Appendix B
Low-Risk Drinking Guidelines

Source: *Low-Risk Drinking Guidelines Report*, October 1999. Reprinted with permission.

In October 1997, the Addiction Research Foundation (ARF), now a division of the Centre for Addiction and Mental Health, along with the Ontario Public Health Association and the Association of Local Public Health Agencies, released a new set of low-risk drinking guidelines for Ontarians. These Guidelines, commonly referred to as the LRDGs, recommended that *healthy people who choose to drink* and *are of legal drinking age:*

- Have no more than 2 standard drinks *on any single day*—up to a weekly maximum of 14 standard drinks for men and 9 standard drinks for women.
- Drink slowly, wait at least one hour between drinks and take alcohol with food and non-alcoholic beverages to avoid intoxication.

The LRDGs also advise that:

- No one begins drinking alcohol for its protective effect against heart disease. Less risky alternatives such as exercise, better nutrition and quitting smoking are recommended. For those who choose to drink can achieve benefits with as little as one drink every other day,
- Those seeking help for a drinking problem follow the advice of their counsellor or health professional.
- Certain groups (e.g., pregnant or breastfeeding women, persons on certain types of medication, suffering from certain illnesses, or individuals engaged in potentially dangerous activities) drink less or not at all.

An ad hoc committee composed of representatives from CAMH, OPHA and alPHa have been working over the past eighteen months to promote the use of the Guidelines among key professional groups and the public-at-large. During this first phase of the Campaign, the Committee and its partner agencies succeeded in:

- securing buy-in, endorsements and assistance from a core group of organizations and opinion leaders, including the College of Family Physicians and the Canadian Centre on Substance Abuse
- pooling financial and in-kind resources to produce 245,000 brochures, 5,500 posters (English and French), as well as a comprehensive orientation package distributed to over 300 groups.
- distributing 145,000 brochures and 2,750 posters across Ontario, with assistance from the LCBO, public health and hundreds of other service organizations
- directly reaching an estimated 600 public health and social service professionals through presentations and displays and another 6,000 through newsletter and journal articles; as well as 50,000 Ontarians through media interviews and general programming.

In November 1998, the Committee met to develop a strategic plan for the next phase of the Campaign based upon a review of activities to date and feedback from public health professionals and CAMH-ARF Community Programs staff. The following were identified as priorities for action:

1. **Ensure the LRDGs become integrated in policies and programs that reduce the risk of alcohol-related problems and improve overall public health and safety.**

   For example, strengthen partnerships with heart health and injury prevention communities. Investigate the possibility of integrating LRDGs into *Canada's Food Guide* and other healthy lifestyle campaigns. Promote the inclusion of the the LRDGs in responsible service policies in licensed establishments, special occasion permit events and municipal facilities; as well as initiatives focusing on home hosting and impaired driving/snowmobiling/boating. Provide one-on-one consulting to health units and others interested in integrating the LRDGs into existing programming. Situate LRDGs as one component of a broader strategy to address alcohol-related problems. Continue to promote broader alcohol policy measures to control alcohol availability and reduce related harm.

2. **Expand the list of groups and opinion leaders that officially and publicly endorse the LRDGs and continue to clarify and support their role in disseminating information on low-risk drinking to their membership, colleagues, the media and the public-at-large.** Examples of supports that could be provided include: public service announcements, media kits and training, regional training/LRDG presentation materials, teleconferences to promote information-sharing and collaboration, collection of success stories, information package for endorsing organizations outlining role and responsibilities, key activities, etc.

3. **Work collaboratively with all levels of government, provincial organizations and local ARF offices, public health units and FOCUS groups to expand point-of-purchase and point-of-service distribution channels for the updated brochures and posters.** At a minimum, these should include: Wine Kiosks, BRI and Brew-on-Premise outlets, alcohol delivery service operators, licensed establishments, Smart Serve Training packages, doctors' offices, walk-in clinics, hospital emergency rooms, pharmacies, public libraries, municipal info kiosks, health food stores, information packages for groups hosting licensed events on municipal property, etc. In order to avoid overlap and duplication, the roles of various groups in the LRDG dissemination process need to be clarified. At minimum, the role and functions of the LRDG Committee, local public health units, FOCUS projects, CAMH-ARF area offices and Ministry of Health-funded resource centres must be clearly defined and agreed upon.

4. **Develop more targeted messages, vehicles and channels for Phase 2 of the LRDG Campaign based on solid health communication principles and local needs and priorities.** Particular care should be taken to address the special needs of ethno-racial and aboriginal populations, youth and young adults, and rural communities. Priority

should be given to those high need groups/communities that have expressed interest in partnering with the LRDG Committee (e.g., the Chinese community). Finally, resources should be targeted to populations and situations where they are likely to yield the highest impact. Targets may include the following: those who are drinking above the Guidelines; those who engage in high risk behaviour when drinking; those who have direct and frequent contact with the latter two groups and are in a position to influence their behaviour; adolescents and young adults who have the highest proportion of high-risk drinkers.

5. **Continue to disseminate research on low-risk drinking and the Guidelines through articles in academic journals, organizational newsletters, presentations and displays at conferences and workshops.** Priorities for action in this area include the production of a CAMH-ARF *Best Advice on Low-Risk Drinking*, ongoing research/publication of academic articles on drinking levels and practices incorporated in the Guidelines and more formal links between the LRDG Committee and the research team that developed the Guidelines.

6. **Track effort and assess impact over the medium-to-long-term to ensure that identified activities are achieving the desired results.** While the preliminary survey of the public health and safety community presented earlier may give us some indication of the receptivity of this group to the LRDG messages, it may not be representative of the professional intermediaries targeted for dissemination. Nor does it give an indication of the impact of the LRDG's on the public-at-large. In order to be successful, Phase 2 of the LRDG Campaign must be guided by measurable and attainable short, medium and long-term goals that clearly link **desired outcomes** (e.g., awareness, behaviour change among specific target groups and the population at large, improvements in general health and safety) to **available resources** (inputs) and **planned activities** (outputs).