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**The normalisation of binge drinking?
An historical and cross cultural investigation with
implications for action**

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EXECUTIVE SUMMARY

- Binge drinking is nothing new in British society and has not always attracted disapproval. Its change in history from a ‘manly’ activity to one associated with out of control women represents wider social change and policy interests as well as the reality of a problem.
- Raucous and drink fuelled public behaviour by young people has been a tolerated feature of British life in the past.
- Institutions, professions and individual professionals differ in the way in which they define and think about binge drinking now : these differences reflect their particular agendas and priorities. Moreover, these differences are not necessarily recognised. ‘Binge drinking’ is often used in a way which implies a common understanding between the various stakeholders. Without a shared understanding amongst stakeholders it is difficult to see how any ‘solutions’ can be reached.
- Binge drinking is an important driver for alcohol policy, but there is no agreement as to what is actually being measured. It is thus difficult to build up an evidence base on which to formulate policy and this leaves any subsequent policy on shaky ground.
- The prominence of binge drinking perceived as a problem of young people in public places recognises a phenomenon but foregrounds it to the detriment of other areas of increased alcohol consumption, for example in the family and at home.

1. INTRODUCTION

Binge drinking is a matter of current social, media and political concern, rarely out of the headlines and a focus of policy activity. Discussion of binge drinking has focussed on the activities of young people and it is believed to have resulted in significant harm to individuals and to communities. The problems attributed to binge drinking are wide ranging. They include negative impacts on the health of an individual, both in the short term (for example, accidents, injury, acute alcohol poisoning) and in the longer term (for example liver damage). In recent years the role of binge drinking in incidents of crime and disorder, particularly in town centres, has been given particular prominence. Binge drinking is sometimes portrayed as a recent phenomenon but it has a history and concern about is not new. That history and the changing role of concern has implications for the understanding of contemporary concerns about the practice.

2. AIMS AND RESEARCH QUESTIONS

2.1 Aims

This project aimed to set the phenomenon of binge drinking in its historical cultural and contemporary context by considering:

- A. Historical and anthropological perspectives;
- B. The definition and measurement of binge drinking;
- C. The contemporary situation in cross national perspective.

The overall aim is to draw lessons for policy through the interaction of social science and historical perspectives.

2.2. Research questions

A. Historical and anthropological perspectives:

- When and why was excessive drinking/binge drinking a concern in the past?
- What have been the drivers of cultural change?

B. The definition and measurement of binge drinking:

- How has binge drinking been defined and understood?
- How has binge drinking been measured and what implications have those measures had?

C. Contemporary perspectives:

- Has binge drinking, however defined, become normalised in the UK?
- If normalisation has occurred, how does this process in the UK compare with other national cultures?

D. Lessons for policy:

- What are the implications for contemporary policy and practice?

3. METHODS¹

A review of the historiography of binge drinking was conducted together with a review of contemporary epidemiological and social science literature on binge drinking. Searches were conducted in English language social science and medical science databases² using a variety of search terms³. A number of foci within the research were identified. For example, there is a considerable body of US literature dating from the mid 1990s which examines binge drinking amongst students on college campuses; and there is a series of studies focusing on Russia and other Eastern European nations dating from the late 1990s. From the searches it was evident that the use of the term 'binge drinking' had grown in recent years (mid/late 1990s onwards) and indeed the National Institute on Alcohol and Alcoholism (NIAAA) database has no records for the term for the decades 1960-1970 and 1970-1980.

In addition the study used recent policy documents, research reports and statistics published by the European Union and the World Health Organisation (WHO) and by UK government departments (usually the Home Office or the Department of Health).

In order to keep abreast of developments we subscribed to the email alerts of a range of addiction and social science journals (e.g. *Alcohol and Alcoholism*, *Addiction*, *Journal of Social Policy*) and also to the 'Daily Dose' (www.dailydose.net) which supplies drug and

¹ The original research plans were altered in response to changes in circumstances and also the emerging data, please see Appendix One for an outline of the changes and reasons for them.

² The primary ones being National Institute on Alcohol and Alcoholism (NIAAA) (<http://etoh.niaaa.nih.gov>), International Bibliography of the Social Sciences (<http://arc.ovid.com>) PsychInfo (www.psycinfo.com) and PubMed (www.ncbi.nlm.nih.gov).

³ The key terms were 'binge drinking', 'heavy episodic drinking', 'risky single occasion drinking', 'heavy drinking occasion', 'heavy drinking', 'risking drinking patterns'. Further more refined searches were conducted by combining terms, for example binge drinking and violence, binge drinking and women and also for specific periods of time.

alcohol news from around the world in the form of links to media articles, press releases and research reports. The Daily Dose alert was a valuable source of information and it also highlighted the high profile that binge drinking has in the media.

In addition information on the project was distributed to members of the Kettil Bruun Society⁴ (KBS) Listserve group along with a request for information about relevant research. In this way we learnt about other current and recent research studies, including one in Russia using a historical perspective to examine contemporary issues⁵. The KBS Listserve group had already conducted (Oct –Nov 2005) a discussion on the definition of binge drinking which provided some valuable leads for this study and illustrated the confusion surrounding the definition of the term. We have also established links with an historical Intoxication Network⁶.

As noted above it was apparent that media had a particular fascination with binge drinking and in order to explore this further a search for the use of the term ‘binge drinking’ was conducted in the on-line indexes of *The Times* newspaper and also of Hansard, the record of proceedings in Parliament and the House of Lords for the period 1985-2005. The results of this are presented on pp. 31-34 of this report.

⁴ The Kettil Bruun Society for social and epidemiological research is an international organisation of scientists engaged in research on the social aspects of alcohol use and alcohol problems (see www.arg.org/kbs).

⁵ Iossif Gurvich and Veronika Odinkova of St Petersburg University are analysing historical trends of alcohol consumption in Russia as part of their research ‘Alcoholization and Health among the Russian Population the post-Perestroika period’.

⁶ Currently under development by Dr Philip Whittington, lecturer in history at the University of Leeds and Dr Angela McShane of the Victoria and Albert Museum.

In addition a workshop was organised in order to understand the views of experts on how the problem of binge drinking is perceived and defined, to analyse the current responses to binge drinking and to identify the challenges and opportunities for future policy and practice (see Appendix Two for details of the programme). A report based on the proceedings of the workshop was compiled and submitted to the AERC (see Appendix Three).

An Advisory Committee⁷ was established which met twice during the year.

⁷ The Committee membership was :Professor Martin McKee, London School of Hygiene and Tropical Medicine, who has researched binge drinking in Eastern Europe, Professor Rob Baggott, De Montfort University, with a specialist interest in alcohol policy and Dr Pui-Ling Li from the AERC.

4. FINDINGS

4.1. *What can we learn from the past?*

Heavy drinking has characterised British alcohol consumption at many periods in the past but the amount of concern such activity has aroused on the part of the public and the state has varied. This section of our report looks at the role of heavy drinking in British society and at the rationales for increased social and policy disapproval of such activity.

4.1.1. **The acceptability of heavy drinking**

There is no doubt that heavy drinking was endemic in society from an early period. William of Malmesbury, for example, (c.1095-1143) in his *History of the Kings of England* wrote that at the time of the Norman Conquest, the English were hard drinkers. 'Drinking is a universal practice, in which occupation they passed entire nights as well as days... They were accustomed to eat until they became surfeited, and drink until they were sick' (quoted in Barr, 1995, p.25). Malmesbury's story was that the Norman victory at the Battle of Hastings was attributable to the differing habits of the opposing soldiery: the Normans spent the night before the battle praying while the English soldiers stayed up drinking. Such accounts are not unbiased and cannot be taken at face value. But there is no doubt that heavy drinking and the consumption of large amounts of alcohol, by men in particular, was seen as normal and even beneficial well into the nineteenth century. *The Gentlemans' Magazine* in the eighteenth century recorded 87 idioms for drunkenness ranging from the genteel 'sipping the spirit of Adonis' down to the vulgar 'stripping me naked'. As Borsay (2005) has noted, heavy drinking at funeral wakes was widespread and until the mid seventeenth century, funds were raised for maintaining the parochial

church fabric through church ales (Borsay, 2005; Borsay, 2006). Hard drinking was notable at all levels of society. It was as acceptable for the local squire to fall dead drunk under the table after a night's drinking as it was for heavy labour to be leavened by periods of heavy drinking. The diary of a seventeenth century apprentice shows how embedded drink was in all aspects of life with the rites of passage, christening, weddings and funerals, normally occasions for heavy communal drinking (Martin, 2006). During times of public celebration ale and wine would be distributed to the common people. At Newcastle on Tyne a fountain was constructed in the market place for George III's coronation, 'the conduit running wine all the time for the populace' (Borsay, 2005). Alcohol consumption and work were not seen as incompatible and periods of heavy labour would be alleviated by alcohol. In the eighteenth century, drink was built into the fabric of social life - it played a part in nearly every public and private ceremony, commercial bargain and craft ritual (Porter, 1985). Alcohol fulfilled many functions, stimulating social bonding and loosening inhibitions as well as enabling arduous labour to continue. Borsay (2006) has also argued that it triggered carnivalesque behaviour in which the norms of everyday life were inverted. He cites the poet and politician Samuel Bamford, who in his recollections of his youth in early nineteenth century Middleton in Lancashire, described how on Easter Monday companies of young men in grotesque dress would stagger from house to house receiving gifts of money and ale, while 'men thronged the ale houses and there was much folly intemperance and quarrelling amidst the prevailing good humour'. On the following day a young fellow who had become so intoxicated as to be incapable, would be selected as mock mayor for the next year (Bamford, 1849).

Such customs recall the practices of pre industrial society and their transfer into different cultures. But what did change from the eighteenth century onward was the response of society to such activities and to heavy drinking. The first inkling of this change was in the Gin Craze of the early eighteenth century which provided an index to the changed attitudes of society and the state. We will look first at this episode which is so often cited, and then at the rationale for changed attitudes later in the eighteenth and nineteenth centuries.

4.1.2. Gin Lane and its place in changed attitudes.

From the 1690s, the distilling industry had increased the production of gin whose low price and easy accessibility led to a steep rise in consumption. Gin consumption rose in response at least partly to government policy to stimulate the distilling industry by reducing duties on 'low wines' made from British corn (Barr, 1995; Warner, 2003). Duties on gin were reduced and increased on beer so that after 1694 gin cost less than beer (Barr, 1995, p.189). By the early 1720s around 2.5 million gallons of spirits were being produced in London annually and it was claimed that this gave each inhabitant of the city a pint of gin a week. From the mid 1720s a campaign was initiated to do something about this new drinking culture. It was finally successful in 1751 when effective legislation was introduced. The campaign reached a climax with the publication in that year of Hogarth's illustrations *Gin Lane* and *Beer Street* which encapsulated the anxieties of the time (see pages 11 and 12). The illustrations underlined the contemporary differences drawn between spirits (gin) and beer, which was seen a healthful and strengthening. Women were seen as failing in their maternal duties, with the corrupt

drinking culture itself feminised through the character of Madam Geneva or Mother Gin. Fears of foreign influence on drinking were also underlined by one version of the print which had a Frenchman being manhandled out of the street by an English working man holding a brimming jug of beer.

Borsay has argued that, in relation to the current concerns about binge drinking,: “The parallels...are uncanny: street violence, damage to public health, costs to the economy, the corruption of women, the reduction of the maternal instinct, and the threat to family life and English identity” (Borsay, 2005, p.46). Furthermore, these similarities are reinforced by the urban location of the “problem” and the key role played by the print and media in shaping and driving the moral panic and the inaction and seeming complacency of the government (Borsay, 2007). The current champions of action on binge drinking have turned to this episode in history for justification. Ian Gilmore, President of the Royal College of Physicians, has evoked the spectre of ‘Gin lane’ in relation to alcohol consumption and increased alcohol related mortality in Britain since the late twentieth century, much as the College itself did in the eighteenth century (Fleming, 2006). In 1726, it presented a petition to Parliament drawing attention to ‘the fatal effect of the frequent use of several sorts of distilled spirituous liquors upon great numbers of both sexes, rendering them diseased, not fit for business, poor , a burthen themselves and their neighbours and too

GIN LANE.



The good Friend with my Daughter,
This Friend with my Son,
A man of a good Trade,
A woman of a good Trade,
A man of a good Trade,

Trade and Skill, such as
By any means to be
But what is the Trade
That is the Trade

Some of the Trade, such as
That is the Trade, such as
That is the Trade, such as
That is the Trade, such as

BEER STREET.



*How James Brough of our City
 Conquered through all means
 And proved all Fasting and Lent
 A new dress and better Meat*

*Labour and All upheld by That
 Accus'd Religion
 By good Will, rather than will the
 And their Cakes in Prison.*

*Some of History, the greatest Men
 From the City of London
 And from the Kingdom of Great Britain
 With Liberty and Love*

often the cause of weak, feeble and distempered children.’(quoted by Royal College of Psychiatrists, 1986.p.21)

Gin Lane has often been used in medical reports on alcohol to represent the history of the health harms associated with consumption. However, the nature of ‘the problem’ which Gin Lane represented and of the governmental and social response needs a little unpicking. Although there was a problem of increased drinking of spirits, this was also a story of consumption by the poor arousing disproportionate attention compared with heavy drinking by the middle and upper classes. Consumption eventually fell after moderate price and licensing controls were brought in, acceptable methods of law enforcement were used, the brewing industry emerged as a strengthened competitor, and drinking fashions changed. Warner has argued that ‘concerns over drunkenness bore very little correspondence to actual consumption, begging the question of whether a reforming elite was reacting to gin per se or rather to larger more intractable threats to their society and way of life.’ (Warner, 2003, p. 4). She draws attention to the variable role of government, taking action in the 1730s although consumption seems to have peaked in the 1740s. In peacetime and with money in reserve, curbing consumption of gin came to the fore, but when war broke out, as it did in the 1740s with the War of Austrian Succession, gin became simply another source of revenue. Other historians have pointed to the fact that high levels of infant mortality attributed to gin consumption seemed to have owed more to unsanitary living conditions, poor water supplies and diet (see Clark, 1983). The high ratio of deaths to births may have owed more to recording practices and certainly preceded the gin epidemic by many years. And some of the best known stories

from that epidemic are known to be apocryphal—for example the gin shop advertisement immortalised by Hogarth, ‘ Drunk for a penny, dead drunk for twopence, clean straw for nothing.’ (Clark, 1983; Warner, 2003). So the gin craze not only tells about actual consumption but also about the ways in which societies and governments react to their perception of the problem. Those reactions are structured by interests which often bear little relationship to the nature of the ‘problem’ at hand.

4.1.3. Why binge drinking began to attract increased disapproval.

The Gin craze episode also heralded a change in public and official attitudes to drinking. Borsay has succinctly summarised the engines of change (Borsay, 2005). The impact of industrialisation and technological change made heavy alcohol consumption incompatible with economic efficiency. Urbanisation increased the proportion of the population living in towns and cities and created environments in which alcohol related disorder could not be so easily contained or tolerated as in the smaller towns and villages. The growth of non alcoholic forms of refreshment such as tea (see Burnett, 1999) and the development of technologies which could deliver unpolluted water also served to undercut beer’s special role as a safe drink and food. An increasingly powerful middle class, supported by the ‘respectable’ sections of the working class, demonised the consumption of alcohol and led a political campaign within central and local government to control access to it. The later history of the temperance agitation and of government policy responses during the First World War were not specifically related to ‘binge drinking’ as such, although outbreaks of public drunkenness and their impact on the economy remained a concern (Harrison, 1971; Berridge, 2005; Greenaway, 2003). It is notable how the role of women

as drinkers was often used in these campaigns-as their role had been highlighted also in the eighteenth century-despite the relatively marginal role of women as drinkers. At the end of the nineteenth century it was the role of women as mothers and the possible effect on the unborn child which was of concern. In the 1920s as Jackson and Tinkler have shown, the concern was for 'modern' girls who were becoming too independent. At every stage the response to women and alcohol has represented the cultural anxieties of the time. (Jackson and Tinkler, 2007). Although the temperance movement did have political successes, ultimately it proved impossible completely to eradicate or undermine the cultural place of alcohol in social life, but this was primarily still male social life.

We can summarise the historical message thus:

- Heavy drinking has been endemic in British society over many centuries and has been culturally embedded in a variety of social and work practices
- It has not always attracted social disapproval or government intervention.
- Key episodes such as the gin craze show that social responses were based on the problem but also focussed only on some aspects such as consumption by the poor which were not necessarily the most important.
- Increased disapproval of heavy drinking had their origin in broader shifts in society after industrialisation. Such disapproval often concentrated upon women's drinking because of wider social anxieties.
- We need to study binge drinking as a social phenomenon and also be aware of the social construction of government and public attitudes to it.

4.2. The definition and measurement of binge drinking.

This section will consider the different ways in which binge drinking has been defined and measured, and how these differences impact on perceptions and understanding of binge drinking.

4.2.1. Defining binge drinking: the basics

The Oxford English Dictionary (OED) defines binge drinking as “a heavy drinking bout” (OED, 1989) and, according to the OED, the origins of the term lie in the English dialect term *binge* which means to soak (a wooden vessel) and OED traces the first recorded use of the term to 1854: Miss Anne E. Baker Glossary of Northamptonshire words and phrases “A man goes to the alehouse to get a good *binge*, or to *binge* himself” (OED, 1989). As we have already noted, accounts of heavy drinking and drunkenness which echo contemporary descriptions can be found throughout British history (see for example Clark, 1983; Barr, 1995) and such behaviour is sometimes regarded as part of the British ‘character’ (Barr, 1995).

4.2.2. Defining binge drinking: the research literature

Within the academic literature, there is confusion. The term ‘binge drinking’ is used to describe two quite distinct phenomena. Firstly, it is used to describe:

a pattern of heavy drinking that occurs over an extended period set aside for the purpose....usually defined as more than one day drinking at a time...A binge or

bout drinker is one who drinks predominantly in this fashion, often with intervening periods of abstinence. (WHO, 1994)

As Gmel *et al* (2003) note, this definition is linked to more clinical definitions of alcohol abuse or dependence. For example, Jellinek's (1960) classic work on the classification of alcoholism includes what he describes as epsilon alcoholism – paroxysmal or periodic drinking, binge drinking – which is sometimes referred to as dipsomania. In Russia the term *zanoi* is “used to describe a period of two more days of continuous drunkenness when the person is withdrawn normal social life” (Leon *et al*, 2007, pp. 2002-2003). In a recent Russian study Leon, Saburova, Tomkins and colleagues (2007) used having one or more episodes of *zanoi* in the past year as an indicator of problem drinking.

Secondly, binge drinking is used to describe a single drinking session leading to intoxication, often measured as having consumed more than X number of drinks on one occasion (Gmel *et al*, 2003). A number of alternative terms are used to describe the phenomenon including heavy episodic drinking, risky single occasion drinking, heavy sessional drinking and simply heavy drinking. It is this second meaning of the term which has become widely used over recent years by researchers and politicians alike and now predominates. The popularity of this use of the term has been traced back to a series of studies of college drinking in the USA conducted by Wechsler and colleagues and more specifically to an article published in 1994 in the *Journal of the American Medical Association (JAMA)* which presented results from a national survey of college drinking (Wechsler *et al*, 1994). Binge drinking was defined as consuming five drinks in row in

the previous two weeks⁸ (later refined to five drinks for men and four for women) (Wechsler *et al*, 1994). Wright (1999) argues that, for researchers, its value lies in its use as a measure of alcohol-related harm, which recognises that a lot of the short-term harm associated with alcohol (e.g. accidents) arises from single episodes of drunkenness, rather than drinking more than the recommended weekly levels or individual daily drinking (DoH, 1995) and indeed Wechsler and Austin in a defence of the use of the term argued that the five/four drinks in a row definition represented the threshold for alcohol-related social consequences (Wechsler and Austin, 1998).

4.2.3. The co-existence of different definitions of binge drinking

Thus, it was soon apparent that there has been a shift in recent history in the meaning of the term binge drinking: the ‘old’ definition of binge drinking (sustained drinking over several days) has been largely, but by no means entirely replaced by the ‘new’ definition of binge drinking (single episode of acute intoxication) and both terms co-exist (if somewhat uneasily) within the alcohol field. For example, the ‘old’ definition is still in the lexicon of terms used by the World Health Organisation but the WHO uses “binge drinking” (and also “heavy episodic drinking”) in the *Global Status Report on Alcohol 2004* (WHO, 2004) to refer to “a risky single drinking occasion” (p.28). Also, the *Journal of Studies on Alcohol and Drugs*⁹ continues to use the ‘old’ definition and authors have to use alternative terms (e.g. heavy episodic drinking) when writing about the ‘new’ binge (for more details please see <http://jsad.com/static/binge.html>). Furthermore, it is

⁸ Wechsler and colleagues were not the first to use this 5 drinks in a row definition, it was drawn from by the Monitoring the Future study, an annual national study of American school and college students conducted by the University of Michigan (see for example, Johnston *et al*, 1991), although they did refine it to take account of gender differences – the 5/4 measure (see Wechsler *et al*, 1995 for discussion).

⁹ Formerly the *Journal of Studies on Alcohol* (until January 2007).

not only with alcohol field that the ‘old’ definition can be found. In two recent UK studies exploring definitions and perceptions of binge drinking, some respondent gave definitions that were in line with the ‘old’ definition of binge drinking and none gave definitions that were based on drinking a specified amount of alcohol (Coleman and Cater, 2007; McMahon *et al*, 2007).

4.2.4. ‘Cut off’ definitions of binge drinking: the fine detail

Within the general definition of binge drinking as a single drinking session leading to intoxication, there is no consensus as to what level of intake constitutes binge drinking (BMA, 2005). The ‘cut off’ points for binge drinking (i.e. number of drinks consumed) vary (see Figure 1) and this has profound implications as the number of people defined as ‘binge drinkers’ will depend upon the cut off used (Jefferis *et al*, 2005; McAlaney and MaMahon, 2006). It is clear that the definition used has a significant impact on the statistics produced and that using different definitions will inevitably produce a perplexing array of figures.

Other factors complicate the situation even further, for example, ‘standard’ drinks vary from nation to nation (ICAP, 2004), which make cross-national comparisons difficult. Cut off definitions have also been criticised for not taking into account factors such as weight, rate of drinking, social context and whether food has been consumed or not (e.g. Midinak, 1999; Murgraff *et al*, 1999; Engineer *et al*, 2003; Hammersley and Ditton, 2004; Wright, 2006) and some researchers favour more qualitative definitions (e.g. Harnett *et al*, 2000; Engineer *et al*, 2003; Richardson and Budd, 2003).

Figure 1: Definitions of binge drinking using different ‘cut offs’

Definition	Examples of usage	Example of results
>8/ >6 units on at least one occasion in past week (72g/54g of alcohol). ‘Heavy drinking’ measure used as a proxy for binge. Current ‘official’ definition.	Cabinet Office – National Alcohol Strategy (2004) ANARP* (Drummond <i>et al</i> , 2004); GHS; BMA web resource (2005); Williamson <i>et al</i> (2003) (GENESiS study)	GHS 2005: (≥ 16 years) Men 19 %; women 8%. Williamson <i>et al</i> (2003) (20-60 years) Men 15%; women 18%. In their 20s: men 33%; women 38%.
$\geq 8/\geq 6$ units on at least one occasion in past week (64g/48g alcohol)	Health Survey for England (HSE) Jefferis <i>et al</i> (2005), national cohort study. Scottish Health Survey (SHS) Welsh Health Survey (WHS)	HSE 2004 (≥ 16 years) men 23%; women 12%. Jefferis <i>et al</i> (2005), prevalence at 23 and 42 years: men 49% and 42%. Women 29% and 19%.
$\geq 10/7$ units i.e. more than half weekly limits in one session. (80g/56g of alcohol)	RCP (2001) Jefferis <i>et al</i> (2005) (national cohort study)	Jefferis <i>et al</i> (2005) prevalence at 23, 33, 42 years: men 37%, 28%, 31%. Women 18%, 13%, 14%.
≥ 11 units on one occasion (88g of alcohol)	Measham (1996)	15-16 years, boys 40 %; girls 24 % Measham (1996)
≥ 5 drinks in a row (gender specific version 5/4). For the US this is = 70g/54g of alcohol).	US campus studies e.g. Weschler <i>et al</i> Niami <i>et al</i> (2003b) ESPAD (European School Survey Project on Alcohol and Other Drugs) 1995, 1999, 2003.	Last 30 days men (≥ 18) 22.2%, women (≥ 18) 7.2 % (Naimi, 2003b) 15-16 years, binge drink ≥ 3 times in last 30 days UK boys 26%, UK girls 29% (ESPAD, 2003)
Pattern of drinking that brings BAC to .08g per cent or above (5/4 drinks in 2 hours)	National Institute on Alcohol Abuse and Alcoholism (NIAAA) 2004.	None found in published literature to date.

* Alcohol Needs Assessment Research Project

4.2.5. Binge drinking: a confused concept

Although the definitions used in academic research are important, what is perhaps more significant are the definitions employed by central government agencies because the statistics generated become the ‘official’ figures upon which policy is based, targets set and trends monitored. However, it is not always clear how these ‘official’ definitions are formulated, on what evidence they are based, and what role the research community

plays in the process. Interestingly, the most commonly cited ‘official’ measure of binge drinking in the UK is not actually a measure of binge drinking at all but of ‘heavy drinking’; the General Household Survey (GHS) does not use the term ‘binge drinking’ but its measure of heavy drinking is often used as a proxy for binge drinking (e.g. in the National Alcohol Harm Reduction Strategy).

McAlaney and McMahon (2006) have shown that these ‘official’ definitions are open to interpretation and this ambiguity is reflected in the ‘official’ figures. In particular, McAlaney and McMahon (2006) highlight that the two series of studies that have been influential in our current understanding of binge drinking in the UK, that is the GHS and the Health Survey for England (HSE), produce markedly different results, because although they employ similar methodology and consumption questions, they adopt slightly different cut offs: the GHS defines heavy or binge drinking as *more* than eight units for men and *more* than six units for women ($>8/ >6$ units) whilst the HSE uses *eight or more* and *six or more* ($\geq 8/ \geq 6$ units). Moreover, McAlaney and McMahon (2006) argue that this difference interpretation of the 8/6 unit definition is often overlooked and this can lead to misleading conclusions being drawn if the results of studies are presented as directly comparable or if assumptions are being made about the definition employed.

In addition, Philip Kolvin (2005) argues that within the UK, key stakeholders, such as Cabinet Office, the Department of Culture Media and Sport (DCMS) and Home Office, have differing conceptions of binge drinking which reflect their institutional agenda and concludes that without agreement it is unlikely that solutions can be found. Studies by

McMahon, McAlaney and Edgar (2007) and Coleman and Cater (2007) have highlighted differences in perceptions between the public and government about what binge drinking, arguing that without a shared understanding of what constitutes binge drinking it is difficult to see how effective preventive measures can be developed. The authors of both studies call for the development of a standard, accessible definition which is recognisable to the public (McMahon *et al*, 2007; Coleman and Cater, 2007).

4.2.6. The change over time: why have definitions changed?

Thus, it is clear that there is confusion surrounding the term binge drinking and no consensus definition. This confusion is due in part due to the change in the meaning ascribed to the term that has occurred in recent history. What is unclear is how this change came about and what it means for policy and it is an area that warrants investigation; why was a 'label' already in use to describe one particular pattern of drinking used to describe a different one? Moreover why was the label generally accepted by the alcohol field, by the public and policy makers? We have outlined a series of themes and issues which we consider to be important here and which we presented as a paper at the binge drinking workshop and to the annual meeting of the Kettil Bruun Society. Among the issues which we have outlined as important are changes in the focus of alcohol science, with an increased emphasis on high risk rather than whole population consumption; the changing role of the alcohol unit with the move from a weekly measure to a daily one; the changed nature of the alcohol policy community with a move away from the influence of psychiatry; changing perceptions of women and young people as drinkers; the role of overseas models, already mentioned in this report; the changes in

product and in organisation in the industry; and the role of the media and public perception. This is an area which we would like to explore in future work although the present funding did not allow time for it.

To sum up this section, we conclude that:

- Binge drinking is a confused concept and its use can mean different things in different contexts.
- This confusion has important policy implications because different government departments use the term in different ways.
- Public discussion and policy development are also confused as a result. For example, *Safe. Sensible. Social. The next steps in the National Alcohol Strategy* (HM Government, 2007) rather skims over the definitional problems in its section on ‘Types of Drinking’ (p.3).
- The use of the term has also changed over time from a lengthy period of intoxication over days in the 1940s and 50s to a defined episode now. The reasons for this historical change in definitions needs investigation.

4.3 Contemporary perspectives

In this section we move from our discussion of the historical perception of binge drinking and the current confusion round the concept to an examination of how the problem of binge drinking as currently constructed is being approached cross nationally. So we are here moving from definitions and cultural construction to the problem of binge drinking. We use the term binge drinking here while acknowledging that it is riddled with confusion.

4.3.1. ‘Sensible’ drinking and ‘binge’ drinking in the UK: prevalence and perceptions

In many nations including USA, Australia, Spain, Sweden and the UK, the government provides guidelines about the consumption of alcohol. In the UK the ‘sensible’ drinking messages were originally expressed in terms of weekly drinking levels (21 units for men and 14 units a week for women) but in 1995 concerns about harms associated with episodes of intoxication led to a change in the message and a shift of focus from weekly to daily guidelines. The recommended ‘sensible’ drinking guidelines are 3-4 units for men a day and 2-3 units for women, with two alcohol free days after heavy drinking (DoH, 1995). The Alcohol Harm Reduction Strategy for England (Cabinet Office, 2004) identified binge drinking as one of the two patterns of drinking¹⁰ that are particularly likely to increase the risk of harm:

¹⁰ Chronic drinking was the other pattern, chronic drinkers were described as “more likely to be aged over 30 and around two-thirds are men. They have increased risk of a variety of health harms such as cirrhosis (which has nearly doubled in the last 10 years), cancer, haemorrhagic stroke, premature death and suicide. They are also more likely to commit the offences of domestic violence and drink-driving” (Cabinet Office, 2004, p.5).

Binge drinkers – those who drink to get drunk and are likely to be under 25 years of age. They are more likely to be men, although women’s drinking has been rising fast over the last ten years. Binge drinkers are at increased risk of accidents and alcohol poisoning. Men in particular are more likely both to be victim of violence and to commit violence offences. There can be greater risk of sexual assault. The impacts on society are visible in, for example, high levels of attendance at A&E related to alcohol (p. 4).

The government argues that from current data it is not easy to identify the numbers who go out “to get drunk” and that “the best available proxy is the numbers who drank above double the recommended daily guidelines at least one occasion in the last week” (Cabinet Office, 2004, p. 10-11) and so binge drinking is thus defined as drinking >8 units for men and >6 units for women. Using this measure it was estimated that 5.9m people in the UK binge drink (Cabinet Office, 2004 p.11). A number of projects arose from the publication of the Alcohol Strategy including an alcohol needs assessment for England. The Alcohol Needs Assessment Research Project (ANARP) found that 21 per cent of men and 9 per cent of women are binge drinkers and that that there is considerable overlap between drinking above ‘sensible’ daily benchmarks and ‘sensible’ weekly benchmarks (Drummond *et al*, 2004, p.13).

4.3. 2. Men and binge drinking: just the young?

The GHS has collected information on ‘maximum daily amount drunk last week’ since 1998. Despite the headlines the proportion of men aged 16 and over ‘binge drinking’

(*more than 8 units* on one occasion in the past week) showed little change between 1998 and 2003 (range: 21-23 per cent) but fell in 2004 in 2005 to 19 per cent in 2005 (Goddard, 2006). In England younger men (aged 16 to 24) are the most likely to binge drink, but between 1998 and 2005 the proportion of men aged 16 to 24 years 'binge drinking' (>8 units) fell from 39 percent to 30 per cent (Goddard, 2006) and similarly in Scotland the proportion of men aged 16-24 binge drinking (*8 or more units*) fell from 45 per cent in 1998 to 40 per cent in 2003 (ISDScotland, 2007). Although binge drinking rates do decline with advancing age the fall off appears to be later than the current policy focus would lead us to believe: whilst only 4 per cent of men in England aged 65 and over reported binge drinking in 2005 and 16 per cent of men aged 45-64 in 2005, men aged 25-44 were not far behind the 'young' with 25 per cent reporting binge drinking in 2005 (Goddard, 2006). Similarly in Scotland, according to the Scottish Health Survey 40 per cent of men aged 16-24 year binge drink, 35 per cent of men aged 25-34 and 28 per cent of 35-44 and 45-54 year olds binge drink (ISDScotland, 2007). These findings are consistent with those from other studies including the British cohort study which found that binge drinking is common across adulthood and not confined to the early 20s; at 42 approximately one in three men were reporting usual alcohol consumption that is suggestive of binge drinking (Jefferis *et al*, 2005, p. 546).

Furthermore, results from the 2004/05 Welsh Health Survey showed that although 32 per cent of 16-24 year olds reported binge drinking (>8 units) it was the 25-34 year olds that were most likely to binge drink with 42 per cent drinking in this manner and that the decline with age was gradual until the age of 65 when it dropped from 21 per cent in the

55-64 age group to 9 per cent in the 65-74 year olds (WSD, 2006). This raises the question as to why binge drinking is seen as something only young men do?

4.3.3 Young women and binge drinking

Whilst young people in general have been the focus of much attention, it is young women who have been put particularly under the spotlight¹¹, with the media presenting binge drinking amongst young women as rising inexorably (e.g. Daily Mail 2004; Hope 2006; Oakeshott, 2003; *The Times*, 2001). These ‘ladettes’¹² as they have been dubbed have been vilified for their behaviour (heavy drinking in public, swearing, rudeness etc) by the media: their behaviour is seen as a sign and product of contemporary society and is a subject of concern (Jackson and Tinkler, 2007). However, historical analysis by Jackson and Tinkler (2007) shows that ladette type behaviour has been noted in the press as a cause of concern in the past, for example, the ‘modern girls’ of the 1920s. Furthermore, the term ‘binge drinking’ is used very loosely and in a manner that suggests that this is the only way that women drink, whilst research by Valentine and colleagues (2006) highlights the diversity of drinking patterns among women.

Although the media often report research findings and official statistics, a closer examination of the original sources suggests a much more complex picture. The following section will focus on binge drinking rather than alcohol consumption more

¹¹ For example, entering the phrase ‘women binge drinking’ into the Daily Mail on-line search facility produced ‘about 9166’ articles¹¹, the vast majority of which focus on the ‘risks’ of women ‘binge drinking’. Women are either seen as ‘*at risk*’ – ‘Rape peril of binge drinking’ (Tozer, 2004) – or ‘*a risk*’, – ‘Lager loutettes “fuel pub violence”’ (Hickley, 2004).

¹² The word ‘ladette’ first gained an entry in the *Concise Oxford Dictionary* in 2001: ‘a young woman who behaves in a boisterously assertive or crude manner and engages in heavy drinking sessions’.

generally. However, it should be noted that within the context of rising alcohol-related mortality, men account for two thirds of alcohol related deaths, with the death rate for men in 2005 being twice that for women and the gap appears to be widening (National Statistics Online, 2006; Breakwell *et al*, 2007). Between 1998 and 2002 the GHS, the number of young women (aged 16-24) reporting binge drinking (consuming >6 units on at least one occasion in previous week), rose from 24 per cent in 1998 to 28 per cent in 2002 (27 per cent in 2000 and 2001), however since 2003, the number has been declining, and by 2005 it was 22 per cent (Goddard, 2006). Goddard stated that: "...data for 2005 support previous indications that the recent upward trend in heavy drinking among young women may have peaked"....although she did caution that "it is not yet possible to be confident that this is a genuine long term trend" (Goddard, 2006, p. 48).

Between 1998-2004 the HSE reported fluctuations from year to year in the numbers of young women reporting binge drinking (consuming ≥ 6 units on at least one occasion in the previous week), ranging from 23 per cent in 1998 to 34 per cent in 2002, and 27 per cent in 2004 (The Information Centre, 2005). However, in Scotland between 1998 and 2003 binge drinking amongst women rose across all ages, with 34 per cent of 16-24 year olds reporting binge drinking (≥ 6 units) in 2003 compared with 31 per cent in 1998 (SDScotland, 2007). Surveys have also highlighted regional differences in consumption patterns, for example, women living in the North East, North West and Yorkshire and Humberside¹³ were most likely to exceed daily bench marks and also to binge drink: these patterns have been broadly the same since the questions were first included in 1998(Goddard, 2005).

¹³ Government Office Regions.

Amongst women binge drinking also declines with age – according to the 2005 GHS 11 per cent of women aged 25-44 were binge drinkers, with four per cent of women aged 45-54 and only one percent of those over 65 binge drinking and overall nine per cent of women binge drink (Goddard, 2006). Both the Welsh and Scottish Health Surveys break age into ten year periods and data from these surveys indicates that women, like men continue to binge drink into their mid 30s; amongst women in 2004/2005 the Welsh Health Survey 24 per cent of 16-24 year olds and 20 per cent of 25-34 year olds reported binge drinking, declining to 15 per cent for those aged 35-44 (WSD, 2006).

4.3.4. How does the UK compare with other nations?

In a European comparison of alcohol consumption per capita the UK ranks around the middle of the 27 countries compared,¹⁴ with a consumption of 11.4 litres per adult in 2003 which continues an upward trend that began in 2000 when it was 10.2 litres (Information Centre, 2007). Prior to 2000 the data for the UK had been relatively stable fluctuating around 10 litres since 1993 (Information Centre 2007, p.13). How binge drinking is defined and measured varies from nation to nation and also between studies; this makes direct comparisons difficult. Anderson and Baumberg (2006) conducted a comprehensive review of alcohol in Europe and concluded that “it is difficult to put all of these together into a coherent picture of binge drinking in Europe” (p.93). The WHO (2004) in presenting data on ‘heavy episodic drinking’ amongst adults in 46 countries (including the UK) also sounded a note of caution because of the different definitions of both ‘heavy episodic drinking’ and at what age someone becomes ‘adult’ (pp.28-29).

¹⁴ Luxembourg has highest at 18.0 litres per capita and Bulgaria the lowest at 5.9 litres. Source: WHO Regional Office for Europe Health for All database <http://data.euro.who.int/hfad/>

In cross national studies of school and university students the UK is generally near the ‘top’ of the table for binge drinking. For example, since the first European School Survey Project on Alcohol and Other Drugs (ESPAD)¹⁵ in 1995 teenagers (aged 15-16) in the UK and other North European countries have reported the highest levels of heavy drinking and intoxication (Hibell *et al*, 1997; Plant and Miller, 2001; ESPAD, 2003). Plant and Miller (2001) note that those teenagers reporting the highest levels of drinking and intoxication – British, Danes, Finns, Irish and Icelanders – are from countries that have long standing reputations as ‘high intoxication’ countries, whilst those teenagers that report the lowest rates – Cypriots, Italians, French Portuguese are from ‘low intoxication’ countries. A similar spatial divide is observed in relation to ‘binge drinking’¹⁶, in 2003 the UK teenagers along with those from other Northern European countries¹⁷ reported the highest levels of binge drinking, with the lowest rates being found mostly in southern European countries with some exceptions e.g. Iceland¹⁸. Likewise, in study of ‘heavy drinking’¹⁹ among students (aged 17-30) in 21 developed and developing countries, the highest rates were reported in Belgium, Colombia, Ireland, Poland (men) and England (women) (Dantzer *et al*, 2006). Data from two European comparative studies²⁰ on adults also suggests a ‘north-south’ divide with the exception of

¹⁵ ESPAD has collected three sets of comparable data amongst 15-16 year olds since 1995 (the fourth survey will be conducted shortly) when it began with 26 countries (including the UK), rising to 35 countries in 2003.

¹⁶ Defined as five or more drinks in a row on three occasions in the last 30 days.

¹⁷ They were Denmark, Ireland, Norway, Isle of Man, Poland, the Netherlands and one exception Malta, with rates of 24-32% (ESAPD, 2003).

¹⁸ The lowest rates are found in Cyprus, France, Greece, Iceland, Hungary, Romania and Turkey (5-11 %) (ESPAD, 2003).

¹⁹ Defined as 5 or more drinks for men or 4 or more drinks for women on at least one occasion over the past two weeks.

²⁰ Eurobarometer survey 2003 which defines binge drinking as 5 pints of beer, 1 bottle of wine or 5 shots of spirit on a single occasion and European Comparative Alcohol Study (ECAS), which defines binge drinking as 4 pints of beer, 1 bottle of wine and 25dl of spirits on a single occasion. As Anderson and Baumberg (2006, pp.93-94) note these definitions for different beverages do not contain the same amount of alcohol.

Sweden which had a level comparable to southern countries e.g. Italy (Anderson and Baumberg, 2006).

Thus, contrasts have been made with the manner in which other peoples drink, particularly the so called ‘wet’ countries including France, Italy and Spain characterised by daily drinking, drinking with meals and avoiding intoxication and what been dubbed a ‘café culture’. It should be noted, however, that there is some evidence to indicate that drinking patterns in some ‘wet’ countries are shifting towards a pattern of intermittent drinking, weekend drinking and drinking to intoxication (see Craplet, 2005 on France; see Gual, 2006 on Spain), more usually associated with the ‘dry’ countries of Northern Europe such as the UK and Finland and ‘binge drinking has become a issue for discussion. For example, the ‘Botellón’²¹ phenomenon whereby hundreds of young people gather on the streets of Spanish towns at weekends to drink to intoxication is a matter of concern (Gual, 2006), at times these street drinking sessions have resulted in public disorder, injuries and public nuisance and some authorities have sought to ban them (Reuters, 2006).

4.3.5. The use of the term ‘binge drinking’ by the media and policy makers

As noted earlier binge drinking appears to get a great deal of coverage in the media (newspapers, radio and television) and be discussed by politicians in relation to a variety of issues including crime and health. In order to establish whether this perception was correct a search for the use of the term ‘binge drinking’ was conducted of the on-line indexes of *The Times* newspaper and also of Hansard, the record of proceedings in

²¹ ‘Botellón’ means ‘big bottle’.

Parliament and the House of Lords, for the period 1985-2005. The results are summarised in Figures 2 and 3 below. Firstly, it is evident that binge drinking is a preoccupation of journalists and politicians and secondly that the use of the term is relatively recent with a dramatic rise since 2004. What is not clear from this data is whether journalists and politicians did not previously discuss such behaviour or have just changed their terminology. In relation to *The Times* a 'quality' newspaper the term began to be used in the late 1990s, with between 10- 20 mentions a year between 1998-2002, then a doubling for the year 2003 (39 mentions). However, 2004 saw a three fold increase in the number of articles including the term 'binge drinking'. Many of these articles were related to the changes to licensing laws enshrined in the Licensing Act 2003. Amongst other measures the Act abolished the notion of permitted hours and opened up the potential for 24 hour opening of licensed premises. Here are a just a few of the headlines:

“Blitz on binge drinking to curb violence” (The Times, 29 April 2004).

“Just one more binge for the road” (an article about high earning women and drinking, The Times 27 May 2005).

“Drink laws will cause teen deaths warns liver doctor” (The Times, 29 August 2005)

“Drinking blamed for big rise in violence” (The Times, 29 October 2005)

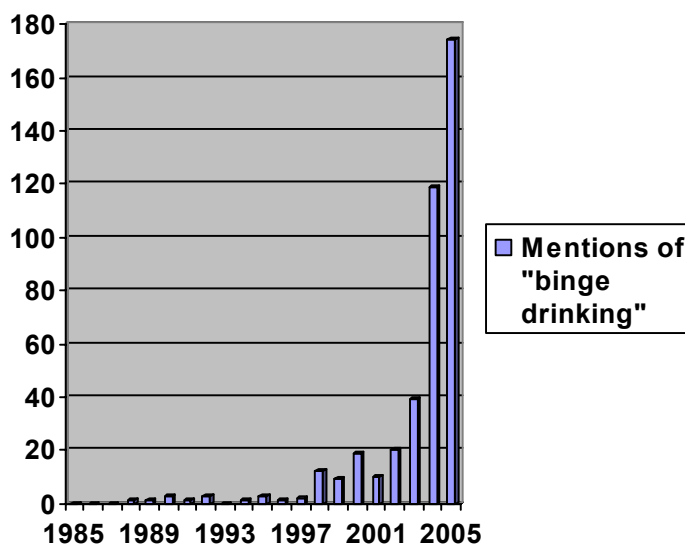
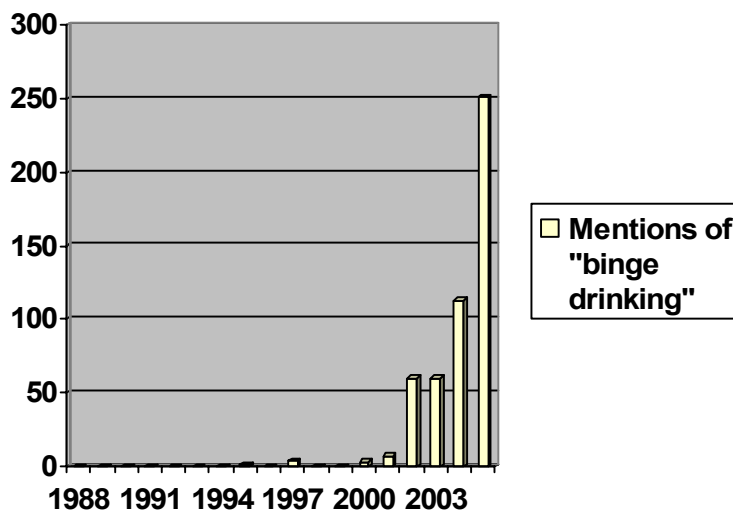


Figure 2: Mentions of the term “binge drinking” in *The Times* 1985-2005.

In relation to the House of Commons and the House of Lords, the term binge drinking came much later, not really featuring until 2004, apart from four mentions in relation to changes in Sunday trading laws in 1997. Interestingly neither the media nor politicians picked up on the issue of binge drinking in 1995 when the sensible drinking message was revised in the light of concerns about the harms associated with episodes of acute intoxication. Although the much of the discussions in the Houses of Commons and Lords has been about the Licensing Act 2003 binge drinking has been brought into discussions about a wide range of topics including broader discussions about public services, drugs, education, railways and transport safety and simplifying married couples allowances. There were repeated references to ‘teenagers’ and ‘young people’ in relation to binge drinking.

Figure 3: Mentions of the term “binge drinking” in the Commons and Lords Hansard and the Official Report (Hansard) Index 1988-2005.



Much of the discussion in the press, Commons and Lords about binge drinking was linked into the introduction of more flexible (and potentially longer) opening hours for

licensed premises, as Rohrer (2006) observed: “Anyone reading the press coverage of the run up to the act coming into force could be forgiven for being left with the impression that the edifice of British Civilisation was about to crumble into the sea”. Moreover it was not just the press but politicians of all hues, senior police officers, church officials, doctors and alcohol campaigners that predicted dire consequences. The “drunken mayhem on the streets” has not materialised (Rohrer, 2006) and indeed the early indications are that there has not been a rise in violent crime (Walker *et al*, 2006) and there is evidence from Suffolk of a reduction in alcohol related crime (Druglink, 2006).

In summary:

- Drinking > 8 units of alcohol for men and >6 units for women - that is more than twice the UK recommended sensible level - on at least one occasion in the past week is used a proxy measure for binge drinking in the main surveys used to formulate UK policy.
- In the UK men of all ages are more likely to binge drink than women and there are regional and age differences.
- Although young men are the most likely to binge drink, the proportion binge drinking appears to be declining.
- Recent prevalence data indicates that binge drinking amongst young women may have reached a plateau or even be declining.
- From the current data it appears that binge drinking is not confined to younger people and that both women and more particularly men continue to binge drink beyond their mid 20s.

- There is also evidence that binge drinking is just one of a variety of ways in which people of different ages drink.
- In cross national studies of school and university students the UK is generally near the ‘top’ of the table for binge drinking.
- There is evidence of a spatial divide between northern countries (e.g. UK, Finland) with their ‘dry’ culture characterised by patterns of intermittent drinking, weekend drinking and drinking to intoxication and southern countries (e.g. Italy, France) with their ‘wet’ culture of daily drinking with meals and avoiding intoxication.
- Binge drinking has received a great deal of attention in the media. Media portrayals focus on the problems associated with binge drinking in public spaces (crime and disorder, nuisance etc), on young people in general (under 25) and young women in particular.

6. CONCLUSIONS AND IMPLICATIONS.

The following section will draw together what has been learnt from the study and consider the policy and research implications. There is a great deal of overlap and inter-play between the issues, although they have been separated for the purposes of clarity.

A Historical and cultural perspectives:

- Heavy drinking akin to binge drinking has been endemic in British society over many centuries and has been culturally embedded in a variety of social and work practices
- It has not always attracted social disapproval or government intervention.
- Key episodes such as the gin craze show that social responses were based on the problem but also focussed only on some aspects such as consumption by the poor which were not necessarily the most important.
- Increased disapproval of heavy drinking had its origin in broader shifts in society after industrialisation. Such disapproval often concentrated upon women's drinking because of wider social anxieties.
- We need to study binge drinking as a social phenomenon and also be aware of the social construction of government and public attitudes to it.
- In recent history there has been a shift in the meaning of the term binge drinking, with the 'old' (extended, clinical) definition being largely displaced by the 'new' (episode of acute intoxication) definition. However, there is still some resistance to this change and the two meanings co-exist, if somewhat uneasily.

- It is unclear from this study quite how this change came about, what the drivers were or the policy implications. This is an area of recent history that requires further investigation.

B The definition and measurement of binge drinking;

- There is no agreed definition of binge drinking. Two distinct meanings have been ascribed to the phenomenon: as an extended period of drinking linked with clinical definitions of alcohol use and dependence and also as single episode of acute intoxication, often expressed in terms of number of drinks consumed.
- Within the 'new' binge there is no consensus on the amount of alcohol that constitutes a 'binge' and a variety of 'cut-offs' are used. The cut offs used vary between nations, studies and professionals and even within nations, this makes it difficult to make comparisons. Cut off definitions have also been criticised for ignoring contextual factors (e.g. speed of drinking, venue, whether food or not has been consumed).

C The contemporary situation in cross national perspective: current prevalence data and trends

- In the UK men of all ages are more likely to binge drink than women and to die from alcohol related causes. The perception is that binge drinking amongst young people, and more specifically young women has risen steadily in the recent past; in fact the evidence suggests a more complex picture and indeed the most recent data suggests that the rate has reached a plateau and is perhaps declining.

- The current preoccupation with specific ‘risk’ groups (young people, women) means that other groups appeared to be overlooked (e.g. middle aged men). Moreover, at times there seems to be a somewhat limited understanding of the behaviour of these risk groups. There is evidence that young people drink in a variety of ways but the picture presented is of a mono-drinking culture. Such a partial picture is not a sound basis for policy making: there is a need to understand the diversity of drinking styles adopted by young people and investigate binge drinking in groups other than the young.
- There has been a focus on public space – on licensed premises, public disorder and public nuisance caused by young binge drinkers - with little attention to drinking in the home, although the recently revised National Alcohol Strategy identifies consumption at home as a key policy issue (HM Government, 2007).
- Given that there is no consensus definition of binge drinking it is difficult to make meaningful cross national comparisons. However, within Europe there is evidence of a continuing gap between northern countries (e.g. UK, Finland) with their ‘dry’ culture characterised by patterns of intermittent drinking, weekend drinking and drinking to intoxication and southern countries (Italy, France) with their ‘wet’ culture of daily drinking with meals and avoiding intoxication.

D Lessons for policy

- Binge drinking is nothing new in British society and has not always attracted disapproval. Its historical change from a 'manly' activity to one associated with out of control women represents wider social change and policy interests as well as the reality of a problem.
- Institutions, professions and individual professionals differ in the way in which they define and think about binge drinking and these differences reflect their particular agendas and priorities. Moreover, these differences are not necessarily recognised. 'Binge drinking' is often used in a way which implies a common understanding between the various stakeholders. Without a shared understanding amongst stakeholders it is difficult to see how any 'solutions' can be reached.
- Binge drinking is an important driver for alcohol policy, but as there is no agreement as to what is actually being measured it is difficult to build up an evidence base on which to formulate policy and this leaves any subsequent policy on shaky ground.
- The prominence of binge drinking perceived as a problem of young people in public places recognises a phenomenon but foregrounds it to the detriment of other areas of increased alcohol consumption, for example in the family and at home.

OUTPUTS

A) Papers for peer reviewed journals:

1. 'Binge drinking: An exploration of a confused concept' has been submitted to the *Journal of Epidemiology and Community Health* as part of a series 'Public Health Past and Present'.
2. 'Binge drinking today: learning lessons from the past' has been accepted by *Drugs: education, prevention and policy*. This will form part of a 'showcase' for the Centre for History in Public Health, London School of Hygiene and Tropical Medicine.

B) Presentations at conferences and workshops:

- A paper entitled 'Binge drinking' in the UK: the recent history of a confused concept' was given by Rachel Herring at the Social Research Association: Annual Conference 2006 *Challenging myths: researching reality- the role of social research*, 6th December 2006.
- A paper entitled 'Binge drinking: a confused concept and its recent history' was co-presented by Rachel Herring and Virginia Berridge at *Addressing binge drinking: challenges and opportunities*, the workshop held at the London School of Hygiene and Tropical Medicine on 14th February 2007.
- A paper entitled 'Binge drinking in the UK: the recent history of a curious concept' was given by Virginia Berridge and Rachel Herring at the 33rd *Annual Alcohol Symposium of the Kettil Bruun Society*, held 4-8th June 2007, Budapest, Hungary.

C) Popular output:

- ‘The normalisation of binge drinking? An historical and cross cultural investigation with implications for action’, *History Centre Newsletter*, Issue 6, Spring 2006.
- ‘Binge drinking: a ‘confused’ concept’, *History Centre Newsletter*, Issue 7, January 2007.
- ‘Binge drinking in the UK: contemporary and historical perspectives’ will be published in *Wellcome History* (summer of 2007).
- ‘Addressing binge drinking- challenges and opportunities’, *Chariot* (Newsletter of the London School of Hygiene and Tropical Medicine), issue 15, Summer 2007, p.13.
- Further possibilities for dissemination are currently being explored with Lindsay Wright, Press Officer at the London School of Hygiene and Tropical Medicine.

D) A report *Addressing binge drinking: challenges and opportunities* based on the proceedings of the workshop.

E) A post-graduate student, Jane McGregor, has recently started research for a PhD at LSHTM under the supervision of Virginia Berridge, funded by a Wellcome Trust research studentship. Her topic is ‘From dependence to binge; a local case study of Nottingham’. She is examining the role of that city over time as a centre of medical, criminal justice and local government initiatives which have helped both reflect and

stimulate national alcohol policy developments. Nottingham has often been cited as a binge drinking flash point in media portrayals.

F) Funding will be sought to explore the historical evolution of the change in scientific definition of 'binge drinking' and its interaction with policy.

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APPENDIX ONE

Changes to the planned research

This study underwent alteration as the work progressed, responding to changes in circumstances in terms of available funding and also to the emerging data. This section outlines the changes made to the planned research and reasons for the alterations.

The original research proposal submitted to the AERC for consideration was for a two year five part study; a literature review; oral interviews with 10-15 key 'actors' in the UK and telephone and email interviews with selected international actors; an interim workshop; a short visit to the CIPH from a US scholar and a European Workshop to be organised in conjunction with a colleagues in Vienna and for which additional funding from another source was sought. One years funding was secured so the proposed research was modified accordingly; the plan was to conduct a literature review and to interview key actors in the current UK scene representing different interests in binge drinking and the policy response to it.

Responding to the data: changes in plan

The intention was to conduct in-depth interviews with key stakeholders (academics, politicians, policy makers) but as the research progressed it became increasingly apparent that such interviews might not be able to address the questions that were emerging from the study and that an alternative strategy was required. What was evident from the study was that there was no agreed definition of binge drinking with term being used in a variety of ways (at times very loosely) and that the meaning ascribed to the term has

changed in recent history: the result was confusion. Thus, there seemed a need to take stock – to think about how the problem of binge drinking is perceived and defined, the current responses to binge drinking and to identify the challenges and opportunities for future policy and practice – and from here the idea for a workshop bringing together an invited group with a professional interest in binge drinking and experience of developing and delivering policy responses and/or research emerged. The plan was to facilitate discussion, with a series of short papers setting the scene and then a chaired panel session focusing on how to address binge drinking in the UK, with the workshop papers and discussion being compiled into a report for the AERC. The proposed change of plan was discussed with the Director of the AERC (Professor Ray Hodgson) who approved and the half-day workshop was held in February 2007 (see Appendix Two) and a report written (see Appendix Three).

APPENDIX TWO

WORKSHOP: ADDRESSING BINGE DRINKING: CHALLENGES AND OPPORTUNITIES

Wednesday 14th February 2007

1.30- 5.30pm followed by refreshments

Bennett Room (LG 80)

London School of Hygiene and Tropical Medicine, Keppel St, London WC1E 7HT.

PROGRAMME

1.30-1.40: Professor Virginia Berridge: Welcome and introduction

What is the problem? *Chair: Dr Betsy Thom*

1.40-2.00: Peter Borsay, Professor of History, University of Wales, Lampeter.
'Binge Drinking and Moral Panics: Historical Parallels?' *Due to ill health Peter Borsay is unable to attend so his paper will be delivered on his behalf by Rachel Herring.*

2.00-2.20: Rachel Herring, Research Fellow and Virginia Berridge, Professor of History, London School of Hygiene and Tropical Medicine.
'Binge drinking: a confused concept and its recent history.'

2.20-2.40: Questions

Responses to the perceived problem *Chair: Dr Rachel Herring*

2.40-3.00: David Foxcroft, Professor of Health Care, Oxford Brookes University
'Measures of alcohol misuse in prevention research.'

3.00-3.20: Martin Plant, Professor of Addiction Studies, University of the West of England.
'Safer Bars: Safer Streets?'

3.20-3.40: Questions

3.40-4.00: Tea

Responses to the perceived problem *Chair: Professor Virginia Berridge*

4.00-4.20: Sir Simon Milton, Leader of Westminster Council, London.
'Westminster: What's working –What still needs to be done.'

4.20-4.30: Questions

Opening up the issues

4.30-5.25: Panel discussion led by Susanne MacGregor, Professor of Social Policy, London School of Hygiene and Tropical Medicine.

5.25-5.30: Dr Betsy Thom: Thank and close workshop. *Refreshments from 5.30*

APPENDIX THREE

ADDRESSING BINGE DRINKING: CHALLENGES AND OPORTUNITIES

REPORT OF A WORKSHOP:

Wednesday 14th February 2007
The London School of Hygiene and Tropical Medicine, Keppel St, London WC1E 7HT.

Betsy Thom, Rachel Herring, Virginia Berridge

Part of:

The normalisation of binge drinking? An historical and cross cultural investigation with implications for action. Funded by the Alcohol Education and Research Council, Grant number: R 02/2005, to the Centre for History in Public Health, London School of Hygiene and Tropical Medicine.

Grant holders:

Virginia Berridge, Professor of History, London School of Hygiene and Tropical Medicine.

Betsy Thom, Reader in Drug and Alcohol Studies, School of Health and Social Sciences, Middlesex University.

Principal Research Fellow:

Rachel Herring, Centre for History in Public Health, London School of Hygiene and Tropical Medicine

Report: June 2007

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Acknowledgements

We would like to thank those who presented papers and all the workshop participants for their contributions to this project. We would also like to thank Susanne MacGregor for valuable comments in planning the workshop and for her helpful summing up of the issues in chairing the discussion session. The list of participants is in Appendix A.

ADDRESSING BINGE DRINKING: CHALLENGES AND OPORTUNITIES

Introduction

Figures from the Alcohol Harm Reduction Strategy for England indicate that there are 5.9 million people in the UK who are ‘binge’ drinkers²². Binge drinking, defined in the strategy as drinking >8 units for men and > 6 units for women in a single session, has been associated with a wide range of health and social problems and has become an issue arousing increasing policy concern and media debate.

A workshop to examine perceptions of, and responses to, binge drinking was organised as part of a broader research study of the history of binge drinking, its definition and measurement and its current prominence. The aim of the workshop was to share knowledge regarding current perceptions of ‘binge’ drinking, current responses, and possible future approaches for policy and practice. The workshop brought together an invited group with a professional interest in binge drinking and experience of developing and delivering policy responses and/or research (see appendix A). Five short papers set the scene, outlining key issues and challenges, and considering the evidence base for policy and practice in the UK². The workshop concluded with a general discussion which considered how binge drinking in the UK might be addressed, what barriers might be encountered in attempting to implement strategies and interventions, and how these might be overcome.

This report presents a brief summary of the papers, the discussions and the conclusions organised under four main headings: What is the problem? What are the challenges? What are the responses? What are the opportunities?

What is the problem?

An historical perspective

As Peter Borsay points out, binge drinking is not an entirely new pattern of behaviour and shifts in perceptions of the concept, of the problem and its solutions are best considered within their historical and contemporary contexts:

Binge-drinking is a phenomenon which has very specific contemporary connotations, and takes a very particular if mutating form in the present. However, to see binge-drinking as something modern is not to suggest that it does not have an historical context. It seems perfectly reasonable, for example, to conceive it as part of an ongoing history of drinking, drug-taking or leisure, and to identify parallels with it in the past. It also appears plausible to argue that the way we interpret and respond to binge-drinking today can be affected by understanding this historical context. (Borsay presentation, 2007)

Borsay uses the 'Gin Crisis' or 'Gin Craze' that swept over London in the early eighteenth century to illustrate parallels and continuities with the past. For one thing, he points to the emphasis on women's drinking as part of the imagery and perceived crisis of that time. (See also research by Warner which discusses the focus on women and women's role at this time³.) For another, he notes how then, as now, there was an issue of governance. Hogarth's Gin Lane depicts criticism of the role of the state:

..... where is the government? You will notice directly under the pawnbroker's sign the steeple of St George's Bloomsbury (built 1720-30), with the nonchalant statue of George I on top, attired in Roman dress, presiding over the chaos beneath him. Nothing could be a greater indictment of governmental complacency. (Borsay presentation, 2007)

The paper discusses responses to the Gin Craze in terms of a 'moral panic' fuelled by factors such as concern about the impact of rapid urbanization upon law and order and the social fabric; the effect of rising levels of wealth, in particular the growth of working class real income, upon pattern of consumption, the will to work, and the fulfilment of domestic responsibilities (See work by Rowntree⁴ in the early 20th. century when there was another wave of concern raising anxieties similar to those described by Borsay); widespread anxiety about the breakdown of the family and a general anxiety about the failure of government to take effective action to remedy the problems. In sum, it was "*the capacity to yoke together the rise in gin drinking to the wider concerns of society that transformed a potential social problem into a genuine 'moral panic'*", shaped and directed by a group of articulate, 'middling order Londoners' concerned about the moral health of society and with the ability to exploit the media of the day. Without denying the reality of the problems and harms which accompany 'binge' drinking, similar processes can be observed in contemporary responses to this particular pattern of alcohol consumption.

The interpretation of reaction to alcohol consumption as a constructed 'moral panic' may be questioned (as it was in discussion), but Borsay's paper makes the point that there are strong similarities to be drawn across different historical periods and that these tend to be forgotten as contemporary debate emphasises what is seen as new and threatening.

Perhaps foremost among the differences discussed, is the current emphasis on youth drinking and alcohol-related behaviour. In particular, Borsay notes that young people have entered the picture not as products of maternal neglect as during the Gin era (See also campaigns at the turn of the 20th. century⁵), but as a force in their own right. He argues that it is:

".... the growth of a self-consciously constructed, commercialized and anti-establishment youth culture, fuelled by rising levels of wealth among young people, in the 1950s and especially 1960s that elevated concerns about youth to a new level. Binge-drinking in this context can be seen as one more of the youth-driven 'moral panics' that appeared from the 1950s, and was identified and categorized by the sociologist Stanley Cohen in his 'Folk Devils and Moral Panics' of 1972."

Borsay contends moreover that the attention directed towards the marketing and sale of alcopops – a ‘feminine’ drink - accompanied by “*images of self-assertive, provocative, rude, pleasure-seeking young women*” symbolise a late 20th century shift in women’s roles from ‘hangers on’ in the drinking scenes of the 1950’s and 60’s to their more central position in public, social and leisure activities which challenge gender stereotypes.

Thus, in considering the current phenomenon of ‘binge drinking’ Borsay poses the question of whether the campaign against binge-drinking is primarily anti-alcohol driven or driven by wider concern over changes in youth culture and the roles of young people and women. So, how might the behaviour be explained?

Young people are choosing to drink heavily and investing a substantial portion of their personal wealth, not just in drink but also in the package of recreational props that accompany it – music, dancing, clothing etc. Binge drinking by young people today differs from the excessive drinking of the gin era which Borsay sees as persistent rather than occasional and more driven by poverty than wealth. Furthermore, it was not accompanied by the calculated theatre that fills the streets of our towns on a Friday and Saturday night. Borsay elaborates on the theatre analogy and highlights a possible explanation for behaviour which has important implications for prevention and harm reduction responses:

“We need to understand more the thrill and excitement of the occasion, the frisson generated by engaging in what is essentially carnivalesque behaviour in which the social norms are challenged and inverted. We need to look more at the performative aspects of binge-drinking. Young people are performing before a virtual audience. However, they do so fully in the knowledge that it is only carnival, that during the week they will return to their normal lives. In this sense binge-drinking, as in pre-modern Carnival, simply reaffirms the norms of society by temporarily challenging them.”

A contemporary perspective

The presentation by Rachel Herring and Virginia Berridge – ‘*Binge drinking: a confused concept and its recent history*’ – explores the more recent use of the term ‘binge drinking’ in research, the media and policy documents. As the title of the paper suggests, the concept has gained enormously in currency over the past ten to fifteen years; but this has been accompanied by considerable confusion and lack of consensus regarding its definition, measurement and meaning for different social groups.

The paper highlights how accounts of heavy drinking and drunkenness which echo contemporary descriptions can be found throughout British history. The ‘malt worms’ of the 16th. century, for example, were described as sitting:

“all day long, yea, all the night, peradventure all the week together, so as long as any money is left swilling and gulling (guzzling) and carousing from one to another, till never a one can speak a ready word...How they stutter and stammer, stagger and reel to and fro, like madmen, some vomiting, spewing and disgorging their filthy stomachs, others pissing under the board as they sit”. (cited by Barr, 1995, p. 26;)⁶.

The first recorded use of the term in 1854 as: *“A man goes to the alehouse to get a good binge, or to binge himself”* conveys the notion of intentionality inherent in some accounts of ‘binge drinking’ today and the 16th. century description of a ‘binge’ as lasting over a period of days and nights is echoed in more recent uses of the term (e.g. to describe the drinking patterns of ‘skid row’ alcoholics in the 1960s) and in the World Health Organisation’s definition as:

“.. a pattern of heavy drinking that occurs over an extended period set aside for the purpose ...usually defined as more than one day drinking at a time...A binge or bout drinker is one who drinks predominantly in this fashion, often with intervening periods of abstinence.” (WHO, 1994, *Lexicon of alcohol and drug terms*)

The paper traces the more recent use of the concept, defined by Gmel *et al* (2003)⁷, for instance, as a *“Single drinking session leading to intoxication often measured as having consumed more than X number of drinks on one occasion”* and documents the tensions surrounding acceptance of the new definition. The point is made that the definition depends on a ‘cut-off’ measure which differs between research surveys and studies and that measures do not take account of factors such as weight, speed of drinking, social context, whether food consumed or not. For example:

- What constitutes a ‘standard’ drink varies from nation to nation: e.g. 8g in UK-19.75g in Japan (ICAP, 2004)⁸
- A US drink contains 14g alcohol =1.6 UK units (Stockwell and Single, 1997)⁹
- ABV and size of servings vary

The importance of understanding measurement issues for the epidemiological picture of binge drinking and the policy and practice implications which follow is illustrated by Jefferis, Power and Manor (2005)¹⁰ who analysed national cohort data using two different cut –offs.

- Using: ≥ 10 units for men and ≥ 7 units for women: at age 23 years 37% of men and 18% of women were binge drinking.
- Using: ≥ 8 units for men and ≥ 6 units for women: at age 23 years 49% of men and 29% of women binge drinking.

Different calculations of the size of the problem also arise between data sets because cut off points are sometimes *more than 8 / 6* units and sometimes *equal to or more than eight/ six* units.

Although, the term ‘binge drinking’ is now generally taken to mean a single drinking session leading to intoxication, it has displaced rather than replaced the use of the term to describe prolonged intoxication over a period of days which continues to have credence and the meaning of the term remains contested.

The paper sets out the argument that current use of the term ‘binge’ must be understood against the background of wider trends and shifts in the nature of the problem since the 1940’s. The older use of the term was linked to the disease concept of alcoholism and chronic intoxication and often perceived as applying to the homeless street drinker. The newer use of the term has emerged from a public health/ epidemiological approach appearing in the 1970s and crystallising by the 1990s around the young, more affluent drinker participating in the ‘night time economy’. The changing use of terminology symbolises the shift from perceiving the problem as stemming from the drinking behaviour of a small, marginalised minority to seeing the problem as the drinking behaviour of mainstream young people, occupying increasingly large areas of public space and becoming involved in increasing levels of public disturbance and alcohol-related harm. The paper suggested various themes which needed further investigation to help explain why this change had taken place (.These included changes in alcohol science and the alcohol policy community and the importation of models from overseas, in particular the US.(more discussion of this in main report)

In discussion, it was suggested that an appropriate definition for practical purposes might be: “*Getting drunk by young people in the public space*”. It was also noted that we can not dismiss ‘binge’ drinking as merely ‘moral panic’ and must look at the reality of the situation. However, the reality is that alcohol consumption patterns defined as ‘binge drinking’ are not confined to young people; that there is little consensus regarding measurement and meaning of the term; and that the term ‘binge’ is inadequate to convey the variety of consumption and behaviour patterns subsumed under that label. The question arises, then, how useful is the concept for the development of policy and practice?

Responses

Three papers aimed to provide examples of responses to the problem of ‘binge’ drinking and to consider the evidence for different strategies and approaches. The papers included reference to the importance of taking into account the wider national context and drew attention to general principles and considerations which influence policy, strategy and the implementation of prevention and harm reduction interventions.

The national context

In his paper, ‘*Safer bars, safer streets*’, Professor Martin Plant set the national context, sketching out the association between trends in per capita consumption and rising levels of mortality and alcohol-related harm as the real price of alcohol in relation to income

dropped between 1964 and 2004. Drawing on large scale survey data, he compared drinking patterns and trends among UK school age children with the drinking of their contemporaries in Europe. Figures from the 2003 ESPAD¹¹ survey indicated that 27% of students had reported binge drinking (5 or more drinks on one occasion) three or more times in the 30 days before interview, placing them fourth from the top behind Ireland, the Netherlands (boys only) and the Isle of Man. Evidence from a number of data sets indicated that young women were increasingly adopting harmful drinking patterns and ‘binge’ drinking. Plant referred to national policies for example, relaxation of licensing hours, rejection of taxation to raise the price of alcohol as detrimental to addressing alcohol-related harm, commenting:

“Hazel Blears rejected the use of tax to control the affordability of alcohol prices in 2005. She justified this on the grounds that the alcohol industry is a big employer. In 2007, over a year after liberalising licensing in England and Wales, she admitted that people still wanted to get drunk”.

He noted that, evidence from other countries indicated:

- Increasing availability of alcohol usually leads to more heavy and problem drinking.
- Liberalising licensing hours in Iceland, Ireland and W. Australia was followed by rises in heavy drinking, violent crime, traffic accidents, illicit drug use as well as extra public health and tourism costs¹².

Plant argues that *“Harm minimisation can work, provided macro policy controls price & availability”*.¹³ In the discussion which followed, there was agreement that macro level policy was important in addressing problem drinking including ‘binge’ drinking. Nevertheless, it was felt that, even within the restrictions imposed by the national framework, action at local level could provide an appropriate, effective response to ‘binge’ drinking. At the same time, as the papers demonstrate, there is as yet very little evidence regarding what type of strategies, actions or programmes might effect change in norms and behaviours relevant to addressing binge drinking in the UK.

The prevention context

In his paper ‘*Non-coercive prevention evidence & binge drinking: school and family approaches*’, David Foxcroft began by commenting on the prevention context, looking in particular at the relevance of the ‘prevention paradox’ to ‘binge’ drinking. Drawing on the findings of research studies, Foxcroft suggested that, since the majority of problems associated with bingeing are found among low volume drinkers, prevention strategy targeting the whole population but with a focus on heavy drinking occasions rather than on overall consumption might be valuable.

The evidence base

It was noted that evidence regarding the effectiveness of different intervention models comes largely from international literature and experience and that much of this is documented already¹⁴. Babor, in a presentation given in Dublin 2004, summarised the findings from a project which rated prevention and intervention strategies according to their evidence base, their breadth of research support and their cost to implement and sustain¹⁵. The results are shown in box 1.

Box 1: Evidence for intervention approaches

Best practice interventions:

- Minimum legal purchase age
- Government monopoly of retail sales
- Restriction on hours or days of sale
- Outlet density restrictions
- Alcohol taxes
- Sobriety check points
- Lowered BAC limits
- Administrative license suspension
- Graduated licensing for novice drivers
- Brief interventions for hazardous drinkers

Least effective interventions:

- Voluntary codes of bar practice
- Promoting alcohol-free activities
- Alcohol education in schools
- College student education
- Public service messages
- Warning labels
- Designated drivers and ride services

Babor (2004) acknowledged, however, that drawing on the evidence base for specific measures and implementing multiple policies and interventions in a systematic way as part of local strategy is more likely to be effective than single interventions. This approach – a ‘multi-component’ programme approach – is discussed below.

In considering the evidence base for intervention, Foxcroft illustrated the point that prevention research studies had used dozens of outcome measures and that the lack of standardised measures posed problems for evaluation and for deciding what the important messages are. Evidence emerging from systematic reviews, examined by Foxcroft and colleagues, supported the conclusions of Babor *et al.* regarding the lack of evidence for the effectiveness for education in schools and public awareness campaigns. Similarly, with respect to binge drinking, there seemed to be little evidence one way or another.

However, the papers by David Foxcroft and Martin Plant offered examples of some interventions where there was some evidence of effectiveness.

Evidence from selected research and intervention programmes

a) Strengthening families programme

Drawing on the ESPAD studies, Plant notes the importance of family relationships, mentioning in particular the finding that UK teenagers report that their parents are less likely to know where they spend Saturday evenings than teenagers in France and that having parents who do not know is associated with heavier drinking. The key role played by families in communicating acceptable norms and behaviours to children and young people informs the 'strengthening families' programmes discussed by Foxcroft.

This programme, stemming from the USA but now being piloted in the UK and elsewhere, has a focus on alcohol and other drug use. It employs skills training and includes parents and children, aiming to improve communication in families, help to clarify expectations and manage strong emotions, and encourage appropriate discipline. Adolescents in the studies discussed were followed up for up to 6 years following baseline.

Follow up studies indicated that the programme had a positive effect in delaying initiation into drinking at 1 ½, 2 ½, 4 and 6 years after implementation with 11-12 year old pupils and their families (strongest at 2 ½ years). Using 'ever been drunk' as the outcome, most people exposed to the programme were less likely, compared to control groups, to have been drunk (at all follow up periods although less so at 6 years). Another measure, whether the young people reported having 3 or more drinks at one time in the previous month - which could be seen as approximating to 'binge' drinking - provided figures which indicated no effects at 1 ½ years, some probable effects at 2 ½ years and no effects subsequently. So, there is a pattern similar in some respects but not as strong for the binge drinking measure as for the measure of delayed time of first drinking¹⁶.

b) A social marketing intervention

Kotler et al. (2002: 19-20) define social marketing as:

The use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify or abandon a behaviour for the benefit of individuals, groups or society as a whole....[it] is largely a mix of economic, communication and educational strategies... As a last resort, the social marketer may turn to the law or courts to require a certain behaviour. (cited in Tones and Green, 2004)¹⁷.

As Tones and Green (2004: 248) note, “*Mass media are more effective when supplemented by additional interpersonal strategies*”. (There are similarities here with ‘multi-component’ approaches – see below).

The example given by Foxcroft of a social marketing intervention again focused on age of first drinking as an outcome¹⁸. This recent study from the USA involved 16 communities (4,216 students) across four major regions of the USA to receive a social marketing intervention or to be a control community. The intervention involved combining community-based and in-school media efforts to reduce marijuana and alcohol uptake among younger adolescents. The intervention included community coalition: community readiness workshops, training in using campaign media; in-school media: print materials and promotional items (e.g. t-shirts, water bottles). After 2 years, young people in the social marketing communities were less likely to have started drinking than those in the control group.

Delaying the age of first drinking

In discussing the research data from the ‘strengthening families’ studies and the social marketing interventions, Foxcroft flagged up the methodological limitations of the studies and cautioned that interpretation of the findings regarding binge drinking were tentative. He noted that, even in interventions where something seems to be going on, we do not have strong evidence of the impact on binge drinking specifically; but it is inferred in the literature. E.g.

A correlational study (USA) by Grant and Dawson (1997)¹⁹ showed that:

- the lifetime alcohol dependence rate of those who initiate alcohol use by age 14 is four times as high as those who start by age 20.
- adjusting for potentially confounding variables, the odds of dependence decreased by 14% with each additional year of delayed initiation.

Two USA prospective studies by Zakrajsek (2006)²⁰ and Warner (2003)²¹ followed up 10/11 year olds and 12 year olds respectively till they were 17/ 18; 23/24 years old and 30/31 years old. The studies used composite measures of problem drinking and alcohol misuse. (e.g. study 1: how many times in past year respondent got drunk, drunk more than planned, got sick, got into trouble with friends and with parents, school, work, police etc.). A similar picture emerged, although not as strong, to that of Grant and Dawson (1997):

- Those who started drinking before 15 were more likely to report misuse and links to problem behaviours in the twenties and even into the thirties.

c) Designing safer bars

Within a harm reduction model, research has provided insights into factors associated with elevated risks that a bar will be a focus for problematic behaviour. Plant's paper indicated that the risk factors include:

- internal physical characteristics and atmosphere (e.g. perpendicular drinking, layout, crowding),
- organisational factors (e.g. beverage promotions, entertainment)
- patron characteristics (e.g. gender, age),
- external characteristics (e.g. location, density)²²

Research has suggested a number of ways to improve safety and reduce harms such as aggressive behaviour, 'glassings' in bar fights and disturbances around drinking venues.

Interventions include, for example:

- altering the physical environment (crowding, noise levels, availability of seating, ensuring good ventilation, location of toilets),
- providing food,
- using shatterproof glasses,
- creating a social atmosphere with clear limits and boundaries on behaviour,
- providing training for server intervention,
- discouraging drinking to intoxication. (see discussion in Graham and Homel 1997)²³.

Server intervention and responsible beverage service have been reported as effective in reducing alcohol impairment and intoxication but as Saltz (1997)²⁴ comments, attention also needs to focus on changing house policies and on community law enforcement. Other approaches, such as pub watch schemes, may also contribute to a reduction in binge drinking and related harm.

While safer bars will not necessarily address the problem of 'binge' drinking, this approach might go some way towards reducing problem behaviours associated with that pattern of alcohol use, especially if adopted as part of a wider strategy and action programme.

d) A local community prevention approach: a case study of Westminster

The paper given by Sir Simon Milton, leader of City of Westminster Council, provides an example of an approach to prevent and reduce alcohol related harm that has received increasing attention in recent years. Before considering the details of the approach taken in Westminster, the origins and key elements of the local community prevention approach will be outlined. Stemming originally from action to address cardio-vascular disease prevention and subsequently from research conducted largely in the USA,

Australia, New Zealand and Scandinavia, the approach supports the use of strategies which focus on populations as a whole in preventing and reducing the burden of disease²⁵. Typically, evaluated demonstration programmes have targeted the prevention or reduction of specific harms at local level (e.g. alcohol-related accidents, city centre anti-social behaviour associated with drinking).

Key factors which distinguishing the multi-component approach from a single component approach are that:

- It consists of a programme of co-ordinated action (projects) to address the problem based on an integrative programme design where singular interventions run in combination with each other and / or sequenced together over time.
- Programme components are evidence based.
- It requires identification, mobilisation and co-ordination of appropriate agencies, stakeholders and local communities.
- It has clearly defined aims, objectives, indicators and measures of effectiveness for the programme as a whole (although individual projects or activities will also have specified aims, objectives and outcome measures).
- Evaluation is an integral part of the programme from the start.

Multi-component programmes typically emphasise modifying drinking cultures and effecting change or modification in local policies, structures and systems; for instance, by improving local policies on alcohol, by strengthening collaborative networks between professional or stakeholder groups, or by involving local communities in efforts to achieve change. In community prevention approaches, whole communities form the target intervention group rather than individuals within the community²⁶.

Although use of the concept ‘multi-component programme’ is not yet common in policy and practice discourse, the approach has been gaining currency – often under the umbrella of ‘multi-agency’ and ‘partnership’ approaches to strategic planning and programme development at local level. The approach taken in Westminster provides an appropriate example of a multi-component programme in ‘action’ and suggests the relevance to tackling ‘binge’ drinking.

Sir Simon started by providing a profile of the local community indicating the interaction between area characteristics and how the problems are experienced. For instance, because Westminster has a high proportion of transient population (e.g. visitors, workers, homeless), there is “*no learned behaviour*” and individuals passing through the Borough are distanced from the consequences of their behaviour whereas in smaller or more stable communities there is likely to be greater perception of the risk of being caught or recognised.

The paper illustrated the kinds of problems that have to be dealt with. For instance, between Thursday and Sunday 87% of all offences take place within 100m of licensed premises, a high percentage of assaults and admissions to A&E departments are alcohol related. Flashpoints for potential problems needed to be identified – in Westminster, these were bus queues, taxi queues and fast food restaurants. Late night problems stem from:

- Premises - high anticipation of punters
- Street and Open Spaces - disorientated pedestrians
- Situations and Incidents - victims and perpetrators
- Dispersal Home - hungry displaced passengers

The massive flows of people into and out of the Borough required careful balancing of the needs of different groups – residents, workers, tourists, those involved in the night time economy. In outlining how Westminster had responded to the challenges, Sir Milton mentioned ways in which action in Westminster had challenged the 2003 Licensing Act: by retaining prior local policy arrangements emphasising restraint which were suited to local needs e.g. by establishing the principle of ‘core-hours’ in designated ‘stress areas’ and, in both planning and alcohol licensing terms, challenging the principle of ‘presumption to grant’ license extensions, which had resulted in 300 appeals upheld or withdrawn. He commented on the costs of enforcement and monitoring which, in a Borough such as Westminster, were not covered by the revenue from licensing fees. Enforcement was necessary, he remarked, because “You can’t tackle binge drinking unless you have effective enforcement activity”. The threat of enforcement could also be used to back persuasion. In one instance, this was used successfully to persuade off-licences in areas frequented by street drinkers and rough sleepers to withdraw from sale high strength ciders and beers.

In discussing specific actions, he highlighted collaborative, multi-agency approaches involving:

- joint tasking/ intelligence gathering between the police and the council
- CCTV - not benign but active
- City Guardians and Civic Watch
- Co-ordinated actions with local businesses (e.g. controlling the opening hours of some fast food outlets)
- Cleaner streets / better street scape
- Action plans for daytime/ early evening development strategies
- Promotion of other “damping” uses e.g. Al fresco dining.
- Using under used car parks as marshalling points for taxis rather than having a free for all on the street.

Although public awareness approaches have been seen as unsuccessful, the 2006 Christmas campaign provided an illustration of how public awareness activity could reach some groups of binge drinkers. It was acknowledged that it would not be possible to change hard core or pre-meditated binge drinkers and violent offenders through campaign awareness. However there was a significant opportunity to influence those who fully intended to have a ‘big night out’ but had a level of self-awareness of the consequences. The campaign was targeted at those ‘Otherwise Sensibles’ (see box 2) and adopted a number of ways to attract notice, through advertisements in toilets and washrooms and on the London underground, posters and beer mats, promotional articles using CCTV, a dedicated non-judgemental web-site, and text messages, including one providing excuses to leave an event.

Box 2 Westminster 2006 Christmas campaign

Targeted at the 'Otherwise Sensibles'

Campaign messages were:

- Know your limits
- Plan your evening
- Organise transport in advance
- Key contacts

The campaign purpose was:

“Change your behaviour - this is for life not just for Christmas.”

The results showed:

- 6,330 hits on website
- Before campaign only 54% said they had not recently had an unfortunate incident getting home
- After campaign 81% said they had avoided such an incident.
- 60% convinced to plan journeys in the future
- 35% convinced to use transport helpline to get home at end of night

The evaluation concluded that:

- People do get engaged by the right type of campaign and intervention
- This was an entry point to support services that was seen as non-judgemental, relevant and practical
- If engaged people will act upon the key messages
- Campaign did increase the use of safe travel numbers
- This facilitated a ***key behavioural change***

In summing up, Sir Simon stressed that solutions have to be 'joined up' involving both national action (reconsideration of tax policy and the role of marketing and advertising; increasing support from government and industry, and more funding to deal with the effects of alcohol) and local action using the tools of policy, enforcement and education to make an impact.

What are the challenges?

In considering the challenges facing policy makers concerned about binge drinking, we are not attempting to provide answers. Rather we are posing the questions which emerged from the workshop as crucial to understanding the phenomenon of binge drinking and developing appropriate policy and practice responses. The discussion was led by Professor Susanne Macgregor who began by summing up some of the themes which had emerged from the presentations and earlier discussion. She discussed three main themes: 'binge drinking' as social construction or reality; the question of responsibility, especially the issue of individual or social responsibility; and questions regarding the definition of effective policy. Her observations and comments are incorporated into the sections below along with those of the participants and presenters.

We need to consider and explain why 'binge' drinking has become a current problem. What have the drivers been? Historical understandings are useful.

A key question here is: are we (or to what extent are we) engaging in moral panic or is there a real crisis? Perspectives differ. On the one hand there is the view that there is a national pre-disposition to drink and to drink in particular ways. This, linked to erosion of social boundaries and the speed of erosion over recent years, may have resulted in a break down of former self-regulatory and social control mechanisms. In the case of young people and binge drinking, this may be related to the wider experiences of being a young person, as documented in the UNICEF report²⁷. Changes in forms of regulation and discipline, messages from marketing sources and the greater 'laissez faire' atmosphere of the times allied with fewer sanctions for socially unacceptable behaviour may be part of the explanation. From another perspective, the current emphasis on binge drinking by young people may reflect concerns over the changing role of women, mothers and parenting; or it may be to do with intergenerational and socialisation issues; or violence and public disorder (rather than health concerns) may lie at the heart of the matter. Are perceptions that there is change (for the worse) in drinking behaviour countered by perceptions that we are a nation which has always liked to get drunk? Relating a complex bundle of problems under the label 'binge drinking' may draw media and public attention and serve to construct a problem rather than convey the reality.

Systematic examination of the existence, emergence and non-emergence of this pattern of drinking in different European countries would help to understand the extent to which this is a 'British disease' or related to other trends and social changes. The historical papers serve as a caution in considering the problem as unique to our times and it is important to look at historical parallels. But historical parallels are not the only 'lesson of history'. The history also tells us, as we have argued in the report, that heavy drinking has not always been considered a problem and that when it has been so defined, this has often been with specific foci not always related to the nature of the problem. Historical analysis tells us more about when bingeing has been seen as a problem and when it is not and by whom. Clearly, better understanding and explanation is needed of the problem as it exists and as it manifests in public and private spheres today. A particular challenge

may lie in taking on board the *carnavalesque* nature of young people's behaviour, the possibility that it is a public *performance to a virtual audience* which is part of a 'carnival' approach (or time out) before the young person returns to everyday life. This would imply a kind of 'normalisation' of 'binge drinking' behaviour which may take different forms (e.g. the 'otherwise sensibiles' and the 'intentional drinking to get drunk drinkers') and may or may not result in different forms of harm requiring a range of responses.

We need to take account of cultural relativity and cultural sensitivity. Cultural parallels are important.

Discussions around the apparent ineffectiveness of alcohol education and awareness interventions provoked comments on the extent to which research evidence (and UK policy) are dominated by an Anglo-Saxon perspective which ignores evidence and intervention models from elsewhere and the cultural differences between countries. To illustrate the point, a letter to *Addiction* from the Chairman of Eurocare, Michel Craplet, was cited. In his letter Craplet asks whether the results of studies conducted in Anglo-Saxon settings are applicable everywhere and challenges the emphasis on control and enforcement as opposed to educational and motivational approaches. He notes how dismissal of educational efforts as ineffective may negatively affect grass roots action and suggests that, in Eastern European countries (for example), people may find a return to state control policy problematic. In countries such as France, emphasising lack of evidence for education, risks loss of funding without necessarily resulting in increased control measures which are unlikely to be implemented for political reasons. Craplet asks that scientists "consider how to be more politically sensitive and more concerned about the grass roots workers in fragile situations". Education, he argues may be both a suitable and necessary approach in many countries, if only to counteract negative marketing forces. He ends his letter by stating that:

*"...we need a more acute position, a more ethical and political approach, even in the field of science, and especially with regard to human sciences. Education is needed: it is democracy. Control by the elite has many failures."*²⁸

The example serves as a reminder of the need to raise questions regarding the cultural applicability of research findings and the use and abuse of research for political, professional and commercial purposes. These issues are important with respect to the development of UK policy but also in relation to the UK's interaction with European neighbours and involvement in European economic and political systems.

We need to deal with scientific uncertainty: improving the evidence base of policy is necessary.

The confusion and multiple uses of the concept 'binge drinking' raise the question of how useful this concept is to describe the reality which encompasses different social groups

drinking in different ways and in different circumstances. There is little research directly relevant to examining issues around binge drinking and even less which investigates the variety of ‘binge drinking’ patterns and groups as heterogeneous rather than homogeneous entities. Furthermore, there is the question of the quality of available research – for example, the lack of measures which enable comparison between data sets. The usefulness of debate regarding the definition of ‘binge drinking’ may be questioned; but it becomes relevant when consumption behaviour is defined quantitatively as a way of categorising groups of people for research and policy action. Then there is the dominance of research originating from the USA; because of this, the use of evidence from systematic reviews to inform policy presents a particular slant which, given what we know about cultural differences, may not point to the best way forward. Presentations given at the workshop indicate the need for good longitudinal research. A further issue is the difficulty of evaluating complex multi-component action where it is not sufficient to isolate and examine individual variables alone. We do not know what constitutes good research in examining the impact of complex programmes of activities to take account of synergistic effects between the components. Finally, while policy ideally is evidence based, we need to ask whether science is the only (or main) form of evidence which comes into the picture and take account of the wider policy process especially in the light of the limited nature of the research evidence on binge drinking currently at our disposal.

In the light of scientific uncertainty, should we consider following the ‘precautionary principle’: theories and principles underpinning preventive action need more debate

In concluding his paper, Foxcroft suggested the potential usefulness of ‘the precautionary principle’²⁹. This principle states that the lack of conclusive evidence should not, where there is serious risk to the nation’s health, block action proportionate to that risk i.e.

Prohibiting an activity where there is scientific uncertainty of potential harm from the activity is justified;

Extending the principle would add the following:

Supporting an activity where there is scientific uncertainty of potential benefit from the activity may be justified.

Importantly, the principle should not, in any circumstance, be applied so that just any preventive action can be justified. Rather, four qualifying criteria should be established:

- The costs and harms associated with a lack of effective action are considered to be high.
- There is some provisional high quality evidence of effectiveness for a specific preventive action, with no indication that the preventive action is in itself harmful, but further research is needed to provide convincing evidence either for or against the preventive action.

- Cost-effectiveness studies or models point to the potential of the preventive action to reduce costs and harms.
- Further high quality studies are fully resourced and planned or ongoing to establish convincing evidence for or against the specific preventive action so that the opportunity cost associated with a possibly ineffective preventive action can be minimised.

Clearly, consideration of the ‘precautionary principle’ as a basis for action on alcohol requires extended debate which was not possible at this workshop. The principle calls into question other fundamental principles which underpin government action and scientific activity, not least questions regarding the production of scientific evidence and the extent to which it is a product of social and political processes.

We need to address questions of responsibility: it is important to balance individual and social responsibility

A number of issues arise under the theme of ‘responsibility’.

Firstly, has the move towards individualism taken us too far away from accepting ideas of social intervention? We have seen an enormous paradigmatic change – not just from the disease model of addiction towards a population-based model – but within a bigger picture, the shift in neo-liberalism with its emphasis on the notion that the state should intervene only with ‘problem’ or ‘high risk’ groups while everyone else takes responsibility for themselves.

Secondly, if we accept the notion of social responsibility, then who is responsible for intervening – the state, civic society, families, the industry, the individual? The role of the industry and of marketing targeted at young people has recently been the subject of increased investigation and debate³⁰, raising issues of the extent to which responsibility can come for self-regulation or requires state regulation. (This might equally well be extended to considerations of balancing self and state regulation in matters of family and individual behaviour). It was pointed out at this workshop that industry serves its shareholders and that its business is to make profits for shareholders. At the same time, it is not in its interests to foster harmful patterns of drinking. We should not expect industry to enter partnerships which are counter to their primary interests; but what we can do is look to them to form partnerships in taking action which fits with their interests and with the interests of other social groups. We need to find the common agenda as part of providing a response to binge drinking.

Thirdly, there is the question of which elements within the state are responsible for intervention? Contradictions between policies (e.g. the 2003 Licensing Act and the national harm reduction strategy for England) have been well versed³¹. But there are different agencies within the state machinery, different interest groups linked to different

departments and shifts in responsibility for alcohol intervention – for instance, the recent shift in responsibility of licensing from the Home Office to the Department of Culture Media and Sport– symbolise the contradictions and conflicts which impinge on responsibility for action.

We need to identify successful approaches to achieving behaviour change: drawing lessons from related fields is possible.

How do you strengthen the infrastructure of influences around young people and how do you reinforce those who are seeking to set boundaries and limits. Managing behaviour change to tackle ‘binge’ (or ‘extreme’) drinking demands a long term view and collaboration between parents, schools and the wider community. Major shifts in attitudes and behaviour have occurred in smoking and in drink driving and these areas of activity provide suitable models for action on binge drinking³². (There were also other interventions to change public and private behaviours at that time, e.g. use of seat belts). These are areas where there has been *increased* regulation rather than liberalisation. These areas also illustrate that, whether it is called ‘education’ or not, there is a need to raise awareness and provide information in order to *begin* the process of behaviour change – this was part of the change which took place with regard to smoking and drink driving. Parallels can also be drawn between the messages given in smoking and drink-driving campaigns which, in part, emphasised harm to other people as a strong rationale for behaviour change. However, strengthening the infrastructure to support normative and behavioural change, requires a range of action aimed at making binge drinking as socially unacceptable as drink driving. i.e. -

We need to strengthen the links between national and local action. Bringing together population based measures, targeted action and local initiatives is key to mounting successful approaches to tackling binge drinking.

What are the opportunities?

The opportunities to address binge drinking (or harmful consumption patterns and associated behaviours with particular reference to young people and ‘public’ drinking) emerged from the papers and general discussion and presented ideas and opinions rather than firm conclusions or recommendations. These are noted briefly.

- There are good opportunities to take prevention and harm reduction action at local level and many local authorities are now developing strategies and action plans to support partnerships and multi-agency approaches to address harm, including binge drinking, where that is seen as a problem for the area. Although it is difficult to provide firm evidence of effectiveness due to the complexity of evaluating such efforts, the approach has been positively evaluated elsewhere, at least regarding short-term impact. There are opportunities to build on this approach to secure longer term changes in local policies and structures which will encourage normative and

behavioural changes. There are also opportunities for local areas to share experiences and ideas with other localities and with policy makers.

- There is some evidence to suggest that action to ‘strengthen families’, appropriately targeted public awareness campaigns, social marketing interventions and interventions to reduce harm in and around drinking venues are useful components of a comprehensive programme although they may have little or no effect on their own.
- We could draw more on other successful attempts to change health related behaviours – such as smoking, drink-driving, use of seat belts – to understand drivers for change and apply these in tackling binge drinking.
- We could learn from our European neighbours about socialisation into drinking cultures, including within the family, and consider whether there are family based factors which might prevent or promote later binge drinking.
- There are opportunities to partner with the industry based on common interests round harm reduction.
- Linking regulation, enforcement, education, awareness and treatment approaches and strengthening the coherence of national and local policy, is likely to open up opportunities to tackle alcohol misuse and binge drinking.

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 29. The 'precautionary principle' was initially developed to cover environmental hazards, for instance the United Nations 1992 Rio Declaration states that "*Nations shall use the precautionary principle to protect the environment. Where there are threats of serious or irreversible damage, scientific uncertainty shall not be used to postpone cost-effective measures to prevent environmental degradation*". More recently there have been calls to extend the precautionary principle to other areas of public safety, for example public health actions including injury prevention where it is argued that the original focus of the precautionary principle on environmental hazards is "*visionary but short sighted*". See Wanless, D. (2004) *Securing Good Health for the Whole Population* London: HM Treasury.
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**WORKSHOP:
ADDRESSING BINGE DRINKING: CHALLENGES AND OPPORTUNITIES**

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