



Responsible thinking

BSA Alcohol Study Group, supported by
SHAAP

SHAAP

SCOTTISH HEALTH ACTION
ON ALCOHOL PROBLEMS
www.shaap.org.uk



BRITISH
SOCIOLOGICAL
ASSOCIATION



This report documents proceedings from the British Sociological Association (BSA) supported by Scottish Health Action on Alcohol Problems (SHAAP) interdisciplinary symposium 'How do different disciplines talk about alcohol and how can we work better together?' held in the Royal College of Physicians of Edinburgh on Friday 22nd April 2016.

Eric Carlin, Director, Scottish Health Action on Alcohol Problems

Good morning everyone, I'm Eric Carlin, and I'm director of SHAAP, and I'm delighted to welcome you to this event on behalf of SHAAP and the Royal College of Physicians of Edinburgh. I want to thank the British Sociological Association for facilitating the alcohol study group, for enabling us to hold this partnership event.

SHAAP is a partnership of the Medical Royal Colleges in Scotland, working together to promote effective policy and practice to reduce alcohol related harm. As such, we've got a focus on health-related issues and possibly mostly on the harmful aspects of alcohol use, seeking to influence government policy and to restrict damaging behaviours of at least parts of the alcohol industry; for example, in their opposition to population level measures on price, availability and marketing.

Supporting and learning from researchers is really important to us. It's never far away from our consciousness that policies such as the implementation of minimum unit pricing, which is still being challenged by a conglomerate of international alcohol producers, fronted by the Scotch Whisky Association, will be proved legal. The legal test for this policy which we hope will be settled this summer is going to be based on whether the evidence supports the policy's efficacy and effectiveness in terms of how it works in conjunction with excise duty, so research is really important for us in our work.

As a sociologist, I'm far more interested in people than I am in alcohol. I first met Carol at the launch of the BSA's alcohol study group on a Saturday morning in Newcastle a few years ago. Now, Saturday morning in Newcastle meant I also experienced Friday night in Newcastle, and maybe

the need to discuss differences in how we talk about alcohol was exemplified by my experience in a pub in Newcastle: My partner and I enquired what white wine was available, and we were told they only had two types. I thought they meant Sauvignon or Pinot or Chardonnay, but the answer I was given was four or eight per cent. So that's Newcastle for you. That highlighted on an informal level why we need to find ways of getting past our misunderstandings and different relationships with how we think about alcohol.

Discussion of how different academic disciplines consider alcohol related issues, including exploring history, culture, pleasure and harms, and how we can work better together is timely and urgent, and that's really what the point of today is. That's all from me, really just to say thank you all from coming, I think it's going to be a really exciting day, really looking forward to the discussions and following up.

Carol Emslie, Senior Lecturer, Lead substance use and misuse group, Glasgow Caledonian University

Good morning, I'm really, really excited to see everyone here today. I'd also like to say thank you very much to SHAAP for their huge generosity with this event.

I consider myself very lucky to have moved into focusing on alcohol research in 2012. The BSA alcohol study group had been set up early beforehand with Tom as a founder member, and he'll say a little bit about the group later on. The Scottish Alcohol Research Network led by Aisha Holloway, who's speaking this morning has been a fantastic way for academics, researchers, clinicians and policymakers in Scotland who are interested in alcohol, to get together and have discussions. Eric had just become director of SHAAP here, there was a real buzz in Scotland in the public health community about changes in alcohol legislation, with discussions about minimum unit pricing. I was lucky enough to go on a Scottish Crucible event when I first joined Glasgow Caledonian University, which was about leadership and development. We were able to go to the Scottish Parliament, and the example that we were given to practise on in the Scottish Parliament was minimum unit pricing with the modelling from the Sheffield group, so all this exciting research, exciting discussion was going on, and I think that's continuing now.

Another thing that I think has been really instrumental but people don't always talk about is the discussions that go on on Twitter. Quite often when I've met people at conferences I've known them beforehand on Twitter, so I hope people will tweet and have that discussion and debate going on Twitter, and social media as well as contributing to the debate here today.

So today what we're hoping for is a broad conversation about alcohol. I hope people are going to be controversial and provocative. We've given the speakers a really broad brief, and thank you to all of the speakers we asked for taking that on board, because in some ways I think that's more difficult to do than to talk narrowly about your academic work, so I'm really pleased that people have done that.

I'm delighted that our first speaker is going to be Dr James Nicholls, who's the Director of Research and Policy Development at Alcohol Research UK. His research background is in the social and cultural history of drinking, and I think James is really an ideal person to kick off today, because as a sociologist, I've always been really impressed about how historians examine the construction of alcohol as a social problem, how they situate it at a certain time, how they ask who is defining alcohol as a social problem, and how they look at how structures such as gender and class are implicated in these constructions. James's current role involves working with academics, policymakers and practitioners across the UK to support the development of alcohol research and the use of evidence in policy, so I don't think you'll have any problems at all dealing with this very mixed crowd today, but I'd like to welcome James Nicholls to start us off, thank you.

■ History and Alcohol Research

Dr James Nicholls, Director of Research and Policy Development, Alcohol Research UK

Thanks Carol, for that introduction, and thanks for inviting me to speak at this event, which I think is really interesting and should be hopefully very, very useful for everyone involved, it's much needed, so much appreciated. I just want to say today that I'm not speaking as Alcohol Research UK, I'm speaking as a representative of historians or people who've engaged in this from a historical perspective. I'm not going to give many historical examples or details, but I'm going to talk about the perspectives and experiences that historical research brings, and you've asked us to be provocative. Hopefully I'll be raising points that will stimulate questions.

This quote is from an email I received a number of years ago from David Harrison, who was then the clerk to the Health Select Committee, and it was an email where he was inviting me and three other historians to present evidence to the Health Select Committee who were doing their report at the time on alcohol which was published in early 2010, and in the email inviting me, David said, where alcohol is concerned, history is often appealed to, but rarely accurately, and I thought that really captured very well the challenge faced by everyone working in this field when it comes to the uses of history, and I think we all know what we mean by that. This is just one example, but basically in many cases if you want to write a story about British drinking, then you take Gin Lane, you point at it and you go, there you go, we've always been like this and you proceed on that basis, it's a very common thing.

It was good to see that the health Committee wanted to go beyond that and try and find a more nuanced report, and the interesting thing was that myself and James Kneale from UCL were presenting at the first session along with Martin Plant and Peter Anderson. James and I were speaking first, and what was interesting about it was that the Committee were fascinated, I mean, they were asking us lots of questions and they were nodding and they wanted to know about Victorian drinking and the gin craze, and restrictions on licensing in World War One and all that kind of thing, and they all seemed very interested, but we noticed that no-one was writing anything down, they were just asking us lots and lots of questions, then

we went off, and Martin and Peter Anderson came on representing public health expertise and social science. Similarly the MPs were asking lots of interesting questions, but this time they all had their pens and were writing down what they said, and I remember me and James went for lunch afterwards and we were saying, it's quite a familiar experience for a historian to come in and provide an interesting series of anecdotes and tales from history that people go, "oh, that's very, very interesting, very good", then they wait for the real scientist to come on so they can actually start taking notes, so we got a little bit neurotic about that.

Funnily enough as it turned out, actually we were completely wrong. In the end a whole chapter was given over to the historical background in that Select Committee report, and that then triggered another series of questions in my mind, because I wouldn't argue necessarily the history that myself and Phil Withington and Angela McShane and James provided was especially brilliant or it necessarily told the committee much that was useful, but what was interesting in the final report was the way that the history functioned in that report. This is a quote from the final paragraph of the executive summary where they said, "the alcohol problem in this country reflects a failure of will and constants on the part of government departments and QUANGOs. In the past governments have had a large influence on alcohol consumption, alcohol is no ordinary commodity, and its regulation is an ancient function of government."

Now, from a critical perspective we could unpick that paragraph in all sorts of interesting ways, what do we mean by the alcohol problem? It was interesting that the phrase, no ordinary commodity, makes it in there not in inverted commas, all sorts of interesting stuff, but what I thought was interesting about it was the way that history is used here, not especially to expose complexity, which is really what history is supposed to do, but rather to drive a political position home. The health Committee had wished to argue for greater state intervention in the alcohol market, and what they did was they found the bits in our evidence that pointed to examples where policy seemed to have influenced culture, and there are examples of that, but the function of history in this context was to provide legitimation for that position. Now, that's not a bad thing and I'm not saying this to say, "oh, that's a terrible thing", but that's just struck me that it's one of the most interesting experiences you have, and I think it's true for all disciplines, of what happens to knowledge when it hits the reality of the policy process.

Some years later I worked quite closely with Evelyn Gillan when she was leading Alcohol Focus Scotland, and she often said to me that one of the lines she liked using when she was speaking to politicians, especially round the rethinking alcohol licensing stuff, was one that I'd dug out from a select committee report from 1932 which said, "our younger generation is growing up to which as a

whole any resort to alcohol excess as a necessary or usual practice is almost totally unknown". This was from a Royal Commission that reported in 1932, the context of which was the decline in consumption after World War One, and the fact that by the 1930s, alcohol consumption across the UK was very low, and young people particularly had started to move away from alcohol, and particularly to move away from pubs, which was a real threat to the industry and they responded quite aggressively to that.

The question is why should a report of 1932 have had any influence in the policy context a few years ago? Well, I think it's partly because if history tells us anything, it's that drinking cultures are neither static nor uniform, that drinking cultures are diverse, they change across geographies, but they also change through time, and the question then is what are the drivers of that change, and that's what history is very often interested in. Evelyn used to say that she thought that this particular quote was powerful because it busted a myth about the inevitability of heavy drinking which acted as a brake on political action. If you could tell politicians that cultures can change, then they're far more likely to back policy that moves in that direction, because they don't feel it's a hopeless case. Now, where policy can actually change culture and what the realities of culture change are is a different matter and one for a completely different talk or maybe for questions afterwards.

In both these cases, though, I think we've seen what Vittal might call, and has called in different contexts, the rhetorical uses of knowledge in policy context. In that respect I think history is like all of our disciplines, it's a series of complex observations about the complicated world from which lots of conclusions can be drawn, but in the policy context it often becomes instrumental and a tool that serves to support or block a particular policy goal, and as I say, that's not a problem. Historians are more conscious than anyone that the story of alcohol policy is not about pure science with a pure relationship between evidence and policy. It's about a whole series of complicated relationships, and that's one of the advantages of history, historians have, as it were, seen it all before.

The work of people like Betsy Thom and John Greenaway, for example, provide detailed evidence historically of how policy development around alcohol is partly about evidence, but it's also and perhaps mostly about personal relationships. John Greenaway particularly is excellent on the role of individual civil servants in driving agendas in departments. It's about advocacy coalitions and policy networks, Betsy's particularly good on that. It's about political calculation, it's about the development of bodies of evidence that support particular policy positions and the opening and closing of what John Kingdon calls policy windows – something Betsy, John and others demonstrate historically. Something history is good for and Carol raised this in the introduction, is the extent to

which battles over alcohol policy are actually battles to frame alcohol problems in a particular way or to put it differently – and apologies to people who aren't trained in old school Gramscian Marxism – to establish hegemony over what alcohol is understood to be. What I mean by this is to create common sense understanding or consensus about the value of alcohol, and I don't mean its monetary value, I mean its social value. Is it a social good that has negative externalities, or is it a social evil that happens to have some positive consequences? It is about the value of alcohol, but also about the nature of the problems it creates and the appropriate policies to respond to these problems.

Something history tells us in no uncertain terms is that alcohol problems are socially constructed, first controversial point. That's not to say they're not real, it's not to say that they're exaggerations, it's to say that how alcohol is understood to create problems, the nature of that relationship between drinking and problems, what problems it's understood to create, why certain behaviours are viewed as problematic and other behaviours aren't, where those problems are assumed to be located, how they should be solved and so forth, reflects the social context in which those problems emerge, but also the ways in which interested parties of the time frame those concerns.

Over time, different constructions of the alcohol problem or alcohol problems have emerged, different constructions have achieved consensus within particular networks of either advocates or specialists, and those networks have fought for and sometimes achieved policy dominance or policy consensus around their construction of alcohol as a problem. There's a relationship between how alcohol problems are diagnosed, the solutions that are proposed, and the political perspective that is brought to those, whether you are more or less in favour, for example, of state intervention in people's behaviour.

The question of why certain policy constructions achieve policy success is a key question, and I think it's partly to do with the alignment between how a problem is framed and the wider broader political environment in which it lands. The development of the modern public health perspective on the whole is itself rooted in a sociological critique of the disease model of alcohol harms, which itself had become dominant after World War Two. The disease model of alcohol harms in turn had achieved dominance over an earlier temperance construction of alcohol as a population wide problem that required supply side interventions partly, interestingly, on availability, particularly, but also on price.

Critics such as Kettel-Bruun saw the 'disease model', which suggested alcohol problems are isolated in small, acutely problematic populations, as creating a clear dichotomy between harmful drinking and non-harmful drinking. This mode stigmatised both heavy drinkers and also let the industry off the hook by isolating harms in a small group.

So there was a diagnostic scientific element to it, and there was also a political element to it, which Robin Room, who, both being a great historian of this and also someone who was involved...was involved in that process from early on, has mentioned quite a few times. People like Harry Levine and other historians of this issue have shown that history is full of paradigm shifts in the understanding of alcohol related harms, but they've also shown that like any paradigm shift or any epistemological shift, those changes are not simply to do with the emergence of new and better evidence, they're to do with a whole array of different social and political factors coming together to create new ways of seeing problems.

Now my point is that when you look at the history of the matter and I'm only talking about problematisations here of course, there are huge other histories of alcohol that we talk about. You see the diagnosis of the problem, the social context of that diagnosis, and the political values of those in agreement with the particular diagnoses are inextricably linked. The things just simply cannot be...there isn't a pure element to this.

So that's a few general observations about history. We were asked by Carol to tackle some very interesting and important questions in our talks, so I'm going to try and just run through some of those now and I'll try and be brief, and again these are just points for discussion, really.

What can history bring to this field of alcohol research? Well, I mean, you could talk for an hour on this, but one thing history does have the advantage of is that it's built on real world examples that have actually happened, and it has the ability to identify patterns across long periods of time. It can start to identify interventions that tend to work, tend to fail and why they might work or otherwise. It also, however, provides a framework for making sense of how drinking is and has been constructed as a social practice, and as a social problem. It can be an analysis to how power works in that process, how science and politics merge, and how political decision making is often contingent on other things than pure scientific truth. Of course it lacks the analytical precision that social and medical science can bring, and yes, it's dependent on partial and documentary evidence and misses materials that are lost in the mists of time, so in that sense history has a large limitations section, but I think that's probably true for everyone in that sense.

How can history help challenge statements in the public domain that are not evidence based? In some respects it's obvious, you take simplistic descriptions of the British drinking culture and you just point to the variations and the diversities and you can challenge those kinds of things. However, I think a proper historical perspective – and again being somewhat challenging here – will also be sceptical in the best sense of the word about terms like the evidence base, because historical research realises that the development of evidence bases is never neutral, and

it's never unaligned to other values and political positions. That's not to say history is relativist and that all evidence is basically the same, but it's to say that every historian is trained to be critically cautious of their sources. Where did the evidence come from? Who was presenting it and who or to what purpose did it serve? So I think it can bring an important critical perspective on some of the assumptions that we may hold about the nature of evidence when we talk about evidence based policy.

Should alcohol research have aims other than alcohol harm reduction? If I were speaking as Alcohol Research UK as a funder I'd have to say, no, because our charitable objective as Alcohol Research UK is to reduce alcohol related harm. Speaking for historians however, absolutely it should, of course it should. One job of historians is to try and reveal truths about the social role of alcohol in the broader sense. Now, if some of that proves useful to harm reduction, then great, so much the better. If not, then so be it, and indeed if historical research throws up difficult questions for people who think they know the answers around alcohol harm reduction, then that's also important. I think historians played quite an important role in challenging the dominance of the disease model late in the 20th century, and they have the right to challenge the dominance of the public health perspective too, if that's what their research points to. I think they have to be prepared to ask difficult questions, that's part of the job of history.

How can we work better together? Well, interdisciplinarity is a challenge and I think today is a really good contribution to that. I have been involved in projects where, with the best will in the world, the history bit has felt a bit like a trailer that's been put on the back of a truck. We didn't want it to feel that way, but it did. That's fine; I think it's inevitable; it's just a work in progress. I think it would be good to see more historical papers in journals like Addiction. Virginia Berridge has been trying to get them in for years, I think there could be a lot more. But I think it's a matter of creating greater dialogue, and I think this is a good attempt to improve that, but I haven't got any real simple answers for interdisciplinarity and the role of history in that.

How can we consider gender, age, ethnicity, SES and so forth in our work? Well, I think it's very hard for anyone coming from a historical background not to argue that consideration of these things is absolutely fundamental and critical to everything you do, because in a sense for me, the reason I got interested in the history of alcohol was because it was just a way of looking at society, it was a thread through which you could look at those social constructs and power. I think especially gender, I have to say, because again if there's something that history has taught me, it is that concerns about alcohol, when they emerge, are very often actually concerns about gender in a different guise. So if Gin Lane and bench girl have anything in common, it's not what they tell us about the reality of

women's drinking, either in the 18th century or frankly in the 21st century, it's what they tell us about how alcohol provides the means for underlying anxieties and concerns about gender to be articulated.

The last question, the tricky political one, let's come to that last, how should we work with the industry? It's a difficult one; it's a question for scientific researchers, a matter of political perspective. Specifically speaking from around historians, I was talking to someone the other day who wants to do work with brewers to explore some of their activities. So what does engagement mean? I think you have to be careful about that. Obviously, taking money for research is one thing, visiting brewery archives, I don't know, is that a different thing? Sharing conference panels with people from the industry, which bits of the industry, are we talking craft brewers, are we talking Diageo? They're not the same thing, though some people will disagree with that.

I think it does mean that we have to clarify what we mean by engagement. It also means we have to clarify what we mean by the industry. History tells us that the alcohol industry has always been politically powerful, it's always thrown its weight around, it's always blocked policies that challenge it, but it's also enormously diverse, it's enormously localised, it's internally contradictory. David Gutzke actually wrote a very good book on the endless battles within the alcohol industry in the late 19th century in trying to challenge temperance, so in many respects the alcohol industry is completely different to the tobacco industry, another challenging thing to say, but there's no tobacco equivalent of the local pub or the regional brewer or the buying of rounds, sociologically speaking, or toasting or wine receptions. Imagine having a fag reception at the end of the conference, no-one would, so they're different. I do also say – and I'm going to be fairly controversial here – but I do become slightly concerned when phrases like 'industry arguments' are used to challenge internal criticism or dissent. I think just because industry finds an argument useful, doesn't mean it's necessarily untrue or shouldn't be articulated, and again I think from a historical perspective there are examples where that's the case.

So I think history has very interesting examples around the relationship between alcohol control advocacy, the big alcohol industry, the small alcohol industry, the diverse alcohol industry, the diverse alcohol control movement as well, all sorts of very interesting things, and it's not just simply two monolithic blocks who have never met in the middle.

To conclude, I think that history has a critical role to play in alcohol research, but not just as the provider of interesting, but ultimately disposable anecdotes. I think that history, obviously in some ways, can provide really important concrete data, it can provide examples and instances from the past of where things have worked and where things haven't worked, so it's useful in that sense, but I

also think – and this is what I'm focusing on here – that it provides and has a duty to provide challenging critical perspectives on some of the presuppositions or some of the ideas or some of the received wisdoms that we all carry around with us. I think historians need to be like a bit of a gadfly in the Socratic sense, challenging that. I think there are opportunities for cross-disciplinary work, some more obvious than others, and again I think this is useful, but I think it's also just a matter of mutual understanding in some ways. I think sometimes historians, especially cultural and social historians, can be a bit sniffy about social and medical science with their big equations and their dubious assumptions, just as social and medical science can be sniffy about historians with their big words and their dodgy dossiers. I think alcohol research is far and away big enough to fit and it's far and away big enough to need all of the disciplines that it attracts, and as I say, I think history is just one amongst many, I think it is interesting, but I also do think it's very important. Thank you.

Questions and Discussion

Q. In terms of the way that alcohol can show social concerns about women, I wondered if you wanted to say more about that or anything about social concerns about men and constructions of men.

I think where that's coming from is moral panic theory, I suppose, which is that the ostensible source or objects of a social concern is very often not the latent source of concern, but I think in terms of gender, I mean, it's interesting to see how... I think the fact that Gin Lane has become the poster for British drinking in history because what that era tells us about is that there was an enormous concern about urbanisation, there was a concern about expenditure of disposable income, and there was a concern about women, especially I think women who were working in domestic service who had some money to spend, going out and spending that money, and alcohol became a problem in itself. But also a way of expressing that anxiety, and I just think that's true all the way along. There were hundreds of photos taken around 2004 of street scenes of booze Britain. I did some media content analysis of this, and in the first few years of concerns about the Licensing Act, about half the photos were blokes punching each other, being pulled apart by police in high visibility jackets, so that was the other trope, was the guys punching each other, usually with their tops off, and police with high visibility jackets, but that filtered away.

Now, the reason that filtered away wasn't because men stopped punching each other, it was because 'bench girl' captured something else that was going on that wasn't just about the drinking, it was about young women, about sexual risk, about all sorts of stuff. So I think that's where concerns for alcohol are never or very rarely, especially in the popular media, just about alcohol. In terms of men, again that's changed over time, so in Victorian

temperance discourse, their concern was about men as fathers, and there was the whole “daddy come home” trope in temperance discourse, and again that reflected the Victorian culture, the domestic sphere, and the whole idea of alcohol as being a threat to that domestic sphere. In the early 20th century John Greenaway has pointed out that the concern became about men as productive and efficient workers in munitions factories, so you have all these gendered roles, women as mothers, women as domestic carers, men as breadwinners, men as efficient workers, all of which I think shape the way in which alcohol is the constant, concerns are articulated around that.

Q. I agree with you about gender, James, but also age, and I wondered if you had any comments on that.

I think it's been interesting the last few years and it's the way in which, ten years ago, the concern was young people, young women in particular drinking, and now there's a real focus on older and middle aged drinkers, and that's partly because I think the evidence has demonstrated that there's this interesting trend in young people drinking less and that people of a certain generation – not mentioning any names – who were young when young people were drinking a lot carried on drinking in that way, but I'm not sure it's just that, I think it's partly a media interest thing, papers like the Daily Mail really like stories about older drinkers because their readers like reading about themselves, so I think there's that about it. Obviously, if you have a wider set of concerns about how you deal with ageing in society, then again alcohol becomes a hook on which those concerns are articulated, so you get the older drinker.

It was interesting two days ago when a report that we funded on the diversity of drinking cultures was published. It was really interesting for all sorts of stuff like diversities of drinking cultures. There was half a line in our press release about older drinkers' bingeing now and again. The next day the headline in the Daily Mail and the Daily Telegraph was 'Older drinkers bust their weekly limit in one night!' It was to be of those occasions where the journalists simply only wanted that story because that was what their readers were interested in and of course looking back historically, historians are reliant on things like newspaper reports, so we get a very distorted view actually of what's going on. We probably get to see in those cases what the interests of journalists were, which may not in any way align with what's going on more broadly. That probably hasn't answered much of your question about age, but I think you're right, age is a really interesting factor.

Q. My question is around anxieties around class construction as well to do with alcohol consumption, because it seems to me a lot of the visibility around it is to do with people who are at the more vulnerable end of the class spectrum. I'm just wondering if you've got any insight into the more affluent alcohol consumption that seems to be either hidden or portrayed in a very different light. Is that seen as a problem?

So when these things go back to the Gin Craze, for example, there was a very significant advocacy movement around gin legislation, and even at the time there were people writing pamphlets saying, well, it's all very 'well complaining about a poor woman drinking gin when half of parliament is downing three or four bottles of wine or port a day', because it was a six bottle a day man culture back then, there was a real culture of upper class hard drinking, which was seen as...and in fact it was only really in the 19th century you got a different sense of middle class respectability, that middle class respectability replaced an older notion of elite masculinity which was actually being quite a hard drinker. So again I think in all those cases, a) what was happening is a concern about class being expressed by those classes who expressed concern about drinking, but b), that then as now, it's much easier to point at other people and say, 'oh gosh, look at those reckless, feckless people over there, aren't they terrible', because they don't look like I do, they don't drink like I do, and they drink in ways that are a social threat to me for other reasons.

Again I think that's absolutely still the case today if you look at the media representations around binge drinking. I don't think they universally avoid talking about the middle class. I think again of the middle class middle aged drinkers, it's become a thing now, it has become an issue, but I think when you look at the horrifying photos of binge Britain, they're totally bound up with ideas about working class culture, and with ideas about the threat and the irresponsibility of class, so yeah, absolutely, and again I think something you can trace historically. I think it's operated differently historically in different eras, but it's always been an issue.

■ Alcohol and the Sociological Imagination

Dr Thomas Thurnell Read, Senior Lecturer in Sociology, Coventry University

This is the sort of event I've had in mind for quite some time whenever the BSA alcohol study group has got together and met, because for all our sort of focus on sociological approaches to studying alcohol, drunkenness and drinking, which is what I'm going to give a little bit of an insight and an overview to, we've always had the sort of nagging sense that we need to do more. As a discipline, sociologists need to open up and be more interdisciplinary, so hopefully we're doing that today, which is a good thing.

I'm going to start with America and a paper by an American sociologist Selden Bacon. I'm really fascinated because this is a paper from 1943 which sets out many of the things I wanted to speak about today, and it does it many decades ago, so this concerns sociology as a discipline and how it relates to alcohol, what it wants to say about alcohol and what approaches it can bring to our interdisciplinary debates today from a number of years ago. Bacon suggests that the sociologist is interested in the customs of drinking, the relationships between these customs and other customs, the way in which drinking habits are learned, the social controls of this sort of behaviour and those institutions of society through which such issues are controlled. The sociologist wishes to know the social categories in which much or little or no drinking occurs, he seeks correlation of amounts and types of drinking with occupational, marital, nationality, religious and other statuses.

Bacon poses some broad questions:

What are the societal functions served by the drinking of alcoholic beverages? What are the social rubs concerned with drinking? What are the pressures for and against this practice? How does this behaviour pattern jibe with other institutions and folkways?

So apart from the use of jibes and rubs which I find to be rather archaic usages, everything else seems very current to me, and in a paper in '91, another American scholar of intoxication, Harry Levine, described Bacon's agenda setting paper as the 'path not taken'. An important part of Bacon's contribution was to say, we cannot, we should not view alcohol purely as pathological, purely as negative when it's so embedded in our culture and in many of our

rituals and our ways of belonging to each other, which I think has been periodically echoed since, in particular by Mary Douglas in her work.

The other thing I'd say about this that interests me is that the passage I just read doesn't refer to drinks, it doesn't refer to drinkers and it refers to drinking, so from this early time we've got sociology concerned with drinking as a social process, drinking not just by distilling it down to individual drinkers, but seeing drinking as an aspect of society that comes alive when drinks, drinkers and the practice of drinking come together. I'm going to spend a little time offering a few suggestions of what I think is important about sociology and what makes it, maybe not unique, but what it certainly brings to approaches to studying alcohol and drunkenness.

So to use the phrase, 'the sociological imagination', which was coined by an American called C Wright Mills in the late 1950s, and actually to very little effect at the time that he wrote the book, but since then it's captured the imagination of many sociologists in defining what is it that sociology does, sociology should attempt to bring together the biography of the individual people into sects with much larger historical changes. So I see lots of links with what James has already been talking about this morning in terms of understanding that grand sweep of history, and how there's a wider canvas of social, cultural, political and economic changes, but for sociologists we do not want to lose track or lose focus of the individual within this, so sociology should be sensitive to the personal troubles of individuals, and I would add to that particular one when we're discussing alcohol, the personal pleasures of individuals, but ask how does that relate to public issues, how does that intersect and interact with how wider public debates and structural forces change over time?

Another reference I want to make in the formative post-war years of cultural sociology and particularly the sociology of deviants, I think it's really useful to return to the work of interpretivist sociologists such as Howard Becker, who brought together in this volume a number of papers, and one of them was about learning to become a marijuana user, and it was in many ways an intuitive, very sympathetic, I would say, analysis of how one is not just born or innately deviant in one's practices, that forms of deviance have to be labelled so, and different types of deviants are subject to these normative frames, and that different social groups, different elements of society have more powers than others to make those judgements stick to other people. Some people have more or less resistance to being stuck to by labels.

So although Becker is talking about other intoxicants, I do think this is important in the legacies, in the way sociology has approached deviants, and that feeds into contemporary approaches of sociology, looking at the sociology of alcohol and drunkenness. So again we see the importance of social process, the importance of power

relationships, I think is very implicit in Becker's work. The other thing I like about Becker's work is how again we see pleasure, we see an attempt to understand the subjective experiences of the people we are studying, the sort of intricate subjectivities and myth making that goes on. He has a whole section on how once users are sufficiently within that sort of subculture of the outsider, they're likely to refer to each other, they learn from each other and the way that practices and myths that shape those practices are constructed within groupings, so I think we're still working with this, and I think there's a lot we can take from these sorts of studies.

The final key text, I think, from sociology that I like to refer to is Erving Goffman, who's a great American sociologist of group interaction, and particularly a number of ground breaking works explains the rules through which we engage with each other in public. It's not because Goffman talks about alcohol apart from this passage, and this is the passage that I read during my PhD when I started work on researching British stag tourists getting horribly drunk in Eastern European cities. So the passage leapt out at me, because it described exactly what I was seeing during my fieldwork, which was alcohol having a profound transformative effect in a way, that social role and social interactions were being destabilised, flipped, reversed, this idea of disinhibition was there.

So I'd like to use this as a point to reflect on my own entry into academic interest in researching issues to do with alcohol and drunkenness, which was through the PhD. I didn't set out to explore drunkenness, now, that seems a bit foolish considering I was researching stag tourists, I should have expected it, but it wasn't a core defined stated element or the aim of my research at the outset. It became that way, and it became a way for me to explore quite complicated issues. We've already been discussing masculinity this morning, but the main theme that I wanted to look at and studying alcohol and drunkenness allowed me to explore this, was that nature, that influence of alcohol in shaping interactions between friends, so emerging out of that research I wrote papers on the relationship between alcohol and the male body, and particularly looking at the idea that there are changing standards of what it means to be male and to exert and to exhibit masculinity through drinking practices.

In this case I argued that the normative frame that insists that men should drink and retain their bodily composure and show how tough they are by holding their beer has either gone or eased. You can see from the images and the impression is that this is more about a celebration of a looseness of the masculine body, a chaotic loss of control. The research also led me into looking at issues to do with male friendship, camaraderie, celebration, the idea of a stag tour as a modern rite of passage and the ritualistic component, so I was always balancing the urge to define what I saw and explain what I saw in terms of drunkenness and spontaneity and a loss of control, but also at the same

time a lot of this is heavily ritualised. There is a very clear stag party or stag tour script, which is about how the group bond together, and the important role that alcohol plays within that.

So this allowed me to talk about a range of issues, particularly friendship, relaxation, excitement, fun, playfulness, and when I talk later today about the edited book that has just come out, I will say something about how useful I found some of the geographical explanations and the use of space and spatialising our accounts of drinking and drunkenness I found very useful through that.

I think this is, in many ways, typical of a whole number of excellent work from sociologists on the role of alcohol. To study it obliquely, I think many sociologists have done that, and one thing that the BSA study group seems to have approved is that at every one of our events we've had a number of new faces, old friends as well, but lots of people coming to the events who've said a similar story. They never set out to look at alcohol, they were looking at the family or they were looking at sport, they may be looking at a sports society in a university, they had other concerns, so again the study of alcohol comes in tangentially and creeps up on them, which is really fascinating. We do have many sociologists who, from the outset, want to look at alcohol, that's their stated aim, but equally for many others, alcohol allows us to research and to think through and talk about issues to do with gender, social class, the family, friendship, relationships, work, these sorts of things.

So I have a few slides and I'm going to talk about gender again, because as I said, it is one of the main interests in studying critical study of men and masculinity is what led me to my interest in sociology of alcohol, and in a number of papers since then and actually since the stag tourism research, I've been working on real ale and craft beer, and finding quite different trope of masculinity and ways of drinking, styles of drinking, and again this speaks to normative standards of gender that are possibly changing, but also how gender intersects with social class, and I think age and generation is particularly important. Particularly this is a national and local inflexion, this is a rich culture, so I've looked at the imagery in real ale, and I'm not going to mention Farage, he's there, though his embodiment of the man in the pub and his invocation of real ale as a sort of symbol of his supposed honesty and directness as a politician, but more recently the image of the craft beer consuming hipster, I find a particularly interesting iteration of these themes around male drinking bodies. I think of Hugh Campbell's work in New Zealand where he's set out this idea of public masculinity where men prove and test and perform their gender identity within drinking spaces, through what they drink and through how they respond to their drinking.

In my contribution to the edited book that emerged from the BSA study group's conference in 2013, I do discuss this image. I don't have bench girl, but I've got bunny girl,

Top Totty. If we're familiar with the incident, this is a real ale, a beer brewed by the Stafford based brewery, Slaters, and it's called Top Totty, and the brewery describes it as 'a stunning blond beer, full bodied with a voluptuous hop aroma'. In February 2012, the shadow Equalities Minister, Kate Green, expressed concern during Prime Minister's Question Time, that this product which features very regressive, sexist, dated imagery so clearly in its branding should be being served on sale in the Houses of Parliament bar. There are two alternatives, one is that it ran out because they had a 72 pint cask and it finished and it wasn't replaced. The other account is that it was 'banned'. Slaters immediately saw a huge increase in sales. They said their phone was ringing off the hook, and this image is of a poster produced by the brewery itself and I've seen these in pubs around my home city at the time, which for me, plays on all sorts of a much wider social and cultural ideas about not just gender, but particularly power and generation, that tends to appear in local pubs that are clinging onto a very gender segregated drinking space.

So again, it's interesting, James referred to alcohol as a constant, and I find alcohol quite interesting because perhaps it is alcohol's presence in British society that can remain a focus and that we can track through changes in terms of gender and in regards to other social divisions. This is another case, I draw on another paper, and this is one of, over the years, numerous attempts by the industry, to launch a female friendly beer, and there's a lot of critical work we can do in unpacking that. I don't particularly have the time to go into great detail, but as you see, Animee is a beer, launched by the Canadian firm Molson Coors in 2011 with a two million pound marketing drive, and one of the beers was pink in colour. Part of this drive was to give out samples through the Toni and Guy hairdresser chain, so deeply derivative, lamentable, in fact, attempt to persuade women that they should be drinking beer. I like the beer writer Melissa Cole who responded to this, saying in fact that it's not the women that are the problem, it's the masculine sexist nature of a lot of beer culture in this country, particularly that is led by the industry.

For another example, seeing as we're in Scotland, the top picture is the Tennents 'lager lovelies', which was a seventies and eighties, I believe, long series. They're very collectable now amongst beer can collecting aficionados, but this is a whole series, a multiple series of lager cans which featured images of Scottish women modelling in provocative poses, so again I think we see the use of taking this wider social cultural frame when we look at alcohol and actually trying to make our approaches speak to all sorts of social issues, rather than just narrow down into focusing on particular problematic users.

I'm not going to go through question by question, but I do have some reflections and I was hoping that today for all of us would be a chance to be quite candid about our own disciplines, maybe, so my last few points relate to what can the sociology of alcohol do, what can it do

better, and I think as I mapped out this attempt to locate the individual subjective qualitative experience within wider structural forces means we sometimes can miss out the middle, and I don't have too much to say at the moment about the industry and how we engage with the drinks industry apart from, as James said, I don't think we should see it as monolithic. In some of my research I've interviewed craft brewers of various sizes of business as well as the Campaign for Real Ale, I think there's a huge range of intermediaries and it's not just us versus the industry. I think that's the wrong way to explore it, and I think there are ways in which we can collaborate, because we have many similar interests, and in fact speaking to my interviews with microbrewers, many of them had very nuanced, very developed conceptions and self-images of themselves as promoting a respectable drinking culture, about quality over quantity, about locating drinking within the local pub, the local environment, involving brewery initiatives to reach out to local charities and things like this.

So through those interviews I had lots of accounts of how brewers saw or envisaged their customers as not your average lager lout, not your average student, shambolic drinker, they invoked those sorts of tropes directly from the media in a lot of cases. I do think sociology has a lot of similarities, and I hope that will be borne out today. I mean, two papers down, we both mentioned gender and social class, and particularly how those issues are contested. I think we do have those similarities. I think we come regardless of our disciplines and professional loyalties, we can't pick up newspapers, we can't see the debates that dominate public discourses without wanting to chip away at that in some respect. I think we are moving in a direction where we're not just focusing on an apocryphal young, dangerous, deviant drinker anymore. I think that the last few years in particular from research and in public domain is starting to widen out to take more into account. There's still a lot more we could do, however.

I actually think a lot of the divisions stopping us being as interdisciplinary as we might want to be are quite pragmatic. I think a lot of things like departmental structures and funding bodies play a part in this. It is very difficult to put together an interdisciplinary team successfully for research funding, but also the journals we read, the research we refer to, it's interesting. Twitter gets mentioned several times today already, and I do think Twitter's something useful in that it takes us out of our disciplinary boundaries when you look at the social academics using social media, we rarely corral ourselves into just one discipline and communicate only with other sociologists or only with other historians. I think the tendency is to lead ourselves thematically, we seek out people and it's been a very good way to open up to interdisciplinary dialogue in that way.

I think I wanted to end with something pragmatic and suggest something that might be useful. I mean, obviously I think we do, but today is about this, we need to talk to

each other and to share our research, share our interests and concerns, share our theories, in a way, because the theoretical frames that different disciplines use are very useful, but depending on what we read as students, as doctoral students, maybe, as we found our way into research, we can be exposed to totally different canons of knowledge which can be very useful, so we need to be interdisciplinary in that sense. So I'm thinking about something like this, and the model I'm taking is the men's bibliography, and this comes from my interest in masculinity, as I made clear, sociology of masculinity. This is a vast online bibliography managed by a masculinity scholar, Michael Flood, who's based in Australia.

We shouldn't be too intimidated, because this is in its 19th edition, it hasn't been updated in a few years, but this brings together all sorts of resources, not by discipline, and I think that's really important, but by particular concerns that we have, particular areas, and I think this could be potentially a model for something very useful that could begin to bridge disciplinary boundaries between all the disciplines who are going to be represented here today, so I'm not volunteering myself for this – I am – but I'd like to work towards some sort of platform for this and find a way, because like myself when I started my PhD and felt my way into the study, the critical research and study of alcohol, I think a resource like this would be excellent, and just to circle back to my first comment about Selden Bacon's 1943 paper, maybe I wouldn't, with this sort of stuff, I wouldn't be able to work in this area for a number of years and not know about that paper, it would be nice to bring it altogether as a resource to share and to foster collaborative interdisciplinary dialogue, so I'll just finish there.

Questions and Discussion

Q. A lot of the examples you drew on, including your own work, the emphasis is on drinking in public spaces, which I guess, if you're interested in social relationships, that's drinking at its most social, but it made me think of something that's common to possibly the history work as well, and contemporary public health work, which is, the emphasis is on public drinking, although that may not be where from a public health point of view the greatest harms are. I'm guessing that there's more historical sources relating to public drinking, I'm guessing that there's probably more sociology and it's easier to do sociology in public drinking, and from my perspective, I find it easier to do work on public drinking, it's just the line of least resistance to get you there. So my question is about...specifically sociology, I mean, is there work done on home drinking, private drinking, do you think that's an area that needs to be developed?

Yeah, I think it's an area that's coming through. I've said in a number of things I've published recently, that sociologists in particular have been too easily drawn towards the noisy,

loud, visible public manifestations of drinking, and through some of the work on real ale, I've been looking at the particularly quieter drinking spaces, and some of that does edge into home drinking as well. I was reading the free newspaper on the way in from the airport this morning, and there was about three separate adverts for mail order beer, craft beer businesses that you sign up for and they send you bottles of beer each week with tasting notes and things like this, specifically to drink at home, so I think it's certainly an area to explore more.

Home drinking is difficult to get at methodologically in the same way that public drinking lends itself to participant observation to visual methods, sensory methods and effect really interesting lines of enquiry, that's coming from geography a lot more than sociology, but there's been some really nice productive overlaps between the two, I think. We need to think creatively about the way that we can get at home drinking or private drinking or solitary drinking and not lose the vividness that the public drinking research gives us, because the tendency is when we do a qualitative interview or we do a survey, it's difficult to get into people's homes, for sure. Good comment, thank you.

Q. I thought that was a really, really interesting range of literature that you've drawn on in that talk. Something I wondered about is from an outside the UK perspective, a lot of other countries tend to have a quantitative focus in sociology, and the UK seems to be heading a bit more in that direction, so I wondered what you made of that development, and if there was any particular opportunities that a move towards, or an inclusion of quantitative sociology might bring?

I think that's a very valid observation. British sociology is famously qualitative, almost exclusively qualitative, actually, despite recent attempts to broaden the provision and skills set of British sociologists, we're just not learning numbers, unfortunately, en masse. I think that multi methods can bring a lot to the table. I think quants are important. I'm not sure, I'm a committed qualitative sociologist, I'm not sure what to respond to that. I think there's definitely a need for that. Possibly reflects my comment about journals, that certainly the research that I do would not be published in quite a lot of journals precisely because it's small scale micro sociology qualitative methods, participant observation, and maybe some reflections are needed of how we keep methodological boundaries as well as theoretical boundaries, how we move beyond them.

■ Nursing: Viewing the world from a different place through a different prism

Dr Aisha Holloway, Senior Lecturer/Clinical Academic Research Fellow, The University of Edinburgh

When Carol asked me to speak I said, that sounds great, that's a wonderful idea, and then she followed it up with, can you come and talk about nursing, and I thought, well, yes, I can talk about nursing, but for this type of audience I wasn't sure. I know there are maybe one or two nurses in the audience, and I was thinking actually, a couple of my colleagues would probably be much better versed to speak about this subject than me as a quantitative researcher interested in randomised controlled trials.

However, here I am, and I've been doing a bit of thinking about this. Usually when I speak to nurses I feel quite comfortable, so I'm a little bit out of my comfort zone, but that's been really good, and I've learned a few things along the way that hopefully I can share with you. So when I was thinking about talking today, what I felt would be useful and hopefully you'll feel the same, perhaps when you looked at the agenda you weren't expecting to see nursing up there, but I thought it was important to try and understand where nursing has come from as a profession, and the context within which it sits and has moved along over the last few hundred years, because I think that very much affects and impacts on how we engage with patients, clients, service users, whatever you want to call them, particularly in the field of alcohol related harm.

So I did a bit of digging, and this is a textbook that everyone in nursing apparently should have read, but I had never read until this last couple of weeks. Anne Marie Rafferty is a nurse, academic, and in the nursing profession is probably one of our leading academic nurses. She was a professor of Nursing policy, she led Gordon Brown's review of nurse education, is currently Dean of the Florence Nightingale School and she wrote this book while she was studying for her PhD in modern history at Oxford University, after she had qualified as a nurse, the first nurse to gain a PhD from Oxford University. It's an introduction to the social history of nursing, published in 1988, and I found this little nugget on the second last page, and what it says is the state of nursing is an early indicator

of more profound social change, and actually as a nurse, I think that's probably very true. We are very intimately involved with people who have alcohol related harm in a way that perhaps some of you haven't been able to get that close to, and I guess nursing itself is a profession that is very susceptible to social movement and what's going on socially, and probably never more so now.

I'm going to spend a little bit of time just talking about the healthcare system and where nursing came into that system, and I'm starting actually by talking about doctors. So in about 1800 we had no legal definition of a doctor and certainly not a nurse. The Royal College of Physicians and Surgeons were licensed to be suppliers of medical treatment, and unless you were very well off, you wouldn't even be able to have a full time career out of it, and I thought what was really interesting – and here we see the first mention of women – for those in the lower classes care was provided often by families and by women, and that's where we first see where nursing as we know it today, evolved from. Another quote I thought was very interesting, and hopefully not many of you have had to engage with hospitals in recent years, but those of you who have, back in 1788 this is what you would have been expected to bring with you – “a change of body linen, stockings, a neck cloth, stocking handkerchief, and to pay the sister, two shillings and nine pence for two towels, a tin pot, a knife, a spoon, an earthen plate and five pairs of sheets, so perhaps the NHS isn't too bad after all”.

So on the backdrop of that we see the notion of nursing threaded-through a number of roles. The domestic nurse, the handywoman and the private nurse, none of these were professions, none of these regulated, but were roles that women were doing, and in those days anyone was calling themselves a nurse. The boundaries between nursing as we know it and domestic service are quite obscure as the role developed over the years. Then we start to see the emergence of some social control and regulation of health, and it resonates with what we've heard this morning and some moral reconstruction around why people were unhealthy and the things that they were doing and the behaviours that they were taking part in, some of them drunkenness, and this attempt for us to stop that and make them healthy. The model of the sisterhood played an important part in the construction of nursing. It was felt that women of a certain class had something to offer these poor people who were drunken and disorderly, or who were suffering the consequences of a number of health behaviours, and the feeling at the time was that people who could be exposed to these women of a certain class would actually learn a thing or two, to be good citizens and how to behave, and how not to participate in bad behaviours, as it was thought of, to maintain their health.

Along with that came that element of moral judgement, which actually I think is still very relevant today in nursing, and also brought with it some idea there had to be a moral character, an element of high moral values with those

who went into the nursing profession, and again that still sits with us to this day. I still am a registered nurse and that means that 24 hours a day I have a responsibility to the regulatory body in the way that I behave. Outside of any healthcare setting I can be held accountable and taken to the Nursing Midwifery Council and be asked to explain my behaviour. Nursing back in those days probably offered some women and carers a stable and respectable alternative to domestic employment, so it was a way for women, who were perhaps unable to have any other profession, whether that be because of social class, to have something that was better or viewed better than domestic service, so hopefully you can get a sense now of where nursing came from. I'm going to jump a little bit forward now that you have the backdrop. In 1923 we then had the first official register for nurses, so that meant that those people who called themselves nurses were able to be on the register and had to have a core set of competencies or a practice that was recognised to a specific standard, and we still have that to this day with the Nursing Midwifery Council.

As nursing tried to find its feet, it did so in the context of a large focus on the biomedical model, and maybe that links back to the conversation earlier a little bit about addiction and about behaviour, and how we treat this as a medical issue, rather than consider it within the social context within which the individual is consuming alcohol, the nursing perspective. The nursing process and perspective was developed and conceptualised by nurse academics and has grown as we have moved towards an all graduate profession. In the last year or two, maybe some of you have seen this idea debated within the media and the profession itself. To be caring you don't need to have a degree or any type of intellect, and we don't need to go into it, but, that's come against some issues in nursing itself.

So the focus on the medical model I think has historically been a problem for nursing and probably hindered its development within health care. But then in the sixties we had the emergence of our own theories of nursing linked to models of nursing as an approach to patient care, largely dominated by American nurses Dorothea Orem and Calista Roy. Many, many great nurses engaged with this work and who also came up with their own analysis and critique of how we engage and respond to patients, and at that time there was also acknowledgement of the biopsychosocial model of nursing, so that we move from this medical model. We started to conceptualise the many facets of an individual's being and how we could engage with them and interact. Still there's always been this tension that exists between a profession that is often very skills and competency based, and a profession that does want to engage with the theoretical underpinnings of health behaviours and our own part in that relationship.

Alongside that we've had challenges around whether we're considered a 'profession' or not, and also in relation

to generalist and specialist nurses. This is particularly relevant when responding to alcohol related harm, as the evidence suggests we see a number of generalist nurses seeing alcohol related harm as a chronic condition that requires very specialist nursing, and actually now, as we're moving more towards a public health approach, we need generalist nurses who can engage and respond at all levels particularly to harmful and hazardous consumption, not just within that very specialist role for those who have dependence. Alongside the clinical academic tensions that we have, generally you find nurses either remain in clinical practice or move to academia, and that role of them working together is very difficult currently because of career structure.

So contemporary nursing, why are we relevant? We're the largest group of health professionals. There are approximately six hundred thousand registered nurses within the UK, we work in many sectors, and we engage with people in every single setting. We have a very privileged position. I can't think of any other profession outside medicine that has the type of engagement and intimacy that nurses do with patients. From the House of Lords to A and E, we're everywhere, but perhaps people haven't viewed us, particularly within the academic world, as having something to contribute. The nature of nursing means that it occurs within the social landscape, which means that we're ideally placed to deliver patient centred care, but also to observe and try and understand, and often perhaps we don't do that as clinicians, just because of workload and time. However, as academics, there's an opportunity to do that from a sociologist perspective.

I think we are very well placed to offer some insight, and I guess for the community nurse, Macpherson suggests that a sociological understanding is vital for nurses, and I went back to the literature just this week, and there actually is quite an active debate about sociology and nursing and where that lies and how the two come together. For nurses during their educational training, they need to really experience more in the curriculum around the relevance of the sociological perspective in nursing and engage more with the topic area. So that's gives you a bit of an insight, when you think about a nurse it's maybe not what you've seen on a Saturday night on Casualty, that actually as a profession we've had a very long and often tortuous journey to be where we are today. So what can the nursing profession add? I've felt a little bit nervous about standing up here representing my profession as one nurse, and within nursing there are many different types of nurses with many different roles, so I don't feel that I can talk for the whole profession, so I thought I could just talk about myself.

I thought this was a bit of an advert, because I thought you must always be networking, so if I come to this event and anybody thinks, oh, I need to work with a nurse, these are my credentials, and actually I put this up because I know there's a few nurses here, and probably this is maybe, I

would say, a typical CV of an academic, perhaps, a nurse academic. So you do a degree in nursing, you have a bit of clinical experience, you do your doctoral study, note cluster randomised controlled trial, and then you do this long period in higher education doing research etcetera.

So here we are now in 2016, I'm still a registered general nurse, but I'm a little bit older and I've been doing alcohol research for quite some years, and I'm now starting to work with other disciplines, and that's what I want to talk a little bit about next. I think about two years ago I had this idea about how we needed to really try and understand what was going on in the lives of people where alcohol had impacted on them and give them a voice. I'd heard Niamh speak at work – because we're both at the same university – I sent her an email and said, could we work together on this idea, and she was really lovely and said, I'm really busy, but yes, I can. She had no idea who I was.

I also roped in some colleagues from ESALA, which is the Edinburgh School of Architecture and Landscape Architecture, because I was very much interested in environment in relation to recovery. So we worked with a number of other colleagues, and I think this is one of the benefits of nursing, we are able and used to engaging with many external stakeholders that I think have got a contribution to make to research. This is the group that we worked with alongside a group of people in recovery from alcohol, and I know some of you have previously heard the findings from this work, and in fact we did a lot of the work in collaboration with SHAAP, but we were really interested in exploring the lives of those in recovery, not in the usual way through surveys or through trials or interventions, did they work, didn't they work. We wanted to focus on what did it feel like to walk in the shoes of these people, and we used a methodology, an innovative methodology called PhotoVoice, where we gave them cameras and provided an accompanying narrative around what they took photographs of in their life, and we were particularly interested in alcohol outlet density and the environment in general.

We spent about nine months establishing a relationship with these individuals, and that came about mostly because we were nurses who were doing the research. We were able to have legitimacy; the people could relate to us, they were able to see what our contribution was. I think they felt safe talking to us and being involved in this. This was something that was very difficult I think initially for them to understand, how they could tell us their story. It can often be quite difficult for people to look back on the very challenging and difficult experiences they've had with alcohol in their lives. "After coming out of recovery treatment I was sent back to my old flat, and this was difficult because that was where my dealer lived and my old alcoholic neighbour who was also a drinking pal lived. It was a horrible place and I felt hopeless there", and the one at the bottom, "life after alcohol can be isolating and lonely. Support is to be found in familiar places, in order

and routine, and most importantly in learning to reconnect with the world".

So that's only a snippet of some of the data that we were able to pull out of the analysis. One of the reasons for using PhotoVoice was to ensure that the participant's voice was heard, and we engaged in a process of framing and persuasion when disseminating the results. The art gave us an opportunity to portray meaningful stories alongside the accounts of these people, so rather than going out there with evidence that is often in a format that's difficult for policymakers to engage with, we went with something that we felt could touch them, in a way. Our work was discussed at Parliament by the Minister for Public Health and various MSPs following a parliamentary event, and we also engaged with the First Minister, at the parliamentary event, around this particular study. So reflections, I think it's not about parity; it's about the perspective as a nursing profession that we can bring. It's about the way nurses think and see, and maybe we have some sociological imagination. It's about engagement with diverse stakeholders. We craft pragmatic innovative solutions and we view the world from a different place through a different prism.

Thank you. So I guess just to finish, that was some of the people who took part in the project, and it was a complete privilege, and it made me wonder why I'd been spending so long doing randomised controlled trials, but I just want to leave you with this final quote about the privilege of nursing, and in my favourite book, *To Kill a Mockingbird* – "you never really understand a person until you consider things from his point of view, until you climb into his skin and walk around in it" – and I think that's what we as nurses have the privilege of doing. Thank you.

Questions and Discussion

Q. I've got one point to make and one question. One is that when SHAAP was being formed, we had a public policy adviser who advised, saying, doctors and nurses have a profile out in the world that you're crazy not to use. If you're going to go out, use the press, then the way in which the public view these professions is very important if you're going to do some campaigning, so all this stuck in my mind, I think you probably turned out to be right about that. I guess my question to you, and you use a nice phrase about nurses as action orientated, there's also a dynamic in there about nurses being good at spotting nonsense, that's a lot of rubbish, that'll never work with the punters, and that is, I think, definitely a dimension that nursing has brought to both clinical work and, to an extent, with advocacy work, so there's, I don't know if you'd describe as cynicism, but there's certainly a critical faculty in there that comes from the nursing profession that I think's a valuable one, but it's, I think, a distinctive one for nursing, and I

just wondered first of all if you think I'm right in that, and if you've got any observations about that.

Yes, I agree, I guess when I'm standing up there talking about the nursing profession there are many dimensions and aspects that we could focus on, and a lot of them not good, as probably the audience realise from public media and things that have happened recently. I think it's a good thing and a bad thing. It can be detrimental to our profession, and there's reasons for that, historically and socially, because of where we've come from and where we feel we need to be, but I think there is a lot in the fact that when a nurse, generally aside from they're just trying to be obstructive, which they can be, about them saying, actually, that's not going to work, or that's not the reality when I'm out there, and likewise with policymakers when they're rolling out ideas or policymaking initiatives, the nurse on the ground who is engaging with people with these issues and challenges, usually is a very good gauge of what's going to work and what's not going to work, so I think often we're not very good at perhaps presenting a narrative of what we can bring to the table.

I think we're still trying to work that out, and it's not about parity, it's not about being there because the medics are there or the sociologists are there, it's about what is the perspective we can bring, how many people in this room can say, do you know what, I've been at the side of someone that is not my relative, is a complete stranger until maybe 24 hours ago, but I'm holding their hand, I'm being there with them, and I'm providing them care, dignity and support. That's a very strong place to be in with an individual, and the majority of the time, people with these type of problems – and I don't like that word problems – often that's what they need. They need respect, they need dignity, they need the basic human feelings and rights that we have as individuals, and that often have been taken away from them because of the stigma of alcohol or because of the experiences they've had. So yes, nurses can be like that, but often I think it's useful.

Q. I'm an ex-nurse as well. I used to be a mental health nurse myself, so this is a nursing comment. Thank you first of all, Aisha, for having nursing up there and doing us such a service, bless you for your work and all that you do in all your interdisciplinary and multi-method base. I'm quoting Catriona Mathieson's work around working with drug users and the sort of stigma that's encountered by people who either take drugs or alcohol or have other kinds of substance problem, when they say that nurses, doctors and service professionals across the board can be as stigmatising and problematic to encounter as any person on the street. So I'm seeing that and what you've said today, and knowing how much you have to do still, and as an educator of nurses, mental health and adult nurses, on any given day at the University of Stirling, wherever I might be, because I also work with postgraduates across Scotland, we constantly still have a challenge

to persuade nurses across their careers, early nurses and those that have been in the profession for a long time, of the need to work human to human, and in your last quote, to get into the skin and walk around in it, because that is a choice that we all might need to make on a day to day basis, whether we're passing someone begging in the street and how we respond to that, to how we deal with our colleagues or our nursing students. So I suppose it's a little bit of a plea that we remain conscious and mindful of every single opportunity we have as citizens and as educators, whatever we do as educators and researchers, to really do what you're advising us to do, and there's no complacency. When I do a lecture around stigma and discrimination and how we deal better with that as nurses, the students tell me stories of being discriminatory themselves to patients as potential drug users because they're in A and E in pain, and they have so many stories like that, where the only person really that's listening is family and friends. Those are the students' experiences, so there really is no room for our complacency in this field, but thank you for all that you do and for everybody's work in this area today.

Yes, I completely and utterly agree with you. I guess today was maybe about our potential, but the reality is, as you say, there are many nurses, and it saddens me to say that some behave terribly towards people who are experiencing alcohol related harm, drug misuse, and yes, I've heard similar stories from students, and it's an interesting phenomenon, the emotional labour of nursing and why that is, and often where that is in nursing, because I think it's something we need to explore further, certainly, and we're only getting into that now, I think, that discussion, but I wonder if it's more obvious in the specialist areas or not, and I think anecdotally in the specialist areas, it's not. I would think that there's less of that, I wonder if it's more in the generalist settings, particularly places like A and E where you do, you hear it all the time, 70 per cent of people coming in at the weekend are in there either primarily or secondarily because alcohol is in the mix somewhere, and you hear it and the nurses are just like, this is just a waste of my time thing. Why is that? What's going on there? Likewise in other settings, I think there's definitely a need for us to explore that further so that we can reach the potential that we have.

Q. A theme seems to have been about the evolution of concepts of alcohol problems to a sort of biopsychosocial model, and I wonder from some personal experiences and general understanding of the way the nursing profession has evolved, where the act of caring and particularly in generalist settings, has been separated out of the nursing profession, so it tends to be nursing assistants and others that sort of do the more basic caring tasks, and the nurses, qualified nurses, tend to do the bio bits, the professionalization of nursing, I think maybe focuses on the physical

manifestations of the problem, and I wonder what that means for how we view alcohol problems, or how the nursing profession views alcohol problems. Is that act of caring undervalued as if we're saying that alcohol problems are holistic and biopsychosocial, but yet we professionalise the bits that only focus on the bio, and I just wonder if you've got a comment on that split between the role of nursing assistant and nurses.

I agree, and now more so than ever, nursing is going through a really very professionally challenging time at the moment. We're now discussing nursing associates, and I guess as a profession we are very worried about the role being taken away from us that we joined nursing to do. That's not something nurses want to do, it's something that's being imposed on us.

■ Epidemiology and alcohol research

Dr John Holmes, Sheffield Alcohol Research Group, University of Sheffield

Thank you to Carol and Eric for inviting me to speak today on behalf of epidemiology. I should say that I'm not an epidemiologist in the traditional sense. However, as you'll see, epidemiology is a very broad discipline with quite blurry edges, and I sit somewhere on those edges where they meet with various other disciplines. Okay, so I'll start by asking, what is epidemiology, and this is from Wikipedia, because I'm not an epidemiologist and I don't have a big pile of epidemiology textbooks to go and get a quote from, so epidemiology is the study of the analysis of patterns, causes and effects of health and disease in defined populations. It's a cornerstone of public health and shapes policy decisions and evidence based practice by identifying risk factors for disease and targets for preventative healthcare.

So I think Wikipedia's done quite well there, actually, it's a nice definition. For those outside the health sciences, their most frequent encounter with epidemiology will be through the newspapers, and I should make clear that not all these headlines are epidemiology stories. Epidemiologists have shown that you can protect against diabetes with yoghurt, sunlight, walking, coffee and eggs, and somewhere out in the internet there's probably a reverse collage of all the things that epidemiologists have shown to cause diabetes in one study or another. A key contribution of epidemiology to society is an understanding of the risk factors which cause positive and negative outcomes, and an estimate of the degree of risk associated with different levels of exposure to those risk factors, and usually the focus of these risk relationships is health outcomes, but the same approach and methods have been used in other disciplines, particularly the social sciences, to study social outcomes such as child development and educational achievement. Epidemiology isn't just estimating risks though, there's a huge amount of valuable descriptive epidemiology done as well, which examines trends in risk factors such as alcohol consumption, smoking and dietary behaviour, and that includes both trends over time and trends across groups within the population. For example we know that alcohol consumption has dropped markedly over the last ten years, so we see trends over time, but at the same time we've seen that young people are no longer the heaviest drinkers in society, so if you see here, male average weekly alcohol consumption in 2006, and you can

see that the young males, the 18 to 24 year olds were the heaviest drinkers in 2006. By 2012, the heaviest drinkers are the 55 to 64 year olds, so we have trends across time, trends across the population.

Less relevant to today's conversation, but important to mention, is that epidemiology also plays an important role in infectious disease research, so it's used to examine the origins and progression of disease outbreaks such as the Ebola outbreak in Africa and closer to home, the outbreaks of things like MRSA on hospital wards and how they move across wards. Okay, so far I've talked about contributions that are specific to epidemiology, but epidemiologists are usually found within health science departments, and those contain a range of overlapping disciplines, including public health, health psychology, medical sociology, health economics and health services research, and as an aside you'll notice that most of those things are disciplines you can't do at undergraduate level in most universities, which means that people come into the health sciences from quite a range of backgrounds, very few of them medical backgrounds, so you actually end up in a very interdisciplinary working environment right from the outset, albeit quite a quantitative biased one.

I'll give you an example of this. The Sheffield alcohol policy model obviously has epidemiology at its core, this is the only graph of the Sheffield alcohol policy model I'm going to show you, but the first part of it, when we look at the impact of minimum pricing on prices and what happens with consumption, is based on public health research, economics and a little bit of psychology. We then look at the impacts of those consumption changes on rates of alcohol related harm, and that's core epidemiology, and we then look at the impact of changes in rates of harm on the cost of the health service and to individuals in terms of quality of life changes, and that's health economics. So epidemiology is right at the centre of these big interdisciplinary collaborations that are increasingly common within the health sciences. Let's get a little bit more specific now and say, what does epidemiology contribute to alcohol research? Well, first and foremost it tells us about the risks of drinking, and depending on how you count them, there are up to 200 health conditions which have shown to be causally associated with alcohol.

Epidemiological studies provide some of the key evidence for those causal relationships, and this often comes in the form of these dose response relationships. Relationships might be linear as in the case of colorectal cancer, they might be curvilinear, as in the case of oral and pharyngeal cancer, so the risks increase at a much higher rate at higher levels of consumption, and perhaps most controversially, there's sometimes J shaped curves, where at low levels of consumption, the risk of drinking is less than the risk of not drinking, and then it exceeds the risk of abstaining at higher levels of consumption. Heart disease is obviously the most famous version of this J curve, but you see it for other cardiovascular diseases as well, and

also for type two diabetes and one or two other conditions. I'll come back to protective effects of moderate drinking later in my presentation, but for just now we'll say that they're disputed.

Epidemiology can also tell us about how drinking differs between drinkers, how it changes over time and who experiences the harms from drinking, and I'll focus on that latter point, who experiences harm from drinking, because obviously other disciplines look at trends and patterns in drinking. A key contribution of epidemiology to alcohol research has been to show evidence on the alcohol harm paradox, that while alcohol consumption is lower in lower socioeconomic groups, rates of alcohol related harm tend to be higher in those groups. Now, this is quite an old graph, but it does make this point nicely, so it looks at rates of alcohol related mortality in England and Wales by socioeconomic group and by age, and you can see the two lines that are going away at the top with the highest rates of harm are the lowest socioeconomic groups, and those gaps obviously get bigger with age, as more people are dying from everything, actually. The point here being there isn't actually much of a trend in alcohol consumption in the UK.

If anything, the lower socioeconomic groups are drinking less, despite that, you're seeing much higher rates of mortality from alcohol in those lower socioeconomic groups, and we don't really have a very good understanding of why that happens, so this is an earlier limitation of epidemiology, it's not necessarily very good at explaining some of the relationships it sees. Mark Bellis led a project recently, an Alcohol Research UK study, and pointed to a greater propensity of drinkers living in poorer areas, to have an overall poor health profile, so they often did other unhealthy behaviours as well, they smoked, they had poor diets, they had a lack of exercise, they had high body mass indexes. They had a broader profile of poor health behaviours which meant if they were heavy drinkers, they were more vulnerable to the effects of alcohol than better off heavy drinkers. However, there's a lot more work to be done on this, and we don't really understand the alcohol harm paradox at the moment.

Epidemiologists also help us to put a number on how much harm alcohol actually causes, and in a sense this is a second order epidemiology which takes the estimates of risk and the patterns of behaviour and the patterns of harm and says, okay, if heart disease and cancer and hundreds of other conditions are caused by lots of different things like yoghurt and walking and sunlight, what proportion of it, how much actual harm is caused by alcohol? This is essentially the question that the global burden of disease study tries to answer, and you can see some of the results they've found here. So this is a list of major risk factors for the global burden of disease, and the proportion of disability adjusted life years, essentially the amount of unhealthy lifetime we have, which is attributable to those, and you can see that alcohol is the fifth leading cause

of disability adjusted life years globally, and you can see that the harm that it causes is split across lots of different things, across violence, injury, cardiovascular disease, cancer and of course liver disease.

Compare that with tobacco which is second in the list, tobacco actually doesn't cause that many harms, it just causes a lot of those harms. It tends to be focused on cancer and of course cardiovascular disease again. It's the one thing that's unusual about alcohol is just the sheer range of things it affects, pretty much everything from where it goes into your mouth to where it comes out the other end, is harmed by alcohol, and the global burden of disease helps us to put a number on that level of harm. So epidemiology also helps us to answer policy questions. The new UK lower risk drinking guidelines lean heavily on epidemiological modelling which we undertook at the University of Sheffield, and the question we were asked to answer was, what levels of alcohol consumption correspond to particular definitions of lower risk drinking, and the definitions in question – there was two definitions – one was a level of alcohol consumption where if everyone drank on that level, the overall population risk would be the same as if everyone abstained, and the second definition of low risk drinking was if everyone drank at this level, one per cent of deaths would be due to alcohol, one per cent of all deaths would be due to alcohol.

You can see the results for that second definition here, and we split them depending on whether everyone drinks daily or whether they split their alcohol across a fewer number of days. If everyone drinks daily and if everyone drank 14 units, one per cent of deaths would be due to alcohol. If everyone drank all their units in a single day and they drank six units, then one per cent of deaths again would be due to alcohol, and that's because if you drink all your units in a single day, you have a much higher risk of acute harms, whereas if you spread them out, you don't. This is essentially the basis of the new drinking guidelines. They came up with a number of 14 units based on lots of graphs like this, so it answers very direct policy questions sometimes.

Okay, finally epidemiology is also increasingly using genetic data under the banner of epigenetics, and this is not really an area I'm qualified to speak about, if anyone's seen epigenetic studies, they tend to really hurt your head, and that's even before you get to the end of the author list, which tends to be about 80 people long. What it does tell us is that we need a much more sophisticated understanding of concepts of nature versus nurture. Looking at those concepts of nature and nurture in isolation based on the results from epigenetic studies, what we're seeing so far is they are becoming increasingly untenable.

So what expertise does epidemiology bring to alcohol research? I'll cover this fairly briefly. Epidemiology traditionally of course is rooted in the strong and robust

application of statistical methods. That said, I learned fairly quickly after joining the University of Sheffield Health Science Department that statistical skill is very much on a continuum, ranging from the kinds of graphs and tables you see in the newspapers through the kinds of T tests and regressions you get taught on the social science degree I did, through to the regressions that are a bit more sophisticated, but epidemiologists do, through to the simulation modelling and Markov chains and all sorts of other fancy things the people who hide out in the darker corners of health science departments do.

So the point being, yes, epidemiologists bring strong statistical skills to alcohol research, but they're on a continuum, and you can always do more with your data if you find the right specialist to ask. A key strength of epidemiology is also having all the best data sets or best quantitative data sets at least, and of particularly value are the cohort and panel studies which follow people for years and decades, in some cases. The first UK cohort study, which I think was the first major cohort study in the world, actually, began in 1946, and has just celebrated its 70th year of following these people right through their lives from birth and surveying them at multiple times points, and these data sets tend to be fantastic in terms of the breadth of measure you get from everything from social, health concepts, family concepts, all sorts of other things, with alcohol alongside them. They tend to be less good in terms of depth, so unfortunately in most of the UK cohort studies, the alcohol measures are pretty weak.

That said, the modern cohort studies, in particular, but also Bio Bank is putting in some good stuff as well, they have much more detail, and they're also bringing in genetic detail as well, so these are going to be fantastic resources going forward. Finally epidemiologists come with lots of systematic reviewing skills, so they know about how to take a very, very large literature, search it, select studies in a rigorous and robust fashion and then synthesise the data from them. They tend to have these mathematical modelling skills, increasingly it's becoming a much more common feature of epidemiological research to bring in a whole range of different approaches, and also it's worth mentioning, and it's not really been talked about today, but there's a huge amount of subject knowledge, so when we work in interdisciplinary projects, it's not just the methodological skills, it's not just the concepts we bring, it's just the background knowledge of these things. In epidemiology's case, they know about health conditions, they know about the relative importance of them and the costs and the importance of them from a societal and political perspective, and that subject knowledge matters.

I'm going to finish by talking about – and we've talked about this a little bit – what does epidemiology not do well? I said at the start I'm not an epidemiologist, but I did discuss this talk with Annie Britton a while back. This was shortly after I'd called epidemiology quite old-fashioned, so she was already on my back, but one thing she said to

me was not to be too hard on epidemiology, so I've tried to be nice and said how good it is, and now I'm going to say all the things I think are wrong with it, and I want to point out four things that epidemiology does not do well. I'm going to pick up on something James said earlier about history not having the hard precise answers that some of the quantitative disciplines offer, and that's certainly true, epidemiology and health sciences are often presented as this hard scientific objective truth, and I want to show that often that's drawing a veil of science over some pretty fundamental limitations, in some cases, that often don't get talked about or picked up.

So I'll start by talking about that epidemiological risk estimates are often subject to major biases which affect both their accuracy, so whether they're right at all, and their precision, how approximate, essentially, are these answers, and this is particularly the case for alcohol. The biases come from numerous sources, so that includes not accounting for drinking patterns, such as whether people binge drink or not, includes excluding healthy people from the samples in many of those cohort studies, so you get a biased population, and that's been shown to actually cause quite major problems in your estimates. It comes from comparing risks of drinking to the risks of abstaining, ignoring the fact that abstainers are actually quite a weird group of people, and I say that as an abstainer. They tend not to be like the general population of drinkers in lots of ways that are difficult to control for.

They often only measure alcohol consumption at a single point in time and then compare that to an outcome, and that's problematic because people change their drinking across their life course. Different people have different trajectories, even if they drink the same at one point in time, and perhaps most importantly – and you'll probably all know this, but if you don't, it should shock you – alcohol consumption is massively underestimated by surveys, by around 30 to 40 per cent in the UK and by up to 60 per cent in many other countries, which when you stop to think about it, is pretty remarkable. Our knowledge, our individual level knowledge of alcohol consumption is based on estimates that are significantly underestimating how much people are actually drinking, so James mentioned earlier a problem with historians having missing and partial evidence. I don't think they're alone.

Among other things, these problems are why we consistently see that moderate alcohol consumption is associated with a reduced risk of heart disease, but yet we still say, alcohol isn't good for you. It's caused partly by these problems, but if a J curve for heart disease risk is wrong because of these problems, it's probably true that the risk relationships for pretty much every other condition are wrong as well to a certain extent, and what does that mean for our estimates of alcohol related risks, and what does it mean for our policy analyses? What does it mean for the new guidelines which were based on these estimates, and whisper it quietly in here, what does

it mean for the estimates of the effects of minimum unit pricing, which are again based on this data? Part of the answer is actually quite positive. We can use sensitivity analysis to look at the effects of these different biases, and as it turns out, the effects of minimum unit pricing are probably underestimated, so good news there.

It's clear that when we say that drinking 'x' units a week is associated with a 'y' per cent increase in breast cancer risk, what we're really talking about is not precise numbers, but a rough indication of the patterns of risk that are associated with approximate levels of alcohol consumption, and we need to start thinking of presenting epidemiological findings in that less numerically precise way that better reflects the actual precision of the evidence.

I just want to briefly show you what difference sensitivity analysis can make. So these are the sensitivity analysis from a drinking guidelines modelling, and on the left bar, the dark blue bar is a base case model, so this is the main model that the main recommendations were based on, and they show that the implied drinking guideline ranges between about five units and 15 units, depending on how many days a week people are drinking, but those numbers vary massively, depending on what assumptions you put into a model, so assumptions about the shape of a risk relationship is a second bar, you get much higher implied drinking guidelines, but perhaps the most important one is that red bar in the middle. That's what happens if you take the protective effects out, if you don't believe that alcohol protects against heart disease, you get drinking guidelines based on these definitions of lower risk which I'm not sure that Jeremy Hunt would have liked if we'd have recommended a drinking guideline of two and a half units a week. So you get major problems with these biases, and we need to think...this is why when people were tweeting about scientific battle cries yesterday, I said something about reading the appendix, because this is where all the sensitivity analysis lurk which have the most important findings in them sometimes.

Second thing that epidemiology doesn't do very well is the social world, and there's a tendency to remove risk factors such as alcohol consumption from the social context in which they're produced. Now clearly epidemiologists know that alcohol doesn't just magically get into the body, but it happens in social processes, but they don't account for it very well in their analyses, and that's what we were talking about in this paper that's been mentioned a couple of times, where we look at the where, when, why, how, who with drinking actually happens, so we get a better understanding of the types of drinking occasions people have and possibly the differences in the risks for different types of drinking occasions. So it may not be that all drinking occasions are equally risky. If you're drinking ten units a week in one occasion and another person is drinking it in another occasion, the risks may be very different, and also the policy solutions may be

very different as well, and we need to start thinking about that, and epidemiology really isn't doing that at all, at the moment, and that's essentially what this wine o'clock indication is about. Wine o'clock is not simply about drinking a certain amount of wine, it's about all these other things that go with it, and those might have risks and policy implications attached.

My third gripe is related to this, and that's that epidemiology copes fairly poorly with qualitative concepts. There is something called the social determinants of health, and we've seen that in things like the Marmot report and the Spirit Level, but nonetheless these social determinants are often treated as quite static things that exist outside individuals and we've talked about gender a lot today, but gender is not a static concept. Its relationships to the rest of the world are not static, and epidemiologists often treat it as if it was.

I'm running out of time, so I just want to move onto my final point, which is to mention how epidemiology is used in the public sphere, and the promotion of the drinking guidelines has left me worried about a new aspect of this, which is the no safe level message, that there is no safe level of alcohol consumption when you're talking about risks of cancer. The risks of moderate drinking for cancer are actually pretty low, but a lot of the messaging has focused on this idea that there is no safe level, and the Royal Statistical Society has been quite critical of this. In fact the Department of Health's own press release made this point, so it's not something the newspapers have made up in this case.

The Royal Statistical Society (RSS) in its response to the drinking guidelines consultation said, "in spite of a risk of consuming at the revised guidelines being acknowledged as minimal, the communications have strongly emphasised potential harms of low level consumptions, particularly cancer, and we would question the ethics of giving an exaggerated impression of the harms of low levels of alcohol consumption", so pretty strong criticism there, and I'd probably agree with that. I think there are important questions here about the no safe level message in terms of what it's trying to achieve, its intellectual honesty and also what it implies to the public about the long term aims of alcohol policy, which are often...which I think merit discussion in themselves, because they're often quite generic and qualitative rather than specific and quantitative, and the public often have a very uncertain impression of what some of the people in this room – myself included – are trying to achieve, and I think this no safe level message plays into that.

So I'll finish my presentation on this point with another quote from the RSS's response, which is "our concern is that scepticism about public health advice might apply to future pronouncements concerning arguably much greater health risks associated with inactivity, poor diet and obesity, but unlike alcohol consumption are increasing

problems.” Once public trust has been lost, it's extremely difficult to win back, so I think there's a real importance that we make the distinction between the presence of risk and the level of risk. We should recognise that there are risks that we take every day which we don't think about because the risks are quite modest, and we shouldn't treat alcohol as special when we talk about its risk, we need to think about the level as well as the presence.

Questions and Discussion

Q. I was really interested at the end there when you were quoting the press release, and it made me think, oh, I must ask him about that. Do you think there's an issue about communications professionals and how they communicate the results of people's work or what the outcomes of reports are to the media and to the general public?

Yes, I think is the short answer, but I think it's much more complicated. Our experience – and we've had quite a lot of experience of dealing with the media because of the work we've done on minimum pricing and the drinking guidelines and various other things – is that researchers have got to take a lot of responsibility for themselves, so we find that when the University of Sheffield's press team writes press releases, we often need to provide a supporting role. They're often not accurate in a scientific sense, they're often not communicating the messages we want to communicate. What's interesting is when we've talked to other researchers, both inside the university and from other universities, is that they don't write their press releases. They hand it over to their press teams and then leave them to it, and they don't challenge them, and what also I thought was interesting was when we had papers published in the Lancet and BMJ, they write their press releases for themselves and send them to you for comment, and the same problem arises – work is needed to improve the scientific accuracy and the exact messages that are being communicated.

So I think researchers have to take a real responsibility to stand up, to press teams who, bear in mind, are not difficult to stand up to. To be quite honest, they're quite happy for you to tell them where the inaccuracies are, and help you to actually make sure the press releases say what's an intellectually honest and appropriate interpretation of the research. I just want to point to something that was in the BMJ, I think last year, which said that the vast majority of badly reported scientific research was not journalists distorting the stories – that's what happened with middle aged pre loaders, just to be clear, it really was half a sentence – but it's not usually that, it's usually the original press release has the inappropriate claim in it, so I think the real responsibility is on the researchers to make sure their research is used appropriately. We can't always control it, but we do need to do more.

Q. We know that people have difficulty interpreting statistical concepts or risk ratios and applying it to what it means to them individually. Added to that we have the problem that people aren't particularly concerned about the health consequences of their drinking, or they have other concerns that are more likely to influence their behaviour, but I found interesting that emphasis of cancer risk in the current guidelines, because if we know that there's a health area that people are concerned about, sometimes over-concerned about, it's about cancer. I was just wondering what your thoughts are about using cancer in that way, perhaps, or cancers, we should say more accurately, as a way of maybe encouraging people to think a bit more about how they're drinking.

I think I'm quite ambivalent on it. One part of me thinks that is important that we get people to recognise the long term health risks of drinking, and that cancer, because it's such a powerful word, even, is a way of doing that, and I was talking with Carol about a project yesterday and we talked about this idea of candidacy and who people see as the potential victims of different diseases. We all know that we're all potential victims of cancer, but we don't think of liver cirrhosis. We know who the liver cirrhosis people are, they're the people who are hanging out on the street with bottles of spirits and white cider, we don't think of liver cirrhosis happening to us, and there's some work on heart disease, I think, that says that people think that people who get heart disease are obese middle aged men who eat too many fry ups, so again if alcohol, the big long term deaths from alcohol are from liver disease, which doesn't happen to us, and heart disease, which doesn't happen to us, you can see why cancer becomes something that the public might actually listen to.

On the other hand, the risks from moderate drinking for cancer are modest, I think that's more true for men than women, some of the breast cancer risks are a little bit higher, but I think the RSS made the point that the risks for other things are much higher, and we happily go about doing those without any concerns, so I do have that ambivalence, and I would like to see more recognition of a distinction between drinking and higher levels of drinking, and particularly I like the triaging of drinking into moderate, hazardous and harmful, or low risk, increasing risk and high risk, and I think I would like to see that brought into the public debate more than it is at the moment.

■ Alcohol research from a Public Health perspective

Dr S Vittal Katikireddi, Senior Clinical Research Fellow and Honorary Consultant in Public Health, MRC/CSO Social and Public Health Sciences Research Unit, University of Glasgow

Thanks very much for inviting me here. I'm afraid that what you're going to hear now is basically a bit like my biography, but just spaced out and a lot longer. So I apologise about that. I've been asked to try and present what it is that medical, or public health professionals might be able to bring to alcohol research, but quite often, I get asked, actually, what do you do in public health practice? So I'm going to try and draw out some of what I've done over the last few years, really as an example of the kinds of things that public health professionals get involved in. It's not atypical, I suspect, but every public health professional, either doctor or specialist, has their own unique story.

The first thing I did, just like the previous speaker, is I looked at Wikipedia. So, what actually is a medical doctor? Well, according to Wikipedia, they're a professional who practices medicine, which is concerned with promoting, maintaining, or restoring human health, through the study, diagnosis, and treatment of disease, injury, and other physical and mental impairments. So, a couple of things to point out: there is this idea of promoting or maintaining health, it's not just all about treating disease, and also, there's an explicit inclusion of both physical and mental health. Typically, when people think about doctors, though, they think about people in white coats, with a stethoscope. So, I'm going to try and give you a bit of a flavour of how those people working in hospitals, and in general practices, could be helpful for alcohol research, but given that I don't do that that much, I'll only touch on it briefly.

As I said, I'm going to be quite personal in terms of the story I'm going to tell. As has been mentioned, I studied medicine here in Edinburgh, worked in a hospital, for a few years, in particular, in some of the more acute specialities, so in places like A&E, intensive care, and that's really where I suspect my first interest in alcohol started – seeing patients who had experienced alcohol related harms. I had

an interest in public health, way back from medical school, but made the switch, and then, started into academia. So, what actually is clinical medicine? It's a really broad church, as it were. The types of things that different doctors do can be really varied. So, of course, when we think about alcohol we think about things like hepatology, and all the problems with liver cirrhosis. We also think about A&E. It's also a huge issue for psychiatrists to deal with. There's a role for public health, I hope. Actually, all the other disciplines that regularly work with patients are typically interested in alcohol, in one way or another, even though, often, we only hear about certain disciplines when it comes to alcohol.

So, the other thing I'm going to try and give you a flavour of is how the clinical academic training process works in the UK. It's maybe a bit different from the process of sociological training, and in particular, you probably don't get enough experience of doing research, to be quite honest, partly because you're trying to gain clinical skills, alongside doing research, you're often trying to run the two in parallel. Within medical circles, this is quite a famous diagram about how, in theory, clinical training, alongside academia, is supposed to happen. So you start off at medical school, if you've got an interest in academia, you're generally encouraged to do what's called an intercalated degree. So that's halfway through your time at medical school, you might do an extra year of the honours year of a biology degree. Following that, you typically work, as a foundation doctor, what used to be called house officers, for a couple of years, which gives you a broad based training in different clinical specialities. For some people, they might get some academic exposure at that point, in terms of being based formally in a university. That's actually quite unusual, to be honest, though.

Following that, you choose what type of doctor you want to be, so what type of specialist do you want to be. Do you want to be a cardiologist, do you want to be a public health person, do you want to be a hepatologist? You're encouraged to go down one route quite early on. That might change in the future. Historically, actually, people would decide on their speciality, maybe a bit later on. Then you work in whatever clinical speciality you're working in for a few years. After a couple of years, you might think, I want to do a PhD, and you then try and get funding, you apply to all the research councils, or all the usual places, try to get a fellowship to buy yourself out of clinical training, and be based at a university for typically three years, so you can do a PhD. You then go back, often people then try and get what's called a clinical lectureship, and that involves working in clinical practice, often half of your time, while the other half of your time, you're doing academic work.

Then, at the end of all that, you then try and get a second fellowship to get some more experience, at a more senior level of research, and that's typically, either at the end, or shortly after you're finished your clinical training. So

that specialist training bit, lasts usually a minimum of five years. It can be as long as nine or ten years, depending on the speciality. Some specialities are longer training than others. If you've managed to do all that, you then end up as a senior clinical lecturer at the end of it. Okay, so that's just a bit of background in terms of how these things work.

So, for the people who are actually working in their lab coats, with a stethoscope, what could they actually bring to alcohol research? Well, I think a hugely important thing they bring is that clinical perspective, and actually, we've heard from Aisha earlier about how important that can be. It's basically the same in terms of nurses and doctors. They have that exposure to the front line, and have a feeling for actually what might be the really important things that would help patient care. The other thing that they might be able to bring is access to patients or access to data. So if you're interested in studying people at the very addicted end of alcohol consumption, then actually working with, say, a psychiatrist, working in addiction psychiatry, might be really helpful. They're also well placed in terms of working within NHS structures. So if you want to carry out recruitment within an A&E setting, or somewhere like that, actually, you often need someone who understands the system, and who can also guide you through the governance procedures.

Because they're coming at things from this applied side of things, they're also very good at translating things from the pure science to clinical practice, and there I'm including under pure science, both the sociological end of things, but also, the lab science, and novel biomarkers, and all those types of things that they might be able to contribute to. We've already heard about the, often, quite persuasive role that clinicians can have in the media, as well. For better or worse, they're often seen in quite a positive light, and still remain one of the more trusted professionals within the public eye. So I'm now going to focus, mainly on public health practice, largely because, actually, most people have no idea what public health consultants, or public health specialists do. I'm going to, largely, present some of the work that I've been involved in over the years, partly because I know that well, and it's easier to do. So, a quite often used way of trying to explain what public health practice is – it's presented here by the Faculty of Public Health – they argue that public health practice is really about three domains.

There's the health protection side of things, which is about dealing with things like infectious diseases, outbreaks, chemicals and poisons, emergency responses. So, for example, in relation to alcohol, I know a colleague of mine, based in London, who works on a mobile tuberculosis screening unit, where they carry out chest x-rays on the streets of London, largely with people who have alcohol related problems, and that is probably a part of the health protection remit there, so that's work being done in collaboration with Public Health England. In terms of the improving services side of things, often, public health

consultants are involved in ensuring clinical effectiveness of treatments, and trying to improve the efficiency of the health service. There's also an important aspect here, if you think about equity of service provision. If you have someone with specific needs, so for example, including people with addictions, are the services being set up and delivered in a way that actually meets those needs in an effective way? Then, the third bit, which has probably got the most amount of alcohol related practice and research in it, is the health improvement side of things, and this is often what people most associate public health consultants with, although, actually, there are a huge array of other consultants working in these other areas.

In terms of health improvement, that includes things like trying to educate people about unhealthy alcohol consumption, or low or high risk, or however you best term it. It also involves a lot of work on the social determinants of health, so actually, are there ways we can better design our housing, better design our communities, to try and reduce the risk of harm, or to reduce the risk of consuming alcohol in a potentially hazardous or harmful way? So, in terms of my own experience then, and this is, I'm really just presenting this to give you a feel of what types of training you get from public health. In my first year, I did the typical thing of doing a masters, in the second year, I worked in a health board, based here in Edinburgh, NHS Lothian. I did some work on health protection, so dealing with outbreaks, and those types of things, some work on cancer screening, and health inequality strategy. During those first two years, I sat the membership exams for the Faculty of Public Health, and the reason I'm flagging that up is because it involves getting quite a broad based set of knowledge. So, public health training gives you a real breadth of knowledge, probably not that much depth, except in very specific areas. You do a lot on epidemiology, you do a chunk on statistics, and you also do some sociology, and that type of thing, as part of your training.

We are not social scientists, and so we get just a little bit of exposure, and hopefully a bit of understanding that allows us to work with sociologists. Then there's a practical exam that involves applying that knowledge to traditional public health practice in our areas, like briefing local authority elected members for example. After that, I then took some time out of the programme to do some research, which I'll tell you about later. Then, the following year, I did some work with the WHO, looking at climate change. I then did some stuff on health services development, and the introduction of smoke free hospitals, here in Lothian, before finishing off with a period of time working at Scottish Government, so working on things like health inequalities, and also, the regulation of non-surgical cosmetic procedures. So, quite a broad range of things and as you can see, you're getting exposed to policy, both at government level, but then also, at a health board, or

even international level, in terms of WHO. So a real focus on policy.

In terms of research experience, it's quite common for medical students to get a little bit of time to do research, but only a very small amount, and not as much as, say, you would, a dissertation, if you were doing an undergrad in, say, sociology. So, you typically have, maybe, four, eight weeks, or something, to carry out a small research project, and that's probably it, in terms of your research training as an undergrad. Then, it's quite common for people working in clinical practice to get exposed to some research or audit. So, things like getting involved in a randomised controlled trial, in terms of recruiting patients, and things like that. That's just to give you a bit of a feel. Then, as you heard, I did some research around minimum unit pricing, and the role of evidence in that – that was really a way of me trying to get some stronger qualitative skills. So the public health training is usually more quantitative, it's very epidemiological. The origins of epidemiology are very closely linked to the development of public health as a speciality. That's quite a departure from some of my colleagues.

The other thing that characterises public health is the idea of collaboration. So, as I mentioned, we're not really experts on that much, but we do have the breadth of knowledge, and so are often quite well suited to working with others. For example, we can get involved in epidemiological stuff, like looking at response bias, and surveys, but we can also then provide some health input into other projects, things like looking at health inequalities, or news coverage of different alcohol policy areas. Now, because I've been speaking about things with actually no real research, I thought I'd throw in a few slides of some on-going research that we're just in the process of writing up. So you've all heard about the alcohol harm paradox, from John earlier, and I'm sure many of you have heard of it before. This is the idea that when you look at alcohol consumption across socio-economic groups, it's not really that strongly socially patterned. If it is, it tends to show that the most deprived are probably consuming slightly less, on average, than the least deprived. Despite that, when we look at harms data, actually there's a very strong social gradient. So the most deprived experience greater harms.

Well, why is that? There are a few potential reasons. One potential explanation is it's just an artefact. The data that we're looking at when it comes to surveys are often separate data sets from the ones we're looking at when it comes to harms. So we might just be missing all the people who are actually experiencing the harms in the survey data, that could be the entire explanation. It might be there's a difference in alcohol consumption patterns, so maybe there's a difference in binge drinking, or something like that. There might be a difference in other risk factors, things like, we know there's an interaction between body mass index, so the level of obesity, if you like, that someone has, and their alcohol consumption, in

terms of specific alcohol harm, so especially liver cirrhosis. There might be reverse causation. It might be that people become poorer as a consequence of their alcohol consumption, or it might be that the relationship genuinely differs.

So, we tried to investigate this, by using linked data. We took data from the Scottish Health Survey, linked that to prescriptions, hospitalisations, and mortality data, to try and understand why this might be.

The other area that we're interested in at the moment is natural experiments. Having been based in places like government, or the health board, often, we introduce things, but we're not able to run a randomised controlled trial (RCT), to understand whether they work or not. This is an approach to try and understand whether an intervention is working or not, in the context of not being able to do that RCT. This is just a couple of examples of work that we've been involved in recently. Looking at smoke free public places legislation, and seeing that, actually, the rates of smoking uptake amongst girls seemed to fall after the introduction of smoke free legislation. That thinking has led to there being a big team of people helping design an evaluation of minimum unit pricing, if and when it gets introduced. Lesley Graham has been particularly key in this, as have people like Clare Beeston in NHS Health Scotland, and Gerry McCartney, and it really draws on the strengths of the multidisciplinary approach. I'm not going to go into the details of this, but as you can see, it's a range of different studies, taking different approaches, which I suppose is, emblematic of a public health approach.

So, what can a public health consultant or a specialist bring to alcohol research? Well, there is some knowledge, hopefully, as I've tried to illustrate. There is generalist knowledge. There is sometimes some specialist knowledge, which varies, depending on which particular public health person you're speaking to. If they have a clinical background, they might have particular expertise around disease processes whereas, other people who maybe have worked in local authorities might particularly understand health promotion in other areas, for example. Often, they'll have experience working in policy or practice; so hopefully, they might be in a position to identify the kinds of research questions that might actually be useful to inform policy and practice. Typically, public health consultants will have on-going relationships with decision makers, particularly since most clinical academics will maintain some NHS work, alongside their research, and they will often. Public health consultants, operate within data holding organisations, so a place like Information Services Division (ISD), have a key role in terms of leadership around data quality, and things like that, for public health.

There are certain specific skills, in terms of epidemiology, and understanding the diagnostic coding of different diseases, but also, through working in lots of different

environments, and different agencies, hopefully, public health consultants should be reasonably okay at interdisciplinary working. However, there are several difficulties. Often people have very different expertise, and different interests. Alcohol is often only a very small component of the type of work they're doing. There can be tensions with a traditional social sciences authorship model, in terms of traditions of multiple authorship within public health and medicine more generally, whereas in sociology that might not be the case. There are also lots of normative, implicit assumptions that public health people often bring, like the idea of being evidence based, without really reflecting on what that means.

I'm going to finish by suggesting some major research gaps. There is big divergence in policy directions, north and south of the border at the moment, and also across different levels of government. There has been a shift in public health from the NHS to local authorities in England, and actually, that's something that we could arguably evaluate. There is a need for more consideration of public health ethics in particular, how we engage with commercial actors, particularly since public health has an informative position here, rather than as pure academics and opportunities in terms of more refined alcohol epidemiology.

Questions and Discussion

Q. It was getting to the interesting bit, where you stopped, about public health ethics, and I just wondered if you wanted to say a little bit more about that, please?

I would say that public health doctors and specialists really have a role as advocates for the populations they serve, as it were. In the way that clinicians often have an ethical obligation to their own patients, public health professionals, typically have obligations to their own populations. However, the ethical principles underpinning public health practice are really poorly developed, in all honesty. So unlike in clinical practice, there's been lots of reflection about how do you analyse a particular ethical challenge. I don't think we're quite there yet, in terms of public health practice. Often, things are done in quite a pragmatic way, which has advantages, particularly when it comes to having to work with quite different sets of political actors, including politicians. Having that flexibility isn't always a bad thing, but it's certainly something that's quite frustrating, and also, can be a challenge, when you're actually working.

Q. It's interesting, what Vittal is saying, I think, about public health people viewing themselves as advocates, and saying that's part of their role, because researchers often differ as to how much advocacy should be a part of their role, and how much presenting the science should be a part of their role.

I want to ask you a question that I come across quite a lot. It's about who owns prevention, because, in terms of public health, of course, we think that must be part of the public health role. But yet, there's a mismatch between the medical profession that cares for the disease, and prevention, and I would argue that it's because there's such a divide there, that we don't have the capacity in work in prevention that we might do. So the example that I, of course, would choose, is oncology, where there's very little interest in prevention, and yet, when I look at public health, I do not see cancer prevention badged high at all. It tends to start with screening, or the factors involved in cancer prevention get merged into the muddiness of public health, and health and wellbeing. So I just wonder, if you, as you're coming through your career, if you've had reflections on that, and what that might mean to communities and researchers, like us, who are interested in prevention and treatment of disease.

I think that's a really tricky question. I think often, public health professionals want to focus on the social determinants of health and there is lots of evidence that suggests that that's where we've been most effective, if we can actually achieve change. The difficulty with that is, it moves away from a disease specific model and a lot of the legitimacy, especially in public forums, public health specialists, or doctors having a voice, comes from them being perceived as experts in health, and disease in particular. So it's a very difficult balance to maintain the credibility that might come from being seen as an expert in disease, to actually being able to influence the broader determinants, as it were. The other aspect is, public health faces a real challenge in being seen as everyone's business, but also, not having a home. It's quite easy for public health measures to be cut, which we're beginning to see in England. Where, actually, because public health is seen as, well, it could be everything – everything that, say, a local authority does, could be badged, in some way, as public health. If it's not clearly demarcated, you often get cuts. So it's a real difficult thing with where can we be most effective, but also, where public health could be sustainable as an influence.

Q. It's a difficult one, because right at the end you said, questions that still need answering, so I thought I'd put one to you, which was, where you said about what the end goal of public health in relation to alcohol is, have you got any preliminary thoughts on that?

The first thing I would say is, I would probably favour a move away from thinking about an alcohol focused end goal, to think about a health focused end goal. One of the things I was trying to do was try and explain that, actually, as a public health person, you often think about it from a health perspective, not necessarily, purely, an alcohol perspective. So, often, you're drawing on knowledge, or experience you've gained, on other topics, and then, maybe think about it in relation to health, but I think you

also, probably want to do that when it comes to thinking about what the end goal is. There are lots of people, in terms of tobacco control, who speak about the end goal being a smoke free future whereas the whole e-cigarettes experience has thrown that into a huge debate. I think, actually, as public health people, we might be better focusing on how we best improve population health, and narrow health inequalities, as our key end goals.

■ Geography

Dr Niamh Shortt, Senior Lecturer in Health Geography and co-director of the Centre for Environment, Society and Health (CRESH), The University of Edinburgh

Thank you to Carol for inviting me along to talk to you today on geography. Many of you may be relieved by the fact that I won't be talking about oxbow lakes, or stalactites, or stalagmites. So, geography is a vast discipline. I'm a health geographer, within the sub-discipline of human geography. Even within human geography, we have many, many sub-disciplines. To say that I'm speaking on geography's behalf, or even health geography's behalf, is probably a little ambitious, but I'll go with it for today. So I'm going to talk about the contribution of geography, and geographical research, to alcohol studies. I'm going to think about inequalities, about what's lacking, what are the biggest challenges. I was particularly struck, as well, by the idea of evidence, and how we think about the evidence base.

So, first of all, in terms of geography, so many of you may have studied geography at school, some of you may have done it at university. I'm an accidental geographer, having started at art college, but liked the look of the field trip to Morocco, so moved across. So for a geographer, space is not something we simply pass through. Raymond Williams has spoken about space as not being a flat surface. Many of you will have taken a train here today, or a bus, and Williams uses the analogy of a train journey, in that we're simply not traversing across a flat surface, but instead, we're cutting through thousands of individual stories. For a geographer, therefore, space is not just a physical locality, but it's an active agent in shaping our relations, and I suppose that means that, as an undergraduate, when we study geography, we study both the physical, and the more social and human geography, to understand landscape from a variety of different perspectives. In saying that, we exist in relation to each other, but we also exist in relation to the environments that we move in, and the environments that we experience.

So these interactions with these spatial characteristics have long been known to shape health outcomes. From John Snow, and the mapping of the cholera outbreak, Will Trayman in geography, to Engles' writings on the conditions of the working class, we know that place matters. Yet much research in alcohol studies has tended to view space as a passive background, the spaces in

which alcohol is consumed, rather than thinking about how the alcohol consumption is related to the spaces and places in which it is consumed. A geographical perspective, therefore forces us to shift our view, from thinking about spaces as flat surfaces, towards thinking of them as active agents that will in some way shape the norms around drinking, and around the cultures in drinking practices. Mark Jane, Jill Valentine, and colleagues, have explored drinking and drunkenness, and how they are differentially, and discursively constructed in different spaces, but at the same time, noting that the role of space within alcohol has been under theorised.

Doreen Massey spoke of places as heterogeneous associations and she described places as unfixed, and in continuous process. So, therefore, that poses a huge challenge for those of us in alcohol studies, who want to think about place, because they aren't fixed, and because they are in constant flux. In this, therefore, when we think about the change, it also emphasises the role of time, and it's something I'll come back to later on, when I think about what's lacking in our discipline. Within alcohol research, places are varied. Public places, for example, with particular emphasis on the night time economy. Private spaces, with recent shifts towards focusing on home drinking, and regenerating spaces, the role of industry in processes of regeneration and gentrification, to name a few. Many of you today have talked about personal stories about what you yourself do in your discipline. So instead of thinking about what I do in my discipline, I've thought about where I've been, and I'm leaning on the idea that Richard Mitchell and colleagues use in an undergraduate textbook, to show that geography and place is important.

We don't live in a vacuum. We live in place, and in turn, we shape it, and are shaped by it. If you take a moment to reflect on the spaces and places that you've lived in, then you'll begin to think about how this has shaped your behaviours, and your responses. Danny Dorling has written about the importance of circumstances, and how we're a product of our geography, but possibly, we should say, we're a product of our geographies, as these places change, both through time, and as we move through them. Cairns and Moon have argued that an increasing awareness of place will help us to better understand the community contexts that foster health behaviours, including alcohol consumption. If I consider how I have moved through place – those of you who listen to the shipping forecast will be familiar with Malin Head, at the very north tip of Ireland, and the Republic, through to Northern Ireland, the University in Nebraska, which always makes me think of the Gene Hackman in Unforgiven that says, "Hell I thought I was dead, too", turns out he was just in Nebraska, to postdoc in Dublin, and then, now, in Edinburgh for quite some time. All of these places have left a mark on me; they're who I am. I've both interacted with them, and they have interacted with me, in shaping my behaviours, and my perspectives.

There's an abundance of research that has shown that there's an association between environment and health behaviours. Unfortunately, this has developed from a historical, environmental, deterministic perspective, which thankfully, in geography, we've moved a long way from. Researchers, now, engage with theories, such as sociological theory, that thinks about the aggregation of individuals, and how these behaviours are shaped in process with the environment. The environment is seen as a consequence of the social process as it's shaped at individual level interactions, but also by broader political macroeconomic environments as well. There has been a relative neglect in considering how these broader contextual factors may shape our drinking practices, beyond, for example, work on outlet density, and here I criticise my own work when I say that within this research, we've tended to treat these spaces as homogenous spaces, with little consideration of any of the social and culture differences within these spaces, never mind the material differences between the outlets themselves.

Much of this may be explained by a lack of interaction between the disciplines, but also, within disciplines, a lack of interaction, perhaps between both sides of methodologies, between quantitative and qualitative scholars. Roux called for context to be brought back into epidemiology, and in bringing such context back, we must think that there isn't just one neighbourhood effect, but there are many, and these are multiple. So, what have geographers done in terms of their research in alcohol, drinking, and drunkenness? They focus on the political, economic, cultural, and spatial processes, and our responses to them; looked at empirical, quantitative work on alcogenic environments, including work on, for example, outlet density that we've explored in Edinburgh; and explored issues of legislation and policy, the night time economy, gentrification, historical patterns of drinking, identity, lifestyle, and the gendered nature of alcohol. Ellaway has been talking about how they looked at the impact of place, and space, in recovery. Most recently, a paper by Whiteford has said that general accounts of recovery have tended to ignore any spatial aspect, and the fact of how location may contribute to the management of recovery capital. All of this research has shown that space and place are important, within alcohol research.

We were asked to think a little bit about inequalities, and I brought this to the forefront, rather than towards the end, because inequality is central to my work, but it's also central to the work of many geographers. Geographers interested in inequalities have paid particular attention to Marxist theories, and theories within welfare geography. It's the uneven distributions of these environments, of environmental goods, and environmental bads, that we should concern ourselves with. They raise particular questions around social justice and accountability. Hooks acknowledged that while sociology is important in the study of inequality, we must also recognise the importance

of geography, and the fluidity of scale. Poverty, social exclusion, and relative deprivation, are all incredibly important here when we think about them, and as a health geographer, we know that these are all strongly related to our understandings of health outcomes.

In particular, within alcohol, we've heard people already today talk about the alcohol harm paradox. We know, for example, that we don't see the same gradient in behaviour as we do with smoking, but we do know that there are greater harms in the most deprived populations, and we need to get a greater understanding of this, we need to put inequalities first and foremost, in our discussions, in alcohol study. Furthermore, the contribution of alcohol to broader inequalities in health is also important, but there may be the danger of a policy outcome here, where one blames people for their behaviours. In health, we tend to blame the groups for their feckless behaviour, or that is the current strand in policy, anyway. We need to exercise caution when we do research like this, that we're ensuring that we're putting out the right messages as well, and that we're not removing these behaviours from the environments in which they're taking place, and from the socio-economic environment in particular. A health capabilities framework helps us here, and Zen's model of the capabilities, in thinking that the ability to choose a healthier lifestyle is bound up in our environments, and that these environments, in turn, are formed by broader political and economic processes, and it's these political and economic processes that we need to begin to question.

A focus on place allows us to think about the more micro level individual behaviours, but also these more macro level political economy questions as well. When we begin to think about alcohol, we could begin to think about it in terms of inequality, and think about whether or not these environments differ for individuals, and, indeed, whether or not the responses to the environment differ, in different income groups. We've shown that outlet density has a greater effect on the most deprived groups, on low income respondents, and this has been shown in previous research, not necessarily with alcohol. Data from the Whitehall study has showed us that for neighbourhood deprivation, the impact of it is greater for those in lower socio-economic positions, and Macintyre and Ellaway have suggested that it's because people in lower socio-economic groups are more bounded and constrained by their environments, so place may matter more for these groups, than for higher socio-economic groups who may be able to move beyond these environments more readily.

I thought about the challenges, and it links back to some of the earlier discussions on stigma. Public opinion, I think is a big challenge, within alcohol research. Exploring lay understandings of health inequalities, and of alcohol, and drinking, Blackster concluded that all social groups tended to neglect structural causes of health and illness, and instead, such lay understandings gave primacy to

individual responsibility. So there's a tendency to do that, and I think we need to move away from that, and think about how and why these decisions are made, or whether or not they are made. The public rhetoric around blame and accountability is really challenging for public health policy, and also, stigmatisation – who is stigmatised, what type of drinking practices, and where, are acceptable? So, for example, do we accept middle aged dinner parties, and not a binge girl? As a result of the public rhetoric, there's stigma, then, around alcohol problems, and we, of course, know that health is impacted negatively by such stigma.

Place based stigma also has a role to play. Characteristics of people in neighbourhoods can mean that entire neighbourhoods become stigmatised, and then responses to that include bad health behaviours. Research from New Zealand has shown that the dual stigmatisation of being a smoker, and residing in a deprived neighbourhood, produces smoking islands that reinforce smoking as an activity. So, we try to understand the role that stigma may play in alcohol and drinking. As Vittal has said, we need a greater understanding of causal pathways, between environment and health behaviours, and again, I'm going to criticise myself here. We need to think more about longitudinal perspectives; we need to try to understand causality better. I've been on the receiving end of criticism about this, and that's fine, I take it, but I do also recognise that we need to try to move on to report causality, rather than association, but with a little asterisk there to say that it's really hard. Thinking about evidence into policy, and we'll come back to this in a moment – how can we get evidence into policy? I know that impact is a buzz word at the moment, and many of us may feel that we're doing it because we're being forced to. However, as I said in the introduction, I do believe that it's a moral obligation that we engage with organisations outside of academia.

In order to do that, we need to learn about the policy making process, and improve our understanding of how policy is made. It is not here, have this paper, read it, and then change policy. Also there's not much point in writing journal articles, expecting everyone to read it, when the average journal readership is two, and I'm sure that Nicola Sturgeon is not amongst that audience of two. We need to do more to get our research out there, than just publish in journal articles. So what is lacking? We had a workshop in December thinking about this – what is lacking in research in alcohol and tobacco, and three main things came out – a longitudinal approach, data and definitions, and a greater focus on inequalities – and I've added, here, critical global health, and a focus on co-behaviours. Claire Herrick has written about the contribution of geography to critical global health, and she argues that we've let people in anthropology, and political science, run away with it, and geographers haven't engaged with critical global health, and I agree. Even though global health is concerned with issues that are very geographical – urbanisation, political ecology, culture of governance – to name just a few, we

need to think about alcohol as a global health problem, and how processes play out differentially in different places, given the complexities of place.

We also need to think about a longitudinal life course perspective. Historians think about time, and geographers think about space, so we need to think a little bit more together. Space has been thought of as devoid of temporality, it is without time, but more recently, we've begun to think about how environments have developed through time, and in particular, how changes in these environments may affect health behaviours, and health outcomes. These changes are linked to the aforementioned global health, but also, to much more local scale. The project I'm involved in with Jamie Pearce and colleagues, which looks at the changing nature of Edinburgh over the past one hundred years, and we've linked this with the Lothian birth cohort of individuals born in and around 1936. We have data on them at aged 11, and then we have data on them from age 70 onwards, and we've gone back to them to get their addresses for every decade in their lives. We know where they've lived throughout their lives, we know all about their health, and their cognitive function in old age, and we've also gone through, and we've created an atlas of Edinburgh over the past one hundred years, that includes aspects of green space, deprivation, for example, alcohol, tobacco, and social activities.

So, for example, here we have alcohol outlets in Edinburgh in 1936, and in 2012, and we've got a couple of other time points as well. What we're trying to do is gather information on their environments throughout their life course, to build-up cumulative effect of exposure, or alcohol outlet density, for example, and also thinking about whether there are critical periods, whether the environments in which they were adolescents has an impact upon their health and wellbeing in later life. So, building in this longitudinal and temporal perspective is important. Data and definitions – for those of you who know me, you'll probably know that I bang on about data a little bit, in that it's difficult to get, and we need to do a bit more in trying to gather data, but also, in terms of definitions. So, for example, we talk about over provision within alcohol outlet density, but what does that even mean. What is over provision, what is an over provided area? You know, we don't know, because this hasn't been defined, and it leaves the door open for many people to challenge that. We need to do better in trying to define the terms that we use. A focus on co-behaviours – people don't just drink, they do other things as well – and I think there's quite a lot that tobacco and alcohol researchers can learn from each other, but again, we don't generally tend to speak to each other.

From the workshop that we hosted in December, and it's linked to the question that James mentioned earlier, the idea of developing a consensus of where we want to be with alcohol studies. What does it mean – tobacco has an end game, the idea of a tobacco free Scotland, but

in alcohol, where is it that we want to be, and that's not clear. There was a discussion at the workshop about, maybe, we should focus on this, we should focus on what is the end game, is there an end game, or what are we wanting to reduce, and when would we be happy with it being at a certain level, and a greater focus on inequality. I think we need to think about the equity impact of alcohol interventions, the impact of alcohol on the most deprived populations, and also on gender, and how places are shaped, that result in unequal environments – what is it that is shaping these environments, what are the processes that mean that there are more outlets, for example, in certain neighbourhoods, and certain environments? What are the main players within that?

Can we work better together? In one word – yes. I think that we need to. I know Niamh Fitzgerald has just built up a really interesting NIHR application, and I think we're beginning to work better together, and I think there's much room for us to have more conversations like this. So I thank Carol for inviting us. Even within disciplines, I do think that, methodologically, we need to think better together, and to engage both qualitative and quantitative aspects of our work. That links to the idea of what is evidence. Evidence based policy making is power laden. Policy makers own research skills and beliefs about the utility of evidence are important factors, but we also hold judgements and values – everyone does – and these characteristics inevitably inform our interpretation, the research questions that we set, and our interpretation of the evidence. So as we may feel that our evidence, our arguments and suggestions, ought to be given credibility, because we claim they're based on robust methods and sound interpretations; our arguments will not be the only ones heard in policy debates.

We did a lot of work with the Scottish Parliament, on outlet density and we encountered a plethora of anecdotal evidence. In an evidence session I delivered to the Scottish Parliament, both members of the Parliament and other witnesses used such arguments, and one witness, who I shall not name, but you can find it in the minutes of the meeting, said that perhaps he was flying – and I quote – “by the seats of my pants”, in expressing a personal view when he criticised my methodology and my results in front of the MSPs. All sort of power elements were at play, including positionality and gender, to name just two. In separate forums, we were told stories of family members drinking heavily all their lives, and dying from what they considered to be unrelated causes. McDonnell has referred to this use of anecdote as an omnipresent form of policy discourse. Experiential and anecdotal evidence are not easily challenged by our empirical evidence, they are different forms of knowledge, and we need to understand that. They do have a role to play, and it could be argued, they have a legitimate role to play in policy formation.

There's a challenge for us to try to understand how we can best engage with different forms of evidence. One

option might be to work with more local communities, to understand better why people have these opinions, and how these opinions are formed. We need to engage more easily with all these different dimensions of the policy and public debates, and know that ours isn't the only evidence, and that in order to make our evidence stronger, we need to understand what other evidence is being used. My final point is that hard data is not the only evidence and that, as academics, we must be really careful to allow space for all forms of evidence, within these conversations.

Questions and Discussion

Q. I'm just interested in your outlet density work, from your social geography background, because I was wondering about what you think the scope is for thinking about how people move through those spaces, and how people interact with it. I'm thinking, in terms of, when you have lots of very small grocery stores and outlets that sell alcohol in deprived areas, and the point you made, we should be much more committed to that. The space in which alcohol is sold is maybe smaller, whereas in more affluent areas, people are moving out a lot more, drinking in greater distances, purchasing their alcohol at greater distances, getting mail ordering. Is there much that you guys have done, or can you see a role for that, for that very social geography to layer on top of the quantitative mapping of outlets against outcomes and consumption?

Yeah, absolutely, so that's one of my own criticisms of my own work, and I'm very open about that as well, in that, a lot of geographical work is now moving on to think about activity spaces. So, we can know where people spend their days. In our tobacco work, we were able to look at where kids went to school, and where they lived so we could come up with some idea of where they spent their time, but for adults, that is much more difficult. There are some surveys that will tell us where people work, but we can try to model that as well but I think we need to get a better understanding of where people move through space. So, Mei-Po Kwan, in the States, has done that, particularly, she has focused on women, and how women move through the city. I do think that if we could, methodologically, think about what ways we can do that, and it may be, it's through qualitative research, that we need to get a better understanding of how people use their space.

That's why Sally Macintyre and Anne Ellaway's work, in Glasgow, was really important, and thinking about people being bounded to their environment, and almost trapped in their environment, and my work, other work, with physical activity, has shown that those in the lowest socio-economic groups, they walk more, but it's not walking for pleasure, it's walking to get from A to B, because that's the way they have to move around their environments. It's an interesting one.

Q. I have a comment rather than a question. The comment follows on from what James just said, which is, as well as looking at where people are actually encountering these outlets in their lives, is also that outlets are not all the same. There are some outlets that won't appeal to some people, and there are some outlets that will. I live closer to an Asda than Waitrose, but because my wife insists, I go to Waitrose. Similarly, the average 60 year old drinker isn't going to go to Yates wine bar on a Friday night, and that's another reason that we need better data. I think this is my never ending frame, basically – too much of the data we rely on for quantitative analysis in particular, is driven by an epidemiologic perspective, that alcohol is just, it's a pathogen that comes into the body and is completely decontextualised, and we really need to start looking at how we can transform those data sets into something that's more useful for thinking about health behaviours, generally, not just alcohol, in a more sophisticated way.

The question I was just going to ask – you mentioned, after you'd put up your relationship between deprivation, and outlet density, is you briefly touched on market economics, or, sorry, economic geography, and I just wanted to ask, how much of that relationship between deprivation and outlet density do you think is to do with some targeting of lower socio-economic groups, and how much of it is a reflection of footfall in areas, of the cheapness of rent for shops, and the amount of money that people who go through those areas, and live in those areas, have to spend? Paul Gruenewald has talked about that a little bit, and I think it's important and I'd just like to hear what you thought about it.

On your first point, on data, and on treating all of these outlets the same. In our previous work, you know, we were only able to distinguish between on sales, and off sales, and total sales. In work that we plan in the future, we hope to get a lot more on size of outlet, in terms of off sales, on shelf space, and all of these different factors. It's obviously complex and gathering the data will be a nightmare, but hopefully we can do it. I think it's really important, because, going back to tobacco again, with the display ban for tobacco, it came into large shops first, and then it came into smaller shops, and there's an inequalities factor there, because the smaller shops are more likely to be in more deprived areas. It was later that the display ban will have come into deprived areas, and maybe that will have an impact on smoking rates in different areas, and so on.

The second point, in terms of footfall, and whether neighbourhoods are targeted. It could be that neighbourhoods are targeted, there's evidence from America that certain neighbourhoods are targeted, particularly black and ethnic minority neighbourhoods in some American cities have been targeted, but we don't have the evidence for that. It's interesting, in our density work, when we do map it by deprivation, we notice that

at the very extreme end of deprivation, areas that are more than 55 per cent income deprived – which if you think about your neighbourhood, and if more than 55 per cent of the population are income deprived, that's a seriously deprived neighbourhood – we see a fall-off in outlet density, largely because there's nothing in those neighbourhoods at all. Maybe there should be, maybe there should be a corner shop in those neighbourhoods, maybe those people are being denied an awful lot. Just simply talking about deprivation as one thing is problematic as well, because there are different scales of deprivation. So, understanding – and this is when I talk about the more macro political and economic process – is about understanding why those environments are that way, and thinking about environmental justice arguments around that is really important, and the processes behind that.

Q. I was really interested in the point you made about space and time needing to intersect more, and I wondered whether your data around outlet density took into consideration trading hours, and the hours of availability of access to alcohol.

In a word – no. So, the data that we had on outlet density, we had to get from each of the individual licensing authorities, and, basically, we managed to get the location, and whether it was on sales or off sales. Some of them had better data than others, and this is why we tried really hard to get the Scottish Government to do something about this. Richard Simpson MSP did put an amendment onto the Air Weapons and Licensing Bill, to say that there should be an alcohol register, much like the tobacco retailers register, but it didn't go through. Michael Matheson MSP argued in the final debate, that it wouldn't go through, and it didn't. I'm meeting with Police Scotland on Thursday, to talk about their AIMS database, which I believe has opening hours, so I'm hoping that we can get access to that, to explore some issues there.

■ Psychology

Dr Richard De Visser, Reader in Psychology, University of Sussex

Thanks to Carol for asking me here, thanks also to Eric and everyone else involved in organising the session today. I found it really useful, sitting and listening to everyone. Now, the pressure is on me to make mine as interesting as everyone else's, and as useful as everyone else's. I've got to start with two confessions, I guess. One is that I'm promiscuous – and I mean that in a professional sense – in terms of I don't just do alcohol research, I do research into sexual behaviour, health service use, gender and health more broadly, so I'm not going to talk to you only about alcohol. I think there's a value in not just focusing on one particular topic. The other confession is that I'm a fake, I'm not a real psychologist, I didn't do my PhD in psychology, I did it in an interdisciplinary research centre, but with a psychology background. I'm shared between the School of Psychology at Sussex, and the Brighton and Sussex Medical School.

The other thing I had to do before starting, as well, because I said to Aisha that I would do this, would be to do the public version of the comment I was going to make on her talk which is that, she doesn't need to advertise, or do any more advertising, because she can do the actual providing of the care and support that people really need. Understanding their stories to provide the psychological or social research influence bits, and do the RCTs. I'm also going to be talking about this from an academic psychological perspective. I'm not a practising clinical or counselling psychologist, and that's a really important part of the work that some psychologists do carry out. I'm going to be talking about it more from the academic psychology perspective, and I have structured my talk around some of the questions that were posed to us by Carol. Hopefully, I'll get to go through them all, but if I don't, then I can talk about them later on.

In terms of "What expertise can psychology bring to the study of alcohol", I think, broadly speaking, it would be this biopsychosocial perspective, which was mentioned before. That we – not necessarily all individual psychologists – but psychologists of different kinds working together can cover all aspects of this biopsychosocial perspective. I think that is required to properly understand current alcohol use, and also where it's come from, and where it might be going to. However, when we talk about psychology, the next question I thought was, well which psychology are we talking about?

We can talk about things but I don't – this is different, this is about receptors in certain parts of mice brains, and how they're linked to certain genetic profiles, and what we might do about this, and how it might inform our understanding of patterns of development of addictive behaviour, particularly alcohol addiction in humans. Really valuable stuff, but I can't do that, I don't get it. We had, on the slide before, I had a little thing, a little logo for SARIC, which is the Sussex Addiction Research Interventions Centre. We had a little launch, and Sarah King, who I don't think is an author on this one, spoke before me, and I sat there, and for the first five minutes, I was like, yeah, I'm with you, got it, got it. About six or seven minutes in, hmm, bit struggling here, and after 20 minutes, I was like, well, you know, I didn't know what she was talking about. It obviously doesn't mean it's not valuable, it's just because I don't have the capacity to understand it. That's an important part, that's very much in the bio end of that biopsychosocial model.

Other things that we might be more used to, or particularly people who are here today, might be more comfortable with, and more familiar with, are things at this end of psychology, which is very much around the health psychology. Health psychologists like making models, and testing models, and measuring things, and refining measurement, often without actually thinking about what they are really measuring. There will be studies like this, so an application of behavioural reasoning theory, really psychological, rational thinking, applied to something that may not be rational, which is around binge drinking among undergraduate students. That's another approach which is using these quantitative methods, which may share a little bit in common with some of the elements of public health research, which Vittal was talking about before. We can now look at some of the crossover that's there, but some of these studies are looking at trying to understand and predict what influences behaviour. The understanding of what the correlates might be and what the modifiable factors are, and then seeing if we can develop interventions to change some of those.

Interventions might look something like this. In a recent study where we were looking at people who weren't able to estimate the unit content of the drinks they consumed, it was hard for them to drink in line with government guidelines. We also knew that when people poured drinks, their usual drinks, of what they thought were units, they were out by quite a bit. Given that everyone we asked in an earlier study said, "Oh can you please tell me how I did?", and then went, "Hmm!", and were really shocked and horrified by that, and said, "I might change my behaviour", we thought we could use this as part of a personalised intervention: talk to people about what they drink, pour their usual drinks, give them valid or accurate information about what they're actually drinking, and then see if it changes their behaviour. So that's where this can

understand what the correlates are, and then see if we can change it, and that's where it comes in.

Again, it's very much focused on individuals. It is very much about quantitative assessment and measurement, and looking at these things over time and it misses out, largely, on a sociological context there, so we're not looking at why people drink in certain ways, at certain times, or in certain contexts, or in certain locations. We can also look at things at a broader level. I have done some work with Alcohol Concern about looking at the impact of Dry January, and we've found there, for example, that a larger scale approach is a public health intervention, if you like, but based on social contagion theory of getting people to stop and think about their drinking, talk about drinking, to see what happens. This can lead to longer lasting changes in people's thoughts about their own behaviour, their capacity to manage temptation or pressure to drink, and their actual patterns of drinking as well. This is where we start to move a little bit from – although it's still individual focused. We are looking at the cultures, or the context in which people are drinking, and try to understand that. We are in the psycho bit, or heading towards the psychosocial parts of psychology.

We can also think about broader scale interventions that don't just focus on individuals. In this case, what we're talking about is using qualitative methods, and combining qualitative and quantitative methods, as part of the process of developing, refining, and evaluating educational interventions in schools, and this is a resilience based focus. There are a range of people involved here and what we've been doing is try to think about, from the research that we've done before, which looked at the reasons why young people do drink, or don't drink – and they're often not health related reasons – how we can use that understanding of what does influence young people's behaviour? How we can address the observation that a lot of them feel unable to resist temptation pressure to drink, and think about developing educational interventions which can be used at an individual level, to allow individuals to develop the skill to resist alcohol, whilst also taking a broader whole school approach, to questioning and thinking about alcohol and its place in society as well. We are recognising that for any intervention, for an individual to be successful, we need to think about not just them and what they have, and what they can do, and what they think, but also the context in which they might be drinking, or deciding not to drink.

Thinking about where we might tie in more closely to things that sociologists might be used to reading – and I picked out this one because it's in Social Science and Medicine, where obviously, sociological stuff is more likely to be published. We do sometimes do purely qualitative research, which is trying to understand how beliefs about alcohol, about masculinity and drinking, that are out there, and social things which might be currently in a particular situation, but have come from, have a

particular historical background to them: how what is out there in the world comes into people's heads, when they're thinking about drinking, and their own patterns of alcohol consumption. So when you think about these, what psychology can do, we can do lots of things, but – and this is the where the but comes in – so what we can do is to use this biopsychosocial perspective, we can use a range of different methods to understand drinking behaviour, and that could be the genetic pharmacological stuff, which is particularly focused on addiction, or we can use quantitative research to develop predictive models of behaviour. We might use qualitative methods as well, to understand better individual behaviour in a social context, and we can use those qualitative methods as part of a process of refining and developing interventions.

Maybe that's what psychologists really should be doing a bit more of. Rather than the model building, they should be working at developing and improving interventions to help to change behaviour. The other things that we can do in psychology – and these are not psychology specific ones, they overlap with public health and epidemiology as well – is to do meta-analysis of quantitative data. Rather than relying on individual studies, or hoping that individuals will read that paper, and then be able to synthesise all of that, we can actually do these meta-analyses, which take the work out of, and lessen demands of certain individuals, but which provide comprehensive syntheses of the current state of knowledge in a particular area. With the expertise in qualitative methods as well, they're developing approaches for meta synthesis of qualitative data, which takes into account variations between different qualitative studies in terms of the groups that are observed, the times of the data collection, age, and those types of things, and try to balance these things together as a parallel to the meta-analysis that's – I wouldn't say easy to do – but easier to do with quantitative data.

The diversity within psychology is a strength, and it's also a challenge, and it's because we talk about this biopsychosocial perspective, but we don't have a clear way of having a coherent integrated biopsychosocial approach. So, we could talk about various things, but we've probably never worked together on these kinds of topics. There is thus a potential for this biopsychosocial integrated approach, but the reality is that it doesn't really work that way, and that is because individual psychologists or individual researchers tend to do either the biological, or the psychological bits, or the sociological, or the social, socio-historical bits, and don't always put them altogether. I think if anyone had the idea that – well, some psychologists might like to think that they do all of it, but the problem is that we can't, and we can't do all those bits as well as some other people. Thus, we do need to work better within the discipline, but also, across those discipline boundaries.

A major limitation of the psychological approach is that the focus is too often just on individuals, and there's often little

attention given to the social context, and social context that includes the historical as well. It is important to think about the social context, because drinking is, typically, for most people most of the time, a social activity we do with other people. We do it as part of socialising, and if you look at the main motives for drinking, among young people and older people, it's not about, not necessarily, or only about the psychopharmacological effects, it is about, it's a social activity we do for particular interaction, for whatever reasons. We get ideas of "I'm part of this group". It is not just about what an individual has going on in their head, it's about the individual's history, their background, their family, whatever it might be, and how that then influences how they interact with particular individuals right now, and how they think they might interact with those individuals in the future. It is something we need to think about in terms of individual narratives, but also, social narratives of where particular individuals fit in a much broader social context. That's what I think is lacking, is bringing together the potential of that biopsychosocial approach, and working further forward.

One of the questions that Carol asked us to think about was about "How can we challenge statements in the public domain that are not evidence based?", and a good thing about the psychological perspective of that biopsychosocial perspective is that we can. We have various types of evidence, or we can work to develop these different types of evidence as well. We have the power of statistics, the convincing nature, we have numbers that say, this is it, this is how strong this association is, and this is what this effect of this exercise might be, and that's where we borrow from our colleagues, and our influences in epidemiology and public health are doing the same. In terms of saying, we can measure this, or we can show this, and that's often convincing, and, as you were saying, Niamh, about what counts as evidence, what do people count as being evidence. That's probably going to be convincing, for some people at certain points, and they also might want to know what is the cost benefit analysis here, what change are we going to get from investing so much into this particular approach?

What I like about the psychosocial things in psychology is well we all love a good story. You see these things, and when I had the article there, you won't just get, here's a report, and here's the statistical evidence, but also, here's the story on the side, which is an illustration of that as well – this is the woman who drinks in this way, or this is the guy who went into treatment, and this is what happened. We can do both of those things. There is the allure of a good story. We'd much prefer to read a story about someone's experience that captures our attention much more than a list of statistics, or a table. I realise we're seeing lots of tables, and statistics. I find them interesting, but not everyone will. The stories – and you can see it as well, in the videos that Aisha had earlier this morning. We sat there and watched and listened to them all, and we

got something about their experience from that. You are aware that they might not be necessarily representative of everyone's experiences, but they capture our attention, and we listen to those, and we can understand what it actually means, a bit easier than some numbers on a page.

From within psychology, there's also the promise of an effective intervention. What we can do with psychological research that's focused on the interventions, is that we can say, "Look if we do this, and then this will be an effect as well". So rather than just measuring things and saying, "This is the association", we can show that these two things go together. We can hopefully convince people that if we do a bit more of this, we will have these socially beneficial and individually beneficial effects, because we can measure what the impact is of doing this. I think that there are a range of sources of evidence that we can use within psychology, but again, it's important to note that these aren't just psychological things. These are things we share with public health, with epidemiology, with sociological research, and with human geography as well.

One of the other questions was "What are the biggest challenges on alcohol in Scotland, the UK, and the world today?" Of course, there are various – we've talked about the health concerns for example. From a psychological perspective, what I was thinking about, what we hear from people when we interview them, when we do our questionnaires is how we can encourage or facilitate healthy behaviour, without appearing to patronise people, or annoy them, or pester them, or whatever else – getting the balance right between providing information, providing support, and help when it's needed, but also, not telling people. People don't like being told what to do, we found this in the research we did with young people in particular. What they don't want are older people who drink telling them not to drink, and that's really interesting. That is where looking at the importance, or the impact of peer to peer methods, peer education, for example, can be more effective, because it doesn't feel like someone other than you telling you what to do. If we can have those stories and experiences coming from people who have, who it's obvious they've had those experiences, those stories are believed more. Therefore, the message that they're conveying is accepted much more easily. I think that's a big challenge in terms of, if we find out that a particular intervention might work, what's the most effective way of delivering that, who should be doing that, in what context, and those are the issues to think about.

I think also, in psychology, we need to get away from the focus which particularly comes from the bio psycho end of things, which is focusing on addiction, and just looking at addiction, and particularly addiction from biological/genetic factors, and instead, consider the impact of various harms, so for example, look at the impact on individual psychological wellbeing, on families, on school progression, on career, whatever it might be, and the

ways in which these are influenced by those psychosocial factors, and the way they influence that. It is those multi directional links between the biological, and the psychological, and the social, and I think that's one of the things that psychology tends not to do. Psychology likes to align itself with the treatment based medical models to identify these individuals, we'll treat them, and help them in some way, and doesn't look so much at broader social issues, and the social contextual factors.

The next question is, "Is it important that we work to reduce alcohol related harm, or, should academic work have other aims?" I guess the answer is yes, because it's not an either, or. I think we should be aiming to do both in all of those things. It's so obvious that there are alcohol related harms that we need to work on, and try to understand, but there should also be those broader aims, and that's part of this understanding of how we've come to be where we are now, and how we can change things. I don't think that the focus just on harm, and having that problem focused view, and treatment focused view of alcohol research, is going to give us everything we want, or everything that we need in terms of understanding the place of alcohol in society, and whether that can be improved, and whether the harms can be reduced in some way.

"How we can work better together?" I think, is having more meetings like this, which are interdisciplinary by definition. Well done to the sociologists of the BSA and SHAAP for organising this. I think there are things like going to topic focused conferences and meetings, and publishing in topic focused journals, rather than publishing in our own disciplines. If you just publish your psychology research in a psychology journal, okay, I mean, today, if you search anything in a particular term in various databases, that things that are relevant will come up, but I think we do need to make more effort to go out and talk to other people. Psychologists shouldn't just go and talk to other psychologists. We learn so much from talking to epidemiologists, and sociologists, and geographers, and historians, as well.

Also I find – and I'm sucking up to everyone now – but I get really bored talking to psychologists about psychology. It's much more interesting to talk to people who are not psychologists. The psychology that I do, social psychology, is much more like the sociological stuff. So I go along and think, "I'm like these people, I'm like these people as well", and I think we also need to do a lot more work to develop truly integrated mixed method designs. Rather than psychologists saying, "Oh we'd better tack on a qualitative bit because that's what the funders might like to see", we do something that involves working with experts within their different disciplines, and making that clear on our applications as well. So we say, we've deliberately got an expert historian on this area, because that's what we need to do the best part of this study, and we've got a geographer doing this part because of this, and the

psychologists are going to do this bit over here because that's what we really need, rather than simply doing some tokenistic view of, oh well we'd better add some qualitative stuff on because that's what people are looking for.

I remember there was one thing that someone was talking about, being on a panel, I think it was for NIHR, when they were talking about interdisciplinary research. There were two psychologists, and one was developmental, and one was social psychology, and they said, well we're different disciplines. You're both psychologists, and you do stuff in exactly the same way; the fact that you have a slightly different adjective in front of your names, doesn't make that much of a difference. Okay, how can we consider some of those variables, or factors, like gender, age, sexuality, ethnicity, et cetera, in our work? It really depends on – and I'm simplifying things a bit here – whether we're coming from a qualitative or quantitative perspective. In quantitative research, these are often considered to be, not confounding variables, but factors that we want to control for, or adjust for, before considering the real psychological ones, the things that we might be able to change. So we might do age and sex adjusted analysis at a first step, and then add in the attitudinal or cognitive factors there. They are the things we might look at changing in any intervention. In contrast to the quantitative research – not all the qualitative research does this – but there is some good qualitative psychological research that actually focuses on these variables, like age, like sex, like ethnicity, the variables that we really need to focus on, as a major focus in understanding why there are variations in patterns of abuse, and experiences of using alcohol, and the outcomes there as well.

Whether we take the approach of looking at these as being variables that we need to control for, or things that are crucial to our understanding, they can also be used to focus interventions on groups most at risk of harm. If we find, for example that men of a certain age are most at risk, we have that information, and we can target the interventions or focus them amongst that group. We will also be able to identify, rather than just taking a one size fits all approach to intervention, we're saying, "OK, if we're doing something with women of this age, we need to focus on these factors. With younger men, we focus on different variables". So it's important to include these, whether we're doing the qualitative or quantitative work.

Then we have the question about "How – how in parentheses there – should we engage with the drinks industry?" I'd say, tentatively, and pragmatically. I think most of us are probably going to engage with the drinks industry either tonight, or on the weekend at some time, as consumers of their products, so I think it would be slightly hypocritical of us just to say the drinks industry, we don't have any association with that, and therefore we can just stand apart from it and say, "Alcohol industry = bad. Us = very good". Some excepted, of course, the abstainers, who can hold that position. I think if we are engaging in work

with, particularly, for accepting any funding for research as well, we need to have a really clear idea beforehand about what the role of industry funders might be, what they might want or expect, what role they might want, or expect to have in the design, the conduct, or the reporting of research, and how we can respond to this. I've had some experiences where we have had funding in those contexts, and it's been important to work out beforehand that there won't be any involvement in how the research is being carried out, or any sensory or veto of publications as well. We've had a situation where we need to report back at the end, when it's been done, but once the funding has been handed over, we can do what we want, in the way that we think is the most valid, or the most appropriate. I think being able to do that is fine, and I think, also, if we want to have approaches that are most effective, we can't pretend that we're able to do this without having any engagement with industry as well. That we do need to, as I said, do that tentatively, and pragmatically, and hopefully, as part of, properly and truly interdisciplinary research that will come out, will hopefully emerge from some of the discussions that have already happened, and will happen for the rest of the day here.

Questions and Discussion

Q. I've been struggling with the cognitive dissonance throughout today. I went to a play last night, called Blackout, which was the stories of people with alcoholism, sort of telling their own story, and there were a lot of people believing that there is such a thing as alcoholism, that you can differentiate it from heavy drinking, and of course there is Alcoholics Anonymous (AA), 80 years old last year, and a very successful organisation. So I was wondering, how we can challenge statements in the public domain that are not evidence based. Do you think AA is evidence based – probably not? Would we, like Stanton Peele, want to take this on, or is that a useful method, or conception of severe alcohol problems, and a useful treatment that we want to leave alone?

I think it's really difficult, I probably won't be able to answer that directly. I think what's important, what's interesting that comes out of that is that, it's about us trying to understand how the general public understands these concepts as well because if a large number of the public do think, do have certain beliefs that aren't supported by the evidence, what can we do about that, how can we challenge that? So if there are certain beliefs about addiction, what it is, and what can be done with it, and if that's what a lot of people think – and yet, there's a small number of people who maybe really know what's going on, who have a different view of that, then it's difficult to then get support for the kinds of treatment, the interventions that we think we have evidence that are most effective. It's quite difficult, because there's also the extent to which people want to be convinced by evidence, or can be convinced by evidence

anyway, and that's maybe one of the things I didn't mention there, is that this idea that evidence will change people's minds, is a bit optimistic as well. So I think there's just that on-going discussion, debate, about what do we mean by these terms, what do we count as evidence, as well.

If we have a situation where someone has undergone a particular treatment, or support experience, and that has worked for them, then that's going to be, for them, really convincing, and for the people they know, whereas it might not apply for everyone else. It's those things, as well, we had those stories, the grandmother effect, and things like that – yes, my grandmother smoked 30 a day, and she lived to about 86. So, it's difficult to do that, because, you know, as John was saying before, you take the epidemiological information, but how do you apply that at individual level? With all kinds of information, people filter, actively and passively, the information that they're given.

Q. I've been absorbing the disciplinary perspectives on this overarching interest. It just came into my mind about participatory design, and it resonates with having, the people that are affected by the overuse of alcohol in the design of interventions and whether that's something that's been addressed in this area. The gentleman was saying about, those are the sort of victims, or those that are suffering, and whether, in fact, we should be considering their inclusion in the design of interventions. I know that's maybe been done, but it goes, it's a spectrum, isn't it, in terms of which intervention is appropriate. It's very complex.

Yeah, it does depend on these types of things. So with the school based things we're doing, for example, there were studies, or, several steps on the way into it, and the earlier ones were just talking to people and just understanding what was going on for them, between 13 and 21. We picked out from that some of the things that seemed to be common themes that might be influential for people. Then, what we did was, we actually asked back some of the people that we'd interviewed about their experiences, and we said, can you be a part of a little video that we're doing, can you tell us a little bit about your story as well. So then you get the sense that it's not just us saying, oh we think we know, so we'll tell you, but it's more about, we think we know this from the stats, but also this is what people are saying, it matches their experience as well, and I think that's an important part of it. Also, there is the selling or marketing of it, that's pretty crass terms to use. If you want other people to take it on board, rather than you just saying, oh we think this is fantastic, if someone else is in a situation and says, this worked, but okay it's not perfect for these people, it's going to be much more convincing, because of that identification with the people who are conveying that message.

Vittal Katikireddi: I think that's a really important point about public involvement in coproduction, in terms of

research, and about interventions. I think that is an increasingly important area for people to be working together on. So, clearly sociologists, and psychologists, and a whole range of other people, have an important role to play in that area. I think, in public health, arguably, the discipline of epidemiology has been quite dominant for years and years, and as a consequence of that, often the public voice, and the patient voice, has been neglected. I think you've really hit on something really important.

■ Discussion and Questions

Q. I'd like to ask a question to James Nicholls, because he answered it earlier. About the end game, so tobacco had an end game. So it's really just broadening the debate in the room, but just because you asked it, I thought I'd ask it back – where do we want to be with alcohol?

James Nicholls: Well I think it's a really critical question, and I think that one of the issues that there is, especially in recent years, the whole learning from tobacco the approach to a lot of the work around alcohol has been that the end games are completely different, actually. I think they are very distinctionary, and even the idea of an end game, actually, to be honest. You can see in tobacco research, there was always the assumption that smoking is a bad thing, we need to try and eradicate it as far as possible, and there were stages along the way, that the ultimate goal was a smoke free society. With exceptions, in some people's case, that would be the goal around tobacco. But it's a very, very different thing, I think, that's going on in alcohol research, and in alcohol policy, and the question is, what is the good society when it comes to alcohol? I don't think any of us have really, really grasped that question, I don't think any of us have seriously said, well, you know, you can look at it from a health perspective, a narrow health based perspective, and you end up around the no safe dose. Clearly you can point to a position where you'll say, well for many conditions, no alcohol consumption is ideal, but that's a very narrow health perspective.

If you look at a wider social perspective, a wider sociological perspective, issues around the pleasures associated with drinking, the social functions of drinking, and the social functions of drinking occasions, then there's no clarity. So I think the first question needs to be, should that even be a road that alcohol research and policy is going down, a grand social vision, or should it be about saying, well lets identify where we think there are harms that need to be tackled, where those harms need to be tackled, we need to tackle them. We need to have an idea around those specific areas, what we think would be an improvement, not necessarily the ideal, but equally, to allow within alcohol research, a continuing investigation of the non- problematic, or non-ostensibly problematic aspects of drinking. Alcohol is a part of our society which is so fundamental, and so ubiquitous, and that is also important.

I think there is a tendency to drag – and again, I'm not speaking, you know, I have previous perspective on this – but a tendency to drag any, and all, research and analysis on alcohol, into that – it's like a gravitational pull. A gravitational pull of making the world a better place, and

of making the world a better place through a public health approach because that's the dominant paradigm, and whether, it's not so much come out of resisting that, but, where that's appropriate, and where other perspectives are appropriate. So, I think it's about saying, first and foremost, even the language, or the idea of an end game, what we want to go down, and if so, how do you break that down into the different disciplines, and the different target areas. So yeah, it's not a clear answer, but that's my general thoughts on it.

Q. I've got a comment, and then a question that's related. I always feel a bit a disciplinary when it comes to things like that – I'm a pharmacist who did a PhD on school drug education, so I guess, I related most to the public health specialist, but I'm not a public health consultant. I don't really know where I sit with this, and I don't know whether that helps or hinders, and that's what I want to ask in a minute, particularly of Vittal, but also of others. I'm interested in this concept of risk, and benefit, that James, I think, has touched on. So, the idea that our studies tend to focus on reduction of risk, and not maximisation of benefit, or pleasure, and it feels, to me, like epidemiology is quite good on the risk side, and maybe sociology is good on risk and pleasure, and maybe psychology is about our ways of thinking about risk and pleasure, both conscious and subconscious.

How does sociology explain the pathways in our brain that are formed, that impact on our psychology in a young age that's both sociological, and psychological, perhaps? It does feel to me like it's, I would find it really hard to be in a single discipline, and, I was also thinking, what is a discipline – is nursing a discipline, or is it a profession, is public health a discipline, or is it a profession with a common goal of public health? Is there something about, what a generalist does, if I could sort of call public health, and maybe nursing, and medicine, more generalist professions? What do they bring to the study of alcohol in a research team, where other people, perhaps, have deeper knowledge within the discipline? What's the role of that – if you're a sort of jack of all trades, which I sometimes feel I am a bit, what does that bring, and how would that help to unpick this sort of balancing of risk and benefits, that seems key to policy change, and behaviour change?

Vittal Katikireddi: It's a really interesting point. So my first response when I got the email about this event was, actually, I'm not a – public health isn't a discipline, I don't think. I think it's a practice. So, unlike, maybe, sociology or geography, where they have a way of looking at things, that helps investigate certain phenomena, I don't think that's the same with public health. I think public health; it's a form of practice. I've tried to illustrate what I think we're trying to do in that practice, but it's not an academic thing whereas, epidemiology, I would say is, and often, epidemiology has been seen as the traditional discipline underpinning public health practice. So that's probably the

closest we have, but actually, I think, practically speaking, public health professionals are typically drawing on lots of different disciplines, and like I've tried to suggest, they don't really have a detailed knowledge of those disciplines, by and large, probably with the exception of epidemiology. So, certainly in my own PhD, I drew on more political science type approaches.

I would say that basically public health is a practice, not a discipline. I think you're right in terms of, we're not very good at looking at the pleasure side of things, and that's been an on-going debate, in terms of how health professionals, more generally, think about health and disease. So although there's the famous World Health Organisation definition of health, in this quite positive way, that includes wellbeing; actually we, famously, tend to only really measure all the disease, and death, and ignore all the positives as it were. Just to pick up on that discipline side of things, the other thing that strikes me is, I think it's been really great having a lot of different disciplines here. Going back to the idea of an end game, there are arguably some disciplines that might have been really useful to have, as well, which might be something for next time round, as it were. So, in particular, I think political science would have a role to play, especially in terms of how we engage with alcohol industries and especially industry because they're very heterogeneous.

Similarly, I think, in relation to the end game, I think there might be a role for philosophers or ethicists. Going back to the point about the role of the public, actually, we're talking about political decisions here, and fundamentally, the type of society we should be living in, is arguably, in a liberal democracy, up to the public. So, actually, I think as a public health professional, I can see that I have a role to play in terms of advocacy for the population, in terms of improving their health but that shouldn't be the only thing that determines how society works. I think there's clearly a role for lots of other interests in that arena. The last group I'd like to pick out, who I think would be useful to have are the economists, and I don't mean the health economists, who do the fantastic work that the Sheffield team do, but I include the more macro economists, and the people who do broader economic type activity.

Richard De Visser: I think the approach I would take is to say, okay, it depends on whether we're thinking about an end game, and what the question is. If we can identify what the question is, I would say what's the most appropriate method to examine that? As I've said before to people, teaching both qualitative and quantitative methods is, rather than saying, I'm a quantitative researcher, so therefore, I'm going to use quantitative methods to do this, but rather say, what do I want to know, and what's the best approach, what's the most appropriate way, or what are the most appropriate ways of answering those questions. You might have something in the way you do mixed method research, because part of the question, some of the questions you're asking are about statistical

associations between things, and some of the questions about experience, whatever it might be. Particularly, if you're thinking about, how do people, how do individuals balance the risk and the pleasure side of things, then you might be able to measure that in some way, but it's going to be much more productive, at least in the first stage, to ask people about what are their experiences, and when do they feel good about drinking, when do they feel bad, and what's the experience like at the time, and afterwards as well.

So, that's why I said I'm a bit of a fake, and apart from the fact that I belong in the psychology department, I don't think it's useful in that way. I do research on health topics, I do research on a range of topics, but, it's not necessarily psychological, some of the things. That's why, when I was putting things up before, some of it looks like research that's being done in other disciplines. It's about putting the question first, I think – what do we want to know, and then coming back and saying, well what methods do we use, and are they what other people in this discipline are using?

Niamh Shortt: Within geography, we've come from a history of using a biomedical model when we're thinking about pathogenic environments. More recently, we've begun to think about salutogenic environments, and more health enabling environments, but within alcohol, that gets really tricky, because what is the message that we want to give, what is it that we're wanting to say? I remember whenever some of our research came out, the same person who 'flew by the seats of his pants' in Parliament, also, was very vocal on Twitter, about some of our work, and most recently, a piece of research came out that was funded by the Campaign for Real Ale, that showed that having a local pub was good for you, was good for your health, which he tweeted about, about how brilliant it was. Neglecting to say that their research was also cross-sectional in association, but our research was all wrong, because it was cross-sectional in association.

So, there's this problem, as well, of well what research do people want to hear, and what messages are they willing to hear, and not willing to hear and I think that's where it becomes just a little tricky in thinking about the messages that we put out there. I think that's a question for everybody to think about, some of the benefits that may arise and whether we want to go down that line, or whether it's actually just a little bit risky.

John Holmes: I wanted to talk about something slightly different. There are some elephants in the room, and one of them is that the people who are here are the people who are already willing to come along, from the health sciences and talk to sociologists, from sociology to come and talk to the health scientists. I came as me, as someone who's quite happy to slag off epidemiology but a lot of my colleagues would not have come to this, and if they had come, would have been looking a bit befuddled. So I'd like to just say what they might have said today.

This is going to end up like an attack on sociology, I'm afraid, but I'm just going to be a little bit caricatured, so I can make my point. I just want to give a sense of why this doesn't happen, why the health sciences don't take in social science perspectives, beyond psychology, which I think they do integrate quite well, actually.

So, one of the reasons is, do sociologists, anthropologists, and other social sciences, really want to work with health sciences because they appear to write impenetrable articles that none of us can understand, and the epidemiologists – and I said this would be caricatured – we tend to blind people with statistics, but at the other end of the scale, we get blinded with suffixes and prefixes, and these words that don't make any sense to us, and that makes it hugely difficult for us to understand what you're trying to tell us, in your articles. Indeed, that is if we can find your articles in the first place, because they don't appear in *Addiction*, and *Drug and Alcohol Review*, and *Alcohol and Alcoholism*, and various other journals that we read, and there's a problem here that, we're not really talking to each other. A good example here is, I actually only found out about Tom's research a few weeks ago, except that it seems that everything he's doing is relevant to what we're doing, and all the kinds of things we're talking about, and I only found out about Carol's research through Twitter. So we have this problem that we're not talking to each other very well, anyway, apart from these sessions where the people who are coming are already interested in talking to each other.

The other – I've been banging on about data all day – but there is this problem that the data sets we're using don't include the things that you want us to talk about. In a sense, we can't work with you if all the skills we have to bring are not, we can't bring our skills to bear on your concepts, because they're not in the data, and some of them are not very amenable to quantitative data, but that's a problem we need to solve together – how do we make those concepts amenable to quantitative analysis? We have started making moves towards that, with looking at social practice theory, and looking at different measures, and I think it's that thing that we need to do more thinking about, to try and make that happen. Lastly, touching on the idea of a biopsychosocial model. It's one of those things that gets talked about a lot, and Richard made the point, it exists as a word, it doesn't really exist as a thing, and every time I see it, what you get is controlling, models that control for gender, and socio-economic status, which is not really a social perspective, it's just chucking in some variables.

I think there is some thought to be put into how do we actually come together in a way that the people that don't come to these meetings can actually work with, the sociologists can work with our data, and if Tom or Carol wants to do an attack on health sciences, that would be great to hear, actually.

Q. My background is nutrition, nutritional science. We came together with a lot of different sociologists. At that time, we have seen an Economic and Social Research Council (ESRC) programme on food choice, which had to be multidisciplinary. I'm currently Chair of the Medical Research Council (MRC) National Prevention and Research Initiative. We will only fund research that is multidisciplinary, and I think we've come a long way, in many of the health behaviours, in recognising that we have to have multidisciplinary approaches. So for those people that aren't at the meeting today, and they could be, they're going to miss out because I really think things have changed, with respect to funding. When people at MRC and research councils are funding multidisciplinary research, there are ways forward.

I'm actually going to give a bit of a plug on behalf of Alcohol Research UK, and the Institute of Alcohol Studies. Because we recognised the silos that alcohol researchers work in, we also recognise that people are incredibly busy, and it can be quite difficult to find the time to come along to these shared events, and just to communicate across departments, and institutions. So we decided to pull together an alcohol research directory, which will be a database for anybody interested in alcohol research to upload a personal profile, share links to past publications but also provide some brief details about ongoing projects. Because we often find it really difficult to find out who's doing what, and I'll often come to an event, and only learn through, over coffee, or like John says, over Twitter conversations, what other people are doing, and we think it could be really useful to have just some landing space for anybody to go in and search for topics or ideas, when they're doing grant applications. We're also going to have a section on the directory where people can advertise where they have data sets that might be available for secondary analysis, if anybody has an interest in a particular area.

We're hoping, well, this is intended to start off as a UK database, for UK based alcohol researchers, but the website has been built with the intention in the future, to roll it out to an international database. We'd like to think of it as a – we started off by saying Google for alcohol researchers, and then we slimmed it down to LinkedIn for alcohol researchers, and now, I think we're just calling it a grapevine. So watch this space, we're hoping it's going to be up in the next few weeks, and as soon as we have an established URL, we'll be sending email alerts round and trying to recruit as many people as possible to upload profiles, so we can get some good critical mass, so more and more people will like to join. Hopefully, the people that aren't here today will be able to learn a bit more about the multidisciplinary approaches in alcohol research. So thanks for that, that's just a plug.

Moira Plant: Thank you, Katherine, and that's really very useful. For a long time, we did a register of UK alcohol research, and people got in touch with each other, they found out what everybody else was doing, and it was really very helpful. I'd just like to say something, and that is that, in the '50s – I was actually very young at the time – there was a US senator, who, they were debating alcohol in the States, and the US senator started out – this is a paraphrase – by saying, if you're talking about the stuff that damages families, ruins lives, kills people, then I'm absolutely against it. If you're talking about the stuff that warms the heart, that gives social meaning to families and parties, then I'm all for it, and I think that's our dilemma.

Our other dilemma, was Selden Bacon who said the way we research alcohol is like researching the car industry by only looking at accidents. With my psychotherapy hat on, if I only asked people what the problems were, and not what the benefits were, I'd only be getting half the picture. Our problem with all of that is, you start asking for the positive aspects of alcohol, and then people say you're in the industry pocket. So that is a real dilemma. The GENACIS project does ask about positive aspects, but it is a real dilemma in this area, and that covers every discipline that we've been talking about today. Thank you for being here, I hope you have enjoyed it, I hope you have learned, I hope you have met people who have been useful to you, and who may be useful to you.

■ Summing-up

Eric Carlin, Director, Scottish Health Action on Alcohol Problems (SHAAP)

Carol asked me to do my Jerry Springer bit. I don't know if that's good or bad. I was saying to a colleague that I thought I was the oldest PhD researcher in the country, and they said, no, no, Margaret Mountford from The Apprentice is older than you. So I don't know whether I was meant to be pleased with that or not. I would just like to say a few words about what I think we've covered today. What we will be doing, as I said, is we will be drawing up a report afterwards which we will circulate, which will hopefully be more coherent than I'm sure I'm going to be. Just to say, in terms of key themes that I heard, that I thought were really important. The inter relationship between the different disciplines, and opportunities to work together, are great. Within disciplines, and across disciplines, we don't necessarily understand each other that well. Just in terms of my PhD stuff, I studied history, I then did a masters in management, and I then began my PhD in the Department of Social Policy, which closed down. I was then transferred into geography, and I'm using mixed methods on my PhD. So, Niamh, I understand your identity confusion, and I think that's actually probably a good thing, in terms of bringing a generalist approach to the generalist issues that we're dealing with.

I think there was a really important thing that came through all of the presentations, and please excuse me if I don't pick up on everybody individually. We need to look at the social dimensions of drinking, so we're not just looking at alcohol, and we shouldn't just be looking at alcohol problems. I think Tom really usefully picked up, for example, the issue about masculinity, and changing masculine identities, and how that then changes how people behave in terms of men using alcohol. All of that is within a social context, where we have values, we have histories, we have cultures, we have assumptions of consumption, and we have pressures from business promoting this product to you, making it ever cheaper. There's an interaction between spaces and places, where we consume. There are additional changes related to how we research, when we're dealing with shifts to home consumption, rather than consumption in public places. That creates both difficulties in terms of the challenges that people have, in terms of their alcohol use, but also in terms of researching and finding out about it.

I think we need to be a wee bit careful, about not just following some of the agenda of what the industry would like us to believe, in relation to ethical positions, and that we're all a bit balanced on this – we're not, they're in positions of power. Niamh really usefully talked about global actions of the alcohol industry, we could have a whole session on that. The other thing is there is a diversity of organisations within the alcohol industry, but still the vast majority of it is dominated by global alcohol producers. So we need to not lose sight of that, in terms of what we're actually dealing with. In terms of problems with different disciplines – excuse me James, if I misrepresent you here – I thought that you said, or you suggested that the problem with history was how other people used history, it wasn't that history, as a discipline, had any particular problems itself. Except you're basically getting invited into policy discussions, as an add on, and they all say, that's a really interesting, nice wee story, but now, we'll go to the scientists, and they can tell us what we're going to do.

What I think history does have in common with the other disciplines, which I think we talked about was there is a tendency to homogenise experiences, and to generalise when we can. We actually need to look far more at the dynamic interaction that people have with other things that are going on around about them, in their environment, in their society, with other people. Nursing and doctors, I thought it was really useful, Aisha, that you talked about what nurses brought to the table, and we talked about – Vittal, you talked – about what doctors brought as well, and I think it was really useful that you highlighted some of the really fantastic strengths that that brings, but also some of the challenges that moral histories, that continue, and they are through the health services, and they are through our caring services, whether we want them to be or not. Pretending they're not there doesn't really resolve the issues. In terms of epidemiology, I thought it was really useful that, John, you talked about the need to interpret social worlds, and changing alcohol experiences within the social worlds.

Also researchers need to not be – nobody has used the term, ivory tower, so please excuse, these researchers who think they're being insulted if I'm using that term – but we can't be in ivory towers. We need to recognise that no matter how good we think our research is it is open to misuse by people who have objectives other than ours. We need to be aware of that, and I think the fact that you're actually raising that researchers have a duty and a responsibility to try and manage public presentation of their findings, in an ethical way, I think that's actually really important. I think that's really all. I just want to finish off then I'm going to pass over to Tom. Thank you very much; this has been a very stimulating experience. Just in terms of the cup being half full – John, you said you heard about Carol's research on Twitter, you heard about it, you got it, you have access to it, so use Twitter, it worked. Thank you very much everyone.

■ Biographies

Chairs

Dr Carol Emslie leads the Substance Use & Misuse research group at Glasgow Caledonian University, and is a convenor of the British Sociological Association's Alcohol Study Group. Her current research focuses on gender and alcohol use. She is a grant holder on a NIHR funded RCT which explores whether texting innovative messages to men in deprived areas will reduce binge drinking, and a qualitative study exploring drinking in LGBT communities (funded by Scottish Health Action on Alcohol Problems). Other research involves working with colleagues on a gender-sensitive scoping review of population-level interventions which influence alcohol-related harm, and a focus group study exploring men and women's drinking in early midlife.

Professor Moira Plant is Emeriti Professor of Alcohol Studies at the University of West of England in Bristol UK and Adjunct Professor at Curtin University Perth Australia. Her areas of interest include women and alcohol, drinking in pregnancy and Foetal Alcohol Spectrum Disorders. She has published on these and other related subjects in peer reviewed journals and books. Moira is the UK lead on Gender Alcohol and Culture: An International Project (GENACIS) which includes over 40 countries worldwide. Moira has acted as advisor to the UK and other governments as well as the WHO and the EU. Moira has recently returned to Edinburgh and continues to act as the UK consultant to the US Collaborative Initiative on Foetal Alcohol Spectrum Disorders, and Scottish Health Action on Alcohol Problems (SHAAP). Moira is a psychotherapist and trains and supervises counsellors.

Eric Carlin is Director of SHAAP (Scottish Health Action on Alcohol Problems – www.shaap.org.uk). SHAAP is a partnership of the Medical Royal Colleges and Faculties in Scotland which campaigns for effective policy and practice on alcohol, including action on price, availability and marketing. Prior to joining SHAAP, Eric spent more than twenty years managing drug prevention and treatment charities and commissioning health services. From 2008–2010, he was a member of the UK Government's Advisory Council on the Misuse of Drugs (ACMD) and he is a member of the committee of DrugScience, chaired by Professor David Nutt. Eric is also currently completing a PhD at Birkbeck College, London, exploring young people's transitions to adulthood in a context of disadvantage.

Speakers

Dr James Nicholls is Director of Research and Policy Development and Alcohol Research UK and an Honorary Senior Lecturer at Centre for History in Public Health, London School of Hygiene and Tropical Medicine. His research background is in the social and cultural history of drinking, and he has worked on areas including history of addiction, the development of temperance, alcohol policy, and representations of alcohol in traditional and social media. His current role involves working with academics, policymakers and practitioners across the UK to support the development of alcohol research and the use of evidence in policy. He co-chairs the Public Health England National Licensing and Public Health Network and sits on the PHE Alcohol Leadership Board.

Dr Thomas Thurnell-Read is Senior Lecturer in Sociology in the School of Humanities at Coventry University. His research has explored social and cultural aspects of alcohol, drinking and drunkenness in relation to a range of sociological issues connecting to sociality, identity and diversity. His research on Stag Tourism in Eastern Europe explored the ways in which masculinity and male friendship is performed and embodied through excessive drinking practices. More recently, he has conducted qualitative research into the consumer group the Campaign for Real Ale and used Real Ale and craft beer consumption practices to discuss identity, authenticity and nostalgia. He is a founder member of the BSA Alcohol Study group and Co-Convenor of the group since July 2012. He is the editor of *Drinking Dilemmas: Space, Culture and Identity* published by Routledge in December 2015.

Dr Aisha Holloway is currently a CNO Clinical Academic Research Fellow, working on a programme of research exploring the feasibility and development of alcohol interventions in male remand prisoners. A Registered Adult Nurse, she has had clinical experience in General Medicine, Acute Medical Admissions and Intensive Care. Aisha was short-listed for PG Educator of the Year in the Nursing Times Student Awards 2015. A Florence Nightingale Leadership Scholar (2014–2015), Aisha undertook a bespoke programme of strategic leadership development focusing on political and strategic leadership in nursing. Aisha has undertaken a Leadership programme at Harvard Business School and visited Congress/Senate, Washington DC, USA as part of the Scholarship, working with Nurse leaders' in the USA in Spring 2015. Aisha has recently completed an 18 month part-time secondment to the Alcohol Policy Team at Scottish Government as an Honorary Nurse Consultant for Alcohol Research and Policy. She is the Chair of the Scottish Alcohol Research Network www.sarn.ed.ac.uk and is a former Chair of the Nursing Council on Alcohol. Aisha has previously sat as a member on the DoH Alcohol Workforce Advisory Group representing Nursing & Midwifery. She is currently a

Non-Executive Director (NED) on the Board of the Royal College of Nursing Publishing (RCNi).

Dr John Holmes is Senior Research Fellow in Public Health, SchARR, University of Sheffield. John completed his PhD in Social Policy and Social Work at the University of York. His doctoral thesis examined risks of online communication and inequalities of internet access. He then worked at the Institute for Social Change at the University of Manchester on research examining influences on child well-being and development as part of 'Social Change: A Harvard Manchester Initiative'. He joined the School of Health and Related Research (SchARR) at the University of Sheffield in 2010 where he has published research on the potential effects of minimum unit pricing and issues of measurement and temporal processes in alcohol epidemiology. His current work focuses on quantitative and qualitative responses to drinking guidelines and incorporating theories of practice into alcohol epidemiology and policy analysis.

Dr S Vittal Katikireddi is currently a NRS Senior Clinical Research Fellow and honorary Consultant in Public Health at NHS Health Scotland. He studied at the University of Edinburgh, completing an intercalated degree in Medical Sciences (Genetics) in 2001 and a degree in Medicine (MBChB) in 2004. Following graduation, he worked in hospital medicine for four years in various parts of the UK and then returned to Edinburgh to carry out public health training. His PhD investigated the relationship between evidence and public health policy through two case studies (minimum unit pricing of alcohol and the English public health white paper, 'Healthy Lives, Healthy People'). His current research uses both epidemiological approaches (including analysis of linked administrative data) and qualitative analysis to inform healthy public policy and reduce health inequalities.

Dr Niamh Shortt is a Senior Lecturer in health geography at the University of Edinburgh and a co-director of the Centre for Research on Environment, Society and Health (CRESH) where she leads a programme for work on tobacco and alcohol environments. Niamh's principal research interests are in health geography, specifically in how the environment shapes our health, health behaviours and health inequalities. Her research focuses on the effect of 'place', particularly on the idea of the 'locale' in which various aspects of the social and natural environment converge to influence health outcomes. Niamh explores the ways in which the environment shapes health and resulting health inequalities. While there is a considerable body of research monitoring spatial inequalities in health, a comprehensive account of why health inequalities continue to rise remains elusive. Niamh believes that addressing this knowledge gap is a moral, political and economic priority.

Dr Richard de Visser is a Reader in Psychology at the University of Sussex who teaches in the School of Psychology and Brighton & Sussex Medical School. Richard has expertise in qualitative, quantitative, and mixed methods research, and his studies of alcohol have been published in numerous journals including Health Psychology, Social Science & Medicine, and Psychology & Health. He is also co-author of the textbook "Psychology for Medicine".

SHAAP - Scottish Health Action on Alcohol Problems
12 Queen Street
Edinburgh EH2 1JQ
Tel: +44 (0) 131 247 3667
Email: shaap@rcpe.ac.uk
www.shaap.org.uk



SHAAP

SCOTTISH HEALTH ACTION
ON ALCOHOL PROBLEMS
www.shaap.org.uk



BRITISH
SOCIOLOGICAL
ASSOCIATION