Medical Effects Panel: Prioritization Meeting Background Information and Agenda

October 21, 2020, 13:00 – 16:00 EST

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Meeting Objectives

Review priorities for the LRDGs 2022, specifically agreeing on:

- Those for whom the LRDGs 2022 are intended;
- The exposure of interest (what, when, where, how much, how often);
- The alternative methods (absolute, relative or net risk) to assess risk (harms and benefits); and
- What should be the purpose of the recommendations.

Participants

Scientific Expert Panel: Medical Effects

- Dr. Peter Butt, Associate Professor, Department of Family Medicine, College of Medicine, University of Saskatchewan
- Dr. Catherine Paradis, Senior Research and Policy Analyst, Canadian Centre on Substance Use and Addiction
- Dr. Kevin D. Shield, Independent Scientist, Institute for Mental Health Policy Research, and Head, World Health Organization/Pan-American Health Organization Collaborating, Centre for Addiction and Mental Health
- Dr. Daniel Myran, Family Physician and Resident, Public Health and Preventive Medicine, University of Ottawa
- Dr. Adam Sherk, Postdoctoral Fellow, Canadian Institute for Substance Use Research, University of Victoria
- Dr. Matthew Young, Senior Research and Policy Analyst, Canadian Centre on Substance Use and Addiction
- Frank Cesa, Director, Office of Alcohol Policy, Controlled Substances Directorate, Health Canada

CCSA

- Dr. Amy Porath, Director, Research, Canadian Centre on Substance Use and Addiction
- Dr. Hanie Edalati, Researcher, Canadian Centre on Substance Use and Addiction
- Dr. Christine Lévesque, Researcher, Canadian Centre on Substance Use and Addiction
- Dr. Alan Martino, Knowledge Broker, Canadian Centre on Substance Use and Addiction
- Dr. Jennifer Reynolds, Knowledge Broker, Canadian Centre on Substance Use and Addiction

Public Health Agency of Canada

- Dr. Marc Avery, Senior Manager, Global Health and Guidelines Division, Public Health Agency of Canada
- Dr. Kate Morissette, Senior Epidemiologist, Global Health and Guidelines Division, Public Health Agency of Canada

Meeting Background

1. National Low-Risk Alcohol Drinking Guidelines

	LRDG 2011	UK 2016*	Australia 2020*
Weekly volume - Females	10 standard drinks (SD)	8.2 SD	7.4 SD
Weekly volume - Males	15 SD	8.2 SD	7.4 SD
Daily quantity - Females	2 SD	2.8 SD**	2.9 SD
Daily quantity - Males	3 SD	2.8 SD**	2.9 SD
Special occasion – Females***	3 SD		
Special occasion – Males***	4 SD		
Minors – Females	Delay or 1 SD		0
Minors – Males	Delay or 2 SD		0
Women who are pregnant or planning a pregnancy	0	0	0 (also applies to women who are breast feeding)
Single occasion	• Set limits for yourself and stick to them. • Drink slowly. Have no more than 2 drinks in any 3 hours. • For every drink of alcohol, have one non-alcoholic drink. • Eat before and while you are drinking. • Always consider your age, body weight and health problems that might suggest lower limits. • While drinking may provide health benefits for certain groups of people, do not start to drink or increase your	• Limiting the total amount of alcohol you drink on any occasion; • Drinking more slowly, drinking with food, and alternating with water; • Avoiding risky places and activities, making sure you have people you know around, and ensuring you can get home safely. • Some groups of people are likely to be affected more by alcohol and should be more careful of their level of drinking on any one occasion: ○ young adults ○ older people ○ those with low body weight ○ those with other health problems ○ those on medicines or other drugs	

	LRDG 2011	UK 2016*	Australia 2020*
	drinking for health benefits.		
Situations where cognitive ability and physical coordination should not be impaired	0	0	
Other general recommendations		• Adopting alcohol free days may be a useful way for drinkers to moderate their consumption. • The CMO should be clear as a core message in future communications that the new guidelines are for "low-risk" drinking not "safe" drinking. And that the vast majority of the population can reduce health risks further if they reduce drinking below the guideline levels, or do not drink at all. • The CMO should publish a more extensive narrative about the basis for the new guidelines, and communicate clearly that: ○ The risk of a number of cancers increases from any level of regular drinking. ○ There is good evidence that cardio-protective effects have previously been overestimated and there are substantial uncertainties around the level of protection still observed. ○ The net cardio-protective effects from mortality attributable to drinking regularly at low levels are likely to be limited in the UK to women over the age of 55. • Department of Health should work with health professionals and experts to review its guidance on higher-risk drinking levels, in light of the new evidence underlying this report. • Systematic research should be commissioned into the understanding, acceptability and uses of the new guidelines by the public, health professions and alcohol industry, including the impact of the supportive social marketing campaigns we recommend. • The guidelines need a well-funded launch campaign followed by continued promotion. • Health warnings and consistent messaging should appear on all	

	LRDG 2011	UK 2016*	Australia 2020*
		alcohol advertising, products and sponsorship.	

* All quantities transformed to Canadian standard drinks: 13.6 gr of pure alcohol.

** The UK does not specify a daily quantity, but indicates that if you drink as much as 14 units (8.2 standard drinks) per week, it is best to spread this evenly over three days or more.

*** Does not apply to youth (legal drinking age to 24 years old).

2. The Basis for Determining a National Threshold

LRDG 2011	**Relative risk approach** based around epidemiological evidence suggesting that low levels of alcohol consumption are associated with reduced annual risk of mortality when compared with not drinking. That is, there is some evidence that low levels of alcohol consumption provide a "protective effect." The LRDG 2011 for average daily consumption were thus set at the level at which risks of drinking were equivalent to risks of abstaining from alcohol. In other words, the threshold level was chosen such that, at the population level, the estimated harmful effects and the estimated protective effects were counterbalanced equally against each other and net mortality risk was the same as if everyone abstained from alcohol.
UK 2016	**Relative risk approach** that set the guidelines at a point at which alcohol harms and benefits were balanced, in terms of the numbers of deaths caused and prevented. And **Absolute risk approach:** "Net risk," which takes account of the research showing levels of drinking where alcohol would be expected to cause an overall 1% lifetime risk of death for those drinking at these levels. Unlike the absolute risk method used in Australia, the method used in the Sheffield model does take account of deaths prevented, for example, from ischaemic heart disease. So the 1% lifetime risk of death is a "net" risk for the population taking account of both deaths incurred and prevented.
Australia 2020	**Absolute risk approach** that focused on the absolute mortality risk due to drinking, compared to the mortality risks from other causes. Thus, the Australian guideline was set such that if the population all drank at that level, 1% of annual deaths would be attributable to alcohol. Selection of this 1% level was informed by guidance and regulations relating to other environmental and health risks and also by risks that appear to be acceptable to the public for other activities, as, for example, the risk associated with driving a car regularly.

Agenda

Time	Agenda Item	Purpose	Speaker
13:00 – 13:15	1. Welcome • Introduction • Agenda Approval	For approval	Co-chairs
13:10 – 13:30	2. Guideline Group membership • Terms of Reference for the Scientific Expert Panels • Declaration of Interest and Conflict of interest	For information	Co-chairs
13:30 – 14:30	3. Reviewing priorities for the LRDGs 2022, by formulating PECO questions: • **P –** Who is targeted by the LRDG 2022? • **E** – Exposure to alcohol is complex. What components are of most interest (what, when, where, how much, how often)? • **C –** What are the alternative methods (absolute, relative or net risk) to assess risk (harms and benefits) of mortality and morbidity? • **O –** What is the purpose of the recommendations? What should the recommendation achieve?	For discussion	All
14:30 – 14:45	**Break**		
13:45 – 15:45	4. Continuing item 3.	For discussion	All

Time	Agenda Item	Purpose	Speaker
15:45 – 16:00	5. Closing remarks and next steps	For discussion and information	Co-chairs