MESAS

Public Health Scotland

Minimum Unit Price for alcohol evaluation research protocol:

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

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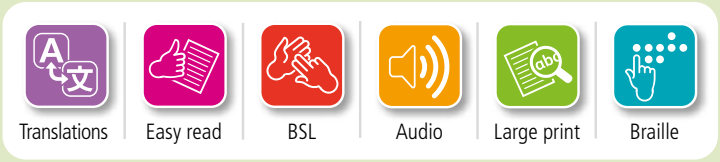

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The Evaluation Advisory Group membership and terms of reference are available online here:

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

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Introduction

In 2012 the Scottish Government passed legislation to implement a minimum unit price (MUP) for alcohol. The legislation was subject to an appeal by the Scotch Whisky Association (SWA) and European partners. In November 2017 the UK Supreme Court rejected the appeal ending the legal challenge. The Scottish Government implemented MUP on 1 May 2018 at 50 pence per unit of alcohol.

The legislation includes the requirement for the impact of MUP on the five licensing objectives, on alcohol producers and license holders, and on different groups to be reported after five years of implementation (Alcohol (Minimum Pricing) (Scotland) Act 2012) Section 3).

The NHS Health Scotland MESAS (Monitoring and Evaluating Scotland's Alcohol Strategy) team has been tasked by Scottish Government to lead the evaluation of the impact of the Act. The MESAS team has developed a broad portfolio of studies covering a range of outcomes. Further details of the evaluation portfolio can be found here: www.healthscotland.scot/health-topics/alcohol/evaluation-of-minimum-unit-pricing

This protocol describes the details of a study that will contribute to an understanding of the potential role of MUP on protecting children and young people from harms from others. The findings from this study will contribute to the overall MESAS evaluation of MUP that NHS Health Scotland is required to deliver to Ministers as soon as practicable after five years of implementation.

It is anticipated that this study will commence in September 2018 and run until July 2019.

Background

Despite some recent declines, alcohol-related harms in Scotland remain historically high. In 2012, the Scottish Government passed legislation to implement a minimum unit price for alcohol as part of a wider strategy to reduce alcohol-related harm in Scotland. The Act includes a 'sunset clause' under which the legislation will cease after five years and before the sixth year unless Parliament makes provision for it to continue. To inform this decision the legislation has a review clause that requires Ministers to report to Parliament on the impact of the Act on a number of outcomes. These include the impact of MUP on:

- the five licensing objectives: preventing crime and disorder; preventing public nuisance; protecting public safety; protecting and improving public health; and protecting children from harm
- groups such as by age, gender, socio-economic status, alcohol consumption and others deemed appropriate
- producers and license holders.

NHS Health Scotland has been tasked by the Scottish Government to lead the evaluation of the impact of the Act. Guided by a theory of change, a portfolio of studies has been developed covering: compliance and availability; alcohol consumption; impacts on health; impacts on crime, public safety and nuisance; impacts on children and young people; impact on household income and economic impact on industry. Full details of NHS Health Scotland's evaluation plan can be found here: www.healthscotland.scot/health-topics/alcohol/evaluation-of-minimum-unit-pricing

As the legislation for MUP requires the assessment of the impact on 'protecting children from harm', this will include the impact of MUP on protecting children from harms associated with others' drinking. Related studies in the MUP portfolio will potentially provide some evidence on the perceived impact of MUP on children and families (see Appendix 1).[*] However, there is currently limited evidence within the

[*] The study of people who drink to harmful levels will potentially provide some evidence on the perceived impact from the perspective of those who drink at harmful levels and adult

overall MESAS portfolio to evaluate the impact of MUP on protecting children and young people from harms associated with others' consumption.[*] This has been highlighted as a significant gap and our Evaluation Advisory Group (EAG)[†‡] recommended that NHS Health Scotland address this through a bespoke study with practitioners working with children and young people affected by harmful parental/carer and sibling alcohol drinking. Practitioners working closely with families are aware of the complexity of the drivers of alcohol consumption and some of the expected intended and unintended consequences of MUP, and would therefore be able to offer an informed perspective on the impact of MUP. In addition, practitioners are likely to be aware of some of the external factors that could impact on children's experiences of harms, independent of MUP.

The purpose of this work is to carry out a qualitative study of practitioners working with children, young people and families in addiction-related services. This study will provide important context for the observed impacts of MUP on children affected by harmful parental alcohol misuse (gathered through related studies in the MUP evaluation portfolio), and an understanding of some of the expected and unexpected

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family members. The study's analysis of Kantar data will evidence whether consumption has changed in population groups of interest (including those with children). In addition, we are supporting researchers to apply for grant funding to evaluate the impact of MUP on household expenditure.

[*] A decision was taken not to carry out a study of children and young people's own voices to understand their experiences of harms from others' consumption and whether MUP has influenced this. This decision is largely attributed to the methodological limitations in children themselves a) reporting b) observing changes in their experiences of harm and c) children being able to independently attribute change observed to MUP, given the range of other factors that will influence their experiences of harms.

[†] An Evaluation Advisory Group for the impact of MUP on children and young people has been established which includes a range of stakeholders who will advise on the overall children and young people evaluation. This will include commissioned research and in-house research (for example monitoring of routine data sources).

[‡] EAG meeting took place on 12.03.2018.

intended and unintended consequences of MUP on children and young people experiencing harm from others' drinking (such as parents, carers, siblings[*]). It is expected that this study will primarily focus on collecting data from practitioners such as health, social care, addictions services and the voluntary sector that currently work with families affected by alcohol.

Impact of MUP on consumption

The introduction of MUP has increased the price at which low-cost, high-strength alcohol is sold to 50 pence per unit, making it less affordable. MUP will have the greatest impact on alcohol sold across the off-trade. Currently 51% of all alcohol sold in the off-trade is sold below 50 pence per unit.[1] Products most likely to be impacted include strong white cider, own-brand spirits and high-strength lager. MUP is expected to reduce population alcohol consumption with the greatest impacts likely to be observed across harmful and hazardous drinkers.[2]

Evidence from related alcohol pricing policies in other countries has shown reductions in consumption and alcohol-related harms. The Sheffield Alcohol Policy modelling (SAPM) of the impact of MUP suggests that MUP at 50 pence per unit (ppu) will have only a small effect on consumption of adult moderate drinkers (1.2% reduction in consumption) but will have a larger effect on adults drinking at harmful and hazardous levels (reductions in alcohol consumption of 2.5% and 7% respectively).[2] The model suggests that effects are larger in those living in poverty across all consumption groups (for example, consumption for people living in poverty that drink at harmful levels is modelled to reduce by 15.3% compared to 4.4% for those drinking to harmful levels not living in poverty). The model does not estimate the impact of MUP on consumption of those under 18 years.

[*] Although the protocol refers primarily to parents, carers and siblings it is acknowledged that children and young people may also be affected by others drinking, including, for instance, other close family members or friends, drinking of others in public places.

Impact of MUP on children and young people

Not all parental drinking is harmful, and the impact of parental drinking can be very diverse. With this caveat, some harmful alcohol consumption can have significant negative consequences for children and young people. It has previously been estimated that 65,000 children in Scotland are affected by parental alcohol misuse, although these figures are likely to be underestimated.[3] Substance misuse was recorded as a cause for concern in 38% of concerns identified at the case conferences of children who were on the Child Protection Register in Scotland in 2016–2017.[4] Children of dependent drinkers are more likely to experience adverse childhood experiences, including being victims of neglect, violence, witnessing violence, being taken into care and are more likely to display behavioural and mental health problems. Additional consequences of parental alcohol consumption include children being late for school, poor attendance and educational attainment, missed mealtimes and children's sleeping patterns being disrupted.[5] It may also mean children, particularly those who are older, having to take on greater responsibilities.[5]

A theory of change has been developed to guide the evaluation of the impact of MUP on harms from others' consumption. In relation to harms to children and young people this includes three hypotheses. First, if MUP results in a reduction in harmful parental/carer alcohol consumption, it is hypothesised that there will be a reduction in the number of children experiencing harms from parental/carer alcohol misuse.

Children and young people are also exposed to the wider social implications of alcohol consumption. Research carried out by the Children's Parliament in 2011 illustrated that children highlight the wider social harms of alcohol and how this impacts on how safe they feel and their ability to play outside in their local area. If MUP results in a reduction in population consumption, which might include a reduction in consumption of alcohol in public places, it is hypothesised that MUP will reduce children's exposure to the wider social implications of alcohol consumption.

Even if MUP reduces parental/carer alcohol consumption, it is possible that MUP will result in an increase in the proportion of family household income spent on alcohol due to increased prices, which could have unintended consequences. However, it could also be hypothesised that there is less household income being spent on

alcohol, which could be beneficial for children and young people.[*]

A further unintended consequence of MUP is substitution to other illicit products, which could potentially result in increased harms for some children and young people.

There are also a number of external factors that will contribute to these outcomes, including welfare reforms, wider socio-economic trends, cultural changes and changes to services and provisions. This range of external factors illustrates the complexity of the context that MUP is operating in and the potential impact on alcohol consumption and harms to children and young people.

These factors will all be carefully considered in the design and implementation of the current study and used in the interpretation of the qualitative data gathered during the fieldwork.

[*] Evidence shows that price elasticity at the population level is <1. This means that at a population level people drink less, but this reduction is less than the price increase so they spend more (a little more for moderate drinkers but much more for harmful drinkers). It is important to note that price elasticity may vary by group.

Aims and objectives

The primary aim of this study is to contribute to an understanding of the potential role of MUP in protecting children and young people from harms from others' alcohol consumption, in the context of complex family lives.

The main objectives of the study are to provide important context for the observed impacts of MUP on children affected by harmful parental/carer alcohol consumption (gathered through related studies in the MUP evaluation portfolio). The study will provide an understanding of some of the expected and unexpected intended and unintended consequences of MUP on children and young people experiencing harm from others' drinking.

The research question the study aims to address is:

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

To address this research question the study will seek to gather the perceptions and understanding of participants on:

- the extent to which parental/carer/sibling drinking impacts on children and young people
- the role of alcohol and children's experiences of harms from others
- the potential role of alcohol price in mitigating harms to children associated with parental/carer/sibling drinking.

More specifically in relation to MUP the study will seek to gather the perceptions and understanding of participants on any general changes or trends they have observed across their existing caseload post-MUP, for instance:

- any changes in alcohol consumption and related behaviour that they have observed in their work with families post-MUP

- any recent changes in parental/carer/sibling alcohol consumption and related behaviour post-MUP expressed by the children and young people they work with or observed by participants in their work with families

- perceptions of the main factors that may have contributed to any changes observed across their existing caseload

- any observed changes in participating organisations of their alcohol-related service provision for parents/carers/sibling and families post-MUP (for example any changes in the care of children and young people by families or changes in family relationships, and how this potentially impacts on what participants do as practitioners in response to these families).

Due to the sensitive nature of these services and the information that will be gathered during focus groups it is important to note that participants will only be asked to discuss general perceptions of changes they might have noticed across the full caseload of families they are currently working with. They will be asked not to discuss any details of individual families during the focus group discussions. Procedures will be put in place by the research team to ensure risks of disclosure or risks to professional integrity are minimised at each stage of the research. These are described in more detail in later sections.

Design and methods

Study design

In order to gather the type of contextual information and practitioner perceptions set out in the aims and objectives it is proposed that this study should be a qualitative design to gather the views of practitioners working with children and young people affected by others' consumption of alcohol. This would enable a more in-depth discussion of issues raised by practitioners in order to gain a deeper understanding of any changes in the behaviours of parents/carers in relation to alcohol post-MUP that have been observed during work with families, and participants' perceptions of what might have led to these changes.

Methods

A rapid review of key literature about harms to children and young people from others' drinking will be carried out to inform the context of this study, the design of research tools, and the analytical stage and interpretation of data gathered during the study.

The proposed research method is to use focus groups with key groups of practitioners working with children and young people affected by others' alcohol consumption. This methodology was fully supported by the EAG whose membership includes a number of experienced practitioners and academics within this field. Previous research has also concluded that focus groups are an appropriate methodology for conducting sensitive areas of research with benefits including the potential for focus groups to provide a mutually supportive, sometimes empowering environment and that focus groups promote a more egalitarian form of discussion as the controlling influence of the group moderator is diluted through group interaction.[6 7]

Focus group interviews will enable a full discussion of the main research areas outlined in the study aims and objectives. It will also enable a higher number of participants to be included in the study than would be possible with individual interviews. It is anticipated that the shared understanding and experiences of focus group participants would enhance the quality of the discussion.

Due to the sensitive nature of the information being collected in this study it is important to ensure that there is no risk to families, children and young people or to the practitioners taking part in focus groups. The participant information sheet (see Appendix 2) states explicitly the importance of not disclosing information, or drawing on examples, that could potentially identify families or family members. This is to ensure the confidentiality of the families with whom they work and that the relationships of trust that people have built up are not breached. Any accidental breach will be treated sensitively and in line with relevant disclosure procedures.

This will be stated again at the start of each focus group with an opportunity for questions. At the start of the groups researchers will also remind participants of the need to maintain the confidentiality of the families with whom they work. Both at the beginning of the focus group, and in response to any potential breaches, researchers will also remind people of the need to respect the confidentiality of the group and the responses of other participants in the context of the discussion.

The research team will provide time at the end of the focus group for participants to raise any issues, comments or concerns they may have about the research process. If participants feel they have any issues of concern or feel they need additional support following the focus group, researchers will discuss this with them and advise that they discuss any issues with their line manager who will be able to advise them about local sources of support for staff if necessary. If participants wish to, it will also be possible to have short breaks in the course of the focus group to help reduce any potential stress of participating.

It is anticipated that around 10–12 focus groups will be completed. These will comprise six to eight participants in line with the methodological literature advising researchers to convene smaller groups when researching sensitive issues.[8] Final sample size and numbers of focus groups will be agreed when full details of relevant participants are obtained. The sample size has been kept flexible at this point to enable us to be led by what the focus groups yield, in terms of themes raised. This number has been chosen to ensure a range of organisations and staff groups with varying perspectives can be included. If the focus groups continue to present the same issues in discussions we may reach saturation and not recruit beyond 10–12 groups. However if new concepts, themes and/or perspectives continue to arise during these focus groups, then we would want to continue interviewing until this

stopped (reach saturation) or we reach our maximum work capacity (estimated at 15 focus groups).

Each focus group will take between 1–1.5 hours and will be arranged to take place at a time and in a venue that is most convenient for participants.

Depending on the themes emerging from the focus groups, the researchers may aim to speak with a small number of service managers to explore the possible implications for service providers. For instance, if participants identify changing trends among the families they work with, it would be helpful to understand the implications for services and managers on how they respond to families and how they are having to support strategic and operational changes to service provision in response to this.

Recruitment of participants

It is recommended that this study would recruit participants from organisations that work with families and children and young people affected by parental or direct family member harmful alcohol consumption. Participants will be recruited using purposive sampling through relevant voluntary sector organisations or service providers. Focus groups will take place within organisations, teams or practitioner groups that already work together professionally on a regular basis to enable participants to speak openly about the issues raised in the topic guide (see Appendix 3). Anonymity of participants and organisations will be protected in the reporting stage of the study. Within transcripts locations and organisations will be anonymised, for instance ‘Includem’ would be replaced with [voluntary organisation], and Glasgow to [city]. However, there might be points that are pertinent to the analysis and we will consider carefully how we present these; it might be we choose not to have a quote related to the point.

Participants will include practitioners working in addiction-related services and organisations, for instance within:

- Scottish Families Affected by Alcohol and Drugs

- NHS services (such as parenting and families services, SNIPS midwife, health visitors, addiction teams)
- Frontline social workers (such as child protection, addictions teams)
- Parents in Recovery Teams
- Education
- Poverty Alliance or the Poverty Truth Commission
- Police
- Includem

Organisations that include family members and carers (such as Scottish Kinship Carers) will be excluded from the recruitment process to ensure individuals are not placed in a situation where they would be asked to answer questions about a context that affects them and the children and young people in their care directly. The EAG will provide guidance on a final list of participant organisations to ensure the recruitment process is transparent and agreed.

Due to the nature of the study it will not be possible to represent all relevant organisations, however every effort will be made to ensure that an appropriate mixture of participants are included in the study to provide perspectives from different practitioner groups (such as health and social care, support workers) and organisations (such as third sector and statutory). It will also be important to include participants working in varying geographical areas to include perspectives on the different challenges that will be faced by families and practitioners working within, for instance, more urban or rural areas. It will also be important to consider levels of deprivation of areas served by participating organisations and teams. It is anticipated that most participants will be working with more deprived families due to the nature of their work.

Participants will be recruited by identifying, with the help of the EAG, a list of relevant organisations and key contacts who will be able to help us identify relevant groups of staff to conduct focus groups with. Key participants and team leads will be contacted by email or telephone initially to explain the purpose of the research and proposed

methods. Guidance will be taken from this key contact about the most appropriate way to recruit other team members that will be best placed to contribute to the research due to their role. However, in order to minimise any risk of participants feeling coerced into taking part, study information will be provided and individual consent obtained (see below).

In order to minimise risks to participants of unintended disclosure the aim would be to recruit to each focus group experienced practitioners either from the same team or who already work closely together to support families. This will be done with the help of service managers and leads to identify relevant groups of staff. They will already have existing relationships, confidentiality agreements and they will be groups of experienced practitioners that are experienced in protecting the families they work with and the relationships between practitioners and families.

This study will not involve asking participants to disclose personal information (about themselves or the families they work with) in the focus group discussion. However, the research team are aware that there remains an ethical issue about the possibility of participants revealing personal information about themselves or sensitive information about individual families in front of other participants. It is also important to note that this may represent a higher level risk if the focus group is being conducted in a workplace where unequal power balances may make individual staff members vulnerable.[9] The participant information sheet will contain details about the conduct of individuals in focus groups. This will be reiterated at the start of each focus group to ensure participants behave in a respectful way in line with guidance on focus groups,[9] this includes asking participants to:

- uphold the principles of respect and respectful behaviour in groups
- respect the privacy of other participants
- commit to the confidentiality of the focus group discussion.

It is not anticipated to be difficult to recruit participants. Difficulties may arise due to the capacity of staff working within busy organisations and challenging circumstances. Every effort will be made to accommodate participants, for instance using existing diary dates where appropriate if focus groups are taking place with single teams/groups of practitioners (such as existing team meetings). In other

circumstances every effort will be made to be flexible about the timing of focus groups to fit around participants working patterns and suitable premises.

A further challenge will be to ensure that all fieldwork is completed within the agreed timeframe to optimise data collection at a time where the potential impact of MUP can be observed. Once the timeframe for the research has been agreed with the EAG recruitment and planning of focus groups will begin immediately to ensure there is sufficient time to arrange meetings and recruit additional participants if necessary.

Informed consent

All participants will receive a study information sheet to keep that sets out the purpose of the research, the reasons for participating and how the information will be used. Potential participants will be given the opportunity to ask questions, prior to deciding whether or not to participate. If they do decide to participate, explicit written consent will be obtained prior to focus groups taking place (see Appendix 4). Participants will be free to withdraw from the study at any time up to the start of the focus group. Once individuals have participated in focus groups discussions it will not be possible to withdraw from the study due to the challenges to identifying individuals within a recording and also the potential for any removal of data to compromise the understanding of other data.[9] This will be made clear to participants in the information sheet (Appendix 2). Withdrawing data depends on the legal basis for which personal data is being processed. The legal basis for processing personal data in this study is because this research is a task in the public interest. This provides us with the legal assurances for not providing the option to withdraw from the study after the focus groups have taken place. Participants will be provided with contact details for the project lead to discuss the study should any further questions or concerns arise.

The Participant Information Sheet (see Appendix 2) will inform potential participants of their right to withdraw from the study. The risk of participants not wanting to participate in the study will be minimised by ensuring that they are provided with clear information about the purpose of the study. At the start of the focus group participants will be requested to respect the confidentiality of the group, and participate in an ethical way (safe, confidential, respectful). Participants will also be

requested not to disclose the names of individual families they are working with. If this is accidentally breached during a discussion this data will be removed from the recording and reported in accordance with the relevant disclosure procedures. This will all be set out in the Participant Information Sheet (Appendix 2) which will also include contact details of the research team should individuals wish to discuss any aspect of the study. The information sheet will also include details of a contact within NHS Health Scotland to raise concerns with if participants are unhappy about any aspect of the study.

Reflecting on the impacts of family alcohol consumption on children and young people is a sensitive and potentially distressing subject. The researchers will provide time at the end of the focus group for people to raise any concerns or issues about the research process. It will also be possible to have short breaks in the course of the focus group to help reduce the potential stress of participating.

Data collection

If all the individual focus group members have consented, the focus group discussion will be audio recorded for transcription to ensure the research process is rigorous and transparent. If taping is not possible the researchers will make detailed notes of the discussion. Two researchers will be present in each focus group to ensure this will be possible.

Verbatim transcription of focus groups will allow more rigorous analysis of data and will ensure transcripts are available for independent verification of this if required, however identifiers will be removed from the transcripts to ensure anonymity. Reflective notes will be also kept, with a note written after every focus group to highlight contextual issues or other insights that might not be captured in the transcript. These notes will be held securely as per the requirements for study data storage set out by NHS Health Scotland. Participants will be asked whether they grant permission to be contacted again in the event a follow-up is required.

Prior to the start of each focus group, participants will be reminded that the researchers are asking about the practitioners' perceptions, reflecting across their caseload, and that they will not be asked to provide specific examples from individual

families. Participants will also be reminded that any accidental disclosure of individually sensitive information may have to be reported following the relevant disclosure procedures. In the course of the discussion the research team will also, as necessary, remind participants about avoiding disclosure and will actively steer the discussion as appropriate. If necessary the researchers will halt the discussion to give participants a break to reduce any potential stress participants may be experiencing.

Focus groups will be based on a semi-structured discussion guide to ensure all relevant areas are included to meet the aims and objectives of the study. Two researchers will be present at each focus group to ask questions, introduce prompts and probe participants on additional issues that emerge during the discussions.

As the focus groups will be carried out with practitioner groups it is not anticipated that there will be any safety concerns for the research staff.

In terms of meeting participant needs, focus groups will be organised at a time convenient to the participants, and they would be situated at a place of the groups' own choosing. The people who will participate in the study are experienced staff and professionals working in Scotland who deal with the public. For this job they would need to have a high standard of English and therefore we will not need to access interpreters in this situation. Other individual needs that may be a barrier to participation would be managed in liaison with participants directly.

Focus groups will be conducted by Public Health Intelligence Advisers from the NHS Health Scotland evaluation team who are experienced qualitative researchers (over five years' experience). As with the rest of the MUP evaluation portfolio, the project team will be providing operational support and review of the study throughout. This will ensure adequate briefing and consistency on understanding study needs.

Data analysis

It is proposed that the focus groups will be fully transcribed for analysis. The data collected during this study will only be used for the original purpose set out in this protocol.

Using the focus group questions as a broad framework the data will be coded and analysed thematically. Emergent themes from the data will also be coded for analysis. The team will develop an analytical framework from the labels generated from coding the first 2–3 focus groups, so that these codes can then be applied to subsequent interviews.

Individual participants will not be identifiable from any report or publication placed in the public domain. Every effort will be made by the research team to ensure that data is not presented in a way that will identify areas and individual organisations. This will be checked by the research team and in the course of the review process to ensure anonymity is maintained.

The data will be coded separately by two members of the study research team and findings compared to ensure consistency of approach and interpretation and validate any recorded themes that emerge from the data. Researchers will return to participants to clarify any points raised during the analysis and check for accuracy where necessary.

As this study will be carried out by NHS Health Scotland it is likely to receive increased scrutiny due to perceived bias. A clear and transparent governance and peer review process, via the EAG, will be required to ensure risk of (perceived) bias is managed. It is proposed this will include:

- peer review and guidance from EAG – research questions, recruitment, data collection methods, analytical framework and reporting
- identification of an external EAG chair (NHS Health Scotland to retain secretariat).

Reporting and dissemination

On nearing completion of the project, a draft report will be submitted for discussion with the Research Commission Panel and the MUP Children and Young People EAG for comment. Independent review of the draft final report by the EAG will be important due to the methodological challenges associated with this study and potential sensitivities about reporting findings. The final research report will incorporate the feedback of the EAG. On completion of the research we anticipate that a final written report and briefing paper will be published on the NHS Health Scotland website. A summary of findings from the focus groups will also be provided to all participants including links to related MUP evaluation studies so that participants are also aware of how their participation has contributed to the wider MUP evaluation portfolio.

NHS Health Scotland will agree with Scottish Government and the EAG a plan for disseminating the study. Further dissemination of research outputs will ensure knowledge and findings are adequately raised, discussed and transferred to other relevant groupings to inform future policy, practice and public understanding. This may take the form of presentations to policy makers, conference presentations, peer-reviewed articles, and so on.

Study limitations

The proposed design of this study presents methodological challenges around the extent to which any changes observed by practitioners could be subsequently attributed to MUP. Often those families in direct contact with services live complex lives and attributing changes that practitioners observe in their work with families independently to MUP will be challenging. In addition, alcohol may only be one factor which accounts for children experiencing parental/carer harms. Furthermore, focus groups can only capture more general perceptions of practitioners. The study is, however, not about establishing and attributing cause, but to obtain an understanding from practitioners with specialist knowledge in alcohol-related services about any changes they perceive within families post-MUP, and whether and how they see this related to MUP.

A further limitation of the study is that it does not include children and young people although there are clear reasons for this decision outlined above (see footnote 2, page 4).

It is important to acknowledge these methodological limitations and being explicit about this in writing up our findings. In addition, the EAG's review of our study protocol, research tools and findings will ensure that appropriate governance is in place to oversee this study.

Timeframe

The Scottish Government implemented MUP on 1 May 2018. It is planned that data will be collected 4–12 months post-implementation of MUP. The reason this timescale has been given is because changes in alcohol price will be immediate, and changes in parental/carer drinking and related behaviours (both intended and unintended) are expected to occur relatively soon in response to price changes. This suggested timeframe would allow time for MUP implementation and any potential impact on individual behaviours to become visible to practitioners working with families, and for fieldwork to be carried out before the influence of MUP becomes less visible among other factors affecting the families. It is recognised that although there may be variation in the potential harms-related expected (and unexpected) outcomes for children and young people over the short and longer term, it is only the shorter-term potential impacts on which this study will be able to provide context.

Following discussion with the EAG they recommended that recruitment and fieldwork begins immediately. It is anticipated that fieldwork will take place between September and December 2018.

The following table sets out an indicative timeframe for the study.

Activity	**Dates**
Development and sign off research proposal	July 2018
Development and sign off research tools	Aug 2018
Recruitment	Aug–Sep 2018
Fieldwork	Sep–Dec 2018
Analysis	Jan–Mar 2019
Drafting report	Mar–Apr 2019
EAG review	May 2019
Addressing report feedback	June 2019
Report sign off and publish	July 2019

Resources

The study will be carried out by Public Health Intelligence Advisers in the Evaluation Team. Their time has been allocated to this study to plan, complete fieldwork, analysis and reporting of findings.

A budget of £2k[*] has been allocated from the MESAS evaluation budget to pay for transcription services of an external agency to enable a transparent and rigorous analysis of data gathered in the focus groups.

Ethical considerations

Research is a core part of the NHS and other care services. Research enables these services to improve the current and future health and wellbeing of the people they serve. Research must conform to recognised ethical standards, which includes respecting the dignity, rights, safety and wellbeing of the people who take part.

As part of the NHS, NHS Health Scotland must comply with the recognised ethical standards set out by the NHS Health Research Authority for all NHS health-related research. Research involving NHS staff, who are recruited by virtue of their professional role, does not require REC review except where it would otherwise require REC review (for example, because there is a legal requirement for REC review, or because the research also involves patients or service users as research participants).

It has been confirmed by the West of Scotland Research Ethics Service that as the proposed study design involves recruiting participants in their professional role there will be no requirement for NHS Research Ethical Review (23 April 2018).

The proposal will be submitted to the NHS Health Scotland Research Development Group for consideration prior to the work starting.

[*] This is based on an estimate for professionally costed services for the transcription of 15 focus groups lasting between 60 and 90 minutes.

Management and quality assurance

The study will be managed and carried out by Public Health Intelligence Advisers in the Evaluation Team at NHS Health Scotland. They will work within the existing NHS Health Scotland governance and reporting structures for the MUP evaluation portfolio.

The key contact for the study will be Jane Ford, Public Health Intelligence Adviser (email jane.ford3@nhs.net).

Due to the methodological limitations of this study outlined above it will be important to obtain independent review by the EAG of the draft final report. This will help to minimise the risks to the perceived independence that may arise as a result of this study being conducted by NHS Health Scotland. The EAG will also be consulted throughout the study for their guidance on study design, methods, analytical framework and the interpretation and presentation of qualitative data. These steps will help to ensure that the study remains transparent, impartial and rigorous throughout and that the integrity of the work is retained.

Project management and governance

The key contact at NHS Health Scotland for project management during this contract will be:

- Jane Ford (Public Health Intelligence Advisor), 0141 414 2738 jane.ford3@nhs.net

Equality

NHS Health Scotland's vision is a Scotland in which all of our people and communities have a fairer share of the opportunities, resources and the confidence to live longer, healthier lives. Our aim is to improve Scotland's overall health record by focusing on the persistent inequalities that prevent health being improved for all.

Advancing equality is fundamental to NHS Health Scotland's vision. It is also our legal duty. The Equality Act 2010 protects characteristics which can make people vulnerable to being discriminated against and experiencing worse health.

People are not defined by any singular characteristic. We all share at least six protected characteristics including age, gender, ethnicity, religion (including none), marital status and sexual orientation. These characteristics, along with others, can combine and intersect to affect health and wellbeing, often varying across a person's life. A narrow focus on one aspect of an individual's or a group's identity may therefore work to the detriment of understanding and responding to the reality of their lives and needs. NHS Health Scotland sees delivering on our duties set out in the Equality Act 2010 as integral to delivering our vision.

Human rights belong to everyone, everywhere, regardless of nationality, sexuality, gender, race, religion or age[*]. They are the basic rights we all have simply because we are human, regardless of who we are, where we live or what we do. Human rights-based approaches prompt consideration of how a plan or policy might drive up

[*] Scottish Human Rights Commission, 2012, http://scottishhumanrights.com/

standards of services and enhance positive impacts for all people. There is a legal requirement on public bodies to comply with the UK Human Rights Act (1998).

In accordance with the Human Rights Act 1998, the Equality Act 2010 and The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 NHS Health Scotland takes every proportionate effort to: eliminate unlawful discrimination, harassment and victimisation and other prohibited conduct; advance equality of opportunity between people who share a relevant protected characteristic and those who do not; and foster good relations between people who share a protected characteristic and those who do not; and enhance human rights.

In addition to these legislative requirements, through Health Inequality Impact Assessments (HIIAs), NHS Health Scotland commits to considering how products and services will impact on the fundamental causes of health inequalities, wider environmental influences and individual experiences of health inequalities.

Health inequalities are unfair differences in health across social classes or between population groups. All public sector and many private sector agencies have a contribution to make to reducing health inequalities. Health Inequalities Impact Assessment (HIIA) is a tool which offers an integrated approach to impact assessment encompassing legally protected characteristics, human rights, wider population groups and social determinants of health. The main aim of HIIA is to strengthen the contribution of policies and plans to reducing health inequalities by improving equity of access, ensuring non-discriminatory practice and acting on the social determinants of health. All new public sector policies and programmes must be impact assessed to meet the requirements of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.

The importance of considering characteristics such as someone's ethnicity, gender or socio-economic status in research cannot be overstated. Research informs policy and programme development which subsequently informs the national actions and policies that emerge. The more we can take account of experiences and perspectives of people with different characteristics, the more likely that those perspectives are integrated into policy and practice. If these issues and perspectives continue to be missed in research, there is a danger that we continue to reinforce

existing inequalities by failing to address discrimination and account for the diversity of experiences and needs in Scotland today.

Data protection

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

This study will comply fully with the requirements of the data protection legislation including the General Data Protection Regulation 2018 and the Data Protection Act 2018.

NHS Health Scotland will be the Data Controller for the data collected as part of this study.

Data collection: participants in the research will be given study information that explains its purpose, what their involvement entails, and the reason for data collection. Written informed consent will be obtained for the above including the participant's organisation and role. The consent form will offer an opportunity for participants to include work-related contact details for the purposes of keeping them informed about the progress and reporting of the study. A copy of information will be given to the participant to keep.

Data storage and management: to ensure confidentiality, all hard copy consent forms will be stored in locked cabinets or containers at NHS Health Scotland. At the start of each focus group participants will be asked to ensure there are no names of services users that would identify individuals to the researchers. Although the focus groups will take place with practitioners and will not contain personally identifiable information relating to individual service users, to ensure best practice is followed all electronic information will be stored in secure password protected dedicated research project files on a secure server. All data will be accessible only to project staff and support staff transferring the file, who are subject to internal information governance.

Data transfer: the recordings of focus groups and interviews to an external agency for verbatim transcription and for the return of transcriptions to NHS Health Scotland. Prior to the transfer of any files to external agencies a transcriber confidentiality

agreement will be in place with individual agencies and this will act as an addendum to their contract of services with NHS Health Scotland. The security of data transfer will be checked by the NHS Health Scotland IT team. Steps will be taken to ensure data remains confidential (for example use of encrypted devices and confidentiality agreements with contracted transcription service agencies). The audio recording will be securely destroyed on publication of the study report, in approximately one year. The transcript and any handwritten notes from the focus groups will be kept for up to five years from publication of the study report before being securely destroyed. Personal data will be securely destroyed following dissemination of the study findings.

Research team expertise

The NHS Health Scotland research team has the relevant skills and appropriate research experience to undertake this work and successfully deliver the research. If challenges arise in staff capacity due to unforeseen time off work this will be managed within the wider capacity of the MUP team and the Evaluation team within NHS Health Scotland. The MUP Evaluation portfolio is an organisational priority, and this will facilitate managing capacity. However, there are competing demands and the staff resource allocated to this study has to be proportionate to the study.

Appendix 1: Current studies within the MUP portfolio

There are two studies within the current MUP portfolio that could potentially contribute to an understanding of the impact of MUP on protecting children and young people from harms associated with others' drinking.

Study of people who drink to harmful levels

MUP is expected to have the greatest impact on those drinking at harmful and hazardous levels. A large study has been commissioned to Sheffield University to understand the impact of MUP on this population subgroup. This study has a number of work packages and will undertake a mixed-methods approach, including both qualitative and quantitative analysis:

- Work package 1 will ask participants (people who drink to harmful levels) themselves about the impact of their drinking on their families, including children. Appendix 1 includes questions that will be considered as part of this work package.
- Family members (although not children) will be interviewed as part of work package 2 to obtain their views on the impact of MUP. Although this will be in relation to impacts more generally, rather than specifically in relation to impact on children and young people. It is estimated that approximately 10 interviews with family members will take place.
- Work package 4 will use Kantar World Panel Alcovision Survey to determine whether consumption has changed in key population groups of interest, including those with children.

Household expenditure study

We are supporting researchers to apply for grant funding to evaluate the impact of MUP on family household expenditure on alcohol and other essential items. This will include analysis of Kantar World Panel purchasing data. It is possible that this will also look at key population groups of interest, including those with children.

Appendix 2: Participant information sheet

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

Participant information sheet (14 November 2018)

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

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

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

Why is the study important?

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

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

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

What is this study about?

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

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

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

Why have I been invited to take part?

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

What does taking part in the study involve?

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

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

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

1 the impact of family alcohol misuse on children and young people, and the role alcohol price may play in that

2 whether you are aware from your work of any impacts on alcohol consumption and related behaviour since the increase in the minimum unit price of alcohol at the beginning of May 2018. In particular whether you are aware of any recent impacts on parental/carer/sibling alcohol consumption and related behaviour

3 the possible factors that may have contributed to any impacts

4 the potential implications for children and young people

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

Do I have to take part?

No, it is entirely up to you.

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

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

What should I do if I want to take part?

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

What are the possible benefits of taking part?

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

What are the possible risks of taking part?

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

As you will appreciate it is important in a study of this kind that the confidentiality of the families you work with and the relationships of trust you have built up are not breached. All the participants will therefore be expected to contribute to the discussion in ways that meet data protection legislation* and local information governance protocols on information sharing. Any accidental breach would be

* General Data Protection Regulation 2018 https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/ (accessed 10 September 2018).
Data Protection Act 2018 www.legislation.gov.uk/ukpga/2018/12/contents/enacted/data.htm (accessed 10 September 2018).

treated sensitively. Where appropriate, any inadvertent disclosure may need to be reported in accordance with the relevant disclosure process.

How will my information be kept confidential?

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

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

The recordings will be transcribed and analysed together with data from other focus groups to produce a report identifying the main themes that emerge from discussions. To ensure anonymity identifiers will be removed from the transcripts. No individuals will be identified in reporting of the study. We may use some direct quotes from what you say in the study reports, presentations and publications but your identity and the organisation you work for will not be revealed.

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

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

In order to collect and use your personal information as part of this research, we must have a basis in law to do so. The basis we are using is that the research is 'a task in the public interest'. Your rights to access, change or move your information

are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. Your personal data will be processed only so long as it is required for this study. We will minimise the processing of personal data wherever possible.

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

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

What will we do with the results?

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

Has the study been approved by an ethics committee?

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

Contacts for further information

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

Jane Ford, Public Health Intelligence Adviser, Public Health Scotland

Tel: 0141 414 2738 or Mobile: 07500 121983

Email: jane.ford3@nhs.net

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

Rebecca Sludden, Research Services, Public Health Scotland

Tel: 0141 414 2760

Email: Rebecca.Sludden@nhs.net

Should you wish to make a complaint about Public Health Scotland's collection or use of data, the UK's independent authority set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals is the Information Commissioner's Office.

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

Appendix 3: Focus group topic guide

A. Introductions and initial exploration of the issues

Introductions

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

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

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

B. Questions specific to MUP

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

(Prompt/reminder – no individual examples.)

- To what extent do you feel MUP has had any impact on alcohol consumption and related behaviour among parents/carers?

- For example positive aspects; how or where people get alcohol from (for example criminal behaviours such as stealing alcohol); substitution with other substances.

- If so, what have the consequences of these been? This might include:
  - positive changes, such as lower amounts of alcohol consumed, less frequent drinking
  - more negative unintended consequences, such as how or where people get alcohol from (for example criminal behaviours such as stealing alcohol), less money to spend on essential goods for children, substitution to other illicit substances, increased family stress; parent/carer/sibling mental health problems; consequences associated with withdrawal; increased stress/mental health problems for children/young people.

- Thinking about your experience since May, have children/young people described any recent changes in parental/carer alcohol consumption and related behaviour?
  - This might include positive changes such as lower consumption, lower frequency of drinking.
  - Unintended consequences, such as less money to spend, substitution to other illicit substances, increased family stress; parental mental health problems; consequences associated with withdrawal; increased stress/mental health problems for children/young people.

- Based on your experience, do you feel there have been impacts on children's experiences of harms from parental/carer drinking?
  - This might include positive or negative impacts.

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

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

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

D. Understanding any changes in service environment

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

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

E. Anything else?

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

Final note

- Note on what happens next: reminder from the information provided about the research process – recordings will be transcribed and analysed together with data from other focus groups to produce a report identifying main themes. Hope to publish in July/August 2019.
- Thank you for your participation.
- We will be here for a few minutes more if you would like to spend some time just reflecting on the process and unwind before going back to your work.

Appendix 4: Consent form

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

Participant consent form

Version 3 (14 November 2018)

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

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

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

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

Please initial box (do not tick):

1 I confirm that I have read and understood the participant information sheet dated (14 Nov 2018) for the above study. I have had the chance to ask any questions and am satisfied with the answers given.

2 I understand my participation is voluntary and that I am free to withdraw from the study at any time before the focus group takes place without giving a reason.

3 I agree to the focus group discussion being audio recorded and transcribed.

4 I understand that any quotes used in reports on the research will not be directly attributed to me or the organisation I work for and I agree to the use of direct anonymised quotes in research reports, presentations and publications.

5 I would like to be sent a copy of the findings of the study.

6 I agree to take part in the above study.

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of person taking consent	Date	Signature

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

References

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