Canadian Alcohol Policy Evaluation (CAPE) Community of Practice

Canada's Guidance on Alcohol & Health - Knowledge mobilization activities

Event #19: October 25, 2023
Simultaneous French interpretation

- Simultaneous French interpretation is available except for the Q&A portion / interprétation simultanée en français est disponible sauf pour la section Q&R (see Chat box for instructions)
We acknowledge and respect the lək̓węŋən peoples on whose traditional territory the University of Victoria stands and the Songhees, Esquimalt and WSÁNEĆ peoples whose historical relationships with the land continue to this day.
Housekeeping

• Today’s webinar includes a presentation and Q&A = 90mins

• The presentation segment will be recorded (not Q&A). Links to the recording and webinar slides will be emailed.

• We invite your feedback about today’s session. A survey link will be shared in the Chat box and via email.

• For persons with lived/living experience stipends: email capecopcoord@uvic.ca

The views and opinions expressed as part of this event are those of the presenters alone and do not necessarily represent those of our funders or other organizations acknowledged
Q&A format

• Use the chat box or Q&A tool to submit a question at any time.

• Use ‘raise hand’ during Q&A segment. The moderator will ask you to unmute to pose your question. Name the presenter to whom you are directing the question.

• The moderator may read aloud questions typed in the chat or Q&A tool.

• Technical difficulties? please message us in the chat.
Dr. Kevin D. Shield
Independent Scientist, Institute for Mental Health Policy Research and Head, WHO/PAHO Collaborating Centre in Addiction and Mental Health, CAMH

Dr. Peter Butt
Clinical Associate Professor
University of Saskatchewan

Eftyhia Helis. M.Sc.
Canadian Centre on Substance Use and Addiction (CCSA)

Bryce Barker, PhD.
Canadian Centre on Substance Use and Addiction (CCSA)
Canada's Guidance on Alcohol & Health: Knowledge mobilization activities

CAPE CoP
25th October 2023
Kevin Shield, PhD
Key results: Implications for the General Public

**Alcohol consumption per week**

Drinking alcohol has negative consequences. The more alcohol you drink per week, the more the consequences add up.

<table>
<thead>
<tr>
<th>Amount of Alcohol</th>
<th>Risk Level</th>
<th>Risk Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 drinks per week</td>
<td>No risk</td>
<td>Not drinking has benefits, such as better health, and better sleep.</td>
</tr>
<tr>
<td>1 to 2 standard drinks per week</td>
<td>Low risk</td>
<td>You will likely avoid alcohol-related consequences for yourself and others.</td>
</tr>
<tr>
<td>3 to 6 standard drinks per week</td>
<td>Moderate risk</td>
<td>Your risk of developing several different types of cancer, including breast and colon cancer, increases.</td>
</tr>
<tr>
<td>7 or more standard drinks per week</td>
<td>Increasingly high risk</td>
<td>Your risk of heart disease or stroke increases. Each additional standard drink radically increases the risk of these alcohol-related consequences.</td>
</tr>
</tbody>
</table>

**During pregnancy, none is the only safe option.**

**A standard drink means:**

- **Beer**
  - 341 ml (12 oz) of beer
  - 5% alcohol

- **Cooler, cider, ready-to-drink**
  - 341 ml (12 oz) of drinks
  - 5% alcohol

- **Wine**
  - 142 ml (5 oz) of wine
  - 12% alcohol

- **Spirits**
  - (whisky, vodka, gin, etc.)
  - 43 ml (1.5 oz) of spirits
  - 40% alcohol
Aim to drink less

Drinking less benefits you and others. It reduces your risk of injury and violence, and many health problems that can shorten life.

Here is a good way to do it

Count how many drinks you have in a week.

Set a weekly drinking target. If you’re going to drink, make sure you don’t exceed 2 drinks on any day.

Good to know

You can reduce your drinking in steps! Every drink counts: any reduction in alcohol use has benefits.

It’s time to pick a new target

What will your weekly drinking target be?

Tips to help you stay on target

- Stick to the limits you’ve set for yourself.
- Drink slowly.
- Drink lots of water.
- For every drink of alcohol, have one non-alcoholic drink.
- Choose alcohol-free or low-alcohol beverages.
- Eat before and while you’re drinking.
- Have alcohol-free weeks or do alcohol-free activities.
Media Reaction – Mostly Positive – Some Negative

Canada’s drastic new alcohol guidelines demand a closer look

Sabrina Maddeaux: Two drinks a week? New guidelines are unsupported and puritanical kill-joys

Health Canada funded report wants drastic alcohol regulations, but group’s own actual evidence doesn’t back it up

Alcohol guidelines misleading

The CCSA’s assertions about increased risk of drinking alcohol are alarmist and distorting, 1

Better Make it a Double: New Anti-Drinking Guidelines Seek Abstinence Through Fear, Part I

Chris Selley: A scorching new critique of Canada's 'pseudo-scientific' alcohol guidelines

Canadians know when they’re being spun, and know when to tune out and go for a pint
Industry sponsored blog post - reaction


International Scientific Forum on Alcohol Research
Peer-reviewed Research - Reactions

“Less is better” is the best message when talking to patients about alcohol

Savita Rani and Andreas Laupacis
Did the media get it wrong?

In short **YES**.

The media is biased towards sensationalizing news.

Some media outlets have ideological biases

Media outlets are not peer-reviewed journals and do not go through the same validation (peer-reviewed) process.

Journalists are not scientific experts and are required to write on a lot of topics.

Media publications are not open scientific forms and responses to opinions are not always published.
Are the guidelines pseudo-scientific?

No

The guideline development was based on and strictly adhered to a standardized scientific protocol.

Guideline development was performed in accordance with the Grading of Recommendations Assessment, Development and Evaluation (GRADE)-Adaptation, Adoption, De Novo Development (ADOLOPMENT) approach.
Are the guidelines based on:
An amalgamation of selected studies of low scientific validity that fit their preconceived notions and ignore many high-quality studies whose results may not support their own views?

This is false.

All articles were considered for inclusion (i.e., a systematic review of all peer-reviewed literature was performed).

Only one RR function can be used for modelling (the most accurate one was chosen).

The most accurate RR function was selected based on AMSTAR (A MeaSurement Tool to Assess systematic Reviews) A standardized tool used to assess systematic review quality.
The results were based on only 16 studies!!!

This is misleading.

The results are based on 16 systematic reviews.

These 14 systematic reviews for chronic diseases are based on: ~364 studies were included in the underlying analyses (208 cohort studies and 155 case-control studies)
<table>
<thead>
<tr>
<th>Study</th>
<th>Disease</th>
<th>Search date</th>
<th>Sex- specific analysis</th>
<th># of studies included in the analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imtiaz et al., 2017</td>
<td>Tuberculosis</td>
<td>Jan 2007 to June 2016</td>
<td>No</td>
<td>4 (3 cohort studies; 1 case-control)</td>
</tr>
<tr>
<td>Samokhavalov et al., 2010</td>
<td>Lower respiratory infections</td>
<td>Jan 1980 to Aug 2009</td>
<td>No</td>
<td>5 (2 cohort and 3 case-control)</td>
</tr>
<tr>
<td>Bagnardi et al., 2015</td>
<td>Lip and oral cavity and other pharyngeal cancers</td>
<td>1956 to Sept 2012</td>
<td>No</td>
<td>52 (4 cohort, 47 case-control)</td>
</tr>
<tr>
<td></td>
<td>Oesophageal cancer</td>
<td>1956 to Sept 2012</td>
<td>No</td>
<td>79 (17 cohort and 62 case-control)</td>
</tr>
<tr>
<td></td>
<td>Larynx cancer</td>
<td>1956 to Sept 2012</td>
<td>No</td>
<td>41 (3 cohort, 38 case-control)</td>
</tr>
<tr>
<td>Vieira et al., 2017</td>
<td>Colon and rectum cancers</td>
<td>Jan 2006 to May 31 2015</td>
<td>Male</td>
<td>14 (all cohort)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>10 (all cohort)</td>
</tr>
<tr>
<td>World Cancer Research Fund International, 2018</td>
<td>Liver cancer</td>
<td>Mar 01 2013</td>
<td>Male</td>
<td>8 (all cohort)</td>
</tr>
<tr>
<td>Sun, 2020</td>
<td>Breast cancer</td>
<td>1990 to Dec 01 2018</td>
<td>Female</td>
<td>22 (all cohort)</td>
</tr>
<tr>
<td>Liu et al., 2020</td>
<td>Hypertensive heart disease</td>
<td>Sept 07 2019</td>
<td>Male</td>
<td>13 (all cohort)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>8 (all cohort)</td>
</tr>
<tr>
<td>Zhao et al., 2017</td>
<td>Ischemic heart disease</td>
<td>June 30 2016</td>
<td>No</td>
<td>14 (all cohort)</td>
</tr>
<tr>
<td>Larsson et al., 2016</td>
<td>Ischemic stroke</td>
<td>Sept 01 2016</td>
<td>No</td>
<td>25 (all cohort)</td>
</tr>
<tr>
<td></td>
<td>Intracerebral hemorrhage</td>
<td></td>
<td>No</td>
<td>11 (all cohort)</td>
</tr>
<tr>
<td></td>
<td>Subarachnoid hemorrhage</td>
<td></td>
<td>No</td>
<td>11 (all cohort)</td>
</tr>
<tr>
<td>Larsson et al., 2014</td>
<td>Atrial fibrillation and flutter</td>
<td>Jan 10 2014</td>
<td>No</td>
<td>7 (all cohort)</td>
</tr>
<tr>
<td>Knott et al., 2015</td>
<td>Diabetes mellitus</td>
<td>Feb 18 2014</td>
<td>Male</td>
<td>33 (all cohort)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>23 (all cohort)</td>
</tr>
<tr>
<td>Samokhavalov et al., 2010</td>
<td>Epilepsy</td>
<td>Jan 1960 to Sept 01 2008</td>
<td>No</td>
<td>6 (all case-control)</td>
</tr>
<tr>
<td>Roerecke et al., 2019</td>
<td>Cirrhosis of the liver</td>
<td>Mar 6 2019</td>
<td>Male</td>
<td>6 (4 cohort; 2 case-control)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>7 (5 cohort; 2 case-control)</td>
</tr>
<tr>
<td>Samokhavalov et al., 2015</td>
<td>Pancreatitis</td>
<td>January 2009 to May 2015</td>
<td>Male</td>
<td>3 (1 cohort ; 2 case-control)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>3 (1 cohort ; 2 case-control)</td>
</tr>
</tbody>
</table>
Do the guidelines account for confounding factors?

Yes. All underlying systematic reviews corrected for competing risk factors.

This includes smoking, BMI etc. The confounding factors adjusted for depends on the study/outcome.
<table>
<thead>
<tr>
<th>Study</th>
<th>Study Location</th>
<th>Sex (% Male)</th>
<th>Age Range (Mean Age)</th>
<th>Sample Size (Number of Tuberculosis Cases)</th>
<th>Follow-Up Duration</th>
<th>Number and Description of Alcohol Consumption Categories</th>
<th>Method of Tuberculosis Ascertainment</th>
<th>Confounders Adjusted for in Analysis of Extracted Risk Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jee et al. 2009[13]</td>
<td>South Korea</td>
<td>Both sexes (64%)</td>
<td>30 – 95 years (data not available)</td>
<td>1,294,504 (13,266) [Note: Number of tuberculosis cases is based on incident cases]</td>
<td>14 years</td>
<td>5 categories: 0 g/day, &lt; 25 g/day, 25 - 49.9 g/day, 50 - 99.9 g/day and ≥ 100 g/day</td>
<td>Minimal 1 hospitalization for tuberculosis, ≥ 2 outpatient visits for tuberculosis, or receipt of ≥ 3 anti-tuberculosis medications. The hospitalizations and outpatient visits ascertainment was based on ICD-10 classification system codes A15 - A19</td>
<td>Age, age squared, body mass index and smoking</td>
</tr>
<tr>
<td>Amoakwa et al. 2015[14]</td>
<td>South Africa</td>
<td>Both sexes (17%)</td>
<td>Data not available (data not available)</td>
<td>908 (59)</td>
<td>Median follow-up of 5-7 years</td>
<td>6 categories: Analysis 1 - alcohol non-user and alcohol user (definition not provided); Analysis 2 - None, 0 – 4 units/week; 5 - 10 units/week and &gt; 10 units/week</td>
<td>Follow-up of participants and review of clinical records and death certificates</td>
<td>Age, sex, smoking, baseline viral load, baseline CD4, tuberculin skin test induration size, body mass index, antiretroviral therapy start and treatment arm</td>
</tr>
<tr>
<td>Hemilä et al. 1999[15]</td>
<td>Finland</td>
<td>Males (100%)</td>
<td>50 - 69 years (data not available)</td>
<td>26,975 (167)</td>
<td>8 years</td>
<td>2 categories: &lt; 30 g/day and ≥ 30 g/day</td>
<td>Clinical diagnoses of tuberculosis identified during follow-up through the national hospital discharge register based on ICD-8 and ICD-9 classification systems' codes 010 – 018</td>
<td>Age, body mass index, marital status, education, residential neighborhood, cigarettes smoked/day and supplementation group</td>
</tr>
</tbody>
</table>
The guidelines use are based on relative risks not absolute risks!

This is: **false**

The guidelines are **report** and are **based** on **absolute risk**

A person’s **absolute risk** of losing 0.0175 years of life (under which is risk), and the absolute risk of losing 0.175 years of life (over which is high risk)

17.5 YLL per 1000 people

17.5 YLL per 100 people
How should I interpret the alcohol-attributable years of life lost

17.5 years of life lost per 1000 people

- Does this mean everyone who drinks this amount loses **6.4 days of life**?
- No.

A good way to interpret it is
(1) That you have **1 in 1000 chance** of dying early from alcohol at this consumption level
(2) That death will occur **on average 17.5 years earlier** (i.e., **17.5 years of life lost**) than the age you would have died if that alcohol-attributable death did not occur.
Why are you telling Canadians to drink <2 drinks per week

The guidance *does not recommend an alcohol consumption amount*. 

The guidelines *convey risk* of alcohol use.

They encourage people to *reflect upon their risk*. 
What the guidelines are are what they are not

The guidelines do not provide advice to specific Canadians

The guidelines provide advice to all Canadians

The presented guidelines are based on the general population of Canada
- This includes poor people
- People who have a lot of risk factors (hepatitis A, B or C, obesity, high blood pressure, smoking etc)
- This includes the homeless
- etc
Risk profile (other than alcohol)

- General population
- Low risk
- Moderate risk
- High risk

Grams per day

Relative Risk

Grams per day
Why include Tuberculosis?

Like all other guidelines and burden of disease analyses we:

1) Included diseases causally related to alcohol use
   - Alcohol has been shown to weaken the immune system leading to TB infections that would not be present if the person was not consuming alcohol
   **Causality** is established by the World Health Organization *NOT THE AUTHORS OF THE GUIDELINES*
   This meets the causality threshold set by the WHO

2) Performed a **systematic** and **comprehensive** analysis
   - I.e., a scientific analysis

3) TB cases and deaths and cases do occur in Canada
   In 2020 there were **1,772 cases** of active tuberculosis reported in Canada
   Although not captured in the guidelines: each TB case requires a tremendous amount of public health recourses to **treat** and **stop the further spread** of TB
How are the risk thresholds determined

We use standard definitions of risk based on environmental regulations (Starr 1969), and BMJ recommendations.

These definitions of risk are standard and are used for other risk factors.
Risk thresholds

Where to set Risk Thresholds
What level of risk is “acceptable“

Starr 1969
1 in 1000 lifetime deaths

Other low-risk drinking guidelines
1 in 100 lifetime deaths

Years of life lost
17.5 YLL per death in Canada
Comparison to other guidelines

WARNING DRINK SIZE VARIES ACROSS COUNTRIES WE NEED TO STANDARDIZE TO G/DAY

We ALSO NEED TO STANDARDIZE TO RISK LEVELS – 1 in 100 lifetime deaths

Canada: no more than 80.7 g / week (6 drinks /week; SD = 13.45 g)

US Dietary Guidelines: 28 g or less in a day for men or 14 g or less in a day for women, on days when alcohol is consumed [No risk level used] (SD = 14 g)

Australia: no more than 100 g / week (10 drinks / week; SD = 10 g)

UK: no more than 112 g / week (14 drinks /week; SD = 8)
Conclusions

The Canadian guidelines are based on a scientific, systematic and comprehensive tools used for setting guidelines in Canada and around the world.

The guidelines convey risk and promote reflection, but do not recommend an alcohol use amount.

The definition of low, moderate and high risk is based on a standard definition used in the scientific literature.
Thank You
Canada’s Guidance on Alcohol and Health

Knowledge Mobilization Approach, Activities, Resources

Presentation by: Eftyhia Helis, Knowledge Broker (CCSA)
Land Acknowledgment

We respectfully acknowledge that the offices of CCSA are located on the traditional, unceded and unsurrendered territory of the Algonquin Anishinaabe people, who have been present on this land and its stewards since time immemorial. As a national organization, we also acknowledge that we work on the traditional lands of many distinct nations, including Métis (settlements) and Inuit (Inuit Nunangat, homeland). We are humbled to have the opportunity to be present on these territories.

We pay our respects to and honour all First Nations, Métis and Inuit as distinct Peoples and as sovereign Traditional Knowledge keepers.

In the spirit of reconciliation with First Nations, Métis and Inuit Peoples in Canada, CCSA is committed to contributing to making positive changes in our relationship with Indigenous Peoples and to honour the Truth and Reconciliation Commission of Canada’s Calls to Action and the United Nations Declaration on the Rights of Indigenous Peoples.
Canada’s Guidance on Alcohol and Health: A National Conversation
Outline

• Overview of knowledge mobilization approach, ongoing and planned activities
  » Engagement and partnerships
  » Publications
  » Media response analysis
  » Evaluation

• Overview of available and planned resources

• Your feedback
Acknowledgement

Bryce Barker (Knowledge Mobilization); Christine Levesque (Research);
Wendy Schlachta (Communications); Jill Harnum (Policy);
Nolan McGreer (Project Coordination)
Knowledge Mobilization Approach

Focus on:
• answering questions most important to communities,
• building awareness.

Goal:
• Facilitate collaboration and encourage tailoring and use of the guidance.

Plan:
• Support the building of tools tailored specifically to community needs, outlooks, interests, and priorities.
Knowledge Mobilization Approach

KM Components (Year 1)

- Understand current CGAH landscape
- Strengthen existing collaborations and expand to form new ones
- Build on existing available information resources to develop additional and more targeted KM tools
- Respond to incoming requests and support others to use CGAH

Develop relevant strategies and resources to support needs of key audiences and populations
New Requests for Collaboration

- International
- Atlantic Canada
- Saskatchewan
- Quebec
- Ontario
- Manitoba
- BC
- Alberta

Established Contacts

- National Reach
- Atlantic Canada
- Saskatchewan
- Quebec
- Ontario
- Manitoba
- BC
- Alberta

Organization Type of Established Contacts

- NPTM Government
- Non-Profit, Advocacy
- Public Health and Community Services
- Research and Academia
- International Contact

- National Reach: 41
- Atlantic Canada: 40
- Saskatchewan: 20
- Quebec: 4
- Ontario: 23
- Manitoba: 20
- BC: 4
- Alberta: 10
Engagement and Collaboration

- National and Regional Partnerships

- Key Partners:
  - Partners with diverse experience with alcohol
  - Health care partners
  - Public health partners
  - Education partners
  - Policy-making partners
  - Indigenous partners
National Partnerships

- National events
- Facilitate collaborations and exchange of already developed resources among various regions
- Collaboration with CISUR:
  - Guidance-based web app

<table>
<thead>
<tr>
<th>Collaborators and groups with expressed interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Institute for Substance Use Research (CISUR)</td>
</tr>
<tr>
<td>Other partners as identified in the engagement process</td>
</tr>
</tbody>
</table>
Regional Partnerships (Atlantic)

- Enhanced understanding of regional efforts, decision-making and service landscape
- Regional Roundtable
- Identification of regional priority areas/populations and champions
- Regionally-specific strategies, tools and activities
- Expansion to other regions

<table>
<thead>
<tr>
<th>Collaborators and groups with expressed interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government of Newfoundland and Labrador</td>
</tr>
<tr>
<td>Government of Nova Scotia</td>
</tr>
<tr>
<td>Government of New Brunswick</td>
</tr>
<tr>
<td>Newfoundland Health Services</td>
</tr>
<tr>
<td>Government of Prince Edward Island</td>
</tr>
<tr>
<td>PEI Alliance for Mental Well-Being</td>
</tr>
<tr>
<td>New Brunswick Medical Society</td>
</tr>
<tr>
<td>St. Francis Xavier University</td>
</tr>
<tr>
<td>Acadia University</td>
</tr>
<tr>
<td>Other partners as identified in the engagement process</td>
</tr>
</tbody>
</table>
Indigenous Partnerships

• Indigenous Partnership and Strategy framework.

• Engage in meaningful partnerships with First Nations, Metis, and Inuit people and organizations at the national and regional levels.

• Aim: To co-develop relevant, appropriate, and tailored messaging and resources that are representative of Indigenous realities, worldviews, and processes.
Publications

Published:

In progress:
- Results of the initial survey assessing how knowing the health impacts of alcohol use influences individuals’ motivation to change their drinking behaviors.
- Methods used in the development of CGAH.
Media Coverage

Number of articles: 2532
Potential reach: 5.9 billion
Content Analysis of Media Coverage


In progress:
- Analysis of media coverage post-launch.
- Manuscript and report to highlight themes and discuss media context and experiences related to alcohol guidance
Evaluation of Guidance Awareness and Use

- Evaluation over a period of 2 years
- Initial focus: Awareness and Knowledge of Canada’s Guidance on Alcohol and Health
- Subsequent surveys will focus on impact measurement
- Annual review of findings to inform future activities
- First survey: February 7 and February 24, 2023 (n=5819)
- Second survey: October 20th – November 2nd, 2023

Report
Canada’s Guidance on Alcohol and Health
Conducted by Leger for the Canadian Centre on Substance Use and Addiction
Communications Toolkit

- Printable key message posters
- Social media assets
- Key messages presentation
- Additional support resources

https://ccsa.ca/canadas-guidance-alcohol-and-health#communications-toolkit
Communications Toolkit

Public Summary Poster

General Key Messages Poster

Youth & Alcohol Poster

Additional Resources

In progress:
Plain language resources for journalists and health professionals
Drink Less, Live More

Any reduction in alcohol use has benefits.

Learn More

Drink Less

Live More

Canadian Centre on Substance Use and Addiction

Drink Less

Live More

Any reduction in alcohol use has benefits.

Visit drinklesslivemore.ca

Canadian Centre on Substance Use and Addiction
Drink Less, Live More
Campaign Goals

• Create public awareness of the new Guidance.

• Build an understanding of the main takeaway of the Guidance (drinking less is better) in French and English.

• Spark discussions of the new guidance amongst people in Canada.

• Correct “two drink/week limit” misinformation.

• **Week of October 9:** Launch of campaign” (approx. 5 weeks)
Endorsements

All ads driven to: http://drinklesslivemore.ca
Year 1 Outcomes

• Year 1 of multi-year efforts
• Various collaborations are currently in progress and planning stages (e.g. accredited event for medical faculty members)
• CCSA aims to lead but also support effectively activities from other groups across the country (avoid duplication)
• Right time to provide feedback
Your feedback
email: alcohol@ccsa.ca
Canada’s new Guidance on Alcohol and Health: Clinical Implications

Peter Butt, MD, University of Saskatchewan, on behalf of the Low-Risk Alcohol Drinking Guidelines Scientific Expert Panels.

October 2023
Recommendation

To reduce the risk of harm from alcohol, it is recommended for people living in Canada to consider reducing their alcohol use.
A Continuum of risk

0 drinks per week
Not drinking has benefits, such as better physical and mental health, and better sleep.

1 to 2 standard drinks per week
You will likely avoid alcohol-related consequences for yourself and others.

3 to 6 standard drinks per week
Your risk of developing several different types of cancer, including breast and colon cancer, increases.

7 or more standard drinks per week
Your risk of heart disease or stroke increases.
Each additional standard drink Radically increases the risk of these alcohol-related consequences.

1:1000
1:100
Clinical Implications

Individualizing risk

In addition to prompting reflection on the risk from alcohol use alone, **people with a personal or family history** of an alcohol-attributable condition should be encouraged to reduce their level of consumption even further or consider abstinence.
**Clinical Implications**

**Increased risk for females - Example**

<table>
<thead>
<tr>
<th>Disease or Injury</th>
<th>Deaths per 100,000 people per year</th>
<th>Average alcohol intake (g/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td><strong>Heart disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>72.1</td>
<td>16.7</td>
</tr>
<tr>
<td>Hypertension</td>
<td>11.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Atrial fibrillation and flutter</td>
<td>10.4</td>
<td>0.6</td>
</tr>
<tr>
<td>Intracerebral hemorrhage</td>
<td>8.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Ischemic stroke</td>
<td>6.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Subarachnoid hemorrhage</td>
<td>2.4</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Liver cirrhosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver cirrhosis</td>
<td>6.9</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast cancer</td>
<td>28.3</td>
<td>17.3</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>21.0</td>
<td>9.2</td>
</tr>
<tr>
<td>Liver cancer</td>
<td>6.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Esophageal cancer</td>
<td>2.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Oral and pharynx cancer</td>
<td>2.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Larynx cancer</td>
<td>0.3</td>
<td>0.2</td>
</tr>
</tbody>
</table>
## Clinical Implications

### Increased risk for males - Example

<table>
<thead>
<tr>
<th>Disease or injury</th>
<th>Deaths per 100,000 people per year</th>
<th>Premature deaths per 100,000 people per year</th>
<th>Average alcohol intake (g/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>5   10  15  20  25  30  35  40  45  50</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>104.1</td>
<td>47.8</td>
<td>-5.0%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>8.4</td>
<td>3.4</td>
<td>7.2%</td>
</tr>
<tr>
<td>Atrial fibrillation and flutter</td>
<td>6.6</td>
<td>1.0</td>
<td>3.3%</td>
</tr>
<tr>
<td>Intracerebral hemorrhage</td>
<td>8.2</td>
<td>3.3</td>
<td>-8.0%</td>
</tr>
<tr>
<td>Ischemic stroke</td>
<td>5.7</td>
<td>1.9</td>
<td>-5.0%</td>
</tr>
<tr>
<td>Subarachnoid hemorrhage</td>
<td>1.6</td>
<td>1.2</td>
<td>21.0%</td>
</tr>
<tr>
<td>Liver cirrhosis</td>
<td>12.2</td>
<td>10.3</td>
<td>15.5%</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>25.5</td>
<td>13.9</td>
<td>3.4%</td>
</tr>
<tr>
<td>Liver cancer</td>
<td>12.2</td>
<td>10.3</td>
<td>15.5%</td>
</tr>
<tr>
<td>Esophagus cancer</td>
<td>9.0</td>
<td>6.2</td>
<td>6.8%</td>
</tr>
<tr>
<td>Oral and pharynx cancer</td>
<td>5.2</td>
<td>3.6</td>
<td>13.1%</td>
</tr>
<tr>
<td>Larynx cancer</td>
<td>1.0</td>
<td>1.1</td>
<td>7.5%</td>
</tr>
</tbody>
</table>
“Contrary to popular opinion, alcohol is not good for the heart.”

“Research in the latest decade has led to major reversals in the perception of alcohol in relation to health in general and cardiovascular disease in particular.”

“Risks due to alcohol consumption increase for all major cardiovascular diseases, including hypertensive heart disease, cardiomyopathy, atrial fibrillation and flutter, and stroke.”
Criteria for Group 1 Cancer Causation

1) Cellular impact demonstrates mechanism
2) Animal models reproduce the mechanism
3) Epidemiological data establishes association
Alcohol Attributable Cancer Deaths

Percentages

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>34</td>
</tr>
<tr>
<td>Oropharynx</td>
<td>33</td>
</tr>
<tr>
<td>Esophagus</td>
<td>32</td>
</tr>
<tr>
<td>Liver</td>
<td>20</td>
</tr>
<tr>
<td>Larynx</td>
<td>22</td>
</tr>
<tr>
<td>Colorectum</td>
<td>11</td>
</tr>
<tr>
<td>Breast</td>
<td>7</td>
</tr>
</tbody>
</table>
A Continuum of risk

- **0 drinks per week**
  - No risk
  - 0

- **1 to 2 standard drinks per week**
  - Low risk
  - 1

- **3 to 6 standard drinks per week**
  - Moderate risk
  - 3

- **7 or more standard drinks per week**
  - Increasingly high risk
  - 7

- **Risk ratios**
  - 1:1000
  - 1:100
A Triaged Approach to Goal Setting

1) Individual risk comfort is variable, and not necessarily grounded in actual personal risk.

2) In general, reduce. Less is better, with a potential goal of 6 SD per week, or less.

3) Increased personal risk of alcohol attributable condition, recommend goal of 2 SD per week, or less.

4) Presence of an alcohol attributable or exacerbated condition, consider 0.
Stages of Change & MI

Precontemplation

Contemplation

Planning

Action

Maintenance

Relapse

Success

(Prochaska & Di Clemente)
Why People Drink: Individualize Approach

<table>
<thead>
<tr>
<th>Personal-effect Motives</th>
<th>Social-effect Motives</th>
</tr>
</thead>
<tbody>
<tr>
<td>For enjoyment</td>
<td>To socialize</td>
</tr>
<tr>
<td>To alter mood</td>
<td>To celebrate special events</td>
</tr>
<tr>
<td>To avoid boredom</td>
<td>To increase power</td>
</tr>
<tr>
<td>To escape problems</td>
<td>Social ritual</td>
</tr>
<tr>
<td>To get drunk</td>
<td></td>
</tr>
</tbody>
</table>

The Benefits of Alcohol Reduction

- Decreased calories - Weight loss
- Improved sleep – More energy
- Improved cognition and memory
- Improved mood
- Decreased blood pressure
- Decreased blood sugar
- Decreased triglycerides
- Decreased liver fat
- Improved sex life
- Improved immune function
- Decreased cancer risk
- Decreased risk of accidents and injuries
- Improved relationships
- Financial savings
Harm Reduction Strategies

Here is a good way to do it
Count how many drinks you have in a week.

Set a weekly drinking target. If you’re going to drink, make sure you don’t exceed 2 drinks on any day.

It’s time to pick a new target
What will your weekly drinking target be?

Tips to help you stay on target
- Stick to the limits you’ve set for yourself.
- Drink slowly.
- Drink lots of water.
- For every drink of alcohol, have one non-alcoholic drink.
- Choose alcohol-free or low-alcohol beverages.
- Eat before and while you’re drinking.
- Have alcohol-free weeks or do alcohol-free activities.
In A Continuum of Risk, Less is Better

0 drinks per week
Not drinking has benefits, such as better physical and mental health, and better sleep.

1 to 2 standard drinks per week
You will likely avoid alcohol-related consequences for yourself and others.

3 to 6 standard drinks per week
Your risk of developing several different types of cancer, including breast and colon cancer, increases.

7 or more standard drinks per week
Your risk of heart disease or stroke increases. Each additional standard drink radically increases the risk of these alcohol-related consequences.
Thank you
Questions?
The views and opinions expressed as part of this event are those of the presenters alone and do not necessarily represent those of our funders or other organizations acknowledged.
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