 per cent).
- 5.7 The majority (78 per cent) indicated that they were in a relationship of some kind at the time of completing the survey. Half were married (50 per cent) and a further quarter were either cohabiting (21 per cent), in a relationship (six per cent) or in a civil partnership (one per cent). The remainder were either single (15 per cent), widowed (two per cent), divorced (two per cent) or separated (two per cent).
- 5.8 Respondents were resident in 19 of the 22 Local Authority areas in Wales at the time of completing the drinkers' survey – see Figure B.1 in Annex B. The largest proportions of respondents were living in Rhondda Cynon Taf (20 per cent) and Powys (16 per cent). The remaining areas contributed between one and six respondents each.
- 5.9 While drinkers from across the breadth and length of Wales participated in the survey, the uneven distribution across Local Authority areas means that it is important to take care when generalising any findings across Wales. For example, drinkers in the North Wales Local Authority areas were not well represented in the study (n=8). It is useful, however, that the sample was evenly split in terms of the type of area in which respondents lived (rural 55 per cent compared with urban/suburban 44 per cent). While this may not fully address the absence of some areas from the study, nor the over-participation of others, it does help to ensure that the views of people living in or close to cities as well as people living in smaller towns and villages and in the countryside are all represented in the research.
- 5.10 All respondents reported having at least entry level qualifications. More than half (57 per cent) reported that their highest qualification was degree level or above (i.e. Level 4 or above).
- 5.11 Most respondents (79 per cent) described being in some form of employment with most working full-time for 30 or more hours per week (62 per cent).
- 5.12 More than two-thirds of respondents (67 per cent) reported a total household income of at least £25,000 per year. The remainder (32 per cent) reported household incomes of less than £25,000 with 12 per cent reporting an income of less than £10,000. Few drinkers stated that they were in receipt of state benefits (16 per cent).

- 5.13 As part of the survey, respondents were asked to complete a series of questions relating to their consumption of alcohol. The aim was to identify different types of drinker that could then be compared in terms of their attitudes towards minimum pricing for alcohol and their predicted behaviours in response to it. The first set of questions were taken directly from the Alcohol Use Disorders Identification Test (AUDIT), which is a 10-item screening tool developed by the World Health Organisation. It was possible to calculate AUDIT scores for 90 of the drinker survey respondents – see Table B.2 in Annex B. Half of the respondents had scores that put them in the low risk category (i.e. seven or under) and just over one-quarter (28 per cent) had scores that put them at medium risk (i.e. eight -15). The remainder were either high risk (seven per cent) or in the ‘addiction/dependence likely’ category (16 per cent).
- 5.14 Overall, the most commonly consumed alcoholic drinks were spirits/liquors (78 per cent) and wine (75 per cent) closely followed by normal strength beer/lager/cider (73 per cent).
- 5.15 When asked how much money they spent on alcohol each week, most respondents (60 per cent) said that they spent between £1 and £25 per week. However, nearly one-third of the sample of drinkers reported higher levels of expenditure, including 17 per cent who spent between £25 and £49 per week, and 14 per cent who spent £50 or more on alcohol per week.
- 5.16 About half of the respondents indicated that they had a history of prior illegal drug use – see Table B.3 in Annex B. The most commonly used illegal drug among respondents was cannabis (43 per cent), followed by cocaine powder (27 per cent), ecstasy (26 per cent) and amphetamines (25 per cent). Respondents with histories of illegal drug use tended to be polydrug users (i.e. they reported use of more than one illegal substance). On average, respondents who had used illegal drugs in the past, had used 4.6 different drug types (ranging from one to 17 different types of drug).
- 5.17 A history of use of prescription drugs that had not been prescribed for them was less commonly reported than histories of illegal drug use. Just over one-quarter of respondents (29 per cent) said that they had used prescription drugs (which had not been prescribed for them) at some point in the past. The most commonly used prescription drugs were pain relievers (15 per cent) and sedatives/tranquillisers (14 per cent).

5.18 Most respondents had never had any experience of substance misuse treatment (81 per cent). At the time of completing the survey, 13 respondents were receiving treatment, 12 for alcohol problems and one for drug problems.

Survey respondents – service providers

5.19 One hundred people working in the field of substance use in Wales completed the ‘provider survey’. Socio-demographic characteristics of service providers who completed the survey are presented in Table B.4 in Annex B, with headline characteristics mentioned below.

5.20 Roughly two-thirds (63 per cent) of respondents were female and the majority (96 per cent) defined themselves as White-English/Welsh/Scottish/Northern Irish/British.

5.21 All 22 Local Authority areas were represented in the survey. Cardiff and Rhondda Cynon Taf were the areas with the most respondents (23 per cent and 19 per cent respectively) while Wrexham, Carmarthenshire and Ynys Mon were the areas with the least (two per cent each)²⁵ (see Figure B.2 in Annex B).

5.22 Most respondents indicated that they were working within substance misuse²⁶ services either as a key worker (28 per cent), manager (17 per cent) or support worker (16 per cent). However, other respondents were: nurses (eight per cent); support workers or managers based in other types of service (seven per cent and four per cent respectively); peer mentors (five per cent); and commissioners (two per cent).

5.23 Most respondents (86 per cent) had worked in their role for at least one year (nearly one-third had been in-post for 10+ years). The sample could therefore be considered a credible one with substantial experience of working in the substance misuse field.

5.24 Most respondents worked within the third sector (80 per cent) with the remainder working in the public sector (e.g. the National Health Service (NHS), HMP Prison Service, Local Government) or private sector organisations (e.g. G4S and a Community Rehabilitation Company).

²⁵ While all areas were represented in the study, some areas were more heavily represented than others. Caution must therefore be taken when generalizing the findings across all areas.

²⁶ The term substance misuse services is used here to cover services that provide support to people with drug and/or alcohol problems.

Interviewees – Service users

- 5.25 Thirty-eight interviews were conducted with 49 respondents²⁷. Socio-demographic characteristics of those service users who were interviewed are presented in Table B.5 in Annex B, with headline characteristics mentioned below.
- 5.26 Most interviewees were male (31 of 49) and most were aged between 45-54 (13 of 49).
- 5.27 All respondents had experienced problems with their alcohol use at some point in their lives and were therefore either current or recent drinkers, consistent with a treatment profile. Just over half of respondents did not use any other substance apart from alcohol.
- 5.28 Normal strength beers/lagers/ciders were the most commonly reported 'main drink type' among the sample (being reported as such by 10 of the 49 respondents), followed by spirits or liqueurs and wine (eight of 49 reporting each respectively as their main drink type) and strong beer/lager/cider (being reported by seven of the 49).
- 5.29 Most interviews took place in Aneurin Bevan University Health Board (17 respondents), Cardiff and Vale (11) and Cwm Taf (eight) and the least in Dyfed (one).
- 5.30 A mixture of urban and rural locations were covered in each health board area.

Interviewees – Providers

- 5.31 Thirty-eight interviews were conducted with individuals involved in the provision of drug and alcohol services. Socio-demographic characteristics of those service providers who were interviewed are presented in Table B.6 in Annex B, with headline characteristics mentioned below.
- 5.32 An even mixture of female and male (19 of each) participants were interviewed and most had over five years' experience of working in the drug and alcohol field (32 of the 38).
- 5.33 Although most respondents worked for drug and alcohol services (27 of 38), a small number of them also came from criminal justice (six), homelessness/housing (two), domestic violence (one) and other non-NHS statutory services (two).

²⁷ Three interviews were group interviews. These interviews contained three, four and six interviewees.

- 5.34 Most were either keyworkers/caseholders (12 of the 38) or team leaders/senior practitioners (eight). A small number of other respondents from other roles were also interviewed, including service managers (three) and support workers (two), and one outreach worker, peer mentor and social worker.
- 5.35 Most interviews took place in Aneurin Bevan University Health Board and North Wales health boards (both 21 per cent).

Summary

- 5.36 This chapter has provided an overview of the characteristics of the providers and drinkers who completed the online survey and of those who took part in a qualitative interview.
- 5.37 The samples were recruited from across Wales and were diverse in terms of their socio-demographic characteristics.
- 5.38 Drinkers were also diverse in terms of their drinking patterns. The combination of wider anonymised survey data and purposeful targeted interviewees ensure that there was good representation of moderate, harmful and hazardous drinkers in the samples. Including a variety of drinker types in the study was important as it enabled the research team to examine variations in perceptions and predictions.
- 5.39 The samples of providers included individuals working in frontline roles as well as managers and commissioners. Many of the providers had long histories of working in the field of substance misuse or with those using alcohol and drugs in other contexts (i.e. criminal justice) and were credible informants about the potential consequences of minimum pricing for alcohol on service users and other drinkers.
- 5.40 In the following chapters data examples are anonymously attributed to individuals within the following sub-groups:
- Provider interview;
 - Provider survey;
 - Service user interview;
 - Service user group interview; and
 - Drinker survey.

6. Potential impact on use of other substances

Key messages

- Alcohol was identified as the clear substance of choice and switching was viewed as unlikely by most drinkers.
- Switching to other substances other than alcohol was only considered likely among certain 'types' of drinker, predominantly those with previous experience of other drug use.
- Among the substances considered most likely for switching were prescribed medications (e.g. benzodiazepines), cannabis and novel psychoactive substances.

6.1 The key aim of the study was to investigate the perceived potential impact of the introduction of a minimum price for alcohol on drinkers' use of other substances. These and related issues were therefore explored in some depth with drinkers and providers in both the surveys and during the qualitative interviews.

6.2 In this chapter the evidence is examined and what the survey respondents and interviewees thought might happen to drinkers' use of drugs other than alcohol is reflected upon.

Likelihood of switching

6.3 All four groups of respondents reported that it was unlikely that mass switching from alcohol to other substances would occur as a consequence of the introduction of MPA – and drinkers were the most adamant that it would be unlikely to happen.

6.4 The strongest suggestions for the possibility of switching lay among the service providers.

6.5 However, there was a degree of subtlety and variation beyond this headline. This included stronger indications about which drinkers, if any, would switch, what were the most likely substances to be used, and explanations for both non-switching and switching.

6.6 The vehemence of the drinker population was stark: more than 80 per cent of the survey respondents thought that their use of other substances was unlikely or very unlikely to be affected (see Table 6.1 below).

Table 6.1: Likelihood of switching (drinkers)

	Very likely	Likely	Neither	Unlikely	Very unlikely	Total
Illegal drugs	2 (2%)	2 (2%)	9 (11%)	5 (6%)	68 (79%)	86 (100%)
Drugs prescribed by a doctor	2 (2%)	1 (1%)	10 (12%)	3 (4%)	69 (81%)	85 (100%)
Drugs prescribed to someone else	3 (4%)	-	9 (11%)	5 (6%)	69 (80%)	86 (100%)
Over-the-counter medication	3 (3%)	3 (3%)	11 (13%)	5 (6%)	66 (75%)	88 (100%)
Non-alcoholic beverages	3 (4%)	2 (2%)	11 (13%)	6 (7%)	64 (74%)	86 (100%)
Food	3 (4%)	-	10 (12%)	5 (6%)	68 (79%)	86 (100%)
Non-beverage alcohol	3 (4%)	-	12 (15%)	3 (4%)	64 (78%)	82 (100%)
Any other substance	2 (2%)	2 (2%)	9 (11%)	5 (6%)	68 (79%)	86 (100%)

Table notes: Some missing cases.

6.7 There were two main reasons for this:

- The first, and most common justification, was that many dependent drinkers had not previously used illicit drugs and had no intention of switching to illegal substances. Many viewed illicit substance use as ‘illegal’, ‘wrong’ or ‘dangerous’, in contrast to their own ‘legal’ problematic use of alcohol:

‘I don’t like drugs. I don’t like the idea of them.’ (Drinker, Interview 13)

‘The idea of doing an illegal drug wasn’t comfortable.’ (Drinker, Interview 23)

- Second, although most participants suggested that poly-drug use was common amongst some drinkers, it was relatively uncommon for drinkers to switch to other substances if they had no previous engagement with illegal substances. Often, participants reported that drinkers and illicit drug users were two distinct populations with different addiction needs and requirements. For example, the pharmacological effects of alcohol were viewed as distinct from that of any other illicit substance:

‘They are two separate entities anyway...Different in terms of their effects. ... But it was mainly the alcohol for me.’ (Drinker, Interview 10).

6.8 Alcohol was consistently affirmed as a preferred drug and the suggestion of doing other things to access it rather than switching to another substance was stronger:

‘They’re just going to still be an alcoholic, they’re just going to get it somehow.’
(Drinker, Interview 25)

‘They’re still going to be addicted to that alcohol, however much drugs they do it’s not going to take that cut of the alcohol away.’ (Drinker, Interview 03)

‘I don’t think I’d just deliberately go out and switch to something that I’m not really interested in.’ (Drinker, Interview 04)

6.9 There was a greater degree of support for the possibility of switching substances from providers, notably within the survey group. Indeed, providers predicted that the use of prescription drugs (obtained legally or illegally) and the use of illegal drugs (e.g. cannabis or cocaine) were most likely to be affected by the introduction of minimum pricing for alcohol (see Table 6.2 below). By contrast, far fewer providers anticipated changes in the consumption of food or non-alcoholic beverages.

Table 6.2: Likelihood of impact on use of substances among users with previous experience of using those substances (providers)

	Very likely	Likely	Neither	Unlikely	Very unlikely	Total
Illegal drugs	31 (33%)	41 (43%)	17 (18%)	4 (4%)	2 (2%)	95 (100%)
Drugs prescribed by a doctor	26 (27%)	39 (41%)	20 (21%)	7 (7%)	3 (3%)	95 (100%)
Drugs prescribed to someone else	30 (32%)	48 (51%)	12 (13%)	4 (4%)	1 (1%)	95 (100%)
Over-the-counter medication	22 (23%)	29 (31%)	30 (32%)	11 (12%)	2 (2%)	94 (100%)
Non-alcoholic beverages	5 (5%)	16 (17%)	38 (40%)	24 (25%)	12 (13%)	95 (100%)
Food	6 (6%)	16 (17%)	42 (45%)	19 (20%)	11 (12%)	94 (100%)
Non-beverage alcohol	15 (16%)	29 (31%)	35 (37%)	11 (12%)	4 (4%)	94 (100%)
Any other substance	13 (15%)	29 (33%)	41 (47%)	4 (5%)	1 (1%)	88 (100%)

Table notes: Some missing cases.

6.10 While the same broad pattern of findings was predicted for both drinkers with and without histories of using those substances, a key difference was the magnitude of the predicted change. Providers were far more likely to predict substance switching among drinkers with previous experience of switching than among drinkers with no such history (see Table 6.3 below). The difference was particularly pronounced for six of the eight groups of substances:

- prescription drugs obtained illegally (57 per cent compared with 83 per cent);
- prescription drugs obtained legally (55 per cent compared with 68 per cent);
- illegal drugs (53 per cent compared with 76 per cent);
- over-the-counter medication (44 per cent compared with 54 per cent);
- non-beverage alcohol (29 per cent compared with 47 per cent); and
- other substances (27 per cent compared with 48 per cent).

Table 6.3: Likelihood of impact on use of substances among users with NO previous experience of using those substances (providers)

	Very likely	Likely	Neither	Unlikely	Very unlikely	Total
Illegal drugs	16 (17%)	34 (36%)	25 (26%)	12 (13%)	8 (8%)	95 (100%)
Drugs prescribed by a doctor	15 (16%)	37 (39%)	26 (27%)	9 (10%)	8 (8%)	95 (100%)
Drugs prescribed to someone else	16 (17%)	37 (40%)	26 (28%)	9 (10%)	5 (5%)	93 (100%)
Over-the-counter medication	12 (13%)	28 (31%)	29 (32%)	13 (14%)	8 (9%)	90 (100%)
Non-alcoholic beverages	4 (4%)	13 (14%)	45 (48%)	20 (21%)	12 (13%)	94 (100%)
Food	4 (4%)	15 (16%)	46 (50%)	14 (15%)	13 (14%)	92 (100%)
Non-beverage alcohol	10 (11%)	17 (18%)	41 (44%)	15 (16%)	10 (11%)	93 (100%)
Any other substance	10 (12%)	13 (15%)	46 (53%)	9 (10%)	9 (10%)	87 (100%)

Table notes: Some missing cases.

6.11 The suggestion that drinkers with previous experience of other drug use were more likely to switch following the introduction of minimum pricing was also echoed in the qualitative interview data. Here, providers suggested that switching was most likely to occur only among individuals who were already consuming drugs. Reasons for this corresponded with the aforementioned explanations given by drinkers (i.e.

providers suggested that individuals who consumed only alcohol made a moral distinction between illicit substance use and their own 'legal' problematic use of alcohol, and were 'anti-drugs'):

'There is a drug hierarchy where people who have a dependency on alcohol, they will look down on people who use cocaine.' (Provider, Interview 15)

'Some of them won't go on ... they're completely anti-drugs.' (Provider, Interview 22)

'They don't tend to mix with drug users, and they see themselves as very different.' (Provider, Interview 08).

6.12 Within the population of those with prior drug use experience (and most likely to switch), were three overlapping types of drinkers: homeless drinkers, poly-drug users and street drinkers.

6.13 Indeed, when asked to state what groups of drinkers they thought were most at risk of substance switching, the group identified by most providers was dependent drinkers (e.g. 'street drinkers', 'problematic drinkers / daily', 'individuals whose alcohol use has escalated out of control', 'chronic alcoholics (over 40 worst hit)', 'chaotic street drinkers and chaotic drinkers', 'alcohol dependent homeless individuals').

6.14 The main reason given was that this group had 'a pressing need to meet their dependency requirements' (Provider, Survey 93) but would not be able 'to afford their alcohol dependency so [would] access a cheaper substance' (Provider, Survey 94). Some providers explained that dependent drinkers needed alcohol to cope with their lifestyle and their problems. One survey respondent explained it well:

'Because they are simply trying to forget shit that has happened to them and numb themselves to what is around them. If alcohol won't be doing this, and there is no or little support, then of course they will use something else.'
(Provider, Survey 72)

Prescription-only medication

6.15 The predicted pattern of switching to other substances, when it did occur, was consistent amongst the respondent groups. This was focused on a combination of factors:

- availability;

- price; and
- mimicking the effect of alcohol.

The strongest suggestions were for use of prescribed medication, both legally and illicitly obtained.

- 6.16 The providers who were interviewed predicted that if drinkers were to switch, it would be to prescription medications that mimic the effects of alcohol on the central nervous system, such as benzodiazepines, (including diazepam, MSJs (street diazepam) and zopiclone) and medications used to treat neuropathic pain, such as pregablin and gabapentin. This was the most commonly cited switching occurrence that providers felt would happen because of minimum pricing.
- 6.17 The providers who completed the survey also anticipated that if any switching were to occur it would be to prescription drugs. Indeed, overall prescription drugs (particularly obtained illegally) were the substances that most providers anticipated would be affected by the introduction of MPA (see Tables 6.2 and 6.3 above). The attraction of these medications is their ability to mimic the effects of alcohol.
- 6.18 This was also a theme present in the drinker interviews. However, instead of a complete switch to these substances, respondents suggested that these substances would be added to help them cope with a lower supply of alcohol. Prescription only medication such as diazepam, or MSJs (street diazepam) were frequently mentioned by drinkers:
- ‘The diazepam is the next closest thing to alcohol.’ (Drinker, Interview 04)
- ‘Going to take something else that gives you the same feeling as a drink, but is a lot cheaper, like Valium.’ (B1, Drinker, Group Interview B)
- 6.19 Aside from mimicking pharmacologically the effects of alcohol, drinkers suggested they would prefer to switch to a substance that was easily available and legal. Some reported that they may look to increase the amount of prescription-only medication they were currently consuming. A few respondents explained that when desperate, they may use these substances to assist with alcohol withdrawal, if necessary:
- ‘Other ways, I suppose you could talk about going to illegal drugs, but that’s crime, so the same bracket. Trying to get more painkillers off the doctors, which I might do, and quite frankly the amount of chemicals that I take is enough, thank you very much. I don’t think just because they’re called legal, they’re necessarily safer.’ (Drinker, Interview 04)

R: Or looking for something else to bridge the gap, like going to your GP maybe, asking for something instead of alcohol.

I: Okay. What might that be then?

R: I don't know, sleeping tablets maybe. (Drinker, Interview 08)

Illegal drugs

6.20 The more limited prospect of switching to illegal drugs was supported through known previous value (use) and the possibility of them becoming relatively cheaper. Indeed, the idea that users with a prior history of illegal drug use would be susceptible to substance switching was mentioned by several providers:

'If a polydrug user this could be an issue.' (Provider, Survey 73)

'Those that already take both drugs and alcohol may turn more to drugs.'
(Provider, Survey 18)

'Unknown, but a possibility of those looking at previous use and starting using again – potentially more affordable options.' (Provider, Survey 78)

'I think it's possible but not for everyone as some people will only ever want to drink.' (Provider, Survey 92)

'Some chaotic drinkers in my experience dabble at times with other substances but have no reason to – if their drink of choice increases this illicit use may increase.' (Provider, Survey 63)

6.21 Providers mentioned a range of substances to which they felt dependent drinkers may switch. For dependent street drinkers, synthetic cannabinoids were the most frequently cited. Providers suggested that substances such as spice were already available and being used by street drinkers in certain localities. This led them to believe that street drinkers may prioritise the substance if alcohol were to become unaffordable:

'And I guess my concern is that if they can't afford the alcohol, will they turn to spice and other things.' (Provider, Interview 32)

6.22 Few drinkers who completed the survey anticipated any change in illegal drug use and hence few details were given. The only substances mentioned by respondents in relation to the use of illegal drugs were cannabis and benzodiazepines:

'Considering switching to benzodiazepines.' (Drinker, Survey 25)

'Sometimes occasionally cannabis but only if the occasion arises, which is very rare.' (Drinker, Survey 50)

6.23 Among the drinkers who were interviewed, most predicted that switching to opioids was unlikely. One poly-drug user (alcohol and heroin), however, suggested that he would prioritise heroin over alcohol when MPA legislation was implemented.

I: So, would you start using other substances?

R: Probably, yes. I probably would go back on the Diamorphine; do you know what I mean?

I: What would you go on, sorry?

R: Heroin.

I: Oh, you'd go on heroin. Diamorphine, yes, you'd go on heroin.

R: Because I couldn't afford... If it were £10 for one three litre, which I would drink and do a handstand after. Or smoke a bag of drugs, I would buy gear.

I: You'd rather have a bag?

R: Yes. I would. (Drinker, Interview 36)

6.24 By contrast, another drinker predicted that he would cut down on his use of illegal drugs such as heroin, crack and cannabis in order to focus his resources on alcohol, which was his preferred drug of choice:

B1: Yeah. Well, I don't spend much on food anyway. But I wouldn't buy drugs. My priority is drink.

I: Okay. So, you'd cut down...

B1: I'd stop using drugs, and I would just spend the money on alcohol.

I: That's interesting.

B1: But that's because I'm not... I drink more. I've always been a drinker. Everything else has been, as much as I've been addicted to heroin, cannabis, crack and whatever, I've always... It's always, the first thing I buy is drink, and I would... Anything else is if I've got money.

I: Okay. So, interestingly, that would cut down your use of other substances.

B1: Yeah. (Drinker, Group Interview B)

Switching to other substances

- 6.25 Less support was given to the idea that drinkers may switch to over-the-counter (OTC) medications, non-alcoholic beverages, non-beverage alcohol or food because of minimum pricing. A little over half of providers who completed the survey indicated that the use of over-the-counter medication (OTC) was likely or very likely to be affected by the introduction of MPA (see Tables 6.2 and 6.3 above). A few respondents explained that when desperate, drinkers would do anything to cope with the withdrawal and may therefore resort to OTC medication:
- ‘People will try anything to kill their withdrawals.’ (Provider, Survey 7)
- ‘People will become more desperate and so will try new things and experiment.’ [Provider, Survey 9]
- 6.26 A small number of providers referred specifically to types of OTC or the desired effect of an OTC:
- ‘For effects predominately the drowsy effect.’ (Provider, Survey 55)
- ‘Codeine 12.8mg in Nurofen Plus.’ (Provider, Survey 72)
- ‘Opiate based medications may increase in popularity.’ (Provider, Survey 40)
- ‘There are cheap cough medicines, however it is quite expensive now to buy a good one. Co-codamol is cheap, and again this is risky with alcohol, it depends on the individual.’ (Provider, Survey 38)
- 6.27 Similarly, most drinkers felt that it was unlikely that their use of over-the-counter medication would change (see Table 6.1 above). The main explanation given was that they did not use these substances very often, if at all, and hence that minimum pricing would not affect their use of them (e.g. ‘don’t buy it’, ‘rarely use anyway’, ‘I only use these when needed’). There were no data from the qualitative interviews to support the view that individuals may switch to OTC medication because of minimum pricing.
- 6.28 For non-alcoholic beverages, the main consideration among providers was that these drinks were ‘not an adequate substitute’ (Provider, Survey 86) for alcohol as ‘these don’t hit the mark’ (Provider, Survey 91). The responses were very similar in relation to food. For the most part, providers were unable to see how food might be a substitute for alcohol:

'This will not be on the mind of someone suffering withdrawals.' (Provider, Survey 7)

6.29 Similarly, drinkers described chocolate as a poor substitute for alcohol but nevertheless acknowledged that there was some potential for increased comfort eating if wine can no longer be afforded:

'I don't consider chocolate a reasonable substitute.' (Drinker, Survey 79)

'If I drink during the week it's usually due to a stressful or bad day at work and a few glasses of wine helps relax. If I cut down on wine due to affordability, then it would probably increase my consumption of comfort eating.' (Drinker, Survey 71)

6.30 However, nearly half of the providers (47 per cent) thought that the introduction of minimum pricing for alcohol was likely or very likely to have an effect on the use of non-beverage alcohol (NBA) (i.e. mouthwash, aftershave, hand sanitisers) (see Table 6.2 above). The consensus among those that gave an explanation for their answer (n=31), was that use of NBA was 'extreme' and only likely to occur among those who are 'desperate'. Nevertheless, it was viewed by providers as a possibility among some dependent drinkers:

'Yes, I have had patients stealing hand sanitisers in the past.' (Provider, Survey 83)

'Possibly for some dependent alcohol users. For the majority, unlikely.' (Provider, Survey 86)

'Could increase use if individual is dependent on alcohol but may not.' (Provider, Survey 47)

'A small number of alcohol dependent 'street drinkers' may take this option.' (Provider, Survey 30)

'People in custody will continue to abuse such substances where they can obtain them.' (Provider, Survey 95)

One provider who completed the survey was concerned about the potential 'health issues' while another expressed real concern about the possibility of drinkers using NBA:

'I'm worried about this one - I've heard people already having discussions about what they can and cannot drink that contains alcohol. The conversation ranged from methylated spirits and how to make it taste 'better' to perfumes and aftershaves and whether alcohol hand gel could be consumed. One person confessed to drinking their mother's Chanel No. 5.' (Provider, Survey 91)

6.31 Unfortunately, the three drinkers who indicated in their survey responses that their use of NBA would be likely to change once the legislation is enforced, all opted out of providing an explanation. The few explanations that were provided by drinkers who predicted no change, were based largely around the fact that did not use such substances and if they did it was 'for the purpose they were designed for' (Drinker, Survey 84). A couple of respondents seemed surprised that the use of non-beverage alcohol was even an option (e.g. 'Seriously???', 'Really?').

Summary

- 6.32 More providers anticipated substance switching among people with a history of using other substances than among drinkers with no such experience. However, the broad pattern of findings was similar across both groups.
- 6.33 Prescription drugs obtained illegally were the substances that most providers thought were likely to be affected by minimum pricing largely due to the potential for benzodiazepines to help drinkers to self-medicate and cope with withdrawal symptoms.
- 6.34 Few providers anticipated that minimum pricing would affect the consumption of food or non-alcoholic beverages, but there were concerns that some desperate and dependent drinkers might use non-beverage alcohol such as hand sanitisers and mouthwash.
- 6.35 The importance of value for money and availability were mentioned in relation to the use of several substances, including illegal drugs as providers predicted that drinkers would seek the 'best bang for their buck'.
- 6.36 Cannabis and spice were identified as potential substances for both those with and without histories of prior use. However, illegal drugs such as cocaine, opiates and heroin were only anticipated among drinkers who had used these substances previously.

7. Awareness and understanding of minimum pricing for alcohol

Key messages

- Levels of awareness were mixed across the samples with survey respondents reporting fairly high levels, possibly due to their exposure to messages about minimum pricing for alcohol in the preamble to the survey. Awareness of minimum pricing was lowest, and in many cases notably absent, among those drinkers who were interviewed.
- Among those with some awareness of minimum pricing, the level of detailed understanding of the policy was generally poor amongst both providers and drinkers, with a few notable exceptions in each group.
- Most providers and drinkers believe that dependent drinkers will continue to consume alcohol problematically regardless of any price increase.
- Most respondents were able to identify and describe a greater range of potential negative consequences for the policy than potential benefits.
- The main perceived benefits identified by respondents were that it may reduce consumption of high strength alcohol among some drinkers and reduce alcohol-related harms, particularly among young people.
- The main perceived concerns identified were focused on the potential increase in acquisitive crime and on health and social harms.

Awareness of plans to introduce a Minimum Price for Alcohol (MPA) in Wales

7.1 The vast majority of provider survey respondents (82 per cent) and a large majority of drinker survey respondents (75 per cent) indicated that they had heard of the plan to introduce a minimum price for alcohol in Wales²⁸, and this was replicated in responses received from those providers who were interviewed. However, most drinkers who were interviewed indicated that they had little awareness, prior to engaging in this research process, of the plan to introduce a minimum price for alcohol in Wales. Only a small number of provider respondents openly admitted that they knew little about the plan.

²⁸ It is possible that answers to this question were influenced by the preamble to the survey and the covering email in which the Welsh Government's plan for MPA was outlined.

- 7.2 Although awareness levels of the policy appear relatively high across most survey respondents, in many cases this was expressed vaguely with little or no further elaboration, such as:
- ‘to place a regulated price per unit of alcohol.’ (Provider, Survey 9)
- ‘Welsh Government want to introduce minimum pricing for alcohol.’ (Provider, Survey 99)
- 7.3 Most providers who were interviewed admitted having very little knowledge of minimum pricing for alcohol beyond a basic understanding of plans to implement it in Wales:
- ‘Really what is reported on the news.’ (Provider Interview 15)
- ‘I believe it’s something to do with the pricing of per unit, is that correct?’ (Provider, Interview 26).
- 7.4 Unlike the providers, no drinkers admitted that they knew little about the plan although in some cases, the answers suggested otherwise. For example, some mentioned only how they had heard about the plan, such as: ‘the internet’, ‘the press’, ‘only saw it on the news once but didn’t take a lot of notice’; while others were non-specific and largely repeated the wording of the question (e.g. ‘minimum unit pricing’, ‘up the price per unit’) or their personal view about it (e.g. ‘it’s wrong’, ‘they want to place another tax on us’).
- 7.5 Only a few providers were able to demonstrate detailed knowledge of the plans for implementing MPA in Wales.
- Roughly one-third of provider survey respondents indicated that they believed the minimum price was going to be set at 50 pence per unit.²⁹
 - A small number of provider survey respondents believed that the minimum price would have a particular effect on certain drinks, such as: ‘massively increase the price of ‘[Brand name]’ type alcohol’, ‘to put a minimum price on high percentage alcohol, e.g. 2 litres of strong cider will be approximately £11.00’.
 - Similarly, a handful of providers thought that it would have an effect on particular types of drinkers, such as: ‘...homeless alcohol dependent people’, ‘vulnerable people’, ‘poor people’.

²⁹ Although the Welsh Government has consulted on their preferred level of 50p per unit, at the time of finalising this report, the implementation level has not yet been set (as regulations need to be laid before the National Assembly for Wales).

- 7.6 Some drinkers were also aware that the price per unit was likely to be set at 50 pence and a few commented on what they thought the aim of the legislation was, such as:
- ‘To try to reduce consumption of alcohol by increasing minimum price.’ (Drinker, Survey 2)
 - ‘To discourage drinking in lower income brackets.’ (Drinker Survey, 45)
 - ‘To avoid cheap alcohol beverages.’ (Drinker, Survey 70)
- 7.7 A small number of drinkers drew a comparison with the increased pricing of cigarettes.
- 7.8 A few drinkers who completed the survey gave more detailed answers flagging up a variety of important points, such as the impact minimum pricing would have on particular types of alcoholic drink and its broad harm reduction goal.
- ‘The idea is to charge a price based on how strong the drink is. Meaning you won't be able to buy things like [Brand] for next to nothing. In theory reducing harm to the people who drink them.’ (Drinker, Survey 23)
- 7.9 A few provider respondents were able to provide some contextual information in their answers. The main sources of this information appeared to be from news articles about the introduction of an MUP for alcohol in Scotland, and APB events or forums. Several providers referred to the rationale for introducing MPA, such as:
- ‘Evidence shows beneficial to health, workplace absence, crime.’ (Provider, Survey 36)
 - ‘... the aim of which is to tackle alcohol-related deaths.’ (Provider, Survey 25)
 - ‘... to reduce the impact on the NHS and services dealing with alcohol misuse.’ (Provider, Survey 79)
 - ‘... deter some from drinking more than they should.’ (Provider, Survey 10)
- 7.10 Like the providers, a few drinkers contextualized their answers and demonstrated awareness that minimum unit pricing had already been introduced in Scotland, such as:
- ‘It will be on a similar line to Scotland as approximately 50p per unit of alcohol.’ (Drinker, Survey 39)

7.11 A small number of providers and drinkers who were interviewed responded with surprise when details of the possible price increases were relayed to them. For these respondents, the interview was the first time they had heard of plans to introduce an MPA in Wales:

‘Well certainly when you said about the white cider, when you said it’s £3.50 and it’s going to cost you £11 something, that really hits quite hard then, doesn’t it?’ (Provider, Interview 08).

‘I didn’t realise it’s going to be that much for those drinks, the increase. That’s taken me back a bit.’ (Drinker, Interview 12)

Attitudes towards minimum pricing for alcohol

7.12 Attitudes towards the introduction of a minimum price for alcohol in Wales were divided among both the providers and drinkers who completed the survey. Similar proportions agreed (37 per cent and 36 per cent respectively) and disagreed (39 per cent and 38 per cent respectively) with the plan while one-quarter of both sets of respondents expressed a neutral opinion on the issue.

7.13 Interestingly, no significant differences in attitude³⁰ were found among the drinkers who completed the survey in terms of: household income, employment status, qualifications³¹, AUDIT score, or history of illegal or prescription drug use. However, significant differences in attitude were found in terms of: sex (females more likely to be in favour), frequency of alcohol use (less frequent users were more likely to be in favour), frequency of spirits use (less frequent users were more likely to be in favour) – although it is not clear from the survey results why these differences exist.

7.14 Amongst those providers who were interviewed, negative expectations consistently outweighed positive outlooks when asked to describe how they felt about plans to introduce minimum pricing for alcohol in Wales.³²

- Responses suggested that most providers were in sceptical agreement with the legislation but had concerns about the effectiveness and unintended consequences of a minimum price for alcohol, such as:

³⁰ For analysis purposes the five categories were collapsed into three: (1) strongly/moderately agree, (2) neutral, (3) strongly/moderately disagree.

³¹ The relationship between attitudes towards MPA and qualifications obtained was approaching significance ($p=.09$). Those with the highest level of qualification were more likely to agree/strongly agree than those with lower level qualifications.)

³² Many of the issues raised were also highlighted in the [Welsh Government’s consultation](#) on the preferred level of the minimum unit price of 50p.

'I don't agree with it. I know it's going to happen, but it's going to make a lot of people a lot more worse off or pushed onto other substances.' (Provider, Interview 22)

'Yes, I think you know I completely understand the rationale behind putting in the minimum unit pricing, but I do have concerns about people swapping to other drinks that perhaps are going to be worse for them in some ways.' (Provider, Interview 29)

- Most providers doubted that minimum pricing would work, particularly for dependent drinkers, whom it was believed would continue to drink regardless of any price increases.
- Providers therefore felt that the legislation was simply a 'tax' on the poor and had concerns about whether the money would be put towards treatment for this cohort:

'Where does the money go, that's another thing, where does the money go for that increase?' (Provider, Interview 04)

- Providers felt that a minimum price for alcohol would be ineffective due to its 'superficial' nature, i.e. treating the 'symptom' and not the 'cause' of addiction. Providers felt that without additional support and treatment for these underlying factors, a minimum price for alcohol would have no effect on the consumption patterns of dependent drinkers:

'Overall, I don't think it's the answer on its own ... I think you're treating the symptom, you're not treating the cause and I think you need to understand why people are doing it, why people are drinking too much and I think that's the primary issue for me.' (Provider, Interview 21)

7.15 The majority of drinkers who were interviewed were overwhelmingly negative about the policy believing that the legislation simply would 'not work', i.e. have no impact on the level of consumption among dependent drinkers³³:

'I would find a way to get the desired effect of the alcohol in my system. People will find a way around it.' (Drinker, Interview 15)

³³ As noted earlier in the report, dependent drinkers form only a small proportion of the drinking population and are not the main target group for the legislation.

'When I was really at the bottom of the pit, when I was on the street and all, I would have found money for any drink to get wrecked.' (Drinker, Interview 29)

7.16 When questioned why they thought the legislation would not work, interviewees usually responded with either one or two responses:

- The first related to the inability of the legislation to tackle the underlying issues that may lead someone into addiction; without addressing these issues first, drinkers would continue to consume alcohol problematically, in spite of any increases in price:

'I have never come across an alcoholic or drug addict who didn't have a mental health issue and vice versa ... It is unemployment, lack of money, benefit cuts. These are the real reasons that people are drinking, and until they sort that out, they can do what they want, they can ban alcohol, they can increase the price, it is not going to change a thing.' (Drinker, Interview 22)

- Second, drinkers felt that the chaotic lifestyles of street drinkers meant they would always continue to consume alcohol despite any potential increases in price. Often this was linked to the comparative lack of resources of dependent drinkers and street homeless populations that render them susceptible to problematic substance use:

'No, people on the streets may be struggling more because they just want to knock themselves out all the time and what's going on. So, they'd be looking for anything to try ...' (Drinker, Interview 08)

Potential benefits of introducing a minimum price for alcohol in Wales

7.17 When asked what they thought the benefits of having a minimum price for alcohol in Wales were, the majority [n=95] of provider survey respondents gave an answer.

7.18 In a small number of cases the respondent found it hard to identify anything positive (e.g. 'I can't see it being any help', 'unsure if any benefit will come from it', 'minimal') whilst some were unable to resist the temptation of describing negative rather than positive consequences, particularly for dependent drinkers (e.g. '... The point is: alcohol is addictive! Why would a small price increase discourage addiction?', 'it will tax the poor and have no effect on problematic alcohol misuse').

- 7.19 A small number of respondents saw that there were potential benefits but only in certain circumstances (e.g. 'depends where the money goes, it could go towards health care and prevention then that would be a benefit').
- 7.20 In most cases, however, the respondents were able to identify clear potential benefits.
- Sometimes the benefits were described in a very general way, such as: 'saving the Welsh economy £783 [sic] over 20 years', 'lower the amount of drinking happening', 'may deter some from drinking as much', 'harm reduction', 'save lives'.
 - More often, specific potential benefits were described, such as: 'reduce underage drinking', 'less criminal activity (in the long term)', 'potential reduction in street drinking and anti-social behaviour', '... possibly reduce the "pre-loading" done by social drinkers', 'encourage people to access treatment for alcohol dependency', 'less hospital admissions', 'reduce police stress on "drunk and disorderly" type stuff', 'more people will choose to drink lower strength alcohol'.
 - The potential benefits for reducing harm among young people were popular responses, as too were the wider potential health benefits.
 - Other interesting, but less commonly reported, benefits included: the positive impact it could have on pubs (e.g. 'upturn in pub industry, not so many pubs closing'); drinks such as strong white ciders being priced out of the market (e.g. 'drinks such as "[Brand name]" et al will be more expensive and therefore will hopefully be priced out of the market'); and Wales becoming an exemplar for taking action to address the problems associated with excessive alcohol consumption (e.g. 'setting an example to the population that alcohol is expensive and can lead to addiction and dependency').
- 7.21 When asked what they thought the benefits of having a minimum price for alcohol in Wales were, the majority [n=86] of drinker survey respondents provided an answer. In many cases, the respondents found it hard to identify any clear benefits (e.g. 'can't see any benefits', 'non, [sic] I do not agree in government interference', 'none, makes no difference to me'). A few respondents elaborated their answers and explained why they thought introducing an MPA was not such a good idea:
- 'None. It won't deter people from drinking. People will spend less in other areas, i.e. children's shoes, school trips, family days out, food etc. The only people benefitting will be the manufacturers.' (Drinker, Survey 21)

'I do understand the need to reduce harmful drinking but raising the price will very likely create a whole variety of hardship.' (Drinker, Survey 14)

7.22 Most respondents were able to identify some benefits of minimum pricing.

- In a small number of cases the comments were very general referring to broad positive effects rather than specific ones (e.g. 'unsure really, I believe it's about harm reduction', 'helpful').
- In most cases, however, respondents described specific benefits, the most common of which was related to a decrease in the consumption of alcohol (e.g. 'less problem drinking', 'less people drinking').
- Some respondents flagged up the potential impact on several different types of drinker including young people (e.g. 'Make alcohol less accessible for some groups such as young people. Would send message that drinking alcohol is a luxury'); moderate drinkers (e.g. 'I think middle of the road drinkers may buy a little less alcohol long term'); and those on lower incomes (e.g. 'It will be less viable for those on lower incomes to purchase vast quantities of high strength cheap alcohol and this would hopefully in turn make them reconsider their choice').
- The potential for minimum pricing for alcohol to result in cost savings to society was another benefit mentioned by several respondents (e.g. 'it will hopefully reduce people becoming so dependent on alcohol and reduce the cost to society (hospital visits, police involvement) as they won't be able afford the white cider, etc').

7.23 A small number of respondents described multiple benefits including decreased consumption, cost savings, reductions in crime, and the potential benefits for businesses:

'Relief for the NHS possibly also any person alcohol dependant being less able to access because of cost as well as young people due to the same reason. Business might also benefit bringing bar prices in line with off licence.' (Drinker, Survey 22)

'Reduce harmful and hazardous drinking patterns, reduce domestic violence, which is largely alcohol enabled/fuelled, and it has been shown to reduce death rates due to alcohol related disease within a remarkably short few years of introduction.' (Drinker, Survey 15)

7.24 Despite the general disagreement and scepticism about efficacy, some of the providers who were interviewed were able to identify clear potential benefits of the legislation. Overall, three main 'positive' threads were anticipated:

- The most commonly cited of these related to the effect the legislation would have on young people. It was asserted by some providers that there was potential for MPA to have some preventative effects among young people (i.e. stopping them from starting):

'Yes, I mean I think students it could have a positive effect because often students go for the cheap beers and ciders and they're definitely not going to be able to afford it. So, I think it'll have a positive effect on students.' (Provider, Interview 32)

- Relatedly, some respondents felt that minimum pricing could be the beginning of 'a cultural shift' in Wales, where alcohol becomes recognised properly as a problem substance. Here, the increased price of alcohol would help the general population become aware of the harms associated with problematic alcohol use:

'And people who perhaps are in work but on minimum wage or very poorly paid, I think for them they're not going to be able to afford to buy what they've been buying. And hopefully it'll help those people look at it a bit more as well and some of the harmful effects of drinking those awful ciders and lagers won't be there because they're not going to be able to afford it.' (Provider, Interview 32)

- Finally, several interviewees saw the potential for minimum pricing for alcohol to act as a 'nudge' factor, but only for those dependent drinkers in the contemplative stage of the cycle of change (or those who have reached rock bottom and are ready to change). Here, the increased price of alcohol may act as an additional trigger to seek treatment and support earlier for some:

'[It's] going to get a lot more through our doors asking for help, basically, that perhaps we're not seeing at the moment, that think they can manage it on their own. Then suddenly they decide, well I can't afford this.' (Provider, Interview 08).

7.25 Only a small number of drinker interviewees were able to identify some potential positives of the legislation. Most of these benefits were described in a very general way, describing wider benefits in relation to health and crime, or only in certain circumstances (e.g. preventing young people from obtaining cheap alcohol).

However, for those who were able to provide more detailed descriptions of potential benefits, three main findings emerged (which mirror the views of providers):

- The most commonly cited of these related to the effect the legislation would have on young people. For some drinkers, the legislation could potentially have a 'preventative' effect on young people's alcohol consumption if prices were to increase:

'But as a prevention for future, yes, I think it is. I really think it is. Because you're thinking, "F**k, I ain't paying f**king eight quid for a bottle of wine. And a bottle of whisky? Jeez, I ain't paying £25 or £30 for a bottle of ...".'

- Second, some interviewees indicated that the legislation could potentially trigger dependent drinkers to seek support and treatment. This trigger would occur when dependent drinkers realised how unaffordable alcohol would become following the introduction of MPA:

'I think either way the end result would have been me seeking help and it could have either come through me saying, I can't afford this, I have to stop it now, **or** it would have come through me not being able to afford it, running into trouble financially or whatever, racking up debt and then thinking, now you're in trouble.' (Drinker Interview 11)

- Finally, although no drinkers indicated that the legislation would make them stop consuming alcohol completely, some did believe that at population level, it would reduce overall consumption levels:

'I think it will in theory at least affect levels of consumption in the general population, but that's a good thing.' (Drinker, Interview 13)

Potential problems of introducing a minimum price for alcohol in Wales

7.26 Both the interviews and surveys also included questions that asked providers and drinkers to identify the potential problems that might arise because of introducing a minimum price for alcohol in Wales.

7.27 All respondents were able to identify a more extensive range of potential negative effects and consequences than they had identified in relation to the potential benefits. The survey responses in relation to the potential problems were also substantially longer and more detailed.

7.28 Broadly speaking, across the data sources, the main themes that dominated the responses were the potential impact on: dependence, crime, health harms, social harms, burden on services (e.g. NHS, police, substance misuse treatment), alternative sources of supply, substance switching, and alcohol switching.

Crime

7.29 The potential for minimum pricing for alcohol to cause an increase in crime was identified by many survey and interview respondents.

7.30 Of all the problems identified by providers, the potential increase in crime was the most widely anticipated. Providers were mainly concerned that there would be an increase in acquisitive crime that would help fund alcohol use. Some respondents referred to crime quite generally in their responses (e.g. 'crime rate could increase to raise funds for alcohol') while others were more specific about the nature of the crime (e.g. 'potential increase in shoplifting of alcohol'). Others highlighted the type of drinker who would be most likely to commit crimes to fund their use of alcohol (e.g. 'Alcohol dependent individuals more likely to commit crime to pay for their alcohol or shoplift to acquire alcohol. Likely that theft/burglary/shoplifting figures would increase.'). The possibility of the legislation causing other types of crime was mentioned by only a small number of providers (e.g. '(It may) contribute to increased violence among peers', 'children may get neglected due to parental use so a rise in safeguarding issues').

7.31 Many drinkers also spoke of their concerns about the potential for increased crime. Sometimes, the comments were general and referred to crime very broadly (e.g. '... those with alcohol problems may find illegal or unethical ways to find the money', 'it might increase crime rates as people will have to finance their lifestyles somehow'). At other times, however, specific crimes were mentioned (e.g. 'theft and robbery levels will go up in high unemployment areas', '...may see an increase of petty crime such as shoplifting or consumption of black market alcohol ...'). The focus for drinkers was very much about crimes that would generate money to fund continued alcohol consumption – either acquisitive crime (whereby the goods are sold to fund money for alcohol) or shoplifting of alcohol.

Health harms

- 7.32 The potential for harm to the physical health of drinkers was another commonly reported problem.
- 7.33 Again, some providers were fairly general in their predictions (e.g. 'risk to health') while others were more specific and identified particular health harms (e.g. 'potentially death, DTs [delirium tremens] and such', 'sudden cessation of alcohol can cause seizures').
- 7.34 The most commonly held perception, in relation to potential health problems, by all providers and the drinkers who were interviewed was the harm associated with withdrawal and the potential for seizures:
- 'A lot of drinkers are going to either die because they can't get any drink...That's part of the problem with street drinkers. They start cutting down and they go into withdrawal, it's just going to increase the number of hospital admissions, because their organs will start shutting down.' (A4 Drinker, Group Interview A)
- 7.35 Some respondents linked potential health harms to specific behaviours. For example, one provider respondent predicted that 'MUP could lead to choices that prioritise alcohol over other essentials with negative impact on health'. Similarly, another provider respondent predicted that those drinkers who already prioritise buying alcohol over other essentials will be 'at increased risk of malnutrition and other health problems'.
- 7.36 During interview, many providers expressed concern that the mental and physical health of dependent drinkers would deteriorate because of minimum pricing, such as:
- 'My first thought was people aren't going to be able to afford it, there's going to be a risk of some cessation, hospital admissions, deaths maybe.' (Provider, Interview 29)
- 'These people are used to drinking 22½ units in one go and can't get hold of that stuff, so I guess that was my initial knee jerk to it really was thinking, are we going to see a lot of guys coming in with fits.' (Provider, Interview 01)
- 7.37 In contrast, the potential for harm to the physical health of drinkers was mentioned by only a small number of those drinkers who completed the drinker survey. One drinker mentioned it generally without specific reference to the nature of the health

harm (e.g. 'health problems'). Another respondent described the potential for 'withdrawal' if alcohol became too expensive for dependent drinkers and another referred to the 'additional stress and hardship' that would be felt by those no longer able to afford to drink. In addition, a small number of respondents referred to the potential health harms associated with the use of illegal alcohol ('more bootleg alcohol will pose more health problems', 'people may brew their own which may bring its own health problems').

- 7.38 The limited reference to potential health harms from this group is notable given the focus that all providers and the drinkers who were interviewed gave to this important issue.

Social harms

- 7.39 The possibility of drinkers foregoing essentials such as food, clothing and paying household bills were mentioned by a few providers who completed the survey (e.g. 'prioritising alcohol over food and other commitments'). Some providers explained that this kind of re-budgeting could have important social consequences (e.g. 'users will have less disposable income – increasing social issues'). One provider explained that it could result in 'more people accessing foodbanks because they cannot afford to buy the food and alcohol they need to keep them safe'. Another predicted that 'money for food/rent/bills will be spent on the alcohol and this will drive up the number of people becoming close to homelessness'.
- 7.40 Concern over the potential impact of this re-budgeting on families, and especially children, was raised by several respondents. One respondent expressed this very clearly:
- 'I work with families where they will drink regardless of cost. If the cost is more expensive, then the children will without fail!!! [sic] have less food, medications, clothes, etc.'
- 7.41 Similarly, another respondent predicted that alcohol dependent people will continue to drink 'regardless of price' and that 'this will impact on young people and this could possibly result in more young people's needs not being met due to financial implications'.
- 7.42 One respondent suggested that minimum pricing may 'encourage some people to choose [sic] essentials over alcohol', a potential benefit and positive outcome. However, this respondent went on to explain that 'it may well encourage others to

choose alcohol over other essentials such as food. This could have a negative impact on family members who don't drink.'

7.43 Relationships with family members were a further aspect that most respondents felt would likely be adversely affected. Some providers were also concerned about the possibility of 'increased friction' and 'arguments' between friends because of drinkers asking to borrow increasing amounts of money:

'It's like I was saying earlier that the people needing alcohol aren't going to be able to get it, are they going to be going to their family members more for money? Are they going to be displaying more antisocial behaviour in families and communities that's harder for people to cope with?' (Provider, Interview 32)

7.44 A range of other social harms were also identified by some providers. These included concerns over:

- social exclusion, alienation and increasing isolation (e.g. 'individuals isolating and not entering services', 'will just alienate/exclude them even more');
- debt and financial hardship (e.g. 'they could also get into financial hardship if they have to spend more to fund serious habits');
- greater social divisions (e.g. 'possible separation of class, those who cannot afford good quality alcohol will be forced financially to have the cheaper option'); and
- more chaotic lifestyles (e.g. 'people will continue to fund their habit, could result in theft, further chaotic lifestyle').

7.45 Most of the perceived health and social problems were linked to dependent drinkers who providers felt would continue drinking regardless of price. However, some providers recognised the potential impact on other kinds of drinker as well as on other stakeholders. For example, one provider predicted that:

'People will avoid buying alcohol in their local shops which could have an impact on local businesses.' (Provider, Survey 29)

7.46 A few providers predicted that the manufacturers would hike up prices across the board resulting in increased profits. One provider described how this might work in practice:

'More debt and manufacturers putting a premium on "better quality" drinks simply to take their products into a higher "class banding" than to distinguish it from "lesser" products. So, it's a tax on everyone and the manufacturers are quids in and the rich get richer.' (Provider, Survey 91)

7.47 While the providers were particularly concerned with potential health harms, the drinkers were more focused on the potential social harms that minimum pricing might bring. Their main concern was that drinkers (and their families) would choose to forego essential items such as food, clothing, rent and paying other bills in order to fund their continued use of alcohol. The consensus of drinker respondents was that dependent drinkers in particular are likely to 'choose alcohol' over everything else. Typical comments made by drinkers included:

'Less food, the risk of higher credit card bills, children not being cared for adequately to name a few of the unintended consequences.' (Drinker, Survey 14)

'People who are alcohol dependent substituting basic essentials as the cost is greater to fulfil their needs. (Gas, electricity & food). The support for alcohol dependency being overwhelmed with greater numbers seeking support for dependency as the person is unable to keep up with the cost. Then possibly the opiate situation where dependant rely on illegal sources of income to keep up. Shop lifting possible sex work etc.' (Drinker, Survey 22)

7.48 While the providers identified a range of social harms, the drinkers were focused mainly on the potential impact on the daily lives of individual drinkers:

- Drinkers had concerns that minimum pricing would result in financial hardship and subsequently to 'more debt' and 'increased poverty'.
- They also expressed concern about the impact on children (e.g. 'it might make children less fed as parents prioritize alcohol over food'); and
- The potential for alienating further an already marginalized section of society (e.g. 'alienate dependent alcohol users further').

7.49 There were concerns among drinkers that minimum pricing targets the poorest members of society:

'Punishing the less well off again!' (Drinker, Survey 41)

'Minimum pricing on anything only really affects those on lower incomes and from lower socio-economic backgrounds.' (Drinker, Survey 40)

Burden on services

7.50 The potential for MPA to cause an increased burden on core services was identified by several respondents. Some providers commented generally on the potential impact on 'emergency services'. Others were more specific and described the potential knock-on effect of health harms on the NHS, the police and substance misuse treatment services, such as:

'If they cannot afford to continue their current drinking levels this will be very dangerous for them. This in turn will have a huge impact on the NHS if they enter withdrawal. Massive impact on the police as the likelihood of people offending to fund their use will increase. Third sector services which are already stretched and have limited funding will be inundated with people desperate for support to commence immediately.' (Provider, Survey 7)

7.51 The increased burden on 'already stretched' services was also commented on by another provider who also referred to long waiting lists for clinical services and the potential danger this creates for dependent drinkers.

7.52 This respondent was also worried how GPs who were not sufficiently trained would be able to deal with the complexity of treating dependent drinkers:

'Dependent drinkers will be unable to fund their alcohol use putting their lives in danger as access to clinical services is subject to significant waiting lists. Impact on A&E admissions due to alcohol withdrawal. Increased crime rates to fund higher price of alcohol. GPs will not receive sufficient training to deal with the complexities of alcohol misuse and withdrawals.'" (Provider, Survey 68)

7.53 Unlike the providers, the potential impact of minimum pricing on services was not a widely expressed concern by drinkers. In fact, only three respondents made any references to the provision of support services in their answers.

Alternative methods of obtaining alcohol

7.54 Many respondents were convinced that dependent drinkers are likely to continue to drink regardless of any increase in price. Some respondents described a range of potential coping strategies that they thought drinkers would use to facilitate their continued use of alcohol. The possibility of drinkers brewing their own alcohol at home was mentioned by several respondents. Some providers were concerned about the unpredictable quality of home brew and the physical dangers of home brewing spirits (e.g. 'could see a rise in home brewing and alcohol related

overdoses through unknown strength’, ‘this can be very damaging when involving spirits’, ‘the potential of dangerous “hooch” seeing an increase’).

- 7.55 Some providers were concerned that the black market for alcohol (which one provider explained already existed in the form of imported and counterfeit vodka) would widen because of minimum pricing:

‘It could encourage more people or criminal gangs to sell counterfeit products.’
(Provider, Survey 9)

‘Increase in the amount of unregulated bootleg and smuggled alcohol.’ (Provider, Survey 81)

- 7.56 One provider highlighted the potential health dangers of black-market alcohol and, like several other providers, drew comparisons with the availability of illegal tobacco:

‘Black-market alcohol may rise, just like illegal tobacco trafficking. If this happens, people will not know what they are drinking and in many parts of the world (including Britain) there has been documented incidents of blindness and death due to counterfeit cheaper alcohol.’ (Provider, Survey 48)

- 7.57 Reference to cross-border shopping was mentioned by a small number of respondents (e.g. ‘prynu dros y bont’ – buying over the bridge). Two respondents commented on the potential impact on businesses close to the English border. One respondent was concerned that they would be ‘more likely to close down’ perhaps due to the cheaper prices on offer in England.

Switching substances

- 7.58 The possibility of some drinkers switching to cheaper substances as a result of minimum pricing was mentioned by several respondents (e.g. ‘people could switch to other cheaper substances’, ‘my fear is that they will go on to cheaper substances’, ‘so higher risk of them ... turning to drugs which would be more affordable’).
- 7.59 The main concern was that switching substances was potentially dangerous and could result in greater harm (e.g. ‘users may use more harmful substances – placing them at greater risk’).

- 7.60 Interestingly, one provider was concerned that switching to the use of drugs would be problematic given that ‘there is even less provision for detox [from drugs] – currently two beds for the whole of [named Health Board Area]³⁴’.
- 7.61 When the possibility of switching was mentioned by providers, this was usually in relation to people who were alcohol dependent:
- ‘People with dependency may choose to use cheaper alternative drugs, Novel Psychoactive Substances (NPS) or need to rely on over the counter or prescribed medication.’ (Provider, Survey 59)
- 7.62 A few providers were concerned that drinkers might switch to using synthetic cannabinoids (e.g. ‘drinkers will switch to cheaper alternatives such as drugs, including spice’). One provider thought that it might lead to the use of ‘NPS’, without specifying which type, and to reliance on ‘over the counter and prescribed medication’. Another was concerned that there would be ‘increased incentive to use products not meant for human consumption’.
- 7.63 The potential for drinkers to switch from alcohol to other substances was mentioned by many of those who completed the drinker survey. For the most part, respondents anticipated that if alcohol became too expensive then drinkers ‘might be tempted to switch’ to other substances as an alternative to ‘getting “out of it”’.
- 7.64 Interestingly, the comments provided about substance switching did not include reference to any specific substance aside from one isolated reference to ‘more solvent use’. The comments were more general than those offered by the providers and included phrases such as: ‘substance abuse’, ‘other drugs’, ‘other substances’, ‘cheaper alternatives’, ‘illegal drugs’, ‘drugs’ and ‘substance misuse’.
- 7.65 A small number of respondents referred to groups who they thought would be most at risk of switching (e.g. ‘those people who buy drinks from supermarkets/off licences might be tempted to switch to other drugs due to cost’, ‘those on low income, especially the homeless. What might they turn to?’).

Switching type of alcohol

- 7.66 The potential for drinkers to switch from one type of alcohol to another was mentioned by only a small number of provider respondents. One provider highlighted the fact that switching to a cheaper, less strong alcoholic drink could

³⁴ The identity of this service has been anonymised for ethical purposes.

‘potentially put the person in to withdrawal because their body is used to strong alcohol’. Another suggested that ‘some people may change what they drink’ and questioned whether some people may drink more dangerous substances to achieve the same desired effect. A further respondent suggested that it might ‘encourage people to drink stronger drinks, spirits instead of cider for example. It will disproportionately affect the poorest and most vulnerable groups ...’.

Displacement

7.67 Several street drinkers noted how the introduction of minimum pricing could displace this population into England where minimum pricing for alcohol has not been introduced. Although the number of responses linked to the effect were small, interviewees spoke of how the movement of homeless populations is a relatively common occurrence. One of the responses noted how this behaviour was more likely to occur than ‘border hopping’ (i.e. an excursion into England with the intention of bringing back cheap alcohol to sell or consume) as this population lack both the funds and transport to travel back and forth:

I: Okay. What about people..? On that same theme, people going to England and bringing it back?

A1: I haven’t heard of that.

A3: I can’t see the homeless doing that, to be honest. I can’t see street people, you know what are called street people, I can’t see them doing that.

A2: Well, if they go away, they’ll stay away.

A3: If they go up there, they’ll stay there.

A1: To be able to bring enough of it back, they’d have to have transport. Most beggars and street people haven’t got transport. So, if they’re going to bring enough back, supply, to be able to turn around and say, “Right, I’ve made a difference by going up there and bringing it back with me,” they’d need a van. It’s not just they haven’t got a van to drive, it’s the funds as well.

A3: If they do it, they’re not going to go there shopping. They’re going to go there, and if they go there, they’ll stay there and drink. (Drinker, Group Interview A)

Summary

7.68 In this chapter the survey and interview data have been drawn on to examine what drinkers and providers know of and think about the MPA legislation as well as their perceptions about the potential benefits and problems (adverse consequences) that might arise as a result of it being implemented across Wales. The main conclusions to be drawn are that:

- Although awareness of the legislation is relatively high amongst survey respondents the level of detailed understanding of the policy is generally poor amongst both providers and drinkers, with a few notable exceptions in each group.
- Most respondents (both providers and drinkers) think that dependent drinkers will continue to consume alcohol problematically regardless of any price increases.
- Most respondents were able to identify and describe a greater range of potential negative consequences for the policy than potential benefits.
- The main perceived benefits identified by respondents were that it may reduce consumption of high strength alcohol among some drinkers and reduce alcohol-related harms, particularly among young people.
- The main perceived concerns identified by respondents were focused on the potential increase in acquisitive crime and on health and social harms.

8. Potential impact on drinking-related behaviours

Key messages

- Most providers were pessimistic about the effect of minimum pricing for alcohol on drinking-related behaviours of drinkers.
- Providers anticipated that dependent drinkers would not be able to cope with the price change and would switch to higher strength alcoholic drinks, brew their own drinks (including spirits) at home, and commit more acquisitive crime to fund their continued use of alcohol.
- Drinkers were less likely to suggest changes in their drinking-related behaviours because of minimum pricing.
- Low/medium risk drinkers specifically anticipated that minimum pricing would have little effect on them largely because they did not drink enough to be affected or because they could afford to cope with the change.
- High risk / addiction likely drinkers anticipated few changes in their use of alcohol largely because they would employ coping strategies (e.g. cross-border shopping, committing more crime) that would enable them to continue drinking.

8.1 An important part of the study was to investigate the potential impact of a minimum pricing policy for alcohol on the consumption of alcohol and associated drinking-related behaviours. Questions were therefore included in both the survey and interviews to investigate these issues. Drinkers and providers were asked to reflect on the potential impact on a variety of behaviours including: the quantity consumed, the type of alcohol consumed, the brand consumed, methods of funding, and the location where alcohol was both purchased and then consumed. In this chapter we review what the drinkers and providers thought might happen.

Quantity of alcohol consumed

8.2 Providers were generally pessimistic about the effect of minimum pricing at an example level of 50p on drinking-related behaviour and predicted that dependent drinkers would continue drinking regardless of increases in price (e.g. 'dependency is dependency and MUP will not affect dependent behaviours').

8.3 Qualitative data from both the surveys and interviews substantiated these findings, suggesting that the legislation would have little effect on consumption due to its ‘superficial’ nature, i.e. treating the ‘symptom’ and not the ‘cause’ of addiction. One provider who completed the survey explained this well:

‘Alcoholism is an addiction and people will do what they have to do to feed their habit.’ (Provider, Survey 26)

8.4 Providers felt that without additional support and treatment for these underlying factors, a minimum price for alcohol would have no effect on the consumption patterns of dependent drinkers:

‘I think it’s a waste of money, they should be putting the money or the attention into why people are drinking and the social side of it.’ (Drinker, Interview 09)

Coping strategies - service providers’ views

8.5 To cope with the increased price increases, providers anticipated that dependent drinkers would deploy a number of ‘coping strategies’. The most widely anticipated of these was ‘switching to alternative forms of (stronger) alcohol’, followed by ‘acquisitive crime’, the ‘home brewing of alcohol’ and ‘purchasing black market alcohol’. For example, more than half of providers surveyed (58 per cent) felt that minimum pricing was likely to affect the type of alcohol consumed by dependent drinkers (see Table 8.1 below).

Table 8.1: Likelihood of effect on drinking-related behaviours (providers)

	Very likely	Likely	Neither	Unlikely	Very unlikely	Total
Quantity consumed	7 (7%)	24 (25%)	17 (18%)	31 (32%)	18 (19%)	97 (100%)
Type consumed	19 (20%)	36 (38%)	16 (17%)	19 (20%)	6 (6%)	96 (100%)
Brand consumed	24 (25%)	33 (34%)	19 (20%)	16 (17%)	4 (4%)	96 (100%)
Method of funding	41 (43%)	36 (38%)	10 (11%)	6 (6%)	2 (2%)	95 (100%)
Where purchased	21 (22%)	36 (38%)	21 (22%)	13 (14%)	5 (5%)	96 (100%)
Where consumed	11 (12%)	17 (18%)	31 (32%)	26 (27%)	11 (12%)	96 (100%)

Table notes: Some missing cases.

8.6 Indeed, in the qualitative responses, the consensus among the providers was that drinkers would seek the cheapest and strongest drink to consume. Most providers commented about how people who drink strong white ciders often do so because of its affordability and relative strength, rather than for enjoyment. As a result, if the price of the cheap, lower strength alcohol (such as cider) became similar to costlier,

higher strength drinks, it was predicted that drinkers would switch over to these higher strength beverages. It was flagged up during the provider interviews that in some cases this switch may contribute to negative health consequences:

‘Yes, and then they’ll think that’s ... obviously spirits are a whole other level of alcoholism, people’s behaviour being affected and so on. So, I know the strong ciders are strong but obviously drinking vodka is another level. So, I think that is a possibility that that’s what people will do, yes.’ (Provider, Interview 32)

- 8.7 Potential increases in acquisitive crime in order to fund more expensive alcohol (e.g. ‘increase in shoplifting or other behaviours that fund addictions such as sex trade’, ‘increase in debt and criminal activity, sex work’) were also predicted by a range of providers; although only a small number of survey respondents described a potential increase in begging and borrowing (e.g. ‘an increased in begging potentially’) or the re-budgeting of existing resources (e.g. ‘divert housekeeping for alcohol’). Shoplifting was cited by many interviewees as potentially the most common coping strategy here, particularly for homeless street drinkers:

‘I think where it will impact is on criminality because now instead of paying like you say one pound sixty five, one pound seventy for a bottle of [Brand name] or [Brand name] cider where it doesn’t contain an apple, if you are saying it’s going to be five pounds then I think shopliftings will go through the roof.’ (Provider, Interview 35)

- 8.8 The possibility of drinkers brewing their own alcohol at home was also mentioned by several respondents in interviews. Some providers were concerned about the unpredictable quality of home brew and the physical dangers of consuming the beverage:

‘I just think people are going to think if they can’t afford to buy the alcohol from the shop they are going to try and make it themselves and then I think we’d be looking at how do you manage that, how do you monitor that? You know how can we measure the percentage of alcohol, you know it’s not always exact when you are home brewing and there could be a risk to alcohol related illnesses and counterfeit booze, criminal activity, there’s quite a lot with that.’ (Provider, Interview 29)

8.9 Finally, concerns over the possible development of a black market as a result of minimum pricing were expressed by many providers in their survey responses (e.g. ‘likely to push alcohol market underground, more moonshine’, ‘there may be an incentive to buy bootleg alcohol’, ‘under the counter, off sales’) and in interviews. Again, providers were conscious of the health implications of black market/imported alcohol and in particular the dangers of consuming highly potent, unregulated alcohol:

‘I’ve seen what happened with tobacco and how they rose the price of that, and now most of the tobacco is counterfeit, at a more affordable price. The same thing will happen with alcohol, and then there’ll be even less regulation on it. God knows what people will end up drinking.’ (Provider, Interview 04)

Coping strategies - drinkers’ views

8.10 Drinkers were less likely to predict changes in their behaviour because of minimum pricing. Indeed, the vast majority (approximately 80 per cent) of drinkers thought that each of the six³⁵ drinking-related behaviours was unlikely to change as a result of minimum pricing for alcohol (see Table 8.2 below).

Table 8.2: Likelihood of effect on drinking-related behaviours (drinkers)

	Very likely	Likely	Neither	Unlikely	Very unlikely	Total
Quantity consumed	2 (2%)	7 (8%)	11 (12%)	24 (26%)	49 (53%)	93 (100%)
Type consumed	4 (4%)	8 (9%)	6 (7%)	18 (20%)	56 (61%)	92 (100%)
Brand consumed	3 (3%)	9 (10%)	6 (7%)	18 (20%)	55 (60%)	91 (100%)
Method of funding	5 (6%)	3 (3%)	10 (11%)	18 (20%)	55 (60%)	91 (100%)
Where purchased	3 (3%)	5 (6%)	10 (11%)	17 (19%)	53 (60%)	88 (100%)
Where consumed	2 (2%)	4 (5%)	11 (12%)	17 (19%)	55 (62%)	89 (100%)

Table notes: Some missing cases.

8.11 Most respondents were convinced that they (and other dependent drinkers) would continue to drink regardless of any increase in price. Therefore, the effect of minimum pricing would be to adapt existing or develop new coping strategies.

8.12 Some respondents described a range of these potential strategies that they thought drinkers would use to facilitate their continued use of alcohol. This included: switching to higher strength alcoholic drinks; brewing their own drinks (including

³⁵ Quantity consumed, type of alcohol, brand of alcohol, funding methods, location of purchase, location of consumption.

spirits) at home; and committing more acquisitive crime to fund their continued use of alcohol. However, these coping strategies varied depending on the level of individual drinking.

- 8.13 One explanation for the difference between the providers' and drinkers' views on the potential impact of minimum pricing on drinking-related behaviours might be related to the type of drinkers under scrutiny. The providers who completed the survey, for example, were asked to consider the potential impact of minimum pricing on the behaviour of 'service users', who by their very nature are likely to be problematic drinkers. The drinkers who completed the survey, however, were asked to consider how the new legislation would affect their own behaviours. The fact that they were mainly low/medium risk³⁶ (with comparatively few high risk/addiction likely drinkers), may therefore help to explain the disparity in views. Indeed, when the research team compared low/medium risk drinkers with high risk/addiction likely drinkers in terms of predicted behaviours, the latter group were far more likely to predict changes in drinking-related behaviour than the former group³⁷.
- 8.14 It is also important to note that there were only a small number of currently dependent drinkers who participated in the qualitative interviews. Indeed, some were currently abstinent, and some were drinking at more moderate levels. It is therefore important to take this into account when reviewing the findings. With this in mind, we have categorised the different explanations based on the type of drinker: low/medium risk, or high/addiction likely. The findings are presented separately below.

Low-medium risk drinkers

- 8.15 Low-medium risk drinkers suggested that they would continue to consume alcohol regardless of any price increase. One common explanation given by survey respondents was that they already consumed low levels of alcohol that would not be affected by a price change (e.g. 'don't consume enough for it to change anything', 'alcohol spending constitutes a negligible proportion of my income', 'Dim ond ychydig o alcohol fi'n yfed. Fi bron byth yn gor-yfed' – translated as 'I only drink a small amount and hardly ever too much'). Another common explanation was that the drinker had sufficient funds available to pay for their alcohol use (e.g. 'wages', 'I

³⁶ Based on their scores on the AUDIT tool see Table B.2 in Annex B.

³⁷ The findings were statistically significant but the small cell sizes (even after collapsing the categories as far as reasonably possible) render the results unreliable.

have funds available', 'I drink relatively expensive alcohol anyway.. in pubs etc'). One survey respondent explained that he/she would not alter the funding arrangements because he/she would adjust the quantity consumed to keep it affordable:

'I don't spend beyond my means, even though I am considered to live below the 'poverty' line. I would probably drink less in pubs etc. and more at home if I were to lose my job. So not really dependant on price increase.' (Drinker, Survey 50)

- 8.16 The general consensus was that low-medium risk drinkers would be able to continue their current drinking patterns following the introduction of minimum pricing either because they could afford not to change anything or because they did not drink enough to have to change anything.

High risk/addiction likely drinkers

- 8.17 High risk/addiction likely drinkers (including street homeless and 'heavy' alcohol users) also anticipated few changes in their use of alcohol. However, in contrast to low/medium risk drinkers, this group suggested deploying a range of distinct coping strategies to enable them to continue drinking. A couple of drinkers described the possibility of moving towards higher strength spirits (e.g. "if the price of larger or wine becomes similar to spirits, I shall probably buy spirit instead"), a finding also reflected in the interview data:

'If a bottle of cider cost £2.50 and then you're going to pay £8.00, you're just going to make people drink vodka instead of cider. Sorry.' (Drinker, Interview 31)

- 8.18 Interestingly, one survey respondent flagged up that if the prices became similar, he/she would switch to spirits to get a faster effect (e.g. 'likely to switch to spirits to get a quicker high if prices converge').

- 8.19 There was also some indication that high risk/addiction likely drinkers may decide to produce their own alcohol if it became unaffordable. While home brewing was infrequently reported among the drinkers, some believed that the home production of alcohol would increase following the introduction of the legislation. Some drinkers even described plans to start producing their own:

'Well, I've looked into it and I've got all the plans and the whole thing ready to make a little distillery in the shed. Pressure cooker modified and you can support your habit and make money.' (Drinker, Interview 09)

'They think I'd be doing fine, and I'd be in my flat with about four home brew kits going. Know what I mean?' (Drinker, Interview 36)

'Yes. I have got friends who make it on quite a regular basis, and I have drunk it and it has been good.' (Drinker, Interview 22)

8.20 Other drinkers, however, stated that it would be unlikely for them to home brew alcohol. One interviewee suggested that he would be unwilling to try anything that had been home produced, whilst a group of street drinkers indicated that this cohort would lack the resources to produce illicit alcohol:

'I wouldn't touch that sh*t. F**k that. I'm not drinking nothing that's not got the top sealed.' (Drinker, Interview 31)

I: No, they wouldn't have the inclination to do it. They wouldn't have the time to do it, the inclination to do it. They wouldn't have the will to do it.

I: Or the place to do it.

A2: And the place to do it as well.

A1: Exactly. And the place to do it as well. No, being honest, I can't see it. Can you?

A3: It takes too long to make it.

A1: Exactly. All you need is potatoes or apple, a bit of bread...

A3: Bit of yeast.

A1: Apples, potato, sugar, water, and somewhere warm to keep it.

A2: It's just the fermentation. But that wouldn't happen. (Drinker, Group Interview A)

8.21 Finally, from the interview data, the most commonly predicted means of obtaining illegal alcohol following the introduction of minimum pricing, was through regular purchase or stockpiling alcohol from countries where minimum pricing currently does not exist, in particular England. Some participants did state that this practice currently exists, and individuals would accumulate alcohol from abroad to sell in Wales when prices increase:

A Yes, just going away for a night or two, coming back with a van full and then selling it off.

Q Where are they getting it from?

A Belgium, anywhere. (Drinker, Interview 02)

8.22 Participants felt that this practice would most likely occur in locations close to the English border (e.g. Newport, Chepstow, Welshpool, Wrexham) where trips back and forth to purchase alcohol could be made with relative ease:

'I could envisage how you might sort of think "well it's only a few miles away, I'll make my way over there and buy it there because it's cheaper", maybe.' (Drinker, Interview 23)

'Well, they can just go over there then, yes. They're going to be, aren't they? That's what they're going to do then, yes, you'd have thought. Especially now the tolls have gone. Why not?' (Drinker, Interview 25)

'Here it's only a matter for us to go down the road. It's worth driving an hour to buy alcohol a lot cheaper...how are you going to address cross-border smuggling? Are you going to have checkpoints on the M4?' (Drinker, Interview 15)

Summary

8.23 This chapter has examined the potential impact of minimum pricing on drinking-related behaviours using the survey and interview data.

8.24 Providers were generally pessimistic about the effect of minimum pricing on drinking-related behaviour. Most anticipated that dependent drinkers would be unable to cope with the price change and would employ a variety of strategies (e.g. switching to strong types of alcohol, brewing their own or committing more crime) in order to continue drinking.

8.25 Drinkers, however, were less likely to predict changes in their behaviour because of minimum pricing. Low-medium risk drinkers indicated that their consumption was unlikely to be affected largely because they could afford to keep drinking the same amount or because they were not big drinkers and would therefore not feel the pinch. 'High, addiction-likely' drinkers also anticipated few changes in their use of alcohol largely because they would employ coping strategies (e.g. cross-border shopping, committing more crime) that would enable them to continue drinking.

9. Potential impact on other aspects of drinkers' lives

Key messages

- Overall, the providers perceived that minimum pricing for alcohol would have largely negative consequences on all aspects of drinkers' lives particularly their financial circumstances, offending behaviour and mental health.
- It was believed by many that the negative effects would be felt most acutely by dependent drinkers.
- Providers and drinkers anticipated that drinkers would employ various strategies to cope with the impact on their budgets. This included: re-budgeting existing resources, borrowing from family and friends, more formal borrowing in the way of tabs at local shops or in pubs, and street begging.
- The potential for an increase in acquisitive crime (mainly shoplifting) was also predicted by many survey respondents and interviewees.
- It was predicted that minimum pricing would have an effect on drinkers' mental health and family relationships largely as a result of the increased strain, stress and anxiety that would be placed on drinkers who would find the price rise difficult to manage.
- The impact that minimum pricing would have on drinkers in receipt of Universal Credit was noted as a specific worry.

9.1 The potential impact of the introduction of a minimum price for alcohol on drinkers' lives more generally was another key aim of the research. Questions investigating the wider effects of MPA were therefore included in both the surveys and the interviews. This chapter examines what providers and drinkers think would happen to drinkers in terms of their: financial circumstances, employment, mental and physical health, relationships with family and friends, housing and living arrangements and also their offending behaviour.

Likelihood of effect on service users' lives

9.2 Providers who completed the online survey were asked to indicate how likely they thought that minimum pricing would affect various aspects of service users' lives (see Table 9.1 below). Perhaps unsurprisingly, financial circumstances were the aspect that most respondents felt was 'likely' or 'very likely' to be affected (85 per cent). This was followed by: offending behaviour (83 per cent); mental health (75

per cent); relationships with family members (67 per cent); housing (58 per cent); relationships with friends (56 per cent); and employment (34 cent).

Table 9.1: Likelihood of effect on drinking-related behaviours (providers)

	Very likely	Likely	Neither	Unlikely	Very unlikely	Total
Family	23 (24%)	42 (43%)	25 (26%)	7 (7%)	1 (1%)	96 (100%)
Friends	20 (21%)	34 (35%)	35 (36%)	7 (7%)	1 (1%)	97 (100%)
Physical health	23 (24%)	38 (39%)	24 (25%)	10 (10%)	3 (3%)	98 (100%)
Mental health	26 (27%)	47 (48%)	14 (14%)	9 (9%)	2 (2%)	98 (100%)
Employment	14 (14%)	20 (20%)	46 (47%)	12 (12%)	6 (6%)	98 (100%)
Financial circs	40 (41%)	43 (44%)	9 (9%)	3 (3%)	2 (2%)	97 (100%)
Housing	21 (21%)	36 (37%)	32 (33%)	5 (5%)	4 (4%)	98 (100%)
Offending	32 (33%)	49 (50%)	12 (12%)	5 (5%)	0 (0%)	98 (100%)

Table notes: Some missing cases.

9.3 In contrast to providers, most of the drinkers who completed the survey felt that minimum pricing was unlikely to affect any of the eight aspects of their lives, including their financial circumstances (see Table 9.2 below). The main reason for this was because they were ‘not big drinkers’ or could afford to cope with the price change. Unfortunately, very few respondents provided explanations for their predictions, possibly due to response fatigue (these questions were located at the end of the questionnaire). It is therefore difficult to identify any clear patterns in the qualitative comments. The general feeling, however, is that high risk/addiction likely drinkers felt that minimum pricing was likely to affect their lives (e.g. ‘it will devastate my finances’) while low-medium risk drinkers felt the reverse (e.g. ‘I’m not a big drinker so I think it will have little / no affect’).

Table 9.2: Likelihood of impact on other aspects of your life (drinkers)

	Very likely	Likely	Neither	Unlikely	Very unlikely	Total
Family	7 (8%)	7 (8%)	9 (10%)	6 (7%)	63 (69%)	92 (100%)
Friends	6 (7%)	6 (7%)	10 (11%)	5 (5%)	65 (71%)	92 (100%)
Physical health	3 (3%)	7 (8%)	13 (14%)	3 (3%)	65 (71%)	91 (100%)
Mental health	6 (7%)	6 (7%)	15 (16%)	4 (4%)	61 (66%)	92 (100%)
Employment	3 (3%)	4 (4%)	13 (14%)	4 (4%)	66 (73%)	90 (100%)
Financial circs	8 (9%)	9 (10%)	12 (13%)	5 (6%)	57 (63%)	91 (100%)
Housing	4 (4%)	6 (7%)	11 (12%)	5 (6%)	65 (71%)	91 (100%)
Offending	4 (4%)	2 (2%)	13 (14%)	4 (4%)	67 (74%)	90 (100%)

Table notes: Some missing cases.

9.4 Interestingly, when drinkers who completed the survey were asked to reflect on the potential impact of MPA on other drinkers, a different pattern of results emerged. Most drinkers (87 per cent, 79/91) anticipated that the introduction of a minimum price for alcohol would affect the lives of other drinkers. The reasons given for this were varied, but there were two common themes, namely, the financial hardship that some drinkers (and their families) would face, and the need for some drinkers to commit crime to fund their continued use of alcohol.

Financial circumstances

- 9.5 Both providers and drinkers were more likely to predict that MPA would have an effect on drinkers' financial circumstances than on any other aspect of their lives (see Tables 9.1 and 9.2 above).
- 9.6 The qualitative responses from the surveys with providers indicated that for most respondents this was not likely to be for the better (e.g. 'more debt potentially, 'poorer', 'more money will be spent on alcohol', 'I used to be a smoker and no matter how many times the prices went up, I still smoked and spent less on other things. I feel the same applies to alcohol).
- 9.7 A few providers thought that this might have a knock-on effect on other aspects of drinkers' lives (e.g. 'their drinking expenditure would increase which may lessen basic need items such as food and heating').
- 9.8 Some providers predicted that the likelihood of financial problems was greater among high risk/addiction likely drinkers (e.g. 'for those on the heavy end of drinking it may mean a greater financial problem').
- 9.9 However, one provider thought that low-medium risk drinkers may be affected too as they 'may divert a greater proportion of their income towards the purchase of alcohol, neglecting other areas such as bills, food, fines, supporting other family members' (Provider, Survey 81).
- 9.10 The possibility that minimum pricing might have a positive effect on drinkers' financial circumstances was mentioned by only one provider, who thought that it may help drinkers to 'keep their finances on an even keel'.
- 9.11 During qualitative interviews, several providers predicted that drinkers would employ various strategies to cope with the financial strains generated by the introduction of minimum pricing. A few providers suggested that some drinkers would re-budget

their existing resources to free up money to spend on alcohol (e.g. diverting money that would be used to pay household bills for alcohol):

'It's a difficult one, especially when you're dealing with my clients with drug addiction, they will go without food to buy a bag of heroin. Now if you apply that to alcohol the same may well apply. So, they may well cut down on food and necessities and things that they should be doing around the house, to save up and buy the alcohol.' (Provider Interview 14)

'They'll make do. They'll find a way to buy their beer or buy their cider and other things will get left. If they're getting their housing benefit and they haven't got enough to pay their rent and their drink, they'll choose their drink over their rent.' (Provider, Interview 22)

- 9.12 The budgeting of existing resources (e.g. food, gas/electricity bills) was the most commonly cited coping strategy among drinkers as well. Most drinkers stated that they had previously done this when unable to afford alcohol. Although budgeting was commonly associated with the foregoing of daily essentials and household bills, the most common response was that they would most likely not spend money on food when in this situation:

'Oh God, yes. If it would come down to food or drink, it would definitely be drink. Oh God, yes, definitely.' (Drinker, Interview 27)

'And if you're in that place where you're still using, and you've got money to buy food or buy drink, you're going to buy the drink.' (Drinker, Interview 14)

- 9.13 Other drinkers noted how they would divert funds from household bills and other essentials to subsidise their habit. Often this had the consequence of increasing debt and financial difficulties:

R: In the past I just never paid my bills.

I: Okay. So, that was your way of funding it?

R: Yes. I didn't pay the bills, I just drank. (Drinker, Interview 15)

'If they're poor then they haven't got an awful lot of money they could, say, drink a lot and decide not to eat, which is equally as bad. Because what happen[s] is that people, they lose interest in eating. They may not pay their bills; they may be evicted. All that sort of thing could happen. If you just say "Okay: 50p" and don't sort of put anything in place for that.' (Interview, Drinker 21)

9.14 Another coping strategy mentioned by both providers and drinkers included borrowing money from friends and close family. Here, two different types of borrowing were evidenced, depending on the type of drinker. For street drinkers, it was common for providers to allude to the 'pooling' of resources among this cohort:

'And then the next day then it's your turn because, "We'll be all right tomorrow because Tom gets money tomorrow," or there'll be a Personal Independence Payment allowance or there'll be some other income-related benefit, you see. So, it works... from a safety point of view it's probably the best thing they could do actually. So, if you're suffering from withdrawal symptoms and we've had ... we drink x amount of alcohol over a period in the morning and I wake up in the morning and I'm not feeling too good and I know that you've got money today then I'll just say, "Tom, I'm feeling awful. I'm shaking, sweating, feeling sick," common withdrawal symptoms. Then I would say, "Go and get us a can of that super strength." Knowing that you've got ... So, it's about security in an unsecure world.' (Provider, Interview 31)

9.15 A similar borrowing strategy was described during qualitative interviews with drinkers as well. These interviewees stated that it was a relatively common procedure, particularly among street drinkers, to pool money to fund purchases when unable to afford alcohol individually:

A2: It could put them off, because the price is so high. But then again, if they're in a group of friends, they'll just chip in. So, it might not be one person buying it, there's three or four people chipping in, and that's how they'll get around it.

A3: But then, doing that, it still works out the same amount of money whether there's three of you...

A1: Exactly. The same amount of money.

A2: Aye, but what I'm saying is, if there's one person they might not do it, but if there's three or four...

A3: They can't afford to buy it themselves, so they'll chip it in.

A2: Chipping in, that's the thing yeah. They'll chip in. They'll just chip in.
(Drinker, Group Interview A)

9.16 In contrast, non-street drinkers were more likely to borrow money or alcohol from close family or friends. This point was stated by both providers and drinkers during qualitative interviews:

‘And one of the issues they do have and it’s a bit of stereotype but it is that mother-son sometimes where the son is forty years old, he’s still living at home, he needs money for alcohol and mum being mum, she gives him the money. So there could be a rise in financial abuse from people who are dependent on alcohol on their family members because at the moment there is that “I haven’t got any money, I need money, you’re my mum, you’re my dad, you’re my wife, my husband, my son, my daughter, give me some money.” You know if you’ve got someone with you twenty-four hours a day saying, “give me a fiver I need a drink” so that could have an impact yes.’ (Provider Interview 14)

‘Friends borrow us money, I just get it where I can really.’ (Drinker, Interview 03)

‘Mates. Yes, friends and family and obviously ask my family to lend me money.’ (Provider, Interview 34)

‘I went down to see my uncle and auntie because I know they drink every night so I knew I could drink in their house for free all night.’ (Drinker, Interview 22)

9.17 Two drinkers noted that, in a previous scenario where they were unable to afford alcohol, they had opened a credit tab at a local corner shop. Both participants felt that this was a coping method that could occur because of minimum pricing:

‘I’ve personally gone down to the shop and said that I’ve left my card in the house, things like that, or I’ll pay tomorrow, and because it’s a local shop they knew me...They didn’t like to do it, but they did, but they cottoned on in the end. People have just got ways around it all, haven’t they?’ (Drinker, Interview 01)

‘I had a credit tab at the corner shop where I’d max that out to £200. So that was one line of obtaining it that would have dried up. But then I perhaps would have got paid, paid that, racked it up again.’ (Drinker, Interview 11)

9.18 Although drinkers were able to obtain alcohol via this method, using this coping strategy led to further debts. A few drinkers expressed the view that some pub owners were also responsible for allowing this practice to develop and consequently increase the financial strain on dependent drinkers:

'Well, I mean, I know some pubs give bar tabs. They're not supposed to. I was given bar tabs in the past, and my whole family, you know, they were fuming because you know, they would have to pay off my bar tabs because... I have such limited money, you know. I was drinking a bar tab that I couldn't afford to pay. You know I was drinking, you know, so... And then obviously people borrow money as well, and that's what I would always have to do, is borrow money off, you know... My family. Yeah, and I've seen other people do it in the pub as well, you know, they're trying to borrow money off people to feed their habit, you know, so it's not, yeah, I think there should be something that literally says that landlords cannot give bar tabs because I've been burnt with that, and it's very worrying how much you can rack up in one... You know, one drinking session, and then, yeah. And then you owe money.' (Drinker, Interview 34)

9.19 During qualitative interviews, some drinkers also stated that they would be looking to 'make money' through certain methods. For street drinkers, this was likely to be begging:

A2: To tell the truth, we sometimes have to go out and make the money, i.e. beg or work for it.

A3: We find the money. (Drinker, Group Interview A)

'I would beg money for it. I would do what I had to do to get a drink. I'm addicted to alcohol.' (B3, Drinker, Group Interview B)

9.20 Non-street drinkers also believed this would occur among the homeless population, although their means of making money were different. For them, selling household items to subsidise alcohol was cited as a more common technique if unable to afford alcohol:

'It's a struggle sometimes. I can't. I borrow off so and so...I might put my Xbox in the Cash Exchange, ah no, PS2, sorry. It's alright at the time. They when a day comes and I go out and spend £40 and get my PlayStation out. £40, £70 odds, £50-£70 odds, do you know what I mean?...Horrendous, you know what I mean? Sometimes you got me in that position as well, do you know what I mean.'
(Drinker, Interview 36)

'For me a few months back, it would be still spending, still buying, looking for money to get, might be selling some junk in the house or anything else like that even.' (Drinker, Interview 08)

Offending behaviour

- 9.21 Most providers who completed the survey indicated that minimum pricing would affect drinkers' offending behaviour (see Table 9.1 above).
- 9.22 In the majority of cases this was because respondents thought that drinkers would commit crime to fund their continued use of alcohol (e.g. 'increased offending to be able to maintain drinking and fund alcohol use').
- 9.23 Some respondents referred to particular types of income-generating crime (e.g. 'burglary, personal theft, shoplifting'), while others were more general in their answers (e.g. 'could lead to offending behaviour'). One survey respondent predicted an increase in a range of different types of crime including importing illegal alcohol, theft, stealing and pub raids:

'Could increase the importing and dealing of counterfeit alcohol. Result in higher thefts of store alcohol. Robbing of alcohol from vulnerable people or just general public. Possible pub raids?' (Provider, Survey 52)

- 9.24 Only a few providers described the potential for a reduction in crime (e.g. 'proven link between alcohol and offending. Presumably, a reduction in alcohol use would impact on an individual's behaviour, reducing alcohol related crime', 'may be less likely to commit serious offences').
- 9.25 Qualitative interviews revealed that most providers were convinced dependent drinkers would continue to consume alcohol problematically despite the introduction of minimum pricing. During these interviews, they described a range of potential coping strategies that they thought drinkers would use to facilitate their continued use of alcohol following the introduction of the new law. Confirming the survey findings, one of the most widely anticipated of these coping strategies was the drinkers' increased involvement in acquisitive crime. Shoplifting was cited as potentially the most common coping strategy, particularly for homeless street drinkers:

'If they cannot afford to buy the amount that they need then, yes, they will I think, they might resort to stealing it.' (Provider, Interview 14)

'The street drinkers just need alcohol, have got to have it, they offend already so they are just going to find ways, like, so begging maybe they'll do more of that but stealing too.' (Provider Interview 37)

9.26 Consistent with providers' views, drinkers also anticipated an increase in their involvement in criminal behaviour as a result of the MPA, especially if they were dependent on alcohol and their financial situation was difficult (i.e. street homeless). The offences that drinkers predicted would witness an increase were shoplifting and robbery:

R: The other thing is people who cannot get alcohol when they are dependent, they could literally die of withdrawal, so I think that is a big concern they haven't really thought through to be honest, and because they know they need their alcohol I think it is going to result in more street crime, robbery and that kind of thing to fund the habit.

I: So, street crime, robbery, what might that look like, how might that happen do you think?

R: I would think generally muggings, but then I think a lot of shops, people going into corner shops and walking out with a flagon of cider. In supermarkets the security is quite lax. If no one is watching, you could quite easily walk out with a flagon under your arm. So, I think there are going to be more stealing from shops and possibly more stealing from people on the street as well.

I: Do you think there is a particular type of drinker that might be more prone to that kind of behaviour?

R: Probably street homeless, because they are in a much worse financial position. If they haven't got a hostel or they haven't got a safe address, they don't get any benefit whatsoever, so I think that is going to be a big issue. (Drinker, Interview 22)

I: In terms of, I'm thinking about spending habits. For instance, if you want to spend more on...?

R: It's a habit, isn't it? It's a drug... addictive. Crime will probably go up.

I: Why would you say that?

R: Well you know, they commit robbery now and everything for drugs, don't they? So, crime would probably go up related to the alcohol. The price of alcohol and stuff, so crime would probably go up. (Drinker, Interview 15)

Mental health

- 9.27 Three-quarters of providers who completed the survey thought that minimum pricing was 'likely' or 'very likely' to have an effect on the mental health of service users (see Table 9.1 above). Opinion was divided, however, in terms of whether the impact would be positive or negative.
- 9.28 Some providers indicated that it could result in improvements in mental health (e.g. 'alcohol is a depressant so mental health should improve', 'alcohol and mental health are related, so it will be some benefit', 'there is a strong link between alcohol misuse and depression so hopefully mental health will improve') or improvements in access to mental health services (e.g. 'If they are drinking, mental health [services] won't touch them. If MUP stops them drinking, they can access this support'.) Others, by contrast, anticipated that there would be a deterioration in the mental health of service users largely due to the stress caused by having to find more money to fund their alcohol use (e.g. 'stress and anxiety due to not having monies', 'more stress of getting money').
- 9.29 Some respondents thought that a deterioration in mental health would result from increased isolation (e.g. 'should they stay at home more to drink alcohol this could affect their mental health') or through strained family relationships (e.g. 'arguments with friends and family will have negative effects on mental health').
- 9.30 Generally, it appeared that providers were concerned about the increased stress that MPA would put on drinkers who they described as being already stressed and under pressure (e.g. 'it's another stress for people who may not be dealing well with current stresses, especially with Universal Credit issues', 'pressures on how to afford the alcohol they require to stay safe physically could result in heightened anxiety or depression').
- 9.31 During interviews, a few drinkers also expressed their worry that the introduction of minimum pricing would increase levels of stress and/or anxiety:
- C2: I can see a lot of stress levels going up as well.
- I: Okay. Tell me a bit more.
- C2: Everybody says it, don't they? When they're stressed out, they have a drink. Wake up the next morning, "Okay, shouldn't have maybe had too much to drink, but I feel better for it." If I can't afford it and I can't have a drink, I'm still going to be stressed. (Drinker, Group Interview C)

9.32 The issue of potential effects on drinkers' mental health was highlighted during qualitative interviews with providers as well. Interviewees overwhelmingly agreed that these effects would be negative, and they indicated that these would be most likely visible in terms of increased levels of stress and/or anxiety among drinkers as a result of minimum pricing:

R: ... I mean if people are more desperate because they can't get their cheap ciders, their level of anxiety is going to be higher and there's a higher risk of things kicking off and ... (Provider, Interview 32)

Relationships with family members

9.33 Roughly two-thirds (67 per cent) of providers predicted that minimum pricing would affect relationships with family members (see Table 9.1 above).

9.34 For the most part, respondents felt that it was likely to have a negative effect through the financial strain that it would put on families (e.g. 'put more pressure on family finances', 'could put a strain on relationships due to wanting money for alcohol').

9.35 Some providers described the potential for drinkers to re-budget their household expenditure and 'spend more money on alcohol and not on family members, e.g. children'.

9.36 Others described a potential increase in borrowing from family members and predicted that 'arguments will follow when they are not given it'.

9.37 Only a small number of respondents anticipated a reduction in alcohol use and an improvement in family relationships (e.g. 'alcohol has a detrimental effect on many families so a reduction in use has to be positive although I am not convinced it will make a huge difference'). One respondent explained that the impact on families would vary by type of drinker.

9.38 During qualitative interviews providers (and to a limited extent drinkers) discussed the potential implications of minimum pricing on drinkers' relationships with family members. Overwhelmingly, interviewees indicated that they anticipated that the legislation would have a detrimental effect in this regard. Specifically, they anticipated it would add to the strains of some already tense relationships which were damaged through the use of alcohol:

- I: Okay. What do you think the impact might be on others? Let's say the families of those who drink, or friends?
- R: I think it could get very difficult because it's going to be... if people are spending more money... you know its whether... we say crime and stuff, but people take from their own families and things and that doesn't get reported, so that doesn't happen... so that might increase, as it sort of moves up the list of priorities, the alcohol, and it's going to cause more strain on families. If it's damaging physical health and things, that's going to be just more worry and more stress for the family members. And then there's the whole legal aspect around if people are trying to make alcohol and things in the families' houses, or if they're buying alcohol in and selling... you know, bringing it in from somewhere that doesn't have the minimum unit pricing and selling it from there whether the family could get in...?... yes, I think is, because it's already a very stressful thing to go through having a family member with substance misuse...yes, this might not help... with the unit pricing. (Provider, Interview 24)
- Q So you've begun to touch on it, what do you think might be the impact into the wider bits of their life, or for families who they live with then, of minimum pricing?
- A Obviously I should imagine it would cause more relationship breakdowns, because that has happened in the past because if people are drinking so much, maybe they may get more argumentative, maybe cause rows to get more drink, that kind of thing, this is what I need. So, I think perhaps more relationship breakdowns, and people perhaps maybe finding themselves on their own a bit more.
- Q So contributing to much more tension in relationships potentially?
- A Yeah. (Provider, Interview 08)

Housing and living arrangements

- 9.39 A similar pattern of results was found among providers in relation to the potential effect of minimum pricing on housing and living arrangements (see Table 9.1 above). In other words, most providers thought that minimum pricing was likely to influence drinkers' living arrangements and for the most part the effect was predicted to be negative. Among those who anticipated a change, most were

concerned that drinkers might lose their homes if they were unable to pay their rent or mortgage (e.g. 'mortgage/rental repayment defaults potential', 'risk of losing tenancy because of spending on alcohol', 'increased debts and increased eviction rate due to non-payment of rent/mortgages'). Only a small number of respondents described a potentially positive impact (e.g. 'could improve retention of tenancies and improve opportunity to gain more stable housing', 'hopefully beneficial effect').

- 9.40 A common theme during the interviews with providers was a worry that the new universal credit arrangements for the payment of benefits would potentially contribute to dependent drinkers' inability to manage their monthly budget. This in turn would lead to drinkers struggling to pay their rent and consequently find themselves at a higher risk of accumulating debt and/or becoming homeless.

'Yes, I think the issue being... I forget the name of it now, but that clearly the way that they get paid their benefits has changed recently, so people get a lump-sum and they're expected to budget themselves. I think hand-in-hand with this, it's already causing problems, I've no doubt that people who are dependent, are probably drinking more because they've suddenly got a big wedge of money arriving, when they should be paying their rent with it and this will only... with those individuals, I'm sure this would exacerbate that problem.' (Provider Interview 21)

'Yes, it could do if people prioritise and we know people prioritise drugs over food, rent, bills, all of that. Yes if you are like I say determined to carry on doing what you are doing there is a possibility that you will have to find more money and that money may have to come out of essentials and especially if you're not getting that much, if you are on like one hundred and forty pounds a fortnight or something it's pretty bleak.' (Provider, Interview 28)

- 9.41 During qualitative interviews, drinkers expressed similar negative views regarding the potential effects of minimum pricing. Some of them made similar points regarding universal credit, while others anticipated that as a result of the new legislation, they would have to prioritise their spending on alcohol over other aspects of their lives, including housing expenses:

I: Okay. So, more of that would happen. So, shifting resources from one thing to another. Okay, so re-budgeting.

C3: Not paying their bills, or things like that.

C4: You end up in debt then.

C1: Not paying your rent.

I Any other things that people might...?

C1: With Universal Credit coming in, and you see that big number of money at the end of the month, they're going to spend that all on booze.

C2: Yes, I think a lot of people would.

C1: That would be the main thing. They've got no money left then to pay their council and their rent, and they just get evicted.

I: So, that could be a consequence. So, they could spend all their money.

C1: They would, yeah. (Drinker, Group Interview C)

'I mean, that's the one thing if you're using any substance and you've got bills, the bills become secondary. I know that, I've been evicted in the past, because....' (Drinker, Interview 14)

I: This is one of the questions that I want to ask you.

R: Clothes and shoes and maybe find themselves out on the streets.

I: Yes, that's what ...

R: If they can't afford to pay rent or anything because they're paying so much for the cider or whatever it is that they used to pay before. (Drinker, Interview 17)

Relationships with friends

- 9.42 The potential impact of minimum pricing on relationships with friends was similar in many respects to the impact predicted for relationships with family.
- 9.43 Many providers who completed the survey were concerned about the possibility of 'increased friction' and 'arguments' between friends because of drinkers asking to borrow increasing amounts of money. One survey respondent anticipated that drinkers may socialise less often because they would not be able to afford it. Another, by contrast, could see that minimum pricing might encourage 'more talking with friends'. Some respondents thought that it might lead to drinkers 'asking for support as they now know they need to stop' or them moving 'away from a negative

circle of friends'. On the flip side, a couple of respondents could see that it 'may cause more in fighting amongst cohorts of drinkers'.

9.44 Consistent with survey data, qualitative interviews with providers revealed a mixed picture in terms of the expected impact of minimum pricing on drinkers' relationships with friends. Some providers believed the legislation would be beneficial in that it would encourage drinkers to socialise more by drinking in pubs rather than alone:

R Well, not stop them. Personally, I do wonder whether it's going to get people back into clubs more, and pubs. Because if high unit pricing is onto the pubs and they are charging the same as the supermarkets, is that trend going to change?

I That's a really interesting point. So, you're thinking in terms of isolation?

R Yeah. You know. People are drinking more in home, you know, but if that changed and the prices for alcohol were the same in the supermarket as they were in the pub, would more people be getting out of their home and going to the pub instead? Probably so. ...

I That's really interesting. I've not heard that one and I think that's really good. Really positive potential consequence.

R Yeah. If the pubs were at the same level as the supermarkets, then what are people more likely to do? Are they going to be going down to their local ASDA, Tesco when the deals are on, should I say aren't on, if the pubs were pricing it the same, because when you look at it, you, you make prices if they're getting charged by the breweries, or whatever, the same price as they are in ..., it could be manageable. There'd be offset then with people getting out into the pubs, community, - more, things like that. Could increase jobs in that sector. Although you'd lose some from other sectors ...

(Provider, Interview 25)

9.45 Other providers though, did not share this optimistic view. Rather, they suggested that for drinkers who suffer from social anxiety, a visit to the pub would not be something they would consider doing. Moreover, a few providers anticipated that pub drinking could also increase levels of alcohol intake:

I: Is it a reasonable statement?

R: It is, if I think about it more though the people who do drink at home drink at home because they don't want to go out but a lot of people isolate themselves, drink on their own because of various reasons. So those people I don't think... they are not going to suddenly be like "oh right I'm going to go to the pub now" but who knows, if could...

I: So, it might be too late for them, but it could be...?

R: For people who haven't quite got there yet then yes definitely. It may work that way. (Provider, Interview 28)

R: So people that I've worked with in my caseload find that going to the pub, actually that's where their drinking escalates and increases in a pub environment and that actually it's kind of a barrier to them, reducing their alcohol use is that fact that they are out and they are getting that social interaction with alcohol. So that's something that just flashed in my mind quickly, if people are spending money in a pub it could be very hard then to break that kind of cycle of going to the pub, having that social interaction and I've got people that drink because they don't really want to drink but they still need that social...does that make sense?

I: Yes, it does.

R: Just to get that social interaction but they are actually using far more alcohol than they want to use because they need that. So, it can work both ways I think. (Provider, Interview 29)

Summary

- 9.46 Overall, the providers anticipated that minimum pricing would have largely negative consequences on all aspects of drinkers' lives particularly their financial circumstances, offending behaviour and mental health. It was believed by many that the negative effects would be felt most acutely by dependent drinkers.
- 9.47 Drinkers, by contrast, indicated that the new legislation was unlikely to affect any aspects of their lives, perhaps because most of them were moderate rather than hazardous or harmful drinkers.

- 9.48 However, when they were asked to reflect on the potential impact of minimum pricing on other drinkers, a different pattern of results emerged. Indeed, most drinkers predicted that minimum pricing would have a negative effect on other drinkers (mainly dependent drinkers) particularly in terms of their financial circumstances, living arrangements and offending behaviour.
- 9.49 In relation to financial issues, providers and drinkers anticipated that drinkers would employ various strategies to cope with the impact on their budgets. This included: re-budgeting existing resources; borrowing from family and friends; more formal borrowing in the way of tabs at local shops or in pubs; and street begging.
- 9.50 The potential for an increase in offending was also predicted by many provider survey respondents and interviewees. For the most part, it was anticipated that acquisitive crime (mainly shoplifting) would be committed either to generate funds with which to purchase alcohol or to obtain alcohol directly.
- 9.51 The potential impact of minimum pricing on the mental health of drinkers was anticipated largely as a result of the increased strain, stress and anxiety that would be placed on drinkers who would find the price rise difficult to manage.
- 9.52 The knock-on effect of this on family members and friends was also a matter of considerable concern to providers and drinkers.
- 9.53 The impact that MPA would have on drinkers in receipt of Universal Credit was a specific worry. Drinkers and providers alike expressed concern that drinkers receiving this benefit (often in one lump sum) would find it even more difficult to manage their monthly budgets once the price of alcohol increases.

10. Preparation, Planning and Support

Key messages

- Many providers did not know whether their organisation was doing anything to prepare for the introduction of minimum pricing for alcohol. Knowledge was greater among managers than staff in other roles suggesting that important messages had not always filtered down to frontline workers.
- While a small number of organisations were preparing for the change in legislation, there was a general consensus among providers and drinkers that more preparatory work was needed to raise awareness about it and to improve access to appropriate support services.
- Only a small number of drinkers anticipated doing anything to prepare for the introduction of a minimum price for alcohol and in most cases the proposed solution was a short-term one that involved stockpiling cheaper supplies prior to the implementation of the law. Longer term solutions such as entering treatment and cutting down the quantity consumed were mentioned by only a few drinkers.

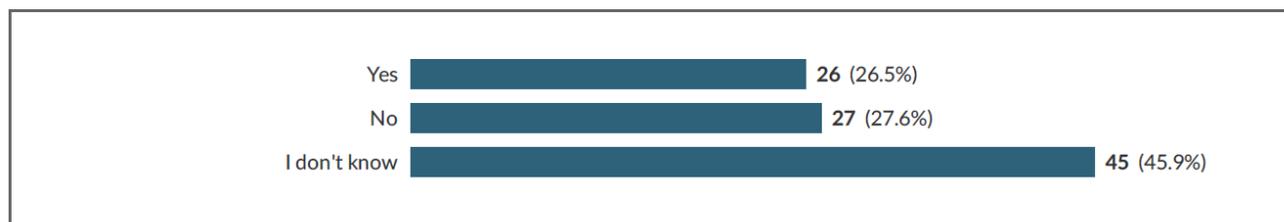
10.1 This chapter draws on data collected from the surveys and interviews with drinkers and providers to examine if, and how, organisations and individuals are preparing for the implementation of the minimum price for alcohol in Wales. What providers and drinkers think might be needed to help drinkers prepare for the change in price is also investigated. The main goal is to establish what could be done to help maximise the benefits of introducing minimum pricing and minimise any potential harms.

Is your organisation preparing for the introduction of MPA?

10.2 Many providers were unaware of what their organisations were doing to prepare for the introduction of minimum pricing. A little under half (46 per cent) of the providers who completed the survey indicated that they did not know what was going on within their organisation in relation to minimum pricing (see Figure 10.1 below).

Figure 10.1: Is your organisation preparing for the introduction of MPA

Is your organisation preparing for the introduction of a Minimum Price for alcohol in any way? (e.g. developing new services, devising new tools, recruiting new staff, promoting awareness of MUP, etc)



- 10.3 Many of the interviewees described a similar lack of awareness: 'I honestly don't know what [agency] is doing' (Provider, Interview 14), 'I mean I feel a bit of the loop myself really' (Provider, Interview 05). Analysis of the survey data revealed that providers in management roles were significantly³⁸ more likely than providers in other roles to know what was happening in their organisation in relation to minimum pricing, indicating perhaps that messages were not filtering down from management to frontline staff. This imbalance of knowledge was also described by some of the providers during their interviews: 'I've not heard anything. Well there's nothing come down to this level, I'm sure there is work being done at some levels, yeah, but it's not being spoken about or it's not fed down to team meetings yet' (Provider, Interview 10).
- 10.4 This apparent lack of information sharing was not necessarily viewed as a problem by providers. One, for example, explained that it did not matter that he/she did not know what was happening higher up because 'at the end of the day, whatever client comes through the door I will tailor my practice towards them as an individual' (Provider, Interview 14). Another suggested that it was not a problem because they needed to wait and see what would happen before devising and implementing any response: 'There's no plan for it, no extra resources, I don't think. It's wait and see if it has that impact and then think, right, that's what we need to do' (Provider, Interview 08). Another provider explained that while he had 'seen no differences whatsoever' within his service, this was not a problem as his organisation was 'a constantly evolving service anyway', which had been aware that minimum pricing was on the agenda for Wales and had 'in fact supported it as a harm reduction method' (Provider, Interview 02).

³⁸ Chi-squared test, 21.221, 2 df, p<.001.

What is your organisation doing to prepare for minimum pricing for alcohol?

- 10.5 When providers did report that their organisations were preparing for the change in legislation, most indicated that the preparatory work was focused on raising awareness about MPA and on signposting drinkers to appropriate sources of support. The survey respondents, for example described that their organisations were: 'promoting awareness', 'raising awareness', 'publicising information to all visitors', 'by giving information', 'sharing info on MUP', 'making service users aware of the changes and the support to get services in that fit their needs'. The providers who were interviewed also described efforts to raise awareness about the introduction of a minimum price for alcohol. One, for example, described the importance of 'being quite open with our service users' (Provider, Interview 29) about the introduction of minimum pricing. Another explained that his organisation was promoting the new law within its premises using bilingual resources provided by Welsh Government: 'So, we got the flyers up that I've got from that event in Llanelli. They're all in our consultation rooms. Absolutely ... bilingually, this is what may or may not be happening' (Drinker, Interview 04).
- 10.6 In addition to awareness raising activities, a few providers reported that their organisation was engaged in other kinds of preparatory work. Some of the survey respondents explained that they were discussing the potential implications of the change in price with service users: 'we are informing service users, and discussing with them the possible consequences to them as individuals', 'discussion about possible outcomes and issues'. One survey respondent flagged up that his/her organisation was focusing in particular on 'promoting positive aspect of minimum pricing' to help service users see it as an opportunity to address their problematic drinking behaviour.
- 10.7 In a few isolated cases, providers reported that they were working in partnership with other stakeholders to help prepare for the introduction of minimum pricing. One manager, for example, explained during his interview that he had invited Trading Standards to come and speak to his team: 'The second thing I've done, is I've contacted the local Trading Standards, and I've got somebody coming in on 2 April to talk to us about counterfeit booze' (Provider, Interview 04). A small number of survey respondents also described engaging with external organisations to help prepare for the change in legislation: 'we are having a visit from Trading Standards

to be able to identify counterfeit booze and the harms’, ‘someone from Alcohol concern has been to our groups regularly’.

- 10.8 In a few cases the partnership approach was being used to help providers prepare for a potential influx of people seeking support: ‘staff are aware of the policy and are working with partners to support more people coming into services’, ‘working with partners to prepare for potential increase in referrals’.
- 10.9 The need for additional resources to cope with a potential increase in demand for treatment and support was a concern for a few of the providers who completed the survey. One explained that his/her organisation was not preparing for minimum pricing because ‘we have no funding to do so’. Others described how their organisations were unable to recruit more staff or develop appropriate materials (e.g. to educate drinkers about the potential harms of switching to other drugs) due to lack of funding: ‘there is limited funding to offer an increased robust service which would include increased educational materials around other drugs’.

What are drinkers doing to prepare for the introduction of minimum pricing?

- 10.10 Most drinkers in this study indicated that they would not be taking any measures to prepare for the introduction of a minimum price for alcohol. Indeed, 82 per cent of survey respondents said that they did not plan to do anything to prepare. For some, the reason for inaction was because they did not believe that the legislation would affect them either because they were ‘not a big drinker’ or because they could ‘afford to ignore it’. For others, the reason for inaction was because they did not have enough resources to undertake any preparatory work. Homeless street drinkers, for example, were flagged up by some interviewees as a group that would find it particularly difficult to prepare for the change in price due to their precarious position living on the streets:

‘Well I don’t see what difference it is going to make now because it is going to happen anyway, and how are they going to prepare for it because they haven’t got the money and resources to buy the alcohol anyway. They can’t plan. It is not as if they can save money going forward because they haven’t got any money.’ (Drinker, Interview 22)

- 10.11 As noted earlier in the report, few drinkers were aware of plans to introduce a minimum price for alcohol prior to the interview, meaning that many had not had the opportunity to consider undertaking any measures to prepare for its introduction.

However, upon hearing of the imminent price increase a small number of drinkers indicated that they may start to stockpile alcohol prior to the law being implemented:

‘Do you know what, when my next shop for cider was going up and I’d buy a couple of boxes and store them up ready for this nonsense.’ (Drinker, Interview 36)

- 10.12 The plan to stockpile cheaper alcohol was also frequently reported by survey respondents: ‘buy prior to changes and keep a stock’, ‘stock up before any price increase’, ‘stock up on alcohol’, ‘prior to the introduction I would probably take advantage of offers and buy in bulk, particularly if an occasion was coming up such as Christmas or planning to host a party’. A small number of survey respondents flagged up that in some cases bulk buying might result in bulk consumption. One explained: ‘I’ll be bulk buying, just in case and probably drink more because of it’. The other gave a more detailed explanation:

‘I have thought about ‘stockpiling’. A possible £10 to £15 saving a week (if bought in advance) is a much better plan than putting money in a bank or savings account. However, the temptation of extra stocks in the house might lead to higher consumption, thus mitigating some of the possible savings’. (Drinker, Survey 50)

- 10.13 A similar point was made by one of the interviewees who had already started stockpiling alcohol due to her precarious financial position having lost her job, rather than in anticipation of the introduction of minimum pricing:

‘It is. I have already started storing, and now you tell me it’s coming in at the end of the year I think I’ll start storing more and more, because I can put my money into that. I don’t need to have too much money hanging around as I’m on benefits. So there will be a little store, which is not clever, because of course if you have alcohol in the house and you come to your last end of bottle, you go, I’m going to bed, and if you’ve got a store, you go, oh, I’ll just have another glass then. So, I think that is a really, really negative thing to do, but if it’s going to save me money, and particularly because I’m losing my job. If I wasn’t going to be losing my job, I wouldn’t be so worried, but the fact that I’m losing my job is going to be huge’. (AP2)

- 10.14 Other preparatory measures were mentioned by only a small number of drinkers who took part in the study. Among the survey respondents, a few indicated that they would seek professional support to help them prepare for the change in legislation: 'what support for dependent drinkers, i.e. detox, rehab support', 'self-refer to CDAT'³⁹, 'will keep going to my key worker at alcohol services and making better choices to stop drinking', 'I am engaging with support to help me stop consuming alcohol'. A couple of respondents suggested that they would try to cut down without mentioning engaging with any services (e.g. 'try and get to my goal of abstinence sooner rather than later', 'would try to stop').
- 10.15 The plan to cut down on his/her alcohol consumption was also mentioned by one of the interviewees who explained that the price increase would encourage him/her to cut down or switch to lower strength lagers. As such, the financial implications of MPA acted as a 'trigger' to reduce consumption:
- I: Do you see yourself doing anything to prepare, let's say that the worst come to worst, you won't be able to get into detox by then, do you see yourself doing anything to prepare for this? Because it will affect you because that's the kind of drink that you drink.
- R: Well no, I'd just have to cut down, simple. Like I say, even if I had that kind of money, I will not spend £9 on a bottle of cider, no way. I could stock my cupboards up or ... I wouldn't spend that, no way.
- I: Okay, so you will prepare by trying to cut down?
- R: Yes, cut down. Either that or change to something else, lager or something. ... (Drinker, Interview 18)
- 10.16 Among the survey respondents, other less frequently mentioned measures included re-budgeting (e.g. 'plan my budget better by buying food from cheaper shops') and cross-border shopping (e.g. 'shop across the border'). These issues are investigated in more depth in earlier chapters of the report.

³⁹ Community Drug and Alcohol Team [CDAT].

What can be done to help drinkers prepare for the introduction of a minimum price for alcohol?

10.17 A small number of people felt that little could be done to prepare for the price change. However, most drinkers and providers⁴⁰ thought that things could be done, and many gave details of possible actions that could be taken. The most popular suggestions among both groups corresponded neatly with the actions already underway in some services, namely, raising awareness about the price change and signposting drinkers into relevant services.

Raising awareness and signposting

10.18 Providers who completed the survey indicated that raising awareness was an important part of their 'educational work' and was needed for staff as well as for drinkers: 'increased staff awareness of new legislation', 'train staff, educate, promote the service, encourage engagement and referral'. A similar point regarding the education of staff was made by one of the drinkers who completed the survey: 'for example I feel that Voluntary Sector Tier 2 support workers to be educated and have the resources on this change so that they can better support and advise clients' (Provider, Survey 63).

10.19 Like the providers, drinkers also recognized the importance of publicising the introduction of a minimum price, largely because so 'many are unaware of MUP'. One interviewee explained:

'I think there should be more advertising, that's the first I've heard of it. So, then it's up to them what steps they're going to take go forward in that. But yes, I think there should be more advertising. I mean I drink every day. I didn't know nothing about that.' (Drinker, Interview 18)

10.20 One survey respondent suggested that awareness raising was particularly important in isolated communities where there was increased potential for the development of a black market in alcohol: 'Awareness-raising schemes in isolated communities, monitoring for black-market spirits and sellers who target alcoholics and vulnerable groups' (Drinker, Survey 48). Other respondents were keen for promotional material to include 'harm reduction support/information' that would help drinkers to manage 'withdrawal symptoms' and other potential consequences of minimum pricing.

⁴⁰ Including 78% of providers who completed the survey.

10.21 Opinion was divided on the value of producing written promotional materials. Some dependent drinkers saw little benefit in developing posters but could see some value in advertising on the radio and television. While television may be accessible to only some drinkers, radio was described as having a wider audience that included street drinkers. One drinker explained during a group interview in a 'wet house' that homeless people often listen to the radio to help pass the time while living on the streets:

A3: I don't think posters being put up would work.

A1: Who's going to read them?

A3: How many homeless go past and read a poster?

A1: Exactly.

I: Do they watch telly?

A3: Yes, put it on the TV.

I: Something about the price.

A3: On the radio. Broadcast it.

A1: On the radio maybe, as well. But how many homeless watch TV or radio as well? At the same time ...

A3: You'd be surprised.

A1: I know a few but...

A3: You'd be surprised how many. They've all got radios. They all listen. What do you think they do of a night? (Drinker, Group Interview A)

10.22 Other drinkers could see the benefits of using a variety of methods, including written materials, to promote minimum pricing and to signpost people into services. Examples given in another group interview with former drinkers now in recovery, included using billboards, signs on buses and posters within agencies where dependent drinkers often go (e.g. food banks, soup kitchens, and church halls):

I: Okay. So, you mentioned about media. What kind of media to get the message out there? What's going to be the best way? What should it look like?

C3: Facebook.

C2: Well, not, not particularly. For these street drinkers, more billboards.

I: Billboards.

C2: Buses. Advertise wherever you can.

C3: Buses, yeah.

C4: Churches like this offer services to people in the community who are homeless, so you could inform the churches and ask the people that, even if they're street homeless, they're accessing some food banks or some sort of support services, where they could be informing their soup kitchen...

(Drinker, Group Interview 3)

10.23 Most drinkers felt that, whatever written messages were going to be given needed to be simple and visual with a limited number of words. Wide dissemination was also thought to be key to ensure that the messages would not be ignored or missed:

'If they're fully aware of it and they understand it, so if they are talking to people, they can explain it to people, you know, and things. I suppose obviously it would have to just be advertised to the max and plenty of... All the information readily available for people, whether that's like, an advert on TV, like literally something that people can't ignore.' (Drinker, Interview 34)

10.24 The importance of using simple messages positioned in locations often visited by dependent drinkers was also highlighted by providers during their interviews. It was hoped that drinkers would be better prepared for the change if they were at least aware that it was going to happen.

'I think in terms of service users and those who drink, there needs to be obviously, again, awareness done by services, again in very simplistic language that people who come into contact with services understand what actually MUP is and what the implications are as well. I think from a service perspective, they can do that via multiple ways, whether it be doing campaigning, whether it be providing leaflets, there's multiple ways that they can do that.' (Provider, Interview 17)

'There needs to be that kind of communication, there needs to be that information in GPs, health centres, dentists', libraries, wherever people congregate.'

(Provider, Interview 16)

10.25 A similar point was also made by a drinker who completed the online survey. This drinker flagged up the importance of breaking down the stigma of help-seeking and of the need to provide support around the clock:

‘Awareness campaigns in places which sell or serve alcohol and also GP surgeries, hospitals, charities and police stations need to be actively promoting support services and looking to break down the stigma of asking for help and accessing help. A lot of help is only available during the hours of 9-5 whereas there is also a high percentage of professional people that drink heavily who cannot access services during these times and also would be afraid of confidentiality and impact on their career if they tried to access treatment.’
(Drinker, Survey 71)

Improving access to services

10.26 In addition to raising awareness about minimum pricing, many providers and drinkers felt that more resources would be needed to help services cope with a potential increase in demand for support following the change in legislation. The importance of improving access to and increasing the availability of support services was flagged up by many of the providers who completed the survey: ‘more funding for psychosocial intervention as well as the clinical intervention. More outreach is definitely needed’, ‘more funding to frontline workers’, ‘better services to help people with serious alcohol problems’, ‘more services are needed, more funding needs to go into detox centres’. Similar points were made by providers during the interviews:

‘Would there be funding in place maybe to offer a higher level of support, maybe detoxing, maybe rehab funding, helping them to make those changes, because those people are not just going to stop. We never tell people to stop drinking when they come in, we try and aim them towards a goal, whether it’s abstinence, whether it’s controlled drink, it is very difficult to achieve. Yeah, so what’s going to happen to them really.’ (Provider, Interview 10).

‘Yes, absolutely need more resources. Staffing levels, we have not got enough staff in XXX you know to cover the amount of Service users we have. You know people’s caseloads are like forty Service users and that’s not really beneficial for the Service users to have that many on a caseload so yes, just having more staff in place really.’ (Provider, Interview 15)

10.27 Drinkers were also keen to ensure that services (e.g. A&E and GPs) were properly resourced to cope with a potential increase in patient numbers. There were calls among the drinkers who were interviewed, for an investment in mental health services to help drinkers address the problems that led to them drinking in the first place:

‘I’ve no idea, I’ve seen people be detoxed and go back out and drink straightaway, so I just don’t know. I think a lot of it comes down to mental health conditions, treating that... I’ve met homeless people that have been abused, all sorts of stuff, and it’s treating those stem problems. I don’t think they’re going to stop it otherwise, I really don’t.’ (Drinker, Interview 03)

‘I have never come across an alcoholic or drug addict who didn’t have a mental health issue and vice versa. They almost go hand in hand. They need to address why peopling are feeling like that. It is unemployment, lack of money, benefit cuts. These are the real reasons that people are drinking, and until they sort that out they can do what they want, they can ban alcohol, they can increase the price, it is not going to change a thing.’ (Drinker, Interview 22)

10.28 Drinkers who completed the online survey also recognized the importance of providing mental health support. However, they also highlighted the need for improving access to a variety of other types of support too including: detoxification; counselling; financial advice; social work; and housing.

‘You will need more debt counsellors and social workers to cope with families cutting back on other household expenditure just so they can have a drink every now and then.’ (Drinker, Survey 75)

‘People may need medical attention if they are unable to drink their tolerance, if they have a heavy dependency on alcohol. Medical intervention, extra beds at detox centres, and maybe free counselling services to help people deal with life without alcohol.’ (Drinker, Survey 33)

‘Increased specialised support for those with serious addiction issues, and financial advice to help people deal with the increased cost in living brought on by minimum pricing.’ (Drinker, Survey 55)

- 10.29 One survey respondent explained that it was important that access to drug and alcohol services is 'easy' and 'with quick response times' (Drinker, Survey 8).
- 10.30 The potential for learning lessons from the Scottish experience was mentioned by a small number of providers, although one recognised that cultural differences may make this difficult (e.g. 'gaining more knowledge, research on how the changes to alcohol in Scotland has impacted drinking in Scotland and see if something similar could happen in Wales', 'difficult to know as Scotland are in the process of evaluating and a very differing culture to Wales'.)

No preparatory work needed

- 10.31 While most drinkers and providers thought that preparatory work needed to be done to help drinkers cope with the introduction of minimum pricing, there were some who thought that no such action was necessary. Indeed, roughly two-fifths (42 per cent) of the drinkers who completed the survey thought that drinkers did not need any specific support systems put into place to help them cope with the change in price. The main reason given was that the necessary support systems already existed. There was some disagreement, however, in terms of whether the existing services would be able to cope with the change in legislation. Some, for example, thought that 'existing support agencies should be able to cope' while others recognised that it existed but thought 'it might not be able to cope with the increased demand'. One respondent described the existing services in some detail:

'Similar services already in place such as Drug and Alcohol Single Point of Access (DASPA) and Drink Wise, Age Well and I think that the possibly growing issue caused by minimum pricing can be brought up during interventions with people accessing these services.' (Drinker, Survey 5)

- 10.32 Other reasons for not providing support were varied and included the idea that people will 'make allowances for the price change' meaning that support would not be necessary. One drinker suggested that providing additional support would be redundant because 'people will drink if they want to no matter how much support they receive' while another was unable to see the need for support 'because they're just setting a minimum price. I don't see what support people would need for that'. Two other drinkers emphasized that the support was needed not to help them cope with the price change but to help them address their core problems: 'Support is not required in terms of cost it is however required in terms of supporting people

allowing them to recognise that they have a drink problem', 'if the price doesn't change someone's "habit", then it is this habit that needs addressing not the cost'.

Timing and funding of the preparatory work

- 10.33 Some providers recommended that the preparatory work and investment in services be undertaken prior to implementation of the law to mitigate any potential harm and to ensure a smooth transition. One survey respondent described the need to prepare in advance to avoid any big shock: 'so we can care plan in advance so it does not come as a big shock/crisis' (Provider, Survey 63). Another suggested that things be made available online ready for organisations and professionals to use: 'have things ready online for agencies/GPs etc to use' (Provider, Survey 65). A similar point was made by a provider during the course of an interview:

'Yeah, I don't know whether, ahead of time, local shop keepers have actually been making it clear in their shops that actually this stuff won't be on the shelves soon. I don't know if it needs to actually go down to street level. I would hope really that you've got the homelessness teams poised at the ready. Obviously we've got our outreach team, I guess really amongst substance misuse services on the wider issue, I think it is something that probably needs to be circulated amongst our client group really. I'd hope that anybody under the umbrella of the local APB would be involved in promoting this as we head towards June really.'
(Provider, Interview 01)

- 10.34 Most drinkers and providers thought that the responsibility for funding the preparatory work (i.e. the promotional material and the investment in services) lay with Welsh Government. However, some survey respondents placed the responsibility elsewhere including with: 'Public Health Wales', 'taxes', 'Health and Social Care', 'local authorities', 'NHS', 'Big Lottery', 'Local Health Boards and Councils', 'service providers delivering substance misuse and homelessness services'. A few providers suggested that the additional costs be funded by the profits that they believed would be generated by minimum pricing: 'unit profits should be used to fund services', 'possibly have more rehab services locally available. Funded by main brands of alcohol', 'a levy from the drinks industry', 'main brands put money into alcohol services to help those who have drinking problems'.

Summary

- 10.35 In this chapter the survey and interview data have been drawn on to examine what drinkers and providers think is needed to help prepare people for the introduction of a minimum price for alcohol.
- 10.36 The main conclusion to be drawn is that while few organisations are currently doing anything to prepare for the introduction of MPA there is wide agreement among drinkers and providers that something needs to be done. The consensus is that any preparatory work should focus on raising awareness of MPA in simplistic and easily accessible terms and on signposting people to appropriate services.
- 10.37 It was also widely agreed that additional resources are needed to ensure easy and quick access to appropriate services that would help people address the causes of their problems as well as to respond to immediate medical and social needs that a change in price of alcohol might precipitate⁴¹.

⁴¹ In December 2018, an extra £2.4million in funding was announced for 2019/20 for the seven Area Planning Boards who are responsible for commissioning local front line substance misuse services. [See Vaughan Gething's Written Statement dated 15 February 2019.](#)

11. Conclusions and recommendations

- 11.1 In this report findings have been presented from a mixed methods study that investigated a range of potential consequences of introducing a minimum price for alcohol in Wales.
- 11.2 The main aim of the study was to investigate whether switching substances (e.g. from alcohol to illegal drugs) may be a consequence of the introduction of a minimum price for alcohol.
- 11.3 The study also had several other important aims including investigating how drinkers might respond to and cope with the change in price and examining how best to prepare for the implementation of MPA.
- 11.4 In this concluding chapter the key findings from the study are summarised and reflected upon in light of the literature reviewed in Chapter 3. A set of recommendations that will help guide the introduction of the new legislation is also presented.
- 11.5 Before doing this it is worth noting that the study involved the collection of an extensive set of data within a relatively short timeframe and has reported on findings from three key activities: a rapid evidence review, 193 survey responses and 76 qualitative interviews⁴².
- 11.6 It is also important to note that while the goal of MPA may be to reduce alcohol-related harm among the population as a whole, the purpose of this study was to focus largely on the views of drinkers engaged in services (who by their nature have alcohol-related problems) and staff providing support to such people. *The findings clearly reflect the context of those asked.*
- 11.7 It should also be highlighted that much of the data collected are perceptions about and predictions of what *might* happen once the minimum price for alcohol is introduced in Wales. As such, the report suggests *possible* rather than actual future scenarios after the minimum price implementation.

⁴² In total, 76 interviews were conducted. Three of the interviews were group interviews, which means that the total number of interviewees (n=87) is greater than the total number of interviews conducted.

Potential for switching substances

- 11.8 In terms of the main aim of the study, the perception of the likelihood of minimum pricing for alcohol leading to switching in substance use behaviour, there were several key messages. The first of these is that for the majority of drinkers, the only switching or change in use is likely to be alcohol related and largely an adaptation of existing behaviour within the new pricing framework (e.g. a switch in type of alcohol or a change in purchasing behaviour). This was suggested because it was felt that for many drinkers, alcohol is a clear drug of choice and crossing over to drugs, and especially towards the margins of legal/illegal activity, was just not an option. There was a suggestion that switching between substances would be more likely to occur amongst certain groups, notably street drinkers and those with prior experience of drug use, a finding also reported by Miller and Droste (2013) and Peters and Hughes (2010).
- 11.9 If switching away from alcohol was to occur, it was predicted that this would most likely be to prescription medications such as benzodiazepines that mimic the effects of alcohol, followed by cannabis and spice, with only a few suggesting a switch to cocaine or opiate use. This finding echoes that of DiNardo and Lemieux (2001) who found that restricting access to alcohol resulted in an increase in cannabis use among high school seniors in the US.

Awareness and understanding of MPA

- 11.10 A key aim of the study was to establish what is already known, if anything, about the new legislation. It was clear among both drinkers and providers that the norm was of very little or no awareness, and what awareness there was had either been triggered by the research process or through news or community discussion. This general lack of awareness was also reported by O'May et al (2016) in their study of dependent drinkers prior to the implementation of MUP in Scotland.
- 11.11 Few respondents in our study had a detailed, concrete and accurate understanding of minimum pricing. Associated with this were three overt attitudes. Firstly, that the principle of doing something about the availability and harm of alcohol was 'a good thing' and was indicative of the beginning of a 'cultural shift' in thinking about alcohol. Secondly, that the introduction of a Minimum Unit Price of 50p (the Welsh government's preferred level) would make very little overall difference to most people's drinking. This was often articulated in sentiments about addiction and dependency being too strong for many 'core' drinkers and about moderate drinkers

being able to afford to cope with the change in price. Finally that, as also reported by O'May et al (2016), the group of individuals it would affect the most are potentially the most vulnerable, i.e. strong cider drinkers, often homeless and with minimum resources to develop alternative, less harmful and sustainable coping strategies.

- 11.12 Typically, within these conversations was a belief that the price change was a tax and questions about where the new revenue would go and whether it would or could be spent on increased treatment provision.

Coping with the implementation of minimum pricing

- 11.13 Given that continued alcohol consumption rather than any mass switching to other substances was predicted, an important part of the study was to establish how in practice drinkers would cope with the price increase and continue to drink. For low-medium risk drinkers, the general feeling was that any increase in expenditure would be absorbed into existing budgets and that no significant adaptation or change in behaviour would be warranted.
- 11.14 However, a different scenario was anticipated for high risk/addiction likely drinkers, and a range of potential coping mechanisms were predicted. There was some concern that many of these strategies could result in negative consequences not only for drinkers but also for their families, friends and the communities in which they live.
- 11.15 The possibility of dependent drinkers switching to stronger forms of alcohol was widely anticipated by service providers and drinkers. It was suggested that when strong ciders become much closer in price to spirits, notably vodka, that many drinkers would elect to spend £14 (28 units) on a bottle of vodka rather than £11.50 (23 units) on a bottle of cider⁴³. Research from other countries suggests that switching from one type of alcohol to another stronger type may well occur following the introduction of MPA. In Germany, for example, an increase in the price of alcopops was associated with an increase in the use of spirits and a switch in preference to beverages associated with riskier drinking patterns (Muller et al., 2010).

⁴³ While switching to a drink that contains fewer total units than a bottle of cider may on the face of it seem like a positive outcome, medical advice suggests that this is not necessarily the case.

- 11.16 The potential for an increase in home brewing (including the notoriously complicated production of spirits) and the use of counterfeit alcohol similar to, or using the same channels as the ones for counterfeit cigarettes (from a black market anticipated to thrive following the introduction of minimum pricing) were also widely anticipated. The potential health consequences of these changes were a source of serious concern. While the evidence base is fairly limited on this issue, there is evidence to suggest that some of these concerns may not in fact be warranted. Research in Thailand, for example, found that switching to illicit alcohol following a tax on distilled spirits was minimal (0.8 per cent) and limited to areas where there was a history of illicit alcohol production (Chaiyasong et al., 2011).
- 11.17 The potential for drinkers to resort to acquisitive crime to fund their continued use of alcohol was frequently suggested by providers. The drinkers we asked were less likely to predict an increase in their own offending behaviour but anticipated that crime was likely to increase among other drinkers, particularly dependent ones. Shoplifting was identified as the most likely type of crime to be committed largely because it would provide fast access to either alcohol itself or to goods that could be sold in order to fund the purchase of alcohol. Other types of income-generating crime included robbery, burglary and mugging.
- 11.18 For some, it was anticipated that any such crime would be committed only by those with experience of such activity. The possibility that drinkers who had not committed crime before would start now was not thought likely. Nevertheless, the potential burden that an increase in acquisitive crime would have on the police and other related services was a matter of considerable concern. However, concerns of this nature may not be wholly justified given the results of previous research. Indeed, studies in other countries have found that coping strategies involving income-generating crime were seldom used by drinkers faced with an increase in the price of alcohol (Faulkner et al, 2015; Erickson et al, 2018).
- 11.19 The possibility that drinkers might re-budget their existing resources to free up money to spend on alcohol was another method of coping reported by providers and drinkers. Most commonly it was predicted that drinkers would forego essentials such as food and household bills to fund their continued use of alcohol. Previous research suggests that this prediction may be a realistic one given that the re-budgeting of resources was one of the most common strategies used by drinkers to

help them cope when the price of alcohol increased in other countries (Erickson et al 2018, Faulkner et al 2015).

- 11.20 For many of our respondents, the potential consequences of re-budgeting as a coping strategy, particularly for family members, were a source of concern. The main problem anticipated is that children will end up going without food and clothing and that housing arrangements will become unstable in the wake of unpaid rent or mortgage repayments. The knock-on effect of all this on relationships with family members (e.g. through increased strain and conflict), and on mental health (e.g. through increased anxiety and stress), were also highlighted.
- 11.21 The potential for drinkers to borrow money to fund their continued use of alcohol was another coping strategy identified in the study (see also Faulkner et al, 2015). While on the face of it borrowing funds might seem like a positive approach to addressing the problem (particularly when compared with committing crime), in practice it was anticipated that this strategy could also have negative consequences. One of the main concerns here was that increasing demands for money would put a strain on relationships and in the worst-case scenario result in family breakdown.
- 11.22 There was also concern that borrowing more formally by way of 'tabs' from pubs and shops would result in an increase in debt and financial pressure, which too could impact negatively on relationships with family members who may be asked to pay off the debt. The impact that minimum pricing would have on drinkers in receipt of Universal Credit was a specific worry. Drinkers and providers alike expressed concern that drinkers receiving this benefit (often in one lump sum) would find it even more difficult to manage their monthly budgets once the price of alcohol increases.
- 11.23 The possibility that drinkers might obtain supplies of alcohol from countries not currently implementing minimum pricing policies was another strategy mentioned by respondents. The potential for this change in behaviour was thought to be most likely in locations close to the English border. However, it was also anticipated that areas deeper into Wales (e.g. in the Valleys) would also make use of cross-border supplies. Interestingly, the potential for cross-border shopping has not been discussed in previous studies that have investigated the consequences of increasing the price of alcohol.

- 11.24 Overall, a range of strategies that potentially would enable dependent drinkers to keep on drinking after the implementation of minimum pricing were identified. Most were negative in that they would involve drinkers participating in behaviours that could result in harm to themselves or those around them. Others appeared more positive on the face of it, but for the most part, these too were predicted to have the potential for negative consequences. The possibility that minimum pricing might result in a reduction in alcohol use and have a positive effect on drinkers' lives was not a common prediction.
- 11.25 It is important to note, however, that these somewhat negative predictions may well not materialise once the legislation is implemented. Previous research in countries where the price of alcohol was increased (through taxation or minimum pricing) has found that harmful coping strategies such as stealing alcohol, committing income-generating crimes and substituting alcohol for non-alcohol beverages are relatively uncommon (Black et al., 2011; Faulkner et al., 2015). Furthermore, there is a substantial body of research demonstrating that an increase in the price of alcohol is associated with a decrease in overall alcohol consumption (Doran and DiGiusto, 2011; Muller et al 2010; Chaiyasong et al 2011). What has been difficult to prove, however, is that any decrease in consumption has been caused by the price change and not by other social interventions or cultural shifts in behaviours.

Preparing and planning for the introduction of minimum pricing

- 11.26 Given the general lack of awareness, it naturally follows that preparation for the impending change by either service providers or drinkers had not really begun to take place. It was in only a small number of areas where efforts to prepare for the change in law had really got underway and in these areas the work had only recently (at the time of the research) begun. Interestingly, many providers did not know whether their organisation was doing anything to prepare for the introduction of minimum pricing. Providers in management roles appeared to be more informed, suggesting that important messages were not always filtering down to frontline staff.
- 11.27 While a few organisations were preparing for the introduction of minimum pricing, many were not, and as such there was agreement among providers and drinkers that more preparatory work was needed. The consensus was that any preparatory work should focus on raising awareness of minimum pricing in simplistic and easily accessible terms and on signposting people to appropriate services. It was also widely agreed that additional resources are needed to ensure easy and quick

access to appropriate services that would help people address the causes of their problems as well as to respond to immediate medical and social needs that a change in price of alcohol might precipitate. Similar findings and recommendations were also made by O'May et al (2016) prior to the implementation of MUP in Scotland.

- 11.28 Unlike the providers who all agreed that work needed to be done by them and their agencies, few drinkers anticipated doing anything to prepare for the introduction of minimum pricing. In most cases, the proposed solution appeared to be short term, and involved the stockpiling of cheaper alcohol prior to the implementation of the legislation. Longer term solutions such as entering treatment and cutting down the quantity of alcohol consumed were mentioned by only a small number of drinkers.

Concluding comments

- 11.29 This study has provided a comprehensive baseline picture of awareness, preparation and expectations amongst drinkers and providers about the impending legislation change. The headline finding suggests that switching away from alcohol to other substances is only likely for specific groups within the current drinking population, namely those with a history of using other substances (see also Miller and Droste, 2013). In this context, much of the evidence suggests that drinkers are likely to adapt their existing drinking-related behaviours to maintain their drinking.
- 11.30 While the focus on harmful levels of drinking and in particular strong cider was welcomed, there was considerable concern that not only is the price change unlikely to have a dramatic impact on overall levels of drinking (among either those dependent or those able to afford it), but that it might also lead to a range of potentially negative consequences and disproportionately impact on an already vulnerable and marginalised group. This in turn suggested the need for resources to be invested in raising awareness about the legislation (among all key stakeholder groups including the police, GPs, A&E and substance misuse agencies) and also in improving timely access to detoxification and treatment services (see also O'May et al, 2016).

Recommendations

11.31 Considering these findings, a series of recommendations are proposed that will help guide the implementation of minimum pricing for alcohol in Wales:

- There is a pressing need to increase pre-implementation awareness among drinkers and services. It is important that people know that minimum pricing is imminent so that they can begin to prepare for its introduction. Increasing knowledge will also help dispel myths that minimum pricing for alcohol is a tax that will generate funds for Welsh Government.
- It is recommended that the publicity material be developed in different formats (both visual and audio) and distributed on different platforms (social media, radio, posters, billboards, in-person) given the diversity of the audience who may be affected by any changes.
- Minimum pricing should be an active part of all the existing closer working and communication agendas for an array of agencies (including health, police, probation, housing/homelessness and domestic violence services).
- Service providers should develop tools that will educate staff and service users about the potential consequences of minimum pricing and ways of reducing potential harms.
- Welsh Government should consider holding several provider events, in the run up to implementation. Given the key role of caseworkers working with specific drinkers such events should be targeted at those working directly with the drinkers most likely to be affected. However, it is important that these events also consider ways of helping hazardous and harmful drinkers who are not currently in touch with services.
- Welsh Government should consider the implementation of various preventative measures to limit any harmful consequences of the legislation among the most harmful drinkers. Particular attention should be given to the most marginalised groups such as homeless street drinkers. These measures include:
 - i. Increasing timely access to alcohol detoxification and treatment services⁴⁴.
 - ii. Ensuring that the Welsh Ambulance Service as well as A&E services are aware and prepared for a possible increase in patients requiring treatment for alcohol withdrawal symptoms.

⁴⁴ Welsh Government has allocated an additional £2.4m of funding to frontline substance misuse services and discussions are well underway with Area Planning Boards regarding the need to improve access to treatment services.

- iii. Ensuring that GPs and healthcare professionals are prepared for a possible increase in patients seeking prescription medication such as benzodiazepines.
 - iv. Educating drinkers on the dangers of switching substances and using counterfeit (both bootleg and homebrew) alcohol.
 - v. Work with Trading Standards to provide guidance to agencies on the availability and nature of counterfeit alcohol.
- Consultation with retailers and the alcohol producing industry should be undertaken to understand how they propose to respond to the change in legislation (e.g. to monitor media coverage and to examine if they will uphold the spirit of the law or navigate their way around it)⁴⁵.
 - During the course of the study, comments were often made about the potential consequences of minimum pricing on young people under the age of 18. We therefore recommend that the impact of minimum pricing on young drinkers including children be investigated as part of the broader evaluation programme.

⁴⁵ Welsh Government is currently in discussions with the Welsh Retail Consortium and the Welsh Government Alcohol Industry Network about their planned response to the new legislation. Welsh Government has also commissioned an impact evaluation focusing specifically on the impact of minimum pricing on retailers.

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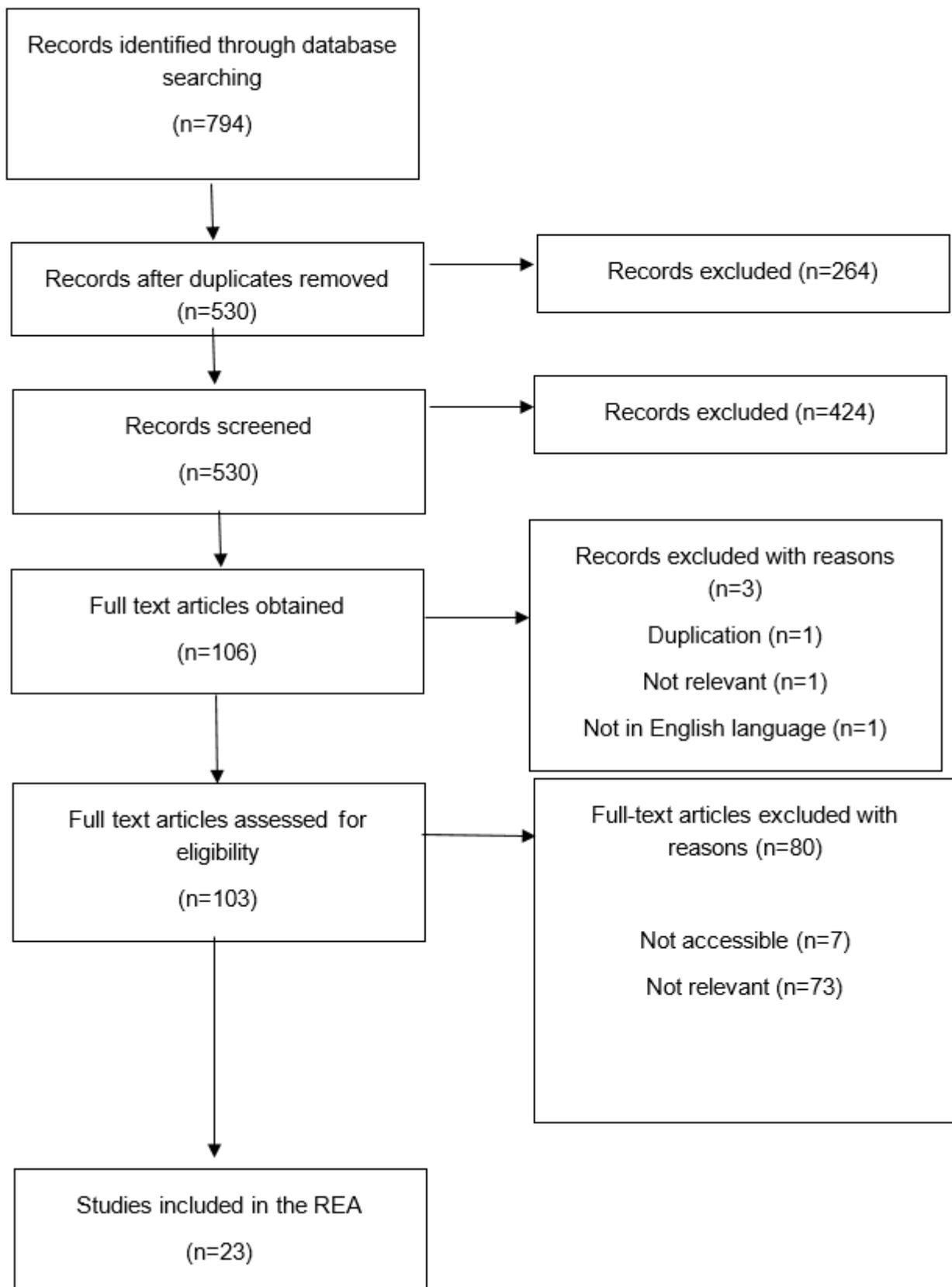
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Annex A – Prisma flow chart of studies identified through the systematic literature search



Annex B – Characteristics of Survey and Interview Respondents (Drinkers and Providers)

Table B.1: Characteristics of survey respondents (drinkers) [n=93]

Gender	n	%
Male	45	48.4
Female	47	50.5
Non-binary	1	1.1
Age		
20-24	3	3.2
25-34	21	22.6
35-44	18	19.4
45-54	23	24.7
55-64	23	24.7
65-74	5	5.4
Marital status		
Married/civil partnership/cohabiting/relationship	70	76.1
Single, divorced, separated	21	22.8
Prefer not to say	1	1.1
Type of area		
Urban	10	11.1
Suburban	30	33.3
Rural	49	54.4
Other [1]	1	1.1

Notes: Some missing cases. [1] 'Industry'.

Figure B.1: Local Authority Area of respondents who completed the drinkers' survey

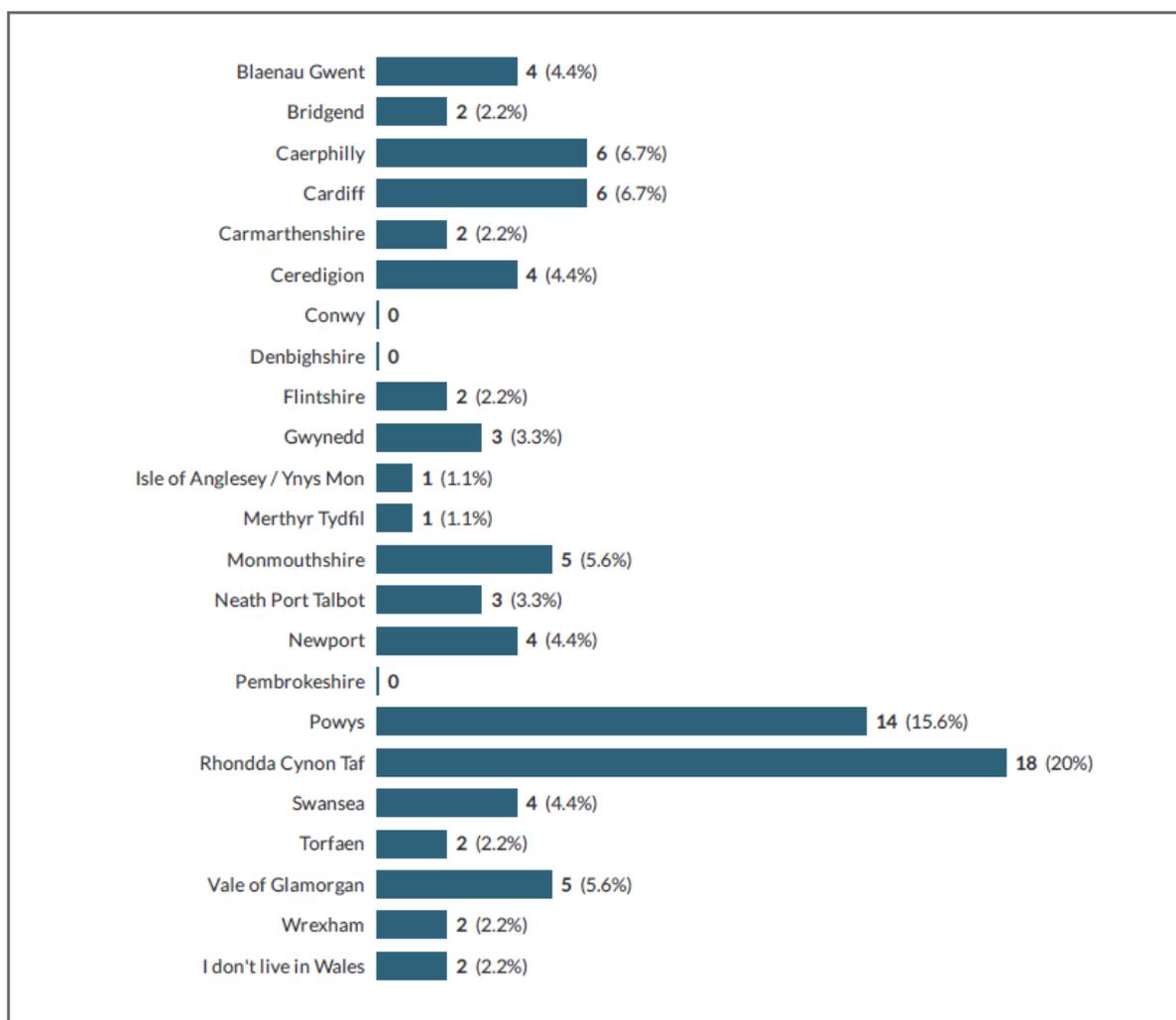


Table notes: 2 missing cases.

Table B.2: AUDIT scores of 'drinker survey' participants [n=90]

AUDIT score category	n	%
Low risk (0-7)	45	50.0
Medium risk (8-15)	25	27.8
High risk (16-19)	6	6.7
Addiction likely (20-40)	14	15.6
Low-medium risk (0-15)	70	77.8
High risk-addiction likely (20-40)	20	22.2

Notes: Some missing cases.

Table B.3: Illegal drug use history among ‘drinker survey’ participants

Substance	Last 7 days	Last 30 days	Last year	More than 12 months ago	Never	Total
Cannabis	6 (7%)	3 (3%)	2 (2%)	28 (31%)	52 (57%)	91 (100%)
Ecstasy	1 (1%)	1 (1%)	3 (3%)	19 (21%)	67 (74%)	91 (100%)
LSD	-	-	-	17 (19%)	73 (81%)	90 (100%)
Magic mushrooms	-	-	2 (2%)	18 (20%)	71 (78%)	91 (100%)
Amphetamines	-	-	3 (3%)	20 (22%)	68 (75%)	91 (100%)
Methamphetamine	-	-	-	4 (4%)	87 (96%)	91 (100%)
Cocaine powder	2 (2%)	1 (1%)	5 (5%)	17 (19%)	67 (73%)	92 (100%)
Crack cocaine	-	-	-	4 (4%)	87 (96%)	91 (100%)
Heroin	-	-	-	3 (3%)	89 (97%)	92 (100%)
Tranquillisers	1 (1%)	1 (1%)	2 (2%)	7 (8%)	80 (88%)	91 (100%)
Anabolic steroids	-	-	-	2 (2%)	88 (98%)	90 (100%)
Non-steroid PIEDs	-	-	-	1 (1%)	87 (99%)	88 (100%)
Ketamine	-	-	1 (1%)	9 (10%)	82 (89%)	92 (100%)
Mephedrone	-	-	2 (2%)	8 (9%)	81 (89%)	91 (100%)
GBL/GHB	-	-	-	4 (4%)	86 (96%)	90 (100%)
Synthetic cannabinoids	-	-	-	2 (2%)	88 (98%)	90 (100%)
BZP	-	-	-		90 (100%)	90 (100%)
Salvia	-	-	-	2 (2%)	88 (98%)	90 (100%)
Khat	-	-	-	3 (3%)	87 (97%)	90 (100%)
Nitrous oxide	-	-	1 (1%)	11 (12%)	79 (87%)	91 (100%)

Notes: Some missing cases. ‘-’ = zero responses.

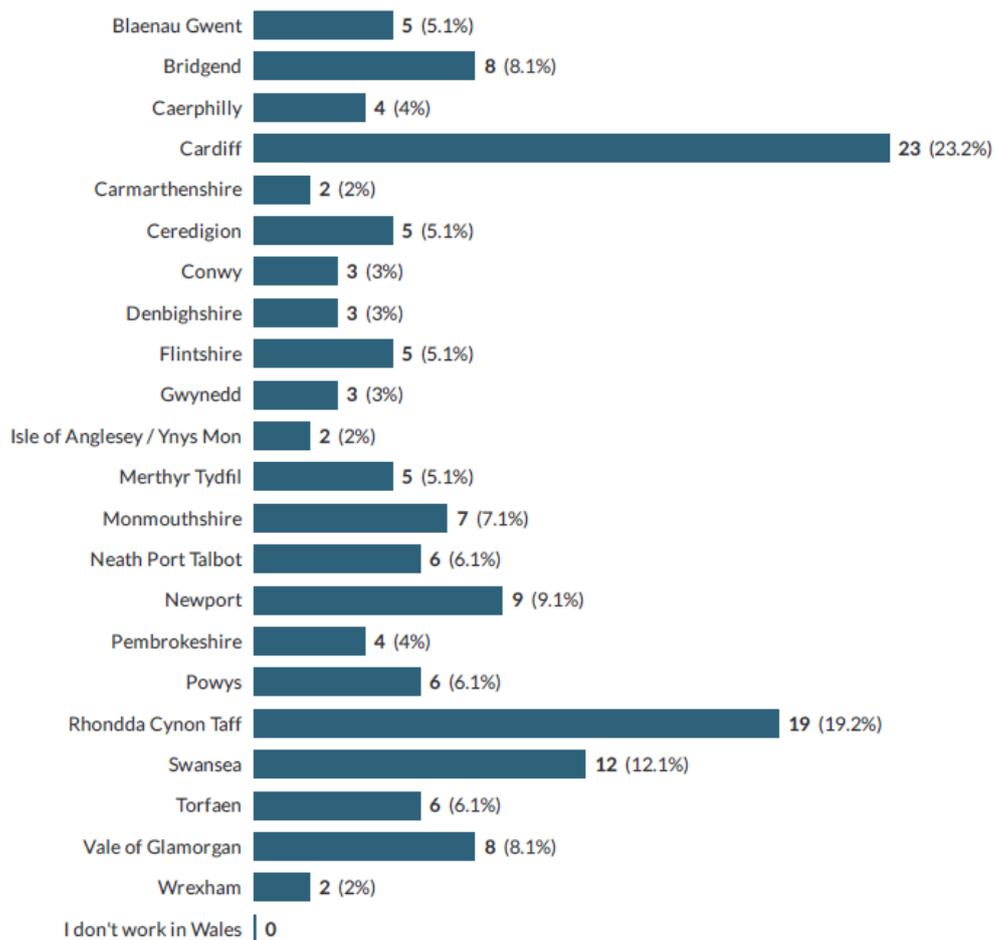
Table B.4: Characteristics of survey respondents (providers) [n=100]

Gender	n	%
Male	36	36.7
Female	62	63.3
Ethnicity		
White - English / Welsh / Scottish / Northern Irish / British	95	96.0
White - Irish	1	1.0
Mixed - White and Black Caribbean	1	1.0
Mixed – Other [‘Welsh/European’]	1	1.0
Other [‘Welsh/Italian/Polish’]	1	1.0

APB Area [1]		
Aneurin Bevan	31	21.1
Cardiff and Vale	31	21.1
Cwm Taf	24	16.3
Dyfed	11	7.5
North Wales	18	12.2
Powys	6	4.1
Western Bay	26	17.7
Type of Service		
Alcohol and/or drugs (specialist)	86	86.0
Criminal Justice	5	5.0
Homelessness/housing	3	3.0
Other statutory (non-NHS)	6	6.0
Role		
Keyworker – drug/alcohol service	27	27.8
Manager – drug/alcohol service	16	16.5
Support worker – drug/alcohol service	15	15.5
Other	12	12.4
Nurse	8	8.2
Support worker – other service	7	7.2
Peer mentor	5	5.2
Manager – other service	4	4.1
Commissioner	2	2.1
Social worker	1	1
Length of Experience		
Less than one year	14	14.3
1-3 years	32	32.7
4-5 years	9	9.2
6-9 years	12	12.2
10+ years	31	31.6
Sector		
Third/voluntary sector – drug/alcohol	66	69.5
Third/voluntary sector – other	10	10.5
NHS	10	10.5
Other	10	10.5
HM Prison Service	3	3.2
Community Rehabilitation Company	1	1.1

Notes: Some missing cases. [1] Respondents were able to select multiple answers to this question.

Figure B.2: In which Local Authority area(s) in Wales do you work? (Please tick all that apply)



Multi answer: Percentage of respondents who selected each answer option (e.g. 100% would represent that all this question's respondents chose that option)

Table B.5: Characteristics of interviewees (service users) [n=49]

Gender	n	%
Male	31	63.3
Female	18	36.7
Age		
20-24	1	2.0
25-34	7	14.3
35-44	9	18.4
45-54	13	26.5
55-64	3	6.1
65-74	1	2.0
75+	1	2.0
No data	14	28.6
APB Area		
Aneurin Bevan	17	34.7
Cardiff and Vale	11	22.4
Cwm Taf	8	16.3
Dyfed	1	2.0
North Wales	4	8.2
Powys	2	4.1
Western Bay	6	12.2
Current or recent drinker		
Current	16	32.7
Recent	26	53.1
No data	7	14.3
Other substance use (exc. Nicotine)		
No	12	31.6
Yes	5	13.2
No data	1	2.6
Main drink type		
Normal strength beer/lager/cider	10	20.4
Spirits or liquors	8	16.3
Strong beer/lager/cider	7	14.3
Wine	8	16.3
No data	16	32.7
Interview Conducted by		
Glyndwr University	5	13.2
Figure 8 Consultancy	1	2.6
University of South Wales	32	84.2

Notes: [1] 38 interviews were conducted with 49 interviewees.

Table B.6: Characteristics of interviewees (providers) [n=38]

Gender	n	%
Male	19	50.0
Female	19	50.0
APB Area		
Aneurin Bevan	8	20.5
Cardiff and Vale	5	12.8
Cwm Taf	6	15.4
Dyfed	6	15.4
North Wales	8	20.5
Powys	3	7.7
Western Bay	2	5.1
Type of Service		
Alcohol and/or drugs (specialist)	27	69.2
Criminal Justice	6	15.4
Domestic Violence	1	2.6
Homelessness/housing	2	5.1
Other statutory (non-NHS)	2	5.1
Role		
Keyworker / case holder	12	31.6
Other - paid stat (non-NHS)	5	13.2
Outreach worker	1	2.6
Peer mentor	1	2.6
Recovery champion	1	2.6
Service Manager	3	7.9
Social Worker	1	2.6
Support Worker	2	5.3
Team Leader / Senior	8	21.1
Practitioner	4	10.5
Other – paid third sector		
Length of Experience		
More than 5 years	32	84.2
Less than 5 years	6	15.8
Interview Conducted by		
Glyndwr University	10	26.3
Figure 8 Consultancy	2	5.3
University of South Wales	26	68.4

Annex C – Topics included within Survey Questionnaires and Interview Schedules

Survey questionnaire topics – drinkers

This survey was arranged into a series of sections to gather detailed information about:

1. Demographics (Gender, Ethnicity, Area of Residence, Age, Relationship Status, Household, Children, Qualifications, Income/Benefits, Employment Status)
2. Alcohol (Drink Types, Quantity, Frequency, Impacts, Location of Drinking, Purchasing, Expenditure)
3. Other Substances (Illicit, Prescription)
4. Treatment received (Past, Present)
5. Minimum Price for Alcohol (Knowledge, Benefits, Problems of having MPA; Extent of Agreement with MPA; Likely Effects of MPA)
6. Switching Substances (Past changes whether Alcohol to Drugs or vice-versa; Future – will introduction of MPA likely affect use of other substances)
7. Potential support needed when MPA is introduced
8. Wider impacts of introduction of MPA (relationships with family, friends; physical health; mental health; employment; financial circumstances; housing; offending behaviour)

A full copy of the survey questionnaire is available upon request.

Survey questionnaire topics – providers

This survey was arranged into a series of sections to gather detailed information about:

1. Demographics (Gender, Ethnicity, Location of Employment)
2. Current Job (Location, Role, Length of Employment)
3. Organisation (Type, Support Offered)
4. Minimum Price for Alcohol (Knowledge, Benefits, Problems of having MPA; Extent of Agreement with MPA; Likely Effects of MPA)
5. Preparation for MPA (What, if anything, is your organisation doing to prepare? What could they be doing?)

6. Potential support needed when MPA is introduced
7. Switching Substances (Likelihood of switching for those who have/haven't previously used other substances; Groups most likely to switch; Possible action to minimise switching)

A full copy of the survey questionnaire is available upon request.

Research into Users Switching Substances

Semi-Structured Interview – Drinkers

Preamble

- Thank you for giving up your time and agreeing to participate.
- Conversation about the incentive and when/how it will be issued.
- Confirmation of: purpose of the interview (exploration of MUP and possible changes in behaviour); about the research team and funding; explore the participation information sheet, voluntary nature and explicit use of data (confidentiality).
- Recording.
- Signing of consent form.
- Outline structure of interview:
 - a) A number of open-ended questions about yourself, your drink and drug use and how MUP might impact on this. Please answer as fully as possible. (I may offer some additional prompts, where appropriate).
 - b) A number of closed questions will be used to capture some answers.
 - c) A number of questions where will be asked to confirm some information or clarify one or two specifics points.

Themes, questions and topics

Theme	Potential opening questions	Things to listen for – further prompts
Self	<ul style="list-style-type: none"> Please tell me something about yourself, your age, who you live with and what you do? 	<ul style="list-style-type: none"> Age, gender, nationality, ethnicity, living with, economic status, employment history.
Current use	<ul style="list-style-type: none"> Please tell me about your current use of alcohol? Do you currently use any other drugs? 	<ul style="list-style-type: none"> Alcohol -type, brand, volume, price. Illegal, illicit and prescribed drug use, expenditure on substances.
Previous use and treatment history	<ul style="list-style-type: none"> What about your previous use of alcohol/drugs? How has your use changed over time? Are you receiving any support for your current use of alcohol/drugs? (If so, can you please say some more about this for each substance). Please tell us about any previous support or treatment that you may have had for alcohol/drugs. 	<ul style="list-style-type: none"> Patterns of use of different types of substance, engagement in drug and alcohol services in the community and within the CJS. Number of episodes, type of treatment, type of agency, community or CJS.
Understanding of MUP	<ul style="list-style-type: none"> Have you heard much about MUP? (Likely for some to have to explain at this point) 	<ul style="list-style-type: none"> Awareness of MUP legislation, use of flash cash cards to illustrate the likely change in costs.
Perceptions of MUP	<ul style="list-style-type: none"> What do you think about this proposed change? 	<ul style="list-style-type: none"> Attitudes and feelings towards MUP Probe for what they think might be the positives and negatives.
Preparation for MUP	<ul style="list-style-type: none"> Do you see yourself doing anything to prepare for the change in prices? 	<ul style="list-style-type: none"> Explore any planning (or not) for MUP; coping strategies.
Switching	<ul style="list-style-type: none"> As you know from the introduction, we are particularly keen to ask your views about potential changes in alcohol and other drug use. 	<ul style="list-style-type: none"> Explore predictions of future behaviour in relation to switching, motives for switching/not switching, risk and protective factors.

	<ul style="list-style-type: none"> • In this light, what impact do you think the changes will have on the type of alcohol you choose to drink? • What about use of other substances? (and any switching between them?) • Why do you think you will do? 	<ul style="list-style-type: none"> • Switching within alcohol (i.e. from one type to another, brand to another); switching from alcohol to another substance (i.e. what substance), sources, funding, reasons.
Review of any previous switching episodes	<ul style="list-style-type: none"> • (If not obvious from earlier questions) • Have there been times in the past when you have changed from alcohol to drugs or vice versa? And if so how and why? 	<ul style="list-style-type: none"> • History of switching (e.g. when short of money, or in different contexts), substances switched from/to, motives, explanations.
Perceived impacts (self and others)	<ul style="list-style-type: none"> • What do you think the impact of the price increases will be on you? • What about the impacts on your family and friends? • How about other drinkers? What impacts can you foresee for them? 	<ul style="list-style-type: none"> • Spending habits, crime, seeking treatment, employment, accommodation, health, wellbeing. • Consideration of the potential impact on family and friends (e.g. less money to spend on food, clothing, accommodation).
Support	<ul style="list-style-type: none"> • What support, if any, do you feel should be provided to drinkers to help them deal with the price increases? 	<ul style="list-style-type: none"> • Discuss potential need for support in relation to health, finances, accommodation, substance misuse, etc.
Anything else	<ul style="list-style-type: none"> • Is there anything else you wanted to say to us about alcohol price, the forthcoming change and other drugs? 	<ul style="list-style-type: none"> • Respondents given the option to provide any further information that they think might be relevant.

- Thank you

Research into Users Switching Substances

Semi-Structured Interview – Providers

Preamble

- Thank You for giving up your time and agreeing to participate.
- Confirmation of: purpose of the interview (exploration of MUP and possible changes in behaviour); about the research team and funding; explore the participation information sheet, voluntary nature and explicit use of data (confidentiality).
- Recording.
- Outline structure of interview:
 - a) A number of open ended about yourself, your drink and drug use and how MUP might impact on this. Please answer as fully as possible. (I may offer some additional prompts, where appropriate).
 - b) A number of more closed questions that will be used by me to capture some answers and/or asked of you to either confirm information given and or capture one or two specifics points.

Themes, questions and topics

Broad topic area	Potential opening question	Things to listen for – further prompts
Self	<ul style="list-style-type: none"> • Can you please just outline a little bit about yourself, so age, gender, nationality etc.? 	<ul style="list-style-type: none"> • Age, gender, nationality, ethnicity.
Experience	<ul style="list-style-type: none"> • What is the nature of your current role? • Can you please tell me something about how long you have been with drinkers and drug users? 	<ul style="list-style-type: none"> • Current role, length of time in current role, nature of role. • Depth of experience in this area of practice.
Awareness of MUP legislation	<ul style="list-style-type: none"> • How aware of MUP are you? • (Likely to need to explore and in some instances explain) 	<ul style="list-style-type: none"> • Awareness and understanding of MUP. • Where their information is coming from. • (Possible use of flash cards)
Perceptions of MUP	<ul style="list-style-type: none"> • What are your views on MUP? • What do you see happening as a consequence of the price increases? 	<ul style="list-style-type: none"> • Attitudes and feelings towards MUP.
Planning for MUP	<ul style="list-style-type: none"> • How, if at all, are you and your agency preparing for MUP, and any support for those you work with? 	<ul style="list-style-type: none"> • Nature of response to MUP, plans for supporting people affected by MUP.
Switching	<ul style="list-style-type: none"> • (if not covered/introduced above) • More specifically how do you see drinker's behaviour changing, in regards to any like change in type of alcohol or other drugs being used as a consequence of MUP? 	<ul style="list-style-type: none"> • Likelihood of different types of drinker switching, who is most at risk, motives, explanations • What will switching look like (i.e. within alcohol or to other substances), what substances, why, how?
Impact	<ul style="list-style-type: none"> • What do you consider to be the likely impact of MUP on drinkers, family friends and others? 	<ul style="list-style-type: none"> • Finances, health, wellbeing, accommodation, clothing, food.
Consideration of support needs	<ul style="list-style-type: none"> • What things do you think can be done to help support people with the price change? • By whom and how do you think this should be done? 	<ul style="list-style-type: none"> • What can be done to help, what do services need to help, when will this be needed, how will it be provided?

Anything else

- Knowing we were going to have a conversation about MUP, is there anything else you thought about or think we should hear on the subject?

- Respondents given the option to provide any further information that they think might be relevant.
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Thank you.