RECORD OF DISCUSSION

Orientation Session Part 2 – Low Risk Drinking Guidelines 2.0

September 30, 2020, 13:00 to 16:15

List of people attending the session:

Mark Asbridge, Mark Avey, Peter Butt, Frank Cesa, Kate Conigrave, François Damphousse, Hani Edalati, Jennifer Heatley, Erin Hobin, Christine Lévesque, Lauren Levett, Victoria Lewis, Alan Martino, Kate Morissette, Daniel Myran, Tim Naimi, Catherine Paradis, Mark Petticrew, Nancy Poole, Amy Porath, Justin Presseau, Jennifer Reynolds, Nancy Santesso, Brittany Sauvé, Adam Sherk, Kevin Shield, Tim Stockwell, Rebecca Sutherns, Kara Thompson, Taryn Walsh, Samantha Wells, Matthew Young.

13:00 to 13:05 The facilitator, Rebecca Sutherns, welcomed everyone to the session and presented the rules of engagement and the agenda.

13:05 to 13:10 Opening remarks

- Catherine Paradis presented the line-up for the day with first a presentation by Dr Nancy Santesso to introduce the methodology for the project. The session will then continue with presentations by Dr. Mark Petticrew on the review of the UK alcohol drinking guidelines and by Dr. Kate Conigrave on the revision of the Australian alcohol drinking guidelines. Information was then provided about upcoming committee meetings. Terms of references will also be shared soon with members of the different committees. Options are currently being looked at as well to ensure that members declare any potential conflict of interest.
- Peter Butt welcomed everyone back and praised the contributions made by the speakers and people asking questions during the first session. He also expressed his gratitude for having both Dr. Petticrew and Dr. Conigrave as speakers for the second session to talk about their respective experience with their country's LRDGs. He also invited Dr Santesso to talk about the distinction between the AGREE II and the GRADE methodologies for developing guidelines.

13:10 to 13:50

Presentation: General introduction to ADOLOPMENT of guidelines

Speaker: Dr. Nancy Santesso from the GRADE Centre at McMaster University

Dr. Santesso started by presenting a comparison between the AGREE and the GRADE methodologies. Generally, AGREE (Appraisal of Guidelines for Research and Evaluation) is an appraisal tool to ask questions about whether a guideline group did specific tasks. It's similar to a check list. If these important tasks are completed, then the guidelines will be of high quality. However, AGREE does not provide guidance on how to accomplish

the tasks. Several examples where provided to illustrate the purpose of both methodologies. For instance, where the AGREE tool might ask if the strenghts and limitations of the body of evidence are clearly described, GRADE provides a system on how to assess those limitations (risk of bias, inconsistency, indirecteness, etc.).

The presentation then focused on the evidence component of the GRADE approach that feeds into making the recommendations. As mentioned during the first session, it will initially be important to prioritize the questions and outcomes that the guidelines will address. The next step will consist of gathering all the evidence to answer these questions. There will be many factors that will potentially require the need for gathering evidence in order to make the recommendations (How large are the benefits or harms? What outcomes are valued by stakeholders? etc.)

As part of the process, in order to avoid duplication, the group could look at the findings made during the development of other guidelines and decide either to adopt or adapt them. If such findings are not available, then new research will be needed (de novo development). This is actually where the word ADOLOPMENT comes from in the GRADE approach. It is a combination of adopt, adapt and development.

With ADOLOPMENT, the goal is not just taking the recommendations from others and take them at face value. For updating the Canadian LRDGs, the group might want to use some of the information that was already reviewed and add its own findings so that it can develop recommendations specific to Canadians.

The ADOLOPMENT approach will help to determine if there is information that can be used from the Australian and UK guidelines for the development of the new Canadian guidelines. Some key points to consider:

- It will be important to check if the priorities of the other guidelines address the same issues than the ones selected for the new Canadian guidelines;
- It will be possible to use the evidence from the other guidelines only if the questions are similar to the ones formulated for the new guidelines;
- The data used for other guidelines is not necessarily applicable to Canada;
- When determining how large are the benefits and harms, the absolute risks (absolute numbers) calculated for example for cardiac events might not be the same for Canada compared to Australia or the UK (the risks of cardiac events may be different in Canada to begin with);
- The level of risks may vary depending on the populations (gender/sex, socioeconomic status, etc.). This could be important if other populations are targeted by the new guidelines;
- The values placed on the health and social harms or benefits of drinking may be different in Canada compared to other countries. For example, even if it might cause a slight increase in strokes, the balance might tip in favor of consuming 1 or 2 drinks per day if the social benefits are given more weight or value;

- The emphasis put on searching for the information for these values. It could just consist of asking members of the committees what is more important for them or it could go as far as conducting original research to determine what those values are among the public;
- Other issues such as the public's acceptability of the guidelines or the feasibility to implement them may differ as well from other countries. Once again, it will be important to decide what emphasis will be put on searching for the information relevant to Canada for these issues.
- Etc.

13:50 to 14:00 Questions

The questions during and following the presentation covered the following issues:

- The difference or challenges in trying to quantify the absolute risks for health benefits or harms compared to social benefits or harms;
- How should the group consider the confidence level of the statistical evidence;
- The way that the GRADE approach deals with major scientific disputes;
- The consideration given to issues such as values, feasibility and acceptability when the end goal (north star) consists basically to improve the long term public health of the general population;
- Baseline risks can have an impact on the overall recommendations; it is possible to adopt methodologies and findings from previous reports and not just other guidelines; how to frame the outcomes to the general public, i.e. how to communicate basic information to the population such as lifetime expectancy changes based on how much people drink; etc.

14:00 to 14:45

Presentation: The review of the UK Chief Medical Officer's Alcohol Guidelines

Speaker: Dr. Mark Petticrew, London School of Hygiene and Tropical Medicine

Dr. Petticrew described the process that was involved in developing the new UK alcohol guidelines that were released in 2016 and the events that happened afterwards.

The process started in 2013. At first, two committees, the Health Expert Committee and the Behavioural Expert Committee, were created to look at and prepare reports on the available evidence based on systematic reviews. These two committees then morphed into the Guidelines Development Group (GDG) to produce the guidelines.

The GDG assessed the evidence from more than 40 systematic reviews and meta-analysis which examined the relationship between alcohol consumption and over 20 health conditions. It also looked at the social costs of alcohol use, including drinking and driving, domestic violence, etc. The GDG also collected evidence from national and international sources. The GDG was asked as well by the Chief Medical Officers (CMO) to provide advice on a methodology for developing new guidelines. Finally, the GDG

commissioned qualitative research to determine the public's acceptability and understanding of the revised guidelines.

Of note, the GDG liaised with the Committee on Carcinogenicity which was working in parallel to review the evidence on alcohol and cancer. Its report was published around the same time as the guidelines were updated. The work of the committee was very helpful because it looked at the areas where the evidence about the link between alcohol consumption and the risk of cancer, particularly breast cancer, became much stronger over the past 20 years.

Some of the main conclusions of the Behavioural Expert Committee included the following:

- Drinkers think that heavy drinking is drinking more than they do;
- People tend to be more aware of short-term than long-term risks;
- There is more awareness of the risks of liver disease and social harms than there is of cancer risks;
- Daily limits may be interpreted as meaning there is a safe level of consumption or positively beneficial level of consumption;
- Little is known about how the public judge acceptable levels of risk relating to alcohol consumption.

The new UK guidelines recommend for men and women not to drink more than 14 units per week, it is best to spread this evenly over 3 days or more, the risk of developing an illness increases with any amount consumed and a good way of cutting down consists of having several drink-free days each week.

The 14 units per week limit was established by modelling the absolute lifetime risk of alcohol-related mortality for those drinking from 7 to 49 units of alcohol per week on 1 or up to 7 days a week (several tables were shown with the results of the modelling). The only observed protective effect was found for women aged 55 or older consuming small amounts of alcohol (1 unit or less per day). Overall, many more years of life are lost due to alcohol than are saved.

The UK guidelines also provide advice on the short-term effects of alcohol such as limiting the total amount of alcohol you drink on any occasion, drinking more slowly, drinking with food, and alternating with water and avoiding risky places and activities, making sure you have people you know around and ensuring you can get home safely.

For pregnancy, the UK guidelines state that if you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all and drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

The release of the guidelines generated several responses, particularly from the alcohol industry. Topics that sparked much debate were the link between alcohol and breast cancer and the pregnancy guideline.

It became apparent that it was really important to know what the public's response would be to the guidelines. For example, having a better understanding on how the public wanted to be informed or how much information it wanted to receive about lower risks or risks of low level of consumption. The GDG commissionned qualitative research from Public Health England on the public's response to the draft guidelines which showed:

- Guidelines were seen as what is permitted to drink rather than recommendations to lower risk;
- Except for high risk drinkers, the information about the risks were considered believable, acceptable and plausible;
- The risk of liver damage is well known but less so for heart disease and various cancers;
- Guidelines were perceived as measured, neutral and focused on information.
- Etc.

The strengths of the UK guidelines come from the fact that the process to look at the evidence was separate from the process to develop the guidelines.

There were several lessons learned from this project including the necessity for committee members to declare interests, public awareness campaigns, as well as independent studies to assess the implementation of the guidelines and to monitor their impact.

There was no alcohol industry representation or input into any of the 3 committees. There were some gaps in terms of the evidence. For example, there was relatively little recent evidence on the health and social costs of alcohol use or around alcohol-free days. Evidence to assess how to develop and provide more tailored messages in relation to age, weight and other factors was insufficient. Significant new evidence on the effects of alcohol on mental health and wellbeing was neither available.

14:45 to 15:00 Questions

The questions following the presentation covered the following issues:

- Comparing the cancer risks between alcohol and cigarettes or with the amount of fertilizers or pesticides allowed in food as an approach to communicate more effectively the cancer risks of alcohol to the public;
- The concerns about the outcome of just informing the public about low-risk drinking, whether this was the initial goal of the whole exercise or whether it morphed over time to just focus on that;
- The need to integrate the guidelines into a larger more comprehensive strategy as a means to achieve larger population level outcomes
- The messages communicated to the public when the UK guidelines were made public. For example, communicating as a main message that the new guidelines show an increase risk in cancer and conveying what the new guidelines recommend to reduce the risk.

15:05 to 16:05

Presentation: Updating the Australian guidelines to reduce health risks from drinking alcohol

Speaker: Dr. Kate Conigrave from the University of Sydney

Dr. Conigrave described the revision process of the Australian alcohol guidelines.

The National Health and Medical Research Council (NHMRC) is responsible for providing guidelines on a wide range of health issues in Australia, including guidelines on health risks from alcohol (since 1987). The previous update of the guidelines was in 2009.

For the 2009 guidelines, the level of drinking which is associated with a lifetime risk of dying from an alcohol-related cause of no more than 1/100 was used. The 2009 guidelines recommend that healthy men and women have no more than 2 standard drinks per day or 4 standard drinks on a single occasion to reduce the long-term and short-term harms respectively. For children and young people aged under 18 years, the guidelines stated that it is important not to drink for the 15-16 years old age group and delay drinking as long as possible for the 17-18 years old age group. Women are advised that not drinking is the safest option when planning a pregnancy or when they are pregnant or breastfeeding.

Dr. Conigrave was appointed as the Chair of the alcohol working committee, convened by the NHMRC to revise the guidelines. Detailed information about the guideline development process and the draft guidelines themselves are available at www.nhmrc.gov.au/health-advice/alcohol .

The draft guidelines released for public consultation in December 2019 were:

1. ***For healthy men and women*:** To reduce the risk of harm from alcohol-related disease or injury for healthy men and women, drink no more than 10 standard drinks per week and no more than 4 standard drinks on any one day.
   The less you choose to drink, the lower your risk of alcohol-related harm. For some people not drinking at all is the safest option.

2. ***For children and young people:*** To reduce the risk of injury and other harms to health, children and young people under 18 years of age should not drink alcohol. people under 18 years of age should not drink alcohol.

3. ***For Pregnancy and breastfeeding:***
   To reduce the risk of harm to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol.
   For women who are breastfeeding, not drinking alcohol is safest for their baby.

The final guidelines are expected to be released at the end of 2020. The Department of Health is responsible for disseminating the guidelines.

16:05 to 16:10 Closing remarks

Peter Butt wrapped up the session by thanking all of the participants of the session, particularly Dr Peter Pettigrew and Dr Kate Conigrave for their excellent presentations. They were very thought-provoking. They got people to think about several key issues such as how to identify the levels of acceptable risk, how to get good evidence, how to settle on reasonable recommendations and how to move forward. He acknowledged their contribution for the launch of this process in Canada.