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Drinking alcohol at home and in public places and the time-framing of risks

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Running Head: Drinking away from licensed premises, time and risk

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Abstract

The United Kingdom has witnessed a steady rise in per capita consumption of alcohol in the three decades leading up to 2004 since when there has been a decline. Much of this increase can be accounted for by increased drinking away from licensed premises. In this article, we analyse the ways in which people who drink away in such settings think about the temporal dimension of risks which they associate with alcohol consumption. We present findings from a qualitative study which explored accounts of drinking away from licensed premises, either at home or in public places such as parks, given by adults and young people age 13 and over. We found that research participants associated drinking away from licensed premises with immediate risks. Those risks they identified included fights breaking out at home or in a public place, drinking to excess, falling over and becoming ill when intoxicated. Respondents mostly did not express concerns about longer-term health risks. However, some research participants did bring in a more extended time-frame in relation to ‘setting boundaries’ so as to avoid gradual escalation of consumption, and avoiding ways in which ‘alcohol can change one’s life’ for the worse. We will argue that the predominance of mostly short-term thinking about alcohol consumption in the face of public health messages about the accumulation of

health risks may be accounted for by the contradictory nature of such advice, and/or by the positive cultural and personal value placed on drinking.

Keywords: Alcohol Consumption, Home-Drinking, Health, Risk , Time-framing

Introduction

In this article, we draw upon a qualitative study which analysed perceptions of risks arising from drinking alcohol away from licensed premises. We focus particularly on the issue of time because, although the health consequences of excessive alcohol consumption are well-established, individuals who drink more than the recommended amount may not take account of longer-term consequences. Hence, better understanding of how drinkers frame this activity in terms of risk over time has public health significance in terms of efforts to reduce levels of alcohol-related disease. Such analysis may also contribute to the social science of risk by shedding light on the ways in which social actors frame time with respect to risks which are officially marked out for their attention.

We will first discuss the context of drinking away from licences premises in terms of both epidemiological evidence and public perceptions of risk. We will then outline the methodology of the study discussed in the article. In the data analysis section we will explore research participants' reasons for drinking away from licensed premises (mainly home-drinking) and their risk concerns. This analysis will provide the backdrop for our analysis of respondents' use of temporal frameworks in thinking about health risks arising from alcohol consumption.

Risk and the consumption of alcohol

UK alcohol consumption

In 1997, the annual consumption in the UK in 1997 was 8.2 litres of pure alcohol per person. By 2003, it had risen to 9.6 litres, the seventh highest per capita consumption in the European Union (World Advertising Research Centre, 2004). Survey, sales and excise returns suggest that levels of consumption in the UK have been falling since 2004 (Alcohol Policy UK, 2009). By 2009, UK consumption among people aged 15+ was just above the European Union mean (Department of Health, 2010). Current alcohol-related mortality and morbidity rates, discussed below, largely reflect the drinking patterns of the mid to late 1990s when more people were drinking well above recommended safe limits.

The trend towards home-drinking

Foster (2008) listed a number of significant changes in the UK drinking culture over the past thirty years. One of these has been a shift towards drinking away from licensed premises, most of which takes place at home. The original Alcohol Harm Reduction Strategy for England (The Prime Minister's Strategy Unit, 2004) did not refer to drinking away from licensed premises. This omission was rectified in the second national strategy document: '*Safe Supportive and Sound*' (Home Office, 2007) which recognised that home-drinking could be harmful. The key findings of a recent review of adult home-drinking (Foster and Ferguson, 2012) were that drinking beer at home has become more commonplace since the 1970s, and that home-drinking of wine increased rapidly after 2000. This review suggested that adults drink at home because it is cheaper, more convenient and more relaxing. Lader and Steel (2009 pp80) surveyed 2,110 adults and found that 72 per cent of their sample had purchased alcohol during the past year and that this figure had changed little from 1998-2009. Low cost and even subsidisation of alcohol prices as a loss-leader is undoubtedly one factor accounting for the increase in the market share of supermarkets. However, Mintel's (2010) internet survey of 836 adults aged over 18 (Mintel, 2010) found only 11 per cent would use pubs even if supermarket prices for alcohol rose. This finding suggests that many British adults prefer to drink at home rather than in pubs or other licensed premises.

The health consequences of excessive alcohol consumption

Although there are some issues concerning methods of data collection and definitions of key concepts such as 'excessive' alcohol consumption which impact upon meaningful comparisons, there is little doubt that European countries including the UK experience substantial rates of alcohol-related mortality and morbidity, particularly among younger adults. The World Health Organization (WHO 2013 pp 8) divides the EU into four segments: Central Western and Western countries (including the UK); Central Eastern and Eastern countries (former Soviet Block); Nordic countries (Scandinavia); and Southern Europe (including Spain, Italy Portugal and Greece). The WHO concluded that, in 2010, standardised death rates directly attributable to alcohol (alcohol-related cancers and injuries and cirrhosis) for men and women combined were highest in the Eastern country group (59 per 100,000), followed by the Central Western countries (Including UK) (28), the Nordic countries (24) and finally Southern Europe (23). The report cites evidence that, in the EU in

2004, alcohol was responsible for 1 in 7 male deaths and 1 in 13 female deaths in the group aged 15-64 years, resulting in approximately 120,000 premature deaths.

In the UK, 6,669 deaths directly related to alcohol were recorded in 2010, an increase of 22 per cent since 2001 (NHS Information Centre, 2012). As always, such historical comparisons may be affected by artefacts, for instance changes in systems for recording reasons for admissions. But this large shift is likely to have resulted at least partly from an increase in morbidity caused by greater alcohol consumption. Given the recent reduction in UK *per capita* alcohol consumption discussed above, future levels of associated morbidity and mortality are likely to decline after a time-lag associated with the operation of disease processes, but alcohol-related disease will continue to be a major national and international public health problem. Professor David Nutt, a former government adviser, depicted the impact of high UK alcohol consumption in the 1990s as a 'time-bomb' (Lister, 2009).

Alcohol consumption, even at low levels, is associated with increased risk of a range of cancers, particularly of the oral cavity, oesophagus and larynx, hypertension, liver cirrhosis, chronic pancreatitis, strokes, and injuries and violence; but a J-shaped curve, with low amounts of alcohol (25-50 grams per day) reducing risk, is found for coronary heart disease (Corrao, Bagnardi and Zambon, 2004). Even when the presence of previously heavy drinkers among abstainers is taken into account, the benefits of moderate drinking in terms of reduced risk of coronary heart disease appears to outweigh greater risks of other conditions, with abstainers and heavy drinkers both estimated to be about 50 per cent more likely than moderate drinkers to die over a 20 year period (Holahan et al, 2010).

Understandings of public health and risk messages about alcohol consumption

Governments have sought to influence the behaviour of drinkers through public health campaigns in which the public are 'educated' about the health consequences of excessive alcohol consumption. This form of attempted behaviour change requires good citizens to take risks responsibly (O'Malley, 2008), systematically placing the onus on the individual rather than the state. However, the specification of 'safe' drinking levels raises quite complex issues, and it is unclear how official messages about responsible drinking are received. Drinking 'excessively' can lead to multiple unwanted consequence for self and others over shorter and longer time-scales, including hangovers and work absences, public disorder offences, domestic violence, family breakdown, addiction and chronic diseases. Focus on a

risk factor, in this case alcohol consumption, may obscure the diversity of the negatively valued consequences with which it is associated, and their variable relationships with the supposedly risky behaviour which is being problematised.

Official specifications of 'safe' drinking levels offer simplified 'encoded' knowledge (Alaszewski, 2010, p. 134). These prescriptions are designed to regulate individual decision-making by keeping guidance simple, directing attention away from uncertainties and controversies in the evidence on which advice is grounded. Recommended daily and weekly maximum drinking levels for men and women vary substantially even between English-speaking countries, from 14 to 42 grams of pure alcohol per day, and 98-161 grams per week for women; and 20 to 56 grams per day, and 190-272 grams per week, for men (Wettlaufer *et al.*, 2012), but these large differences are not brought to the attention of the public whose faith in their national guidelines might otherwise be subverted. In the UK, and no doubt elsewhere, governments have modified their health advice several times, on at least three occasions between 1987 and 1995. Such changes can undermine the credibility of alcohol 'experts' (Green *et al.*, 2007). For instance, advice has recently incorporated guidance about temporal patterns of drinking, with abstinence for at least two days per week and avoidance of binge-drinking episodes recommended (O'Dowd, 2012). In consequence, drinking patterns which would previously have been defined as 'safe', such as a UK man consuming three units of alcohol every day, are now rendered 'risky'. Further complications arise from the widely promulgated if controversial epidemiological conclusion alluded to above that regular consumption of modest amounts of alcohol reduces the risk of heart disease among older adults (Krenz and Korthuis, 2012). Given these complexities, the inescapable arbitrariness of any cut-off between safe and unsafe drinking, the positive valuing of alcohol consumption in contemporary culture and ruthless marketing by the industry, it is unsurprising that the introduction of low risk drinking guidelines appears to have no net effect on alcohol consumption (Babor *et al.*, 2010).

Understanding of alcohol consumption guidelines is affected by confusion over how this quantity is expressed, usually in terms of units of alcohol. Gill and O'May (2007) investigated the accuracy with which individuals could estimate the number of alcohol units that they had recently consumed. They found that the average drink poured at home contained 2.05 UK units of alcohol. Only a quarter of their 297 research participants were able to estimate unit content with accuracy, and there was an average tendency towards

substantial underestimationⁱ. Those who underestimate their alcohol consumption may not realise that they have exceeded the recommended intake, and thereby put themselves officially at risk of future health problems.

These specific complications of risk calibration for alcohol consumption are compounded by generic difficulties with probabilistic thinking about the future. Breakwell (2007) noted that individuals find understanding probabilities difficult. Perceived control, familiarity, and willingness to engage in risky behaviours all appear to influence individuals' risk perceptions (Hawkes and Rowe, 2008). In context of this article, because the home is traditionally seen as the place where autonomy and familiarity are assured, those who drink at home may feel more insulated from harm than if they were drinking elsewhere (Holloway et al, 2008). Furthermore, a willingness to engage in behaviour where the aim is enjoyment and relief from stress may result in associated risks being underplayed. For young people drinking in public places outside licensed premises, propensities to take risks in order to discover their own personality to and fit in with their peer group may be most pertinent to their decision-making about alcohol consumption (see themed issue, Alaszewski 2013, Spencer 2013, Thing and Ottesen, 2013)

Individuals locate behavioural choices which they are told are risky in temporal frameworks. Disregarding purported longer term negative effects and concentrating on more immediate benefits enables individuals and social groups, encouraged by marketing strategies operated by commercial interests, to take risks comfortably (McClure et al, 2007). Comfort can be maintained in the face of risk messages by creating self-generated temporal horizons which those who might be deemed at risk opt not to look beyond (Heyman et al, 2010, pp. 114-116). In a study of sunbed use, Murray and Turner (2004) found that users thought a tan improved the way they looked. Despite acknowledging the evidence that sunbed use carried increased risk of skin cancer, they were more concerned with possible ageing effects than with its health impact. In this case, the preferred time-frame might encompass getting a tan immediately, and skin-ageing in the close to middle future, but exclude developing skin cancer over the longer term.

It is possible that when individuals drink alcohol they structure time in a similar way. However, there is currently there little research into how drinkers balance immediate benefits such as enjoyment against possible short and longer term harmful consequences. Some researchers and health professionals are concerned about possible harmful consequences of

home-drinking, but home-drinkers do not appear to share their concerns. Holloway (2008 p 542) concluded that home-drinking ‘remains a normal, unremarkable, unproblematic practice in the eyes of many’. As happens so frequently with public health issues, health professionals may problematise a risk factor which predicts merely an aggregate increase in the probability of long-term harm, in this case resulting from the progressive escalation of levels of home-drinking in some cases; whilst individuals can reasonably locate themselves among the majority who will not be affected because they restrict themselves to moderate and ‘safe’ levels of alcohol consumption. With respect to young people consuming alcohol in public places, considerations such as fitting in with their peer group may impel them to disregard potential future harm (Spencer 2013, Thing and Ottesen, 2013).

Methods

This article draws on data drawn from a study conducted in Blackpool in autumn/winter 2008, a seaside resort in the North-West England. The town is in economic decline and marked by social deprivation (North West Public Health Observatory (2011)). Ethical approval to conduct the study was provided by Middlesex University School of Health Studies Health Ethics Sub-Committee. Research participants will be referred to by pseudonyms throughout.

The main aim of the study was to explore local residents’ perceptions of the ways in which alcohol was consumed outside licenced premises. Such drinking was mostly carried out at home, but young people who drank in public places were also included in the study. Views were explored through focus group discussions with individuals from a wide range of backgrounds. Four focus group discussions were carried out, with participants recruited through Blackpool-based voluntary sector organisations, residents groups or personal and professional contacts of the Blackpool-based research team such as youth workers, probation officers and social workers. Table 1 outlines some attributes of the study sample, including a sketch of the predominant drinking patterns in each of the four groups. It was originally intended to ask the participants to complete a questionnaire regarding regular alcohol consumption patterns, but we decided not to do this, as it might have inhibited the focus group discussions. More comprehensive details of the methodology and recruitment procedures are provided in Foster et al (2010).

- Insert Table 1 here -

In total, 38 individuals participated in the focus groups discussions, and the median age of the participants was 43 years old (range 13 to 75 years). Group A, which included the youngest participants, tended to describe the most risky behaviours; and Group C, individuals recruited through residents association of a housing estate were the most risk-averse. Group D, a gay and lesbian group, were the most frequent drinkers, and drank alcohol in both licensed premises and their homes. This group were also more likely to describe drinking at parties where a large amount of alcohol was consumed. Finally, Group B, community volunteers, tended to be settled with families and drink at home rather than in licensed premises.

We invited focus group participants to explore a number of issues related to the consumption of alcohol. The main questions on which discussions were based were:

- Why do you drink at home?
- On what occasions do you drink in licensed premises?
- What are your beliefs concerning home-drinking?
- Who makes the decision to drink in your household?
- What are some of the rituals that surround drinking that takes place at home?

We encouraged the groups to have wide ranging conversations about how and why people drank away from licensed premises, and the discussions included reflections on the risks involved in drinking in different places. Two Blackpool based researchers, Donald Reade and Sakthi Karunanithi, both of whom were public health trainees sponsored by the Mersey Deanery, facilitated the focus groups . Each focus group discussion was audio-recorded and transcribed. One of the authors (John Foster) then coded the transcriptions with another member of the research team (Donald Reade), and both agreed the coding categories. These categories were developed using Miles and Huberman's (1994) approach in which data reduction is followed by data display, and then conclusion-setting and verification. Once we had developed the code book, we initially analysed the data using open coding to identify themes, and then explored the relationship between themes using axial coding. Finally we undertook selective coding, examining the data set to see if we could find exceptions or contradictions. At each stage of the analysis, two members of the research team worked independently and then compared their analysis. If they could not resolve any discrepancies,

a third member of the team (Sakthi Karunanithi) would have arbitrated. In practice all discrepancies were resolved without arbitration.

A number of limitations have to be acknowledged. The study uses a qualitative methodology and no claims can be made about the generalisability of the findings. It is likely that the findings apply outside the Blackpool area, at least among socioeconomically and culturally similar groups. The initial focus of the study was not upon risk, and the discussions, although linked to the questions listed above, were free-flowing. Issues of risk were raised by the participants themselves. The use of explicit questions about risks to longer-term health might have biased responses towards such concerns.

Findings

Our analysis of the free-floating discussions highlighted complex understandings of risk. We did not directly ask focus groups to discuss risk, but noted when risk-relevant topics were considered. Most research participants reported that they drank away from licensed premises for enjoyment and because it was convenient. They did not see such drinking as either inherently safe or unsafe. The quote below from Tom a 16 year old indicates that he felt that whether drinking at home was safe was dependent upon the type of friends he was drinking with:

It's not just the type of drink. It depends upon the type of friends that you have got. I have got two sets of friends. Some that come round, ... you can have a quiet drink with, watch TV, play games, whatever. I have also got friends that come around and get rowdy, and you have got the police coming to your door because you have music going on, and it spills onto the street and somebody is getting hurt because we are all drunk and have decided to have a fight with someone else.

Kevin a 52 year old man from the resident's group noted that if he fell over in a pub people would be there to help him, whereas at home he would be alone.

I think if you are at home on your own drinking and you do something like fall down the stairs and there is nobody to help you. If you do it in a pub, there are [others there to help you].

Karena a thirty year old woman from the Gay and Lesbian group was concerned about being sick when drinking at home.

I have a drink because I like the flavour of it and it just helps me to feel relaxed. I would never drink at home to get drunk. I don't want to be sick and fall over at home.

Colin, a member of the community volunteers group, unusually, identified a cumulative risk of gradual escalation from home-drinking.

I think there is a danger with the amount we are now drinking in our homes. A nation of binge drinkers because you are more comfortable in your home and you don't have to worry about getting the taxi home. Nobody is going to tell you have had enough. You can carry on where your normal intake for the week should be X and Y but that's gone out the window when you are at home. As you said you will have a glass of wine every night but it is a big glass and probably two full glasses.

Colin was concerned about the weakening of restraining factors associated with drinking at home rather than in licensed premises. However, focus group members mostly tended to see home-drinking as 'normal', and as a reflection of a wider societal change. Awareness of long-term health impact was implicitly rather than overtly expressed, as the following interaction between two members of the resident's group illustrates:

John (55 years old): I don't think people are aware of what they are drinking. I think they take it as natural, just another day comes. I don't think if you ask an ordinary person they would say they drink all the time

Mary (57 years old): It's become part of life, part of daily living. Most people will say I have a bottle of beer or glass of wine when I get home.

Location in a Temporal Framework

The focus groups did consider the relationship between drinking risk and time, albeit not in great detail. There were some interesting discussions of drinking consequences over a short time-frame, the ways in which individuals sought to set drinking boundaries, and the impact of life changes on drinking.

Immediate risk time-framing Most focus group members did not believe that their alcohol consumption was causing risks to their future health, as they saw their drinking as merely episodic. The only exception was in the focus group made up of community volunteers where the view was expressed that drinkers might be blind to longer-term risks:

Interviewer: Do you think people consider their long-term health when they drink at home?

Colin (40 year old): I don't think anybody thinks about it.

Brenda (42 year old): Well a lot people think, 'It will never happen to me'.

Both Colin and Brenda seemed to accept that long-term drinking might have harmful effects, but identified mental devices that are used to deny or disregard these dangers. Others differentiated their own, as they saw it, restrained drinking from consuming alcohol to excess. Angela, a 30 year-old women who took part in the community volunteers group, stressed the occasional aspect of her own imbibing which she differentiated from binge-drinking:

I have a few glasses of wine and put it down, and some people think, 'What is the point unless you can get plastered?' You have some who binge drink, then don't touch it for a month, and then go on a binge.

David, a 25 year-old man who took part in the gay and lesbian focus group said he did drink regularly, but described how he controlled his drinking and avoided harm by setting himself strict time limits:

I have a drink every night, but I know what my limits are and I always wait until nine o'clock. I don't have a drink before nine o'clock in the evening, and when I do I usually have my first drink between 9 and 10 in the evening. I drink a can of beer. I will get myself a beer, and, every night, I will drink 2 to 4 cans.

However, he also indicated that, at weekends, an episode of drinking with friends could involve consuming 10 cans of beer:

We do a lot more nights in at weekend, rather [than] going to clubs now. So, if a group of friends come around, I will probably have a lot more. It might go up to 6/8, or, if it's late, it may go up to 10 beers.

The participants in the young people's focus group described their experience as novice drinkers and explained how they learned to control their drinking and achieve 'controlled' drunkenness (Laghi et al 2012) through trial and error. For example, Tom, a 16 year-old, stated that:

When you turn 13-14 you are allowed to go out at night, and it's like all your mates are drinking. And it's like, 'It can't harm can it?', and you carry on drinking. The first time you touch drink, you don't know what your limits are. But once you have been drunk a few times, you know that you can drink 10 cans, and you will be a bit tipsy. But if you touch 15, then you are badly wasted [very drunk].

One member of the community volunteer's focus group, Colin, did believe that he and his partner had developed a pattern of regular drinking, but did see this pattern as particularly risky:

I have been with my partner for 18 years, and we never had any drink in the house at all [for the first 10 years], and it only kind of started 8 years ago. It was just the odd one here and there, and I have got into a pattern now, and it is something that we both do every night. We never used to drink in the house, ever.

Using Time in Boundary-Setting for Alcohol Consumption

Although focus groups members did accept that drinking away from licensed premises could be risky, they all saw themselves as being 'sensible' drinkers. They also described the actions they took if they felt that their drinking might be dangerous, and were particularly concerned about their responsibilities as parents. Those who had children described the measures they implemented to limit risks to their offspring, particularly restricting the times when they drank, usually to periods when their children were in bed. For example, as Brian a 35 year-old man who took part in the community volunteers focus group, put it:

I have a nine-year old son, and we don't make a habit of having a drink when he is up. So if he goes to bed at nine o'clock, then we will have a drink. It is not reasonable to drink at five or six o'clock.

A similar framing was evident in other narratives which did not anchor reasonableness in terms of children being absent. For example, Diane, a 40 year-old woman in the residents' group, indicated that she drank more if she started drinking at 6 pm rather than 9 pm:

If I have a double whisky at six o'clock rather than nine o'clock, and don't go to bed until eleven, I may end up having seven instead of three.

The use of time restrictions as a way of managing drinking seemed to be a common strategy amongst our focus group participants. Edward, a 45 year-old man from the resident's group, described the ways in which his wife used a time limit to manage her drinking and he used the language of abstention, 'not touching a drop' outside the permitted time-period to describe her behaviour:

A lot of people have a specific time. My wife will not touch a drop until eight o'clock.

This strategy can be compared to that encoded in the old UK licensing laws which were designed, with little success, to cut down drinking by restricting the time-frames in which pubs were allowed to open. Possibly, personally chosen 'licensing hours' work more effectively than government-controlled ones because they accord with the personal needs and experiences of those who choose to use this self-regulatory temporal tactic.

Controlling drinking through life changes

Adult Participants Some participants, especially in the residents focus group, indicated that in the past they had been concerned about risks of drinking adversely affecting their future health. They tended to see their high level of alcohol consumption as caused by others, usually partners or friends, and had implemented life changes as a way of minimising the consequent risks. For example, Charles a 56 year-old man in the residents' focus group, described how he had moved away from a heavy-drinking group which included his former wife and her friends:

My ex-wife was an alcoholic, and we used to drink heavily at home and in the pub. Then I realised [that] drink was taking over her life. So while she carried on drinking more and more and friends encouraged her too - allowing them to drink at the same time - I went the other way and stopped drinking.

Eileen a 54 year-old woman also in the residents' focus group described taking similar action to protect herself and her children:

Some people drink with their partners because, 'If you can't beat them, join them'. I could not beat my husband, so I joined him. I was drunk every day of the week. I was getting up in the morning, no breakfast, no nothing, going into the pubs, clubs and drinking in the house ... One morning I finally woke up, I looked in the mirror and I thought, 'Oh my God Almighty. What are you doing to yourself?', and I have got three children. I decided there and then that was it. He said to me, 'Are you ready to go to the pub'. And I said, 'Right, there is the door. Use it, and don't come back'.

Such drastic action was taken to deactivate the risk of becoming an alcoholic, and, by implication, the disastrous health and social consequences which would follow.

Discussion

In this article, we have discussed drinking at home and in public places and examined the ways in which time influences how individuals perceive and manage risks. Those who took part in our research project mostly did not appear to perceive their drinking as a source of longer-term health risks, and tended to see excessive alcohol consumption as a problem faced by 'others' who failed to manage their drinking effectively. They acknowledged that drinking could be harmful to themselves, but thought of harm in terms of the immediate consequences of a drinking session, such as setting a bad example for children, feeling sick, falling over or getting into fights. In general, research participants seemed to view home-drinking as a series of individual episodes involving risks, rather than as a recurrent activity which might put them at cumulative risk.

The apparent lack of a long-term personal risk perspective about alcohol consumption might be considered from a public health perspective as a 'failure', or even as 'denial' of the downside of a culturally valued, enjoyable activity. Slovic, in the interview article in this special edition (Heyman and Brown 2013) discusses evidence from his research (Slovic, 2010) that perceptions of positive and negative consequences are negatively correlated, meaning that individuals show a reluctance to acknowledge downsides of positively valued activities and vice versa.

However, what might be viewed as complacency from a public health perspective can be accounted for in terms of how current official messages about safe drinking are likely to be interpreted. (Moreover, this seeming lacuna did not totally exclude indirect concern about risks to future health, as will be argued below.) With respect to official safe-drinking messages, the notion of a consumption threshold above which drinkers place themselves ‘at risk’ is intended to offer a robust and practicable guide to safe drinking levels, but conveys the implicit impression that lower levels of alcohol consumption banish risks. The setting of inevitably arbitrary (and nationally varying) thresholds beyond which alcohol consumers put themselves ‘at risk’ implicitly but logically conveys the impression, however unintentionally, that those who stay below a specified drinking quantum will be ‘not at risk’. The elision of smallish absolute risk increases into the absence of risk, combined with systematic underestimation of the amount of alcohol contained in a drink, may explain why research participants did not even consider the implications of their sometimes quite high alcohol consumption profiles for their longer-term health. Such simplification is predicated on the background cultural assumption that risks are material objects, which must therefore be either present or absent, rather than merely probabilistic predictions of the future.

Crucially, however, although research participants did not see themselves as at risk, they took steps to safeguard their futures by avoiding, or withdrawing from, situations in which their drinking might escalate. One manifestation of this protective strategy was setting limits to the daily time period in which alcohol would be consumed, usually by not starting until the evening. Although the gain from such partial abstinence could be undone by drinking more quickly in a shorter time-period, this strategy did give research participants a sense of control over their encounters with a potentially addictive substance. A second self-regulatory strategy, mentioned by two members of the residents’ group, involved breaking off relations with heavy drinkers, in one case a partner, and, in the other, a set of friends. Such decision-making entails setting a boundary between acceptable and dangerous drinking equivalent to that encoded in public health literature, although almost certainly at a much higher level of alcohol consumption. Both of the above responses, that of limiting the ‘permitted’ daily time for drinking, and that of withdrawing from contact with dangerous drinkers, perhaps apply more strongly to home-drinking, in which boundaries from other life zones are weak, than they do to consuming alcohol in licensed premises. They may be understood as second-order risk management strategies involving efforts to avoid perceived risk factorsⁱⁱ. In this indirect

sense, perhaps not one which public health specialists would be comfortable with, research participants did attempt '*colonization of the future*' (Giddens, 1994, p. 7).

Conclusion

Our study showed that adults and young people did not directly consider longer-term risks to their health when drinking away from licensed premises. They focused mostly on risks in the here-and-now. This lacuna from a public health perspective may be rooted in an unfortunate juxtaposition of two factors: the structure of official advice itself which is based on the simplifying notion that those who stray above an arbitrary threshold put themselves 'at risk', thereby inadvertently conveying the implication that others are 'not at risk'; and systematic underestimation of personal alcohol consumption abetted by the drinks industry. This reification of risks as material entities which therefore either exist or do not exist, in combination with persistent underestimation of the amounts of alcohol contained in drinks, may enable alcohol consumers to ignore possible downsides of a valued activity.

However, some focus group members did identify the problematic drinking routines of other people, judging that the alcohol consumption in question exceeded 'normal levels'. They took immediate steps to protect themselves and their children by ending their personal relationships with those whose drinking they regarded as unsafe. Others attempted to avoid the risk of escalation by limiting the daily time periods in which drinking would take place. Such strategies can be characterised as second-order risk management. Any attempts to encourage members of the public to make informed decisions about drinking in relation to current epidemiological findings must start by recognising the weaknesses in the evidence itself, and also the paradoxes arising from the construction of simplified 'encoded' guidelines.

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Table 1. Characteristics of Study Sample.

Group	Description	Gender Balance	Age -Range	Indicative Drinking Pattern
A	Young People: Some from care and in settled relationships	9 Men 6 Women	13-21	Some street drinking and frequent heavy episodic drinking. Regular home- drinkers
B	Community Volunteers	1 Man, 3 Women	30-50	Regular drinkers at home and in public houses. Occasional heavy drinking at family parties
	Members of a residents' association from a working class housing estate	6 Men, 9 Women	25-75	Tended to drink mostly at home. Some had a family history of alcohol problems and were infrequent drinkers.
D	Attendees at a gay and lesbian centre	1 Man, 3 Women	25-30	Frequent drinkers at home and in licensed premises.

				Had highest disposable income
Total		17 Men, 21 Women	13-75	

ⁱ The public tendency to underestimate personal alcohol consumption is convenient for the drinks industry who thereby sell more of their product. It has been abetted by a global trend towards stronger wines and beers (Coltart and Gilmore, 2012).

ⁱⁱ Such second-order risk management is also seen in healthcare practice, for example in relation to the use of statins to reduce levels of 'bad' cholesterol which are considered to increase the risk of coronary heart disease (Hann and Peckham, 2010).