Alcohol and Public Health

Framing and communicating risk

Summary of Presentations

January 2019

Drug and Alcohol Research Centre,
Middlesex University

Introduction

Research findings are often complex, generally first disseminated in academic or professional journals and directed towards other academics, professionals and policy makers. They provide the 'evidence' that is transmitted to a wider public through media reports, official guidelines, advocacy websites and newsletters.

The process of translating research into public messages inevitably involves interpretation, selection and emphasis on chosen parts of the evidence. The message is often placed within a 'frame' (or 'frames') of understanding which influences how the process evolves. For instance, the frequently stated belief that messages to the public should be simple and consistent to avoid confusion, 'frames' the general public as unable to process and use more complex information and at the same time provides implicit guidelines for the production of the public message. Similarly how risk factors are framed and communicated may convey very different 'facts' about the level of risk depending on the use of statistics, the language in which the message is couched and the context in which it is conveyed.

Over recent decades, public health has assumed a prominent role in conveying research-based messages to the public on a range of health behaviour issues. But the processes by which this is done remain obscure and the relationship between research and public messages as an output are relatively unexplored. A number of questions guided the impetus to organise this conference: How transparent is the process of translating complex research findings for public consumption? Are there ethical dilemmas arising from the need to select and emphasise some 'facts' to the exclusion of others or from the way in which statistics are presented or from assumptions regarding what the public understands or 'needs to know'? What happens to the research findings as they shift into and between different transmission modes and pathways – from journals and reports to official public health messages to advocacy documents or into the media?

The conference, held at Middlesex University on November 20th 2018, aimed to open up a discussion on the issues outlined above and in particular to critically examine:

- the processes through which complex research findings on risk factors are 'translated'

into public communication;

- the factors which influence how public communication is framed;
- and the ethical dilemmas that may arise in the processes of selection and interpretation of research findings for public communication.

Acknowledgements

The conference was supported by a Network Development Grant from Alcohol Change UK and by the journal, *Drugs: Education Prevention and Policy.*

The conference presentations

Professor Susanne MacGregor (London School of Hygiene and Tropical Medicine) Framing and communicating 'alcohol and risk': issues and challenges

Professor MacGregor's paper aimed to set the scene, to frame the themes for the conference, identifying some key issues and challenges and discussing key concepts. In itself, this was an exercise in 'framing'. Professor MacGregor noted that framing constructs a 'problem' and indicates appropriate solutions: it singles out specific target groups. There are different levels of frames – beginning with the grand narratives of modernity. Within western societies, there are differences between traditionally Protestant and Catholic countries and Temperance and Non-Temperance cultures. There have been battles between welfare state ideas and institutions and those of neo-liberalism; between policies focusing on supply and those on demand; and between those orienting towards law and order/ criminal justice approaches and those focusing on social and health concerns.

Alcohol use is not always seen as a 'problem'. Whether it is or not depends on which groups of people are using alcohol, how, where and when. The media have a strong influence on perceptions. One challenge is how to communicate about risk without increasing the stigmatisation of certain groups. Other groups influencing the framing of the alcohol issue include the public health community and the alcohol industry.

The other concept on which this conference focuses is 'risk'. Risk can be viewed positively when seen as a characteristic of adventurers or entrepreneurs. Certainly the term risk is ubiquitous today with references to risk assessment, risk management, at risk groups, risky behaviour and so on. The term has different meanings in ordinary language and among different specialisms. It rests on the notion of probability and depends on statistical calculations. In public health, the dominant specialism concerned with risk is epidemiology. With increase in knowledge, increase in specialisation and increased complexity in calculations (aided by developments in ICT) the gap has grown between experts and the general public and thus the problem of communication has also increased.

In global, European and UK alcohol policies, the focus is mainly on high-risk, unacceptable levels of risk. Alcohol policies aim to raise awareness as one part of a package of measures. Policy is the dominant frame as its ideas become established in laws and regulations and in institutions and practices. Government ideas of risk are also linked to their central concern with costs.

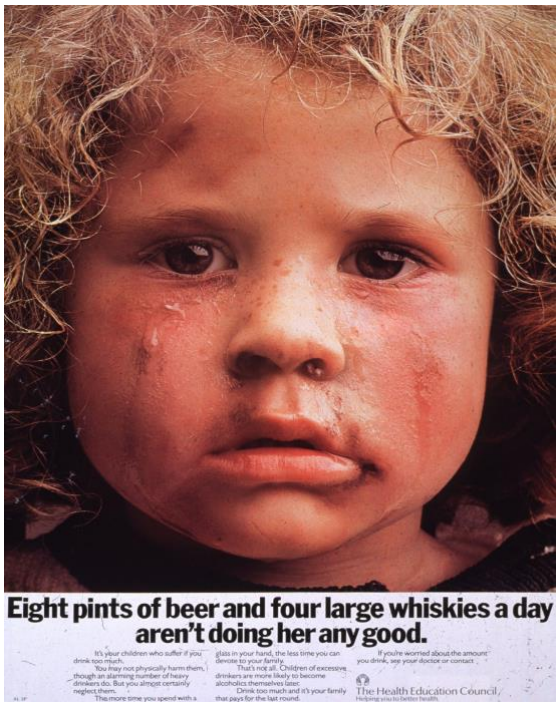
Types of drinking behaviour have been categorised into lower, increasing and high risk in England. For public health, an issue is whether to try to change behaviour by increasing knowledge and changing attitudes or to try to shape the choices people make by altering the environment in which they live. Problems of communication include misleading media and mixed messages. One conclusion is that 'one size does not fit all'. Various methods and channels can be used as appropriate for different sub-groups. Messages may conflict with personal experience, or deeper ideas of fate, and people may find it hard to think much about the future, especially when their current circumstances are very demanding.

Attempts have been made to target specific sub-groups like students, or middle-aged women, or older people, though resistances are encountered. Graphs can be particularly influential, particularly with policy makers. Lessons learnt include the need to agree the message, and to make sure the message is clear. Compression (of complex messages into simple ones) is a big danger. A challenge for public health is that the public is not a monolith; so segmented approaches are needed. A great challenge at present is declining trust in the state and in experts. Some approaches using marketing techniques have been criticised as a form of manipulation. Another ethical issue is the use of personal information held in data banks to target sub groups. The best approach may be to use face to face communication as much as possible and to aim at dialogue and public engagement rather than telling people what to do – preaching and moralising have always been resented. . (Click here to download the powerpoint slides)

Professor John Coggon (University of Bristol Law School) Ethical Considerations in Framing and Communicating Public Health Information

Public health is both a science and an art. As a field of practice and area of policy, it encompasses the ethical—and ultimately political—mandate to promote the public's health and to reduce health inequalities. Within public health discourse, we find claims about obligations to communicate health improvement and protection messages to politicians and to different publics. This presents practical challenges, for example regarding effective communication (raising e.g. matters about how information is framed) or how different public narratives are set. It also raises ethical challenges, for example about the propriety of selecting different forms of information, about what *respectful* communication entails, and about ensuring transparency. Ethical communication in public health requires consideration in particular of the mandate for action: what motivates and justifies decisions about communication? And it requires consideration of the 'rules of engagement': does everyone, within and beyond public health, have the same obligations in relation to provision of information (and if not, on what basis and in what ways do they differ). To explore these points, this paper first looked to the inherent connections between public health and ethics, including in relation to communication of information. As part of this, it focused on the possible distinctions between professional ethics, ethics as advocacy for the public's health, and ethics as philosophical reflection. It then drew from the framing and rationales expressed by Johan Mackenbach, and looked at distinct methods and levels of political engagement by members of the public health workforce. This invites thought regarding both ideological and prudential issues in communication. And it leads to analysis of a range of points of engagement, from the politically passive to strong levels of political and public engagement. The talk concluded with reference to a report recently written by Professor Coggan for the UK Faculty of Public Health on the 'nanny state'. Nanny state accusations beset a great deal of public discourse concerning health and health policy. The report aims both to explain the nanny state debate, and provide practical guidance on how to respond to nanny state slurs in public discourse.
(Click here to download the powerpoint slides)

Associate Professor Alex Mold (London School of Hygiene and Tropical Medicine)
Alcohol and health education in the 1970s and 1980s



This paper examined how risk featured in attempts to communicate with the public about the dangers of alcohol consumption.

Focusing on health education campaigns in Britain during the 1970s and 1980s, the paper identified three different phases. These phases were characterized by a change in target population group, from alcoholics or heavy drinkers, towards all drinkers. This development was underpinned by the notion that every drinker needed to keep their alcohol consumption in check, and more broadly, by changing ideas about risk. Health education campaigns around alcohol began to discuss risk more explicitly, but the types of risks discussed, and the strategies suggested for dealing with these, was a fairly narrow and restricted notion of the risks posed by alcohol. Campaign materials tended to concentrate on the short-term risks posed by drinking and the individual actions necessary for ameliorating these. This raises questions about who or what was being targeted through the language of risk, how risks are framed, and the ways in which these are communicated to the public.

Professor Janne Tolstrup (National Institute of Public Health, University of Southern Denmark) Alcohol and breast cancer: informing the public

Breast cancer risk inclines linearly with increasing alcohol intake.

Breast cancer is the most prevalent cancer occurring in women.

Communication from public health stakeholders exaggerates the impact of alcohol on the individual risk of developing breast cancer.

Alcohol is associated with the risk of developing a range of diseases. In public health, the association between alcohol and breast cancer has been the subject of particular interest because breast cancer risk inclines linearly with increasing alcohol intake, meaning that even a low intake can in theory be causative. Furthermore, breast cancer is the most prevalent cancer occurring in women.

The aim of this presentation was to examine how the risk of breast cancer from alcohol is communicated by national public health stakeholders and if this communication is in

accordance with scientific evidence. For this purpose, communication examples from various media, webpages and campaigns were identified and examined. Two examples are mentioned below.

The statement “Each glass increases risk by 10%” occurred repeatedly, and was also identified in a slightly more charged version as ”The truth is – for each glass you drink, your risk goes up by 10%”. In all identified examples, the unit was not given, making it incomprehensible which amount “each glass” entails (is it each glass of alcohol in the lifetime, each daily or weekly glass that was meant?). A statement in correspondence with scientific evidence would be “per daily drink, breast cancer risk increases by 10%”. In Denmark, citizens are habituated in thinking in terms of weekly and not daily drinks, and a statement without unit leaves the interpretation up to the receiver who would most likely interpret it as “1 glass/week increases risk by 10%”and not the correct interpretation which would be “7 glass/week increases risk by 10%”.

Statements ”You yourself decide the risk of developing breast cancer” and “You don’t have to sit and wait to be hit - you can actually do something to avoid it” were also used by national public health stakeholders. Both statements imply a causal and large attributable fraction of breast cancer to alcohol. However, scientific evidence shows an attributable fraction of 5%. Furthermore, in women drinking a max of 7 drinks/week, the attributable fraction is 1% only, or equivalently that 99% of cases occurring in women in this drinking range is caused by factors other than alcohol. Thus, the scientific evidence does not support the referred statements.

In conclusion, examples identified in media, webpages and campaigns showed that communication from national public health stakeholders were exaggerating the impact of alcohol on the individual risk of developing breast cancer. While at the population level, even small increases in breast cancer risk translates into a high number of cases due to the high diseases prevalence, at the individual level, the above examples are not scientifically supported and are likely to cause unnecessary fear and guilt in especially women.

Julian Strizek (Austrian Public Health Institute, Vienna) Measuring alcohol-related harm to others

It is a not new to either non-experts or experts in alcohol research that alcohol consumption may not only have negative effects on drinkers themselves, but may also adversely affect his or her social environment. However, this issue recently gained more attention and was coined by the term *alcohol-related harm to others* (replacing other less useful terms like passive-drinking) and efforts to quantify its impact on society were increased.

Questions on three dimensions of *alcohol-related harm to others* (harm from others drinking during childhood, harm from close drinkers and harm from others drinking to the community) were included in the Standardized European Alcohol Survey (SEAS), developed in a 3 year project co-funded by the European Commission. However, survey data seems to be an inadequate tool to measure alcohol related harm from others drinking and the reported figures can be questioned for several reasons. First, marginalized populations who may suffer most from negative effects of other peoples' drinking are most likely to be underrepresented in survey populations, just like problems on severe harms (e.g. violence from family members) will be underreported just like other sensitive issues. Secondly, the causal effect of alcohol on different negative outcomes (e.g. aggressive behavior) cannot be assessed by simply asking people whether they experienced such behavior from people who had been drinking, but would need to be assessed in experimental designs. Thirdly, the assessment of harm from alcohol on the community cannot be isolated from a more general attitude towards alcohol, since people implicitly will take both positive and negative effects into account when asked about the harm deriving from other people's actions. Furthermore the assessment of being negatively affected using a standardized instrument largely depends on personality traits and therefore does not produce valid measures for the real level of harm.

With regard to the communication of results it seems unethical to mix up severe levels of harm (e. g. physical violence or traffic accidents) with minor harms (e. g. nuisance or being woken up at night), which either may camouflage severe problems or lead to an unjustifiably problem inflation when associated only with severe harm. Arguments by

proponents in favor of the concept *harm to others* are framed by the idea of revealing the "real" harm of alcohol and given voice to neglected and vulnerable populations (e.g. family member of drinkers). A wide range of complex social problems is causally attributed to the individual misbehavior of heavy drinkers and results are often used to justify strict alcohol control measures. This perspective is challenged by critics who highlight the weak empirical basis for these claims and who portray *harm to others* as a pseudo-scientific way to justify a paternalistic alcohol policy. Instead of using questionable quantitative measures to estimate the "real amount" of harm more research on *how* alcohol affects social life may help to gain a better understanding of feasible interventions. (Click here to download the powerpoint slides)

Dr. Emma Milne and Dr. Rachel Herring (Middlesex University) Drinking in pregnancy – a precautionary tale?

The consumption of alcohol in pregnancy has come to the fore of public health messages over the last twenty years. In the UK, the current advice given to women is that they should abstain from alcohol for the entirety of their pregnancy. Advocacy messages from charities, and political rhetoric and official policy provided by Government agencies and health associations, as well as charities connected to alcohol and pregnancy, promote this message, presenting evidence that consumption of any alcohol may be harmful for the unborn child. However, it is not always clear what evidence is being used to support such messages. Drawing on a theoretical approach of framing communication, this paper examined the development of messages relating to women's consumption of alcohol during pregnancy, through an examination of website content from one major advocacy group, and examination of official policy documents provided by Government departments and by medical associations. The presentation reviewed the evidence being used to support the narrative, assessing moral judgments being made about women who choose to drink alcohol while pregnant.

Panel discussion: What influences how research based evidence on alcohol related risk is translated into public messages?: Perspectives from Europe.

Commentaries from five European experts elaborated on themes raised in the plenary papers.

Using Danish alcohol policy as an example, **Torsten Kolind** drew attention to the importance of a historical and cultural perspective in understanding how the rather liberal alcohol political approach in Denmark has come into being. Against this background, he discussed some of the factors that influence how research based evidence on alcohol related risk is translated or not translated into public and policy messages. More specifically, he considered: the role of the temperance movement, the importance of influential policy entrepreneurs in the alcohol area, the emergence of social science alcohol research, the different legislative domains (national and on municipal level) influencing alcohol policy, and the view of the general population.

Adding to the multiple internal factors influencing alcohol policy, **Franca Beccaria** emphasised the important influence of risk discourse coming from outside a country and the effect this could have on national policy. She illustrated her comments with respect to Italian policy. In Italy, she noted, alcohol consumption had been reducing prior to much of the debate on alcohol-related risk and prior to any major legislation to reduce problem consumption.

Michael Schaub referred to the last public alcohol campaign in Switzerland "How much is enough?" and its crushing independent evaluation report. He discussed how the Federal Office of Public Health reacted to this officially. After years of failing and being criticized as the 'health Talibans' and even after their proposed prevention law failed, they tried with a humorous campaign, stating that every person has to know his or her personal limit - but still trying to communicate very low levels of non-risky alcohol consumption. This is another example of how a prevention awareness campaign can go wrong and have no measurable effect on population level.

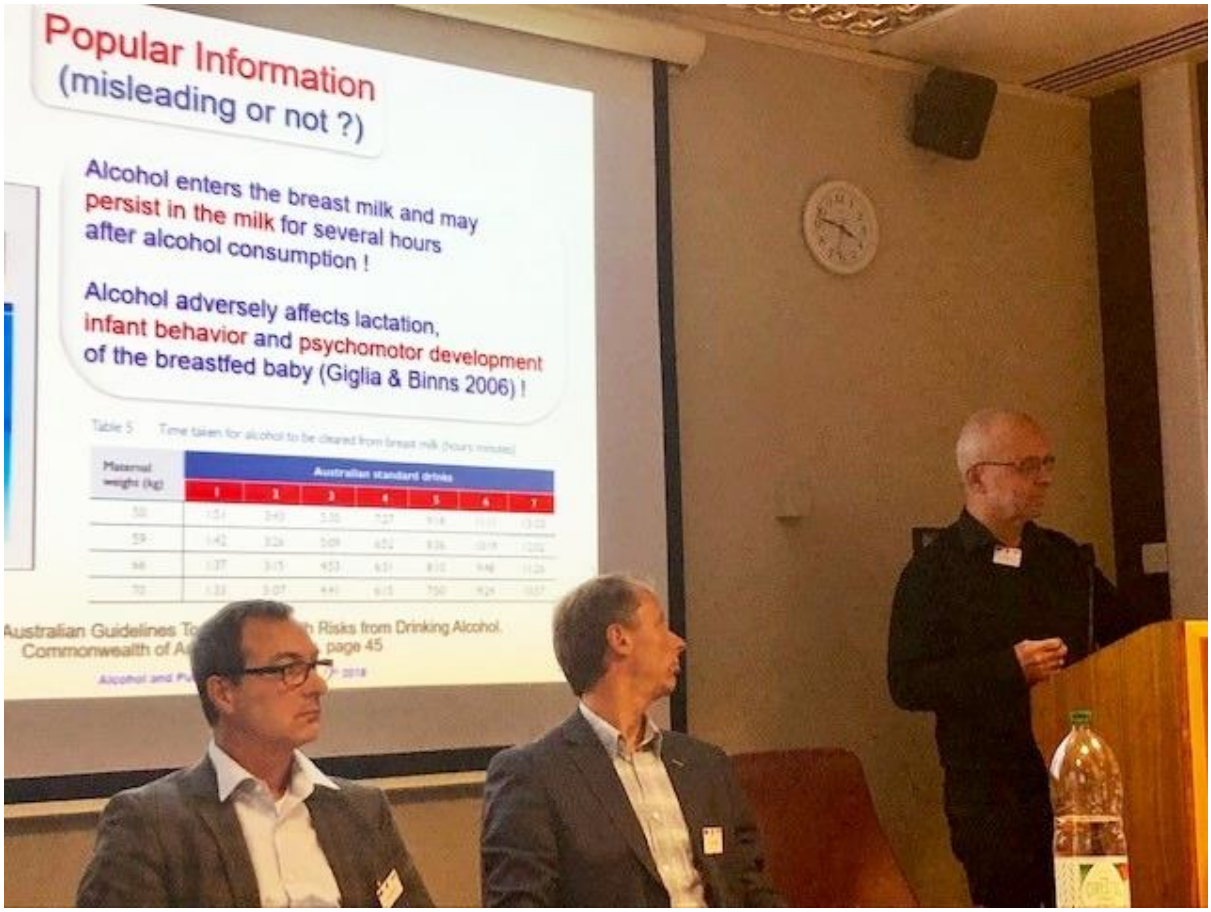
left to right: Dr. Alfred Uhl (Austria), Dr. Franca Beccaria (Italy), Dr. Michael Schaub (Switzerland), Dr. Artur Schroers (Germany), Professor Torsten Kolind (Denmark), Dr Anthony Thickett (chair: Middlesex University)

In relation to risk communication on alcohol, **Artur Schroers** suggested that 'risk competence' (a life skill to assist in coping with risk situations/ factors/ events linked to substance use[1]) should be promoted. We need feedback from users who are aware of actual risks and can describe them. Important are 'safer use rules' based on the experience of users' accounts. A good example of 'safer use rules' are techno-scene information brochures. These are passed on to others and trusted. Besides, dangers related to drug use are different for different individuals and situations.

1. Fahrenkrug, H. (1998). Risikokompetenz - eine neue Leitlinie für den Umgang mit "riskanten Räuschen?" [Risk Competence—A new guideline for dealing with "risky intoxication"?]. *Suchtmagazin*, *24*(3), 23-27

Alfred Uhl, using the example of alcohol consumption while breastfeeding, added to the discussion on how the inadequate analogy "mother-alcohol-baby" during pregnancy and while lactating can lead to incredibly erroneous conclusions.

There is no scientific evidence that moderate alcohol consumption in the mother causes a problem for the baby; but since heavy alcohol consumption in the mother undoubtedly can cause severe damage to the baby, the precautionary message for the mother is to refrain from drinking alcohol while pregnant. The situation is totally different while lactating. Since the baby drinks mother's milk and dilutes it in its system, the breastfed baby reaches a maximum BAC of 2% of the mothers BAC - which is irrelevant. If the mother needs 2 hours to reach a zero BAC state, the baby only needs 2 minutes. Ripe bananas, fresh apple juice, bread and many other food items have a much higher alcohol content then mother's milk at peak level after consuming 2 pints of beer over a short period of time. There is only very little literature on alcohol effects and metabolism in babies, but the existing literature demonstrates that even very young babies survive intoxications with high alcohol levels as well as adults and that babies' elimination rate is almost identical to the rate in adults.



Alcohol and Public Health: Framing and communicating risk

Tuesday November 20th 2018

Drug and Alcohol Research Centre

Middlesex University

The Boardroom (C219-220), 2nd Floor College Building, access via main entrance.
Middlesex University, The Burroughs, Hendon, London NW4 4BT.

Programme

9.00 am: Registration and coffee

9.30 am: Jan Williams, Dean, School of Health and Education: Welcome and introduction to the conference

Session1: Chair: Dr. Karen Duke, Associate Professor Criminology, Middlesex University

10-10.45: Prof. Susanne MacGregor, Emeritus Professor, Middlesex University and Honorary Professor, London School of Hygiene and Tropical Medicine**:** *Framing and communicating 'alcohol risks': issues and challenges*

10.45-11.30: Dr. John Coggon, Professor of Law, Bristol University (Honorary Member, UK Faculty of Public Health, Co-Director, Centre for Health, Law, and Society) *Ethical considerations in framing and communicating public health information.*

11.30- 11.45: Break

Session 2: Chair: Dr. Karen Duke, Associate Professor Criminology, Middlesex University

11.45-12.30: Dr. Alex Mold, Associate Professor in History, London School of Hygiene and Tropical Medicine. *Alcohol and health education in the 1970s and 1980s.*

12.30- 1.15: Lunch

Session 3: Chair: Prof. Betsy Thom, Professor of Health Policy, Middlesex University

1.15-1.45: Dr. Janne Tolstrup, Professor at the National Institute of Public Health, University of Southern Denmark. *Case Study: Alcohol and Cancer – informing the public*.

1.45-2.15: Julian Strizek, Mag. Austrian Public Health Institute, Vienna. *Case Study: Measuring alcohol-related harm to others.*

2.15-2.45: Dr. Emma Milne and Dr. Rachel Herring, Middlesex University.

Case Study: Drinking in Pregnancy – a precautionary tale?

2.45- 3: Break

Session 4: Chair: Dr. Anthony Thickett, Senior Lecturer Tourism, Middlesex University

3-4.15: Panel commentaries and discussion: *What influences how research based evidence on alcohol related risk is translated into public messages: Perspectives from Europe*.

Associate Professor Torsten Kolind (Denmark)

Dr. Artur Schroers (Germany)

Dr. Michael Schaub (Switzerland)

Dr. Franca Beccaria (Italy)

Professor Alfred Uhl (Austria)

4.15pm: Close of conference

The conference is supported by a Network Development Grant from Alcohol Research UK and by the journal, *Drugs: Education Prevention and Policy*