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RACP Submission to NHMRC Consultation on Draft Australian Guidelines to Reduce Health Risks from Drinking Alcohol

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,000 physicians and 8,500 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

The RACP welcomes the opportunity to comment on the *National Health and Medical Research Council (NHMRC) Draft Australian Guidelines to Reduce Health Risks from Drinking Alcohol*. The RACP has been calling for a revision of the guidelines for several years, including in its key policy and advocacy statement, the Alcohol Policy 2016. We support the much-needed update and offer the following comments intended to better align the final document with the most recent and best available evidence on the health effects of alcohol.

RACP comments on draft Australian *Guidelines to Reduce Health Risks from Drinking Alcohol*

The comments have been arranged in the order set out in the questionnaire developed by NHMRC to solicit feedback on the guidelines.[1]

Format

We suggest that the guidelines be accessible both as a PDF and in the new MAGICapp format. The MAGICapp platform appears to include both numerical and author date references, making for easy searching and navigation.

Plain English Summary

The College finds the summary generally well-written and easy to follow. However, we believe that:

- It is overlong: the summary should be limited to a synopsis of the evidence rather than containing an extensive discussion of the evidence base.

- Some statements might be rephrased and strengthened to better reflect the evidence. For instance, the statement “For some people not drinking at all is the safest option” might be improved by simply saying “Not drinking at all is the safest option” which is supported by the evidence that even small amounts of alcohol present health risks. Indeed, the guidelines themselves claim that “there is no amount of alcohol that can be stated as safe for everyone.” This is a more accurate restatement of the evidence and reflects the World Health Organisation (WHO) advice that there is no safe level of drinking.[2] Words to that effect ought to appear early and prominently in the document (they are currently on page 12 of the guidelines).

- The use of the word “acceptable”, as in the phrase “a level of risk that is acceptable for those who drink alcohol”, might be contentious in this context: some readers might understand it to mean that there exists a well-established safe level of alcohol use while others might read it as a statement of judgement of any drinking behaviour which could in turn lead to the dismissal of the guidelines by some drinkers. Elsewhere in the document the guidelines discuss the difficulty of defining “acceptable

[1] We will use the term ‘guidelines’ when referring to the entire draft publication but ‘guideline’ when referring to a specific guideline within the draft e.g. guideline one on reducing the risk of alcohol-related harm.

[2] WHO Advisory: How can I drink alcohol safely? http://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/data-and-statistics/q-and-a-how-can-i-drink-alcohol-safely

risk thresholds" and the challenge of clearly communicating context-dependent concepts of risk at a population level.

Background

The graphs included in the background section of the guidelines are particularly useful. The addition of a graph of alcohol consumption by age and sex would be equally valuable. Figure 3.3 which illustrates alcohol abstinence by the age groups of 12 to 15 and 16 to 17 should not include the bar for the age group 12 to 17 as it is clearly a summation of the other two groups and does not add clarity.

The section on "Effects of alcohol: different for each person" should also note that effects of alcohol may vary depending on an occasion even for the same person, particularly over a lifetime.

Understanding risk

This section of the guidelines is clear and persuasive. However, the comparisons with the 2009 guidelines are not helpful for readers not familiar with these guidelines and thus unnecessary.

Guideline One: reducing the risk of alcohol-related harm over a lifetime

This section represents a dramatic change from the 2009 guidelines which included separate sections on minimising risk over a lifetime and from drinking alcohol on an occasion. The negative effects of even small amounts of alcohol appear to be minimised by the estimate of minimal harm at 10 drinks per week. This might work to reduce public awareness of the risk of small amounts of alcohol, such as the two drinks per day discussed in the guideline.

The following statements might be rephrased for emphasis and clarity:

- "Drink no more than 10 standard drinks per week and no more than 4 standard drinks on any one day" should read "Drink no more than 4 standard drinks on any one day and no more than 10 standard drinks per week". Such a rephrasing more forcibly argues for lower levels of consumption.

- "The less you choose to drink, the lower your risk of alcohol-related harm" should be amended to read "The less you drink, the lower your risk of alcohol-related harm" as it is the physical act of drinking that causes harm.

- "Drinking alcohol within this guideline has substantial net benefits, as opposed to drinking above it" might be interpreted to mean that alcohol can be beneficial. The statement should say: "Drinking alcohol at or below maximal levels within this guideline has substantial net benefits, as opposed to drinking above it."

- "For some people aged over 60 years, drinking alcohol increases the risk of falls and injuries, as well as some chronic conditions" should be amended to say "For people aged over 60 years, drinking alcohol increases the risk of falls and injuries, as well as some chronic conditions", as the statement applies to all people over 60.

Guideline Two: Children and young people under 18 years of age

The guideline states that "There is no clear 'safe' or 'no-risk' level of alcohol consumption for children and young people under 18 years." In fact, there is no clear 'safe' or 'no-risk' level of alcohol consumption for anyone, which should be emphasised in light of the guidelines' stated objective to enable people to make better decisions based on their perceptions of risk and benefit.

It would be also appropriate to note here the varying legal drinking ages of other countries and regions, some of which can be as high as 25 years old.[3] The legal age of drinking in a country serves as the basis for

[3] WHO Global Status Report on Alcohol and Health 2018
https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1

accepted social norms; by highlighting the fact that Australia is among the countries with a lower age at which alcohol can be purchased and higher levels of alcohol consumption and harm, we can situate Australian drinking patterns more clearly in a global context.

The section should make a stronger point about the impact of parental behaviour on drinking habits of young people. Not only are parents the second most common source of alcohol supply to teenagers but drinking in front of children normalises this behaviour. A change in Australian drinking culture effected within both the family and society is urgently needed and should be endorsed in the guideline.[4]

Guideline Three: Pregnancy and breastfeeding

This section fails to adequately incorporate evidence of harm to unborn and young children from paternal drinking, as evidenced in the study[5] quoted in the guideline. This leads to insufficient recognition of the importance of paternal alcohol consumption and results in a gender-biased guideline. Since women are more likely to drink alcohol if their partner drinks[6], the guideline should include recommendations directed at both partners. Accordingly, the guideline could be amended to state that:

- No level of alcohol intake by pregnant mothers is safe for the baby and
- There is good evidence that alcohol intake by partners of pregnant women makes it more likely that the mother will drink alcohol during pregnancy; therefore, it is recommended that partners also abstain during pregnancy.

The guideline should also emphasise that intimate partner violence is a mediating factor between maternal alcohol consumption and poor outcomes for children.[7]

Australia has a systemic problem of cultural association between young adulthood and alcohol. The guideline presents an opportunity to begin to change community norms by recognising that Australia's relationship with alcohol is a result of historic, cultural and economic factors, rather than an enduring norm. An opportunity to initiate such systemic change might be lost if the advice remains limited to one half of the population.

Section 7.5 should begin with a statement to that effect, such as: "The current association between young adulthood and alcohol in Australia results from our colonial history, cultures of alcohol, and the economic and political power of alcohol industry. Greater wellbeing of Australians may be achieved through re-considering our relationship with alcohol. Since planning for pregnancy is planning for a new beginning, this may be an appropriate time for individuals to re-consider their relationship with alcohol."

Appendix 1: Drinking frequency

The section should begin with a brief plain English statement to the effect of: "Information on how frequently the Australian population drinks alcohol is difficult to obtain. This is partly because different surveys of Australian drinkers of alcohol use different definitions of frequency. These definitions may not adequately reflect the contribution of alcohol to health risks. Here we summarise important national surveys that have been used to estimate risk in these guidelines."

Appendix 2: Administrative Report

It would be useful to include here the professional backgrounds of the NHMRC team who developed the guidelines. Information on committee membership should include contributors' State or Territory so that readers can clearly see the national representation of the committee.

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[4] Latendresse S J, Rose R et al: Parenting Mechanisms in Links Between Parents' and Adolescents' Alcohol Use Behaviors. Alcoholism. 2007

[5] McBride N, Johnson S: Fathers' Role in Alcohol-Exposed Pregnancies: Systematic Review of Human Studies. American Journal of Preventive Medicine. 2016

[6] Collins, R L, Parks, G, Marlatt, G A. Social Determinants of Alcohol Consumption: The Effects of Social Interaction and Model Status on the Self-administration of Alcohol. Journal of Consulting and Clinical Psychology. 1985

[7] Devries, K M, Child, J C et al: Intimate partner violence and alcohol. Addiction. 2014

Appendix 3: Glossary

The definition of dependence might be clearer if it were presented as a list of items.

Appendix 4: Abbreviations and acronyms

The acronym HED (for heavy episodic drinking) is not used in the guidelines and is unnecessary.

Appendix 5: Australian standard drinks

The section includes informative illustrations of Australian standard drinks in various containers, such as glasses, bottles and cartons. It would be helpful to provide a clear definition of a standard drink early in the document, so that readers are not, for instance, led to equate a restaurant serving of wine with a standard drink. The guidelines might also explicitly address Australians' current understanding of what a standard drink is.

Concluding comments

The RACP thanks NHMRC for the opportunity to comment on the draft revised Australian guidelines to reduce health risks of alcohol. We appreciate NHMRC's work on updating the national guidelines; we also call for an urgent revision of *The Guidelines for the Treatment of Alcohol Problems*, a resource for health professionals that has not been revised in the last 10 years.

In any public health guidelines, it is important that advice be consistent, clear and cautious, erring on the side of preventing harm and protecting health. A recent systematic analysis of alcohol-related burden of disease concludes that "the level of consumption that minimises health loss is zero."[8] This recommendation is not adequately reflected in the draft guidelines which currently state that "For some people not drinking at all is the safest option." The RACP believes that the evidence for alcohol-related harm, even at a low or moderate level of consumption, is stronger than the draft suggests. We recommend reproducing this statement of current evidence clearly in the document.

Finally, we would like to reiterate that these guidelines present a unique opportunity to communicate to the public that Australia's relationship with alcohol is a result of historic, cultural and economic factors, rather than an enduring norm, and to challenge and change community norms that influence national consumption patterns. Key parts of this change will include making the social and economic determinants of alcohol use explicit in the text of the guidelines and ensuring widespread and effective dissemination of the guidelines to health professionals and the public.

[8] Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. Lanced 2018