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Public Awareness of Alcohol-related Harms Focus on younger adults (PAAHS-FYA)

Final Report

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Public Awareness of Alcohol-Related Harms – Focus on Younger Adults
Final Report
Prepared for Health Canada
Supplier name: Phoenix Strategic Perspectives Inc.
March 2024

This public opinion research report presents the results of 20 online focus groups conducted with Canadian adults, aged 19 to 35 years. Four 90-minute sessions were conducted with participants living in each of the following five regions: Atlantic Canada, Quebec (French), Ontario, the Prairies, and British Columbia. In each region, two sessions were conducted with youth (aged 19-24), one with men and one with women, and two sessions were conducted with young adults (aged 25-35), one with women and one with men. The fieldwork took place between January 31 and February 13, 2024.

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Executive Summary

The Controlled Substances and Cannabis Branch of Health Canada commissioned Phoenix Strategic Perspectives (Phoenix SPI) to conduct qualitative public opinion research (POR) with youth (aged 19 to 24) and young adults (aged 25 to 35) across Canada to explore awareness of alcohol-related harms.

1. Research purpose and objectives

The purpose of this POR was twofold: to obtain a more in-depth understanding of the target audience's knowledge and attitudes about alcohol-related harms as well as their willingness to support policies and adopt behavioural change; and to determine appropriate knowledge mobilization and dissemination approaches to reach these groups.

The primary objective of this research was to develop a contextual foundation of young Canadians' general awareness and knowledge of the risks and harms associated with the consumption of alcohol. Specifically, the research was designed to: assess knowledge of alcohol-related harms and identify the most effective communication methods of raising awareness of alcohol-related harms; examine the target population's intentions to reduce alcohol consumption and identify information that could best support behavioural changes and/or intentions to reduce alcohol consumption; understand attitudes towards alcohol reduction education, alcohol labelling, and other policies; and explore knowledge of, and interest in, low and non-alcoholic beverages.

2. Methodology

Twenty online focus groups were conducted with Canadian adults, aged 19 to 35 years. Four 90-minute sessions were conducted with participants living in each of the following five regions: Atlantic Canada, Quebec, Ontario, the Prairies, and British Columbia. In each region, two sessions were conducted with youth (aged 19 to 24), one with men and one with women, and two sessions were conducted with young adults (aged 25 to 35), one with women and one with men. All groups included a mix of participants by age (within the recruitment parameters), education, household income, alcohol consumption (those who consume alcohol and those who never or no longer do), and cultural backgrounds. Participants received an honorarium of $125. The fieldwork took place between January 31 and February 13, 2024.

3. Highlights and key themes

Young people consume alcohol for a variety of reasons, but two reasons stand out: as a social activity and as way to relax. While drinking habits and patterns tend to depend on context and circumstances, participants considered up to five alcoholic drinks per week to be a reasonable amount for people their age. Among young people who do not consume alcohol, religion and culture, health and lifestyle are the top reasons.

Participants had no difficulty explaining why people their age consume alcohol. The association of drinking with socializing was the most frequently identified factor influencing drinking patterns. There were two dimensions to this emphasis on drinking as a social activity, one recreational or celebratory (e.g., getting together with friends, holidays, birthdays, etc.) and the other normative or prescriptive (i.e., the perception that people their age are expected to consume alcohol in the context of social activities). Drinking as a way to relax was also routinely identified as a reason why people of their age consume alcohol. Other reasons given by participants to explain why people

their age consume alcohol included as a coping mechanism to deal with things such as stress, anxiety, depression, boredom, and problems; for the enjoyment of it; and because alcohol is an integral part of some cultural celebrations and events.

The types of alcohol typically consumed included wine, beer, hard liquor, coolers, and cocktails, with context and circumstances generally influencing the type of alcohol consumed, how much is consumed and how often. Examples of this included consuming wine with a meal, mixed drinks at home, beer at a pub, shots at a bar, and cocktails on weekends. The number of drinks per week identified as 'reasonable' for people their age varied widely, ranging from none to as many as 15 drinks. Despite variations, the large majority of participants felt that a reasonable number of drinks fell somewhere within a range that did not exceed five drinks per week.

Among participants who do not consume alcohol, three reasons were identified most often to explain why: religious reasons or cultural influence; health-related reasons, which included not liking the effect of alcohol on one's body and its impact on mental health; and lifestyle, such as being fitness oriented, being a parent, or planning a pregnancy.

Everyone had read or heard of some health-related risks associated with alcohol consumption, although most said there is not enough health information available about the risks and harms associated with alcohol use. If looking for this type of information, participants would turn to government, health services, and Google. That said, young people would prefer to receive this information via social media, posters/billboards on public transit, traditional media, and product labelling.

Participants identified general risks and harms associated with alcohol use, based on information they had heard or read. Risks and harms associated with alcohol use most often included liver disease, cancer, obesity and weight gain, as well as depression and other mental health issues. Except for a few references to liver and stomach cancer, participants did not identify any specific type of cancer. The education system, traditional news media, and social media were most often mentioned as sources of this information about the risks and harms associated with alcohol.

While participants could point to some risks and harms associated with alcohol use, there was limited awareness of the new drinking guidance by Canadian Centre for Substance Use and Addiction and only modest awareness of the term 'standard drink' or the number of standard drinks in typical alcohol containers.

Most participants said there is not enough health information available on alcohol. If looking for health information, participants would turn to government, health services, and Google. Government and health services were identified because of their perceived trustworthiness and because of the amount of data they collect. Notably, participants would prefer to receive information about risks and harms associated with alcohol use via social media (with a focus on Instagram, Tik Tok, and YouTube, but also Reddit and Facebook), posters/billboards on public transit, traditional media (e.g., radio, and television), and product labelling.

Among participants, there was a widespread assumption that knowing more about the harms of alcohol use would impact decision-making when buying or consuming alcohol. Topics for public health education materials on the harms and risks associated with alcohol consumption that would resonate with participants include the parallel between alcohol and smoking, the link between alcohol and cancer, and statistics related to the harms of alcohol consumption.

A large majority of participants believe that knowing more about the harms of alcohol use would have an impact on their decision (or, among participants who do not consume alcohol, the decision of people they know who do consume alcohol) when buying or consuming alcohol. Those who think their own decision-making would *not* be impacted said their alcohol consumption is limited, they already are well informed about the harms of alcohol use, and they do not like to have health-related information like this directed at them.

Aspects of the public health campaign materials presented in the focus groups that participants said resonated with them routinely included the parallel drawn between alcohol and smoking, the link between cancer and alcohol consumption, and the use of data, i.e., 7,000 cancer cases. The parallel drawn between alcohol and smoking was described as effective because young people have been raised in an environment in which the health risks posed by smoking have long been known, proven, and taken for granted as common sensical. The link to cancer was considered effective because of the causal nature of the connection between the two (and the fear this instils) while the use of data was viewed as effective because numbers are concrete.

Suggestions for ways government can reduce alcohol consumption tended to fall into two categories: regulatory measures and public education.

Suggestions for regulatory measures included increasing the cost of alcohol (i.e., taxing it more), restricting the availability of alcohol, legislating generic packaging (as is the case with cigarettes), offering tax incentives for producers of low/non-alcoholic beverages and non-liquor serving establishments, limiting or restricting alcohol advertising, and restricting the depiction of alcohol consumption in movies.

Suggestions for public education included health-related messages on the risks and harms associated with alcohol consumption that are concrete and meaningful. Concrete referred to messages that are evidence-based (e.g., data showing the effects of alcohol on the brain) and meaningful referred to information that people can use to relate to their personal circumstances or use for decision-making (e.g., X number of drinks per week increases the likelihood of Y disease by Z%).

Other types of public education initiatives suggested by participants included, for example, promoting alternatives to alcohol consumption (e.g., non-alcoholic beverages), sponsoring or promoting alcohol-free events with a focus on having fun without drinking, providing information on the financial impact of reduced alcohol consumption, and emphasizing the connection between alcohol and mental health issues.

Most believe labelling will get people to think about the potential harms of alcohol and consider reducing their alcohol consumption.

There was widespread agreement that alcohol labelling would be an effective way to get people to think about the potential harms of alcohol and to consider reducing their consumption, mainly because of the visibility of such information at the point of sale. In addition to the visibility of such information, it was also routinely noted that such information would induce people to think about potential harms and risks because it allows them to contextualize it in a personalized way. Specifically, information about the number of standard drinks in a container and the number of drinks per week associated with various risk levels allows people to gauge their own consumption habits and to reflect on them.

Those who felt that labelling would *not* be an effective way to get people to think about the potential harms of alcohol and consider reducing their consumption focused on one reason to explain why: the impression that information alone is not effective. Participants who took this position sometimes pointed to what they considered to be the limited effectiveness of labelling on cigarette packages in getting people to stop smoking.

There were some differences in perspectives based on age in relation to reasons for drinking alcohol, the risks and harms of alcohol consumption, sources of health-related information, and the perceived effectiveness of the health information campaigns reviewed as part of the focus group.

When asked why it is that people their age drink alcohol, 19-to-24-year-olds tended to focus on not wanting to miss out on social activities which often include alcohol consumption. In contrast, 25-to-35-year-olds tended to focus on drinking as a social expectation associated with fitting-in, such as meeting colleagues for a drink after work. While weight gain and depression were identified as risks associated with consuming alcohol by participants from both age cohorts, these conditions were more likely to be identified by participants aged 19-24. Social media and school/education were both more likely to be identified as sources of information about the risks and harms associated with alcohol by younger participants. Finally, although most participants said the health information campaigns presented in the focus group would get people their age to at least consider the health effects of alcohol, younger participants were more inclined to say this than older participants.

Concluding observations

Young people involved in this study had some awareness of general harms and risks associated with the consumption of alcohol. At the same time, a large majority said that knowing more about the specific harms of alcohol use would have an impact on decision-making when buying or consuming alcohol. These findings suggest that young people are receptive to communications/messaging about the harmful effects of alcohol consumption and that such communications/messaging *could* impact their behaviour. Consequently, a communications strategy targeting young people would not face the challenge of having to overcome resistance to the basic message that there are risks and harms linked to the consumption of alcohol.

That being said, findings from this study suggest that a communications strategy targeting young people on the topic of alcohol consumption needs to be mindful of the following in order to be successful:

- The social dimension of alcohol consumption. Alcohol consumption is inextricably linked to socializing and fuelled, at least to some extent, by peer pressure. Any communications strategy that ignores this is unlikely to be very effective with members of this demographic.
- Messaging that resonates. While receptivity to messaging removes the challenge of convincing young people of the validity of the message, this receptivity also involves a challenge. A communications strategy is less likely to be effective if it enunciates generalities that young people already know or believe, i.e., 'alcohol consumption poses risks to your health', 'alcohol consumption is linked to cancer'. In order to resonate, messaging must provide concrete and relevant information about the effects of alcohol consumption, including things they do not know or might not think about.

- Effectively reaching young people. Any communications strategy designed to reach young people will need to employ social media.

4. Limitations and use of the findings

Qualitative research is designed to reveal a rich range of opinions and generate directional insights rather than to measure what percentage of the target population holds a given opinion. The results of these focus groups provide an indication of participants' views about the issues explored, but they cannot be quantified nor generalized to the full population of Canadians between the ages of 19 and 35. As such, the results will be used by Health Canada to support the development of knowledge mobilization tools that increase literacy about the risks and harms of alcohol use among people in Canada and reduce alcohol-related harms.

5. Contract value

The contract value was $99,790.30 (including applicable taxes).

6. Statement of political neutrality

I hereby certify as a Senior Officer of Phoenix Strategic Perspectives that the deliverables fully comply with the Government of Canada political neutrality requirements outlined in the *Communications Policy* of the Government of Canada and Procedures for Planning and Contracting Public Opinion Research. Specifically, the deliverables do not contain any reference to electoral voting intentions, political party preferences, standings with the electorate, or ratings of the performance of a political party or its leader.

Alethea Woods
President
Phoenix Strategic Perspectives Inc.

Introduction

Background and objectives

Alcohol holds a social and cultural significance in Canada as it does in many parts of the world. Given its association with pleasurable social activities, such as attending music festivals, family gatherings and parties, watching sports, and/or to de-stress or to cope,[1] it is not surprising that alcohol is the most used psychoactive substance in Canada.[2] People in Canada are also exposed to extensive alcohol marketing and advertising. These factors, known as the commercial determinants of health, can play a large role in shaping our social environment and influencing behaviour.

It is well documented that commercial determinants of health play a major role in positioning alcohol as an appealing substance.[3, 4] However, other factors should be considered in examining alcohol use and its impact among people in Canada, including the motivations for alcohol use and willingness to change behaviours. For example:

- Just over three-quarters (76%) of Canadians aged 15 and older reported drinking alcohol in the past year, with men more likely to consume alcohol than women.
- Of those who reported past-year drinking, a higher proportion of youth (aged 20 to 24) experienced alcohol-related harms.[5] Youth report drinking alcohol for several reasons, including the curiosity to try alcohol, association with social activities, peer pressure, or stress from interpersonal issues.[6]
- Between 2007 to 2020, the alcohol-attributable death rate rose faster for females (28%) compared to males (22%).[7] Young adult women (aged 25 to 35) report using alcohol due to anxiety, stress, and pressures of maintaining a personal and professional life.[8]
- Younger adults are increasingly interested in the 'sober-curious' movement by exploring non-alcoholic beverages (NoLos) as an alternative to traditional alcohol products or not drinking at all.[9]

Overall, alcohol incurs over $19 billion in costs to Canadian society in terms of health care and law enforcement costs, as well as indirect costs related to lost productivity. This is more than any other substance.[10] While alcohol is socially accepted, and its use is widely tolerated and promoted, it has a significant impact on the health and well-being of people in Canada compared to other substances. Specifically:

[1] https://www.annualreviews.org/doi/10.1146/annurev-publhealth-052220-020447
[2] Health Canada. (2019). Canadian alcohol and drugs survey (CADS): Summary of results for 2019. Accessed 2023-09-26.
[3] https://jamanetwork.com/journals/jamapediatrics/fullarticle/204410
[4] Wettlaufer, A., Giesbrecht, N. (2022). Women, wine and the web: Marketing #Alcohol to women and girls. Ottawa, ON: Health Canada.
[5] https://www.canada.ca/en/health-canada/services/canadian-alcohol-drugs-survey/2019-summary.html#a2
[6] https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/2018-preventing-problematic-substance-use-youth/2018-preventing-problematic-substance-use-youth.pdf
[7] https://csuch.ca/explore-the-data/
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6430711/
[9] Why millennials and Gen Z are helping lead the zero-proof drink surge | CBC Radio
[10] CSUCH - Explore the Data

- In 2020, there were over 17,000 alcohol-related deaths and 652,000 emergency visits in Canada.[11]
- Alcohol causes over 200 diseases and conditions, including cardiovascular and liver disease, and Fetal Alcohol Spectrum Disorder.[12]
- Alcohol increases one's risk of seven types of cancer, including cancer of the mouth, larynx, pharynx, esophagus, liver, colon, and breast.[13]
- Alcohol disproportionately elevates the risk of injury and disease among women due to biological factors that impact female's processing of alcohol, leading to faster rates of intoxication, slower elimination from the body, increasing alcohol-related harms.[14]

Although some evidence shows that people in Canada have a general understanding that alcohol use can increase harms,[15] limited and dated research existed on Canadians' level of awareness of specific alcohol-related harms.[16] To get a better understanding of alcohol literacy, Health Canada commissioned Phase I of the Public Awareness of Alcohol-Related Harms Survey (PAAHS) to provide an up-to-date assessment of the general population's level of awareness of alcohol-related harms. The survey revealed that many people in Canada are still unsure or don't believe that alcohol use, including at lower levels, is a risk factor for many serious diseases, such as breast, mouth, and throat cancer.

Consumers have the right to know the level of risk associated with consumer products, in particular those intended for human consumption. The results of Phase I indicate that young people in Canada wish to receive more information about alcohol-related harms. However, gaps remain in determining the most relevant information for youth and young adults who indicated a willingness to change their behaviour, and how such information should be communicated.

This purpose of this research was to expand on the results from the survey to obtain a more in-depth understanding of the target audience's knowledge and attitudes about alcohol-related harms as well as their willingness to support policies and adopt behavioural change; and to determine appropriate knowledge mobilization and dissemination approaches to reach these groups, including age- and gender-based messaging that influence alcohol consumption.

The primary objective of this research was to develop a contextual foundation of young Canadians' general awareness and knowledge of the risks and harms associated with the consumption of alcohol. Specifically, this qualitative research built on the existing evidence base with the following objectives:

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[11] Canadian Substance Use Costs and Harms Dashboard. Available at: https://csuch.ca/explore-the-data/. Accessed 2023-08-29.

[12] Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., Teerawattananon, Y., & Patra, J. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. The Lancet, *373*(9682), 2223-2233.

[13] International Agency for Research on Cancer Monograph. (2014). IARC Monographs on the Evaluation of Carcinogenic Risks to Humans. Available from https://monographs.iarc.fr/wp-content/uploads/2018/08/14-002.pdf.

[14] https://www.ccsa.ca/sites/default/files/2023-01/CCSA_Canadas_Guidance_on_Alcohol_and_Health_Final_Report_en.pdf

[15] https://publications.gc.ca/collections/collection_2019/sc-hc/H21-313-2019-eng.pdf

[16] Vallance, K., Stockwell, T., Zhao, J., Shokar, S., Schoueri-Mychasiw, N., Hammond, D., ... & Hobin, E. (2020). Baseline assessment of alcohol-related knowledge of and support for alcohol warning labels among alcohol consumers in northern Canada and associations with key sociodemographic characteristics. *Journal of Studies on Alcohol and Drugs*, *81*(2), 238-248.

- to assess knowledge of alcohol-related harms in the target population and to identify the most effective communication method(s) for raising awareness of alcohol-related harms (e.g., social media, advertising);
- to examine the target population's intentions to reduce alcohol consumption and to identify information that could best support behavioural changes and/or intentions to reduce consumption of alcohol;
- to understand attitudes towards alcohol reduction education, alcohol labelling, and other policies (i.e., taxation, etc.); and
- to explore knowledge of, and interest in, low and non-alcoholic beverages (NoLos).

This findings from this research will provide additional guidance to Health Canada on appropriate methods of raising awareness, to support the development of knowledge mobilization tools that increase literacy about the risks and harms of alcohol use among people in Canada and reduce alcohol-related harms.

Methodology

To meet the objectives, 20 online focus groups were conducted with Canadian adults, aged 19 to 35 years. Four 90-minute sessions were conducted with participants living in each of the following five regions: Atlantic Canada, Quebec (French), Ontario, the Prairies, and British Columbia. In each region, two sessions were conducted with youth (aged 19-24), one with men and one with women, and two sessions were conducted with young adults (aged 25-35), one with women and one with men. Participants included those who consume alcohol as well as those who have never, or no longer, consume alcohol. All groups included a mix of participants by age (within the recruitment parameters), education, household income, and cultural backgrounds. Participants received an honorarium of $125. Attendance was good, with 145 individuals participating in the study. The fieldwork took place between January 31 and February 13, 2024. More information about the methodology can be found in Appendix: Technical Specifications.

Notes to readers

- Qualitative research is designed to reveal a rich range of opinions and generate directional insights rather than to measure what percentage of the target population holds a given opinion. The results of these focus groups provide an indication of participants' views about the issues explored, but they cannot be quantified nor generalized to the full population of Canadians between the ages of 19 and 35.
- As mentioned in the Methodology section, the focus groups were segmented by age and gender. The Detailed Findings present results in an aggregate manner; noteworthy differences by sub-population are identified where relevant.
- The research instruments can be found in the Appendix along with more information about the technical specifications of research.

Detailed Findings

Alcohol use

This section reports on issues related to alcohol consumption. This includes participants' perceptions about why people their age consume alcohol, their perceptions about the number of drinks per week considered reasonable for people their age, descriptions of typical drinking habits and patterns among participants who consume alcohol, and reasons why participants who do not consume alcohol have decided to stop doing so or not to start drinking at all.

Young people consume alcohol for a variety of reasons.

Participants had no difficulty explaining why people their age consume alcohol or identifying factors that influence drinking patterns in their age group. A variety of reasons and factors were identified, but two were identified most often: drinking as a social activity and as a way to relax or unwind at the end of the day.

Drinking as a social activity

The association of drinking with socializing, i.e., consuming alcohol in the company of others, was the most frequently identified factor explaining or influencing drinking patterns in participants' age group. In addition, it was often the first reason identified by participants to explain why young people consume alcohol. There were two dimensions to this emphasis on drinking as a social activity, one recreational/celebratory and the other normative/prescriptive.

Participants routinely identified the consumption of alcohol with recreational activities and celebrations or special events that bring people together. This included, for example, getting together with friends, holidays, vacations, and birthdays. In this context, it was also sometimes noted that alcohol consumption facilitates social interaction by allowing people to loosen-up and relax around others, be at ease, or feel less inhibited. In this sense it functions as an icebreaker in situations where people come together for the purpose of socializing.

At the same time, another routinely identified aspect of drinking as a social activity was its normative or prescriptive character. Participants often observed that among people of their age there is a certain amount of peer pressure when it comes to drinking, or an expectation that one will consume alcohol in the context of social activities. In this sense, drinking was sometimes described as a way to fit in, to avoid missing out on social activities, and to avoid the perception of being anti-social.

While the influence of the normative/prescriptive dimension of drinking was acknowledged by participants from both age cohorts, the aspect emphasized tended to differ by age group. Younger participants, those aged 19-24, tended to focus on not wanting to miss out on social activities which often include alcohol consumption. Older participants, those aged 25-35, tended to focus on drinking as a social expectation associated with fitting-in, such as meeting colleagues for a drink after work or attending networking events.

Drinking as a way to relax

Drinking as a way to relax was also frequently identified as a reason why people of their age consume alcohol. This was described by a few participants as having a drink at the end of a busy and/or difficult day or week as a way to decompress or wind down.

Other reasons for drinking alcohol

Other reasons given by participants to explain why people of their age consume alcohol were identified less frequently and included the following:

- Alcohol as a coping mechanism: This included drinking to deal with things such as stress, anxiety, depression, boredom, and problems or frustrations (e.g., a bad day at work).
- Pleasure: Consuming alcohol for the sheer enjoyment of it, including its taste and its effects.
- Cultural/family background: The consumption of alcohol was sometimes explained as part of one's cultural and/or family background. For example, wine being served at family meals, alcohol as an integral part of cultural celebrations and events, and alcohol consumption as part of local or regional culture.
- Curiosity/novelty: A few younger participants indicated that one reason people of their age (19-24 years) consume alcohol has to do with the novelty of it, curiosity about it, and a desire to experiment. It was noted in this regard that once alcohol is legally available to young people, its consumption can come to be perceived as a right of passage.
- Pairing alcohol with food: A few participants, primarily ones aged 25-35, said one reason people their age consume alcohol is that it pairs well with food/meals.
- Something to do/routine: A few people mentioned that they live in a small community where there is not much to do that doesn't involve drinking.

The perceived influence of alcohol marketing as a factor that influences drinking patterns was mixed. Some felt that it plays no role at all. Some others acknowledged it has an influence but emphasized that it has more to do with social media influencers, e.g., TikTok videos about new drinks, than with marketing by producers of alcoholic products. It was also suggested that marketing is more likely to be a factor influencing what types or brand of drinks people choose to consume than a factor influencing the decision to consume alcohol in the first place.

Most think a reasonable number of drinks per week does not exceed 5.

The number of drinks per week identified as 'reasonable' for people of their age varied widely, ranging from none to as many as 15. In addition, participants were more likely to identify a range, such as two to three or three to five drinks, than an absolute number, and a few indicated that the number would vary depending on the type or amount of alcohol in the drink.

Despite variations, the large majority of participants felt that a reasonable number of drinks fell somewhere within a range that did not exceed five drinks per week. Relatively few identified numbers higher than five, and most identified the reasonable number as three or fewer drinks per week. A few participants volunteered that the number of drinks considered 'reasonable' would depend on what was taking place during the week. For example, if the week included any events that involve the consumption of alcohol, then the number of drinks considered reasonable would increase for that week.

Asked if the number of drinks they identified would be spread across the week, or on how many days per week it is reasonable to consume alcohol, participants routinely indicated that they had the weekend or the end of the week in mind or identified no more than a few days per week.

Drinking habits and patterns tend to depend on context and circumstances.

The types of alcohol typically consumed by participants who drink alcohol routinely spanned a range that included the following: wine, beer, hard liquor/mixed drinks, shots, coolers, and cocktails. That said, what was 'typically' consumed was often qualified. Participants explained that context and circumstances are factors that influence the type of alcohol they consume. Examples of this included consuming wine with a meal, having mixed drinks at home, drinking beer at a pub and/or in the summer/when there is hot weather, having shots and cocktails at a bar, drinking beer during the week, and drinking cocktails on weekends.

The circumstances in which participants who consume alcohol typically do so were varied but not random. In other words, such circumstances tended to be habitual or patterned in the following kinds of ways:

- Where: at home, at parties, in bars, pubs and restaurants, at sporting events, and at concerts.
- When: on weekends, after work, during celebrations or special events, when on holiday or vacation, with a meal, in the evening, and when relaxing.
- With whom: family, friends, partners, colleagues, and alone/on one's own.

Though it may be self-evident, it is worth noting that where, when, and with whom participants typically consume alcohol are factors intertwined with one another. For example, at home *with* family, after work *with* colleagues, on weekends *with* friends, etc.

Context and circumstance also influence participants' choices about how much and how often they drink. Contexts and circumstances in which participants said alcohol consumption tended to *increase* or be higher included the following:

- on weekends
- during the summer
- during holidays and vacations
- at celebrations/special events
- with friends as opposed to family members
- if friends or colleagues are drinking more
- after a difficult day at work
- if bored
- if at home
- at a bar
- during happy hour
- if one has more money to spend
- when relaxed/at ease

On the other hand, circumstances or contexts in which alcohol consumption was described as generally *lower* include the following:

- if working the next day
- if planning to exercise/work out the next day
- on weekdays
- if driving
- with family as opposed to friends

Many have felt the need to reduce their alcohol consumption for varied reasons.

In nearly every group there was at least one consumer of alcohol who said they have felt the need to consider reducing their alcohol consumption. Various factors led these participants to this consideration, although many reasons focussed on the physical effects of alcohol. These included health concerns or considerations, such as a greater focus on personal fitness, difficulty exercising, difficulty sleeping, getting older and feeling the effects of alcohol more acutely, and being tired of feeling the day after-effects of drinking.

Other reasons for reducing alcohol consumption included adverse effects on personal relationships, financial considerations (i.e., the need to budget), work responsibilities (i.e., having to go to work the day after consuming alcohol), the impression that their alcohol consumption was becoming too routine, less peer pressure to consume alcohol, the perception that they had become too dependent on alcohol consumption during the COVID-19 pandemic, and overconsumption of alcohol during the holidays.[17]

Religion/culture, health and lifestyle are the top reasons for not consuming alcohol.

Almost all participants who do not consume alcohol said they have someone in their life who drinks, whether friends, co-workers, or family members. A number of factors were identified as reasons for not drinking in the first place or no longer drinking alcohol, but three were identified most often: religious reasons or cultural influence/background; health-related reasons, which included not liking the effect of alcohol on one's body, not liking its effects on one's personality, its impact on mental health, and the need to take medication that does not support drinking; and lifestyle, such as being fitness oriented, being a parent, or planning a pregnancy.

Other factors were varied, ranging from the cost of alcohol to personal conviction. For some participants, the cost of consuming alcohol makes it prohibitive, while for some, alcohol holds no appeal (i.e., they dislike the taste and/or smell of alcohol) or they never developed a taste for alcohol. Others mentioned that they do not consume alcohol because they do not want to lose control of themselves when intoxicated, or because alcohol no longer appeals to them after consuming too much of it during the pandemic. Being focused on one's career or studies was another reason offered for not consuming alcohol, as was personal conviction. Regarding the latter, this refers to making a conscious decision to avoid alcohol based on first-hand experience with the effects of alcohol addiction in one's family.

[17] The fieldwork was conducted in January and February, a short time after the December holiday season.

Knowledge of alcohol-related harms and information needs

This section reports on participants' knowledge of alcohol-related harms and issues related to information about the risks and harms associated with alcohol use.

Many health-related risks associated with alcohol consumption.

Participants mentioned a variety of risks, including broad risks and harms associated with alcohol use, as well as some specific ones, based on information they had heard or read. Moreover, in most groups the risks and harms identified included a mix of both physical and mental effects on health. Risks and harms associated with alcohol use most often included liver disease, cancer, obesity and weight gain, as well as depression and other mental health issues. Except for a few specific references to liver and stomach cancer, references to cancer were general in nature. Participants did not identify any specific type of cancer. Although weight gain and depression were identified by participants from both age cohorts, these conditions were more likely to be identified by younger participants, aged 19-24.

While risks and harms associated with alcohol cannot always or necessarily be neatly categorized as physical, mental, and behavioural, the additional risks and harms identified by participants have been categorized as such to facilitate their review.

Physical risks and harms

- heart disease and high blood pressure
- alcohol addiction/dependency
- diabetes
- renal failure
- fetal alcohol syndrome
- problems with pregnancies or lactation
- infertility (identified only by men)
- alcohol induced comas
- premature aging
- brain/neurological damage/damage to nervous system
- Alzheimer's/alcohol-related dementia
- fatigue/lack of energy/sleep disruption
- seizures
- blood poisoning
- jaundice
- dehydration
- digestive issues/slower metabolism
- inflammation
- physical injury (e.g., falling while intoxicated, driving drunk, etc.)

Mental risks and harms

- anxiety
- brain fog
- impaired judgment.
- difficulty concentrating
- psychological issues (unspecified)

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- psychoses
- social isolation
- memory problems

Behavioural risks and harms

- aggressivity
- irritability
- a sense of invincibility
- lack of motivation
- moodiness
- withdrawal symptoms

It was also noted that alcohol use can destroy relationships, serve as a 'gateway' to the use of other substances, have widespread health effects (i.e., 'affect everything'), and that nothing good is associated with alcohol from a health perspective.

School, traditional media, and social media were most often mentioned as sources of information about the risks and harms associated with alcohol.

Participants identified various sources for the information they had heard or read concerning the risks and harms associated with alcohol use. These included the following, with those identified most often preceded by an asterisk (*):

- *school/education (pre- and post-secondary)
- *traditional news/media (i.e., radio, television)
- *social media (platforms mentioned included Facebook, TikTok)
- provincial health services
- Health Canada
- Éduc'alcool (among francophone participants)
- Center for Disease Control (CDC)
- World Health Organization (WHO)
- personal research (including reading scholarly articles)
- podcasts
- pamphlets
- anecdotal information/word of mouth (including parents)
- work (i.e., working in a health-related field)
- health professionals, such as a family physician
- first-hand experience

A few participants specifically referenced Canada's Guidance on Alcohol and Health as a source of such information.

Social media and school/education were both more likely to be identified as sources by younger participants, aged 19-24, while traditional media, including television, radio and print news, were more likely to be identified by older participants, aged 25-35.

Limited awareness of the new drinking guidance by Canadian Centre for Substance Use and Addiction.

Awareness of the new drinking guidance released in 2023 by the Canadian Center for Substance Use and Addiction was limited, with no more than a few participants in any group having heard of the guidance. Participants who were aware of new drinking guidance recalled the following information:

- even low-level consumption of alcohol is not good/no level of consumption is safe
- re-assessment/lowering of the number of drinks considered to be low risk
- two drinks per week as recommended/low-risk/safe[18]
- the risk level to health increases with the number of drinks
- there is a difference between the number of drinks recommended for men and women
- alcohol consumption can adversely affect the heart

A few participants recalled hearing or reading about reactions to the guidelines on social media, observing that the reactions from those on social media included expressions of surprise or dismissiveness.

Few aspects of alcohol guidance were considered unclear or confusing.

After exploring awareness of the new drinking guidance issued in 2023, participants were asked if there are any aspects of alcohol guidance in general that they find unclear or confusing. Here, participants commented on any guidance on alcohol consumption that they knew about. In response, relatively few participants identified aspects which they considered unclear or confusing. Those aspects that were described as such included the following: the meaning of one drink or a 'standard' drink; how to understand the difference between levels of risk, i.e., 'high', 'medium', and 'low' risk; conflicting information about alcohol consumption during pregnancy, i.e., during which trimester(s) one should or should not consume alcohol; and conflicting information about whether or not small amounts of alcohol, such as wine, are good. Regarding the conflicting information about consuming small amounts of alcohol, participants noted that studies seem to come to different conclusions every few years.

Some awareness of the term 'standard drink' as well as the number of standard drinks in typical alcohol containers.

At least a couple of participants in all groups said they have heard the term 'standard drink'. When it came to estimating the number of standard drinks found in typical containers of beer, wine, coolers or cider, and spirits, results were mixed. Participants who provided responses were usually correct in estimating the number of standard drinks in a bottle of beer, cooler or cider. On the other hand, estimates of the number of standard drinks in a bottle of wine and spirits were often too high or too low. Some participants hesitated to venture an answer, noting (correctly) that the number of standard drinks in typical containers of various types of alcohol depends on the percentage of alcohol in the type of alcohol in question. A more detailed breakdown of results follows.

When it came to the number of standard drinks in a typical bottle of beer, cooler or cider, participants who volunteered an answer most often said (correctly) that each contains one

[18] The expression 'recommended' was the language used by participants. The guidelines themselves do not 'recommend' any number of drinks.

standard drink. No one indicated that a typical bottle of beer or cider/cooler contained less than one standard drink, while over-estimates ranged from two to five standard drinks in the case of a typical bottle of beer and two to three standard drinks in the case of a typical bottle of cider or a cooler.

In the case of a standard bottle of wine, estimates ranged from a low of three standard drinks to a high of 20-22, with estimates most often taking the form of ranges. While estimates of the number of standard drinks in a typical bottle of wine were often too high or too low, many were correct or not off by much, sometimes because of the ranges identified by participants. For example, they often included estimates such as three to four, four to five, four to six, five to six, five to 10, six to eight, or eight to 10. In the case of wine, it was also noted that the number of standard drinks would depend on the size of the wine glass, the assumption sometimes being that a typical glass contains 5 oz of wine.

When it came to a typical bottle of spirits, estimates ranged from a low of four to five standard drinks to a high of 40-50. It should be noted that the estimate of four to five standard drinks was an outlier and an exceptionally low estimate; all other estimates started at a minimum of 10 standard drinks. Some participants did not identify a number of standards drinks in a typical container of spirits, but they noted (correctly) that one standard drink corresponds to one shot glass of spirits or 1.5 oz of alcohol.

That even small amounts of alcohol increase the risk of cancer is not surprising information for many.

The information that drinking alcohol, even at low levels, increases the risk of cancer was not surprising for many participants. That said, most groups included at least one participant to whom this information was new and/or surprising. More specifically, to some this information was either both new and surprising, new but not surprising, or surprising but not new.

It is important to recall that participants' knowledge of the link between cancer and alcohol consumption was very general in nature, with only a few references to specific types of cancer offered when they were asked about risks and harms associated with alcohol use. The fact that most participants did not consider the information shared by the moderator to be new—that even low levels of alcohol increase the risk of cancer—should not be interpreted as a greater depth of knowledge or understanding of this particular health risk. Instead, participants were open to accepting that alcohol consumption, along with other things, can cause cancer. Indeed, it was volunteered by some participants at different points during the discussion that "many things cause cancer".

Most think there is not enough health information available on alcohol.

Most participants said they do not think there is enough health information available on alcohol, with women more likely to say this than men. Asked what specific information would be most helpful in understanding the potential risks and consequences associated with alcohol consumption among people their age, participants most often identified information about specific risks associated with alcohol consumption, and information about the level/degree of risk associated with it.

Examples of helpful information about specific risks included the following:

- specific types of cancer linked to alcohol consumption
- the risk/effect of alcohol consumption on specific organs
- the number of drinks per week considered dangerous
- early signs that one's health is at risk as a result of alcohol consumption
- data/statistics on alcohol addiction levels in young people

Examples of helpful information about the level or degree of risk included the following:

- the risks posed by alcohol consumption compared to the risks posed by smoking cigarettes
- data/statistics comparing the brains of people who consume alcohol to those who do not
- correlation between the number of drinks per week and risk levels, e.g., X number of drinks per week increases one's chances of harm Y by Z%
- the difference between levels of risk, i.e., how to understand 'high', 'medium', and 'low' risk
- level/degree of risk posed by different types of alcohol, e.g., is beer v. wine v. spirits

In response to the question about information that would be most helpful in understanding the potential risks and consequences associated with alcohol consumption, a number of participants referred in a general way to labelling. These participants believe alcohol labelling would be an effective means to improve understanding of the potential risks of alcohol consumption among people their age. However, they did not specify what kind of information they would like to see on the label).

Other information considered helpful by participants, but identified less frequently, included the following:

- the number of calories in a standard drink
- the effects of alcohol on both physical and mental health
- short and long-term effects of alcohol consumption
- how long it takes before the effects of alcohol consumption begin to appear
- the emotional and social impacts associated with alcohol consumption
- signs of alcohol addiction
- sources of credible information about the health risks posed by alcohol consumption
- how alcohol interacts with various medications
- tracking data in general/longitudinal studies

Government, health services, Google - top information sources about risks/harms of alcohol use.

Participants collectively identified a variety of sources they would go to if they wanted information about the risks and harms associated with alcohol use, but three sources were identified most often: governments, health services, and Google. Government and health services were typically identified as sources because of their perceived trustworthiness, reliability, or credibility, but also because of the amount of data/information they collect and can make available to the general public.

The only government sources identified specifically were Health Canada and provincial health services/departments. Specific health services identified as sources for such information included the following: Éduc'alcool (among francophone participants), mental health lines, the Mayo clinic, Web MD, the Centre for Disease Control, the National Health Service (NHS), the World Health Organization, and university health/wellness centers.

Asked what makes a source of information credible, trustworthy, or reliable, the following factors were identified: perceived neutrality, objectivity, and the absence of a conflict of interest; working in the public interest and/or for the public good; and the use of an evidence-based approach, including providing information supported by data derived from research, citing sources, using reputable and peer-reviewed sources, and providing up to date information.

The main reasons for using Google were its perceived effectiveness and helpfulness in terms of finding such information, and habit (i.e., it is often the first source people will go to when looking for any information online). With this in mind, Google was sometimes described as a good first step in accessing such information because of the sheer amount of information it gives access to. Other sources of information, and reasons for using them, included the following:

- Parents, because they are trusted.
- Family physicians, because they have medical expertise related to the individual in question, have their patients' best interest in mind, and because they will know which additional sources to point one towards.
- Podcasts and videos, because they are user-friendly, i.e., they provide information in a way that is easy to follow, and one can engage with them at one's own pace.
- Non-profit organizations, including Mothers Against Drunk Driving (MADD), because they work in the public interest.
- Online forums/tutorials/blogs because they are interactive and allow for the sharing of information, perspectives, and experiences. This source was identified primarily by younger participants, aged 19-24.
- Social media (YouTube, Reddit, TikTok, Twitter/X, Instagram), as a reflex/habitual first step and because these platforms are easily accessible.
- Scientific journals/articles because they are credible/trustworthy.
- Universities, because they are considered centers of research and objective/neutral.
- Wikipedia and ChatGPT (at least as a start) because they deliver results quickly.

Almost no-one identified alcoholic beverage companies as a source they would go to for such information.

Preferred ways of receiving information about risks/harms of alcohol use routinely included social media, posters/billboards, traditional media, and product labelling.

Various preferred ways of receiving such information were identified by participants. Those identified most often included social media (with a focus on Instagram, Tik Tok, and YouTube, but also Reddit and Facebook), posters/billboards on public transit, traditional media (e.g., radio, and television), and product labelling. Social media was identified as a preferred source most often by younger participants, aged 19-24.

Other preferred ways of receiving such information included the following:

- in pamphlets
- by email
- through videos
- through social influencers
- through a family physician

- through reputable sources
- through ChatGPT
- through online ads (in sidebars)
- in-person, e.g., at school/university events
- where people drink alcohol, i.e., in bars or pubs
- through podcasts
- on websites (unspecified)

In response to this question, a few participants did not identify a preferred medium but focussed instead on what would facilitate the use of such information. With that in mind they said that they would like to receive such information in pdf formats, in a way that is 'concise', 'not overwhelming', 'easy to share', and 'that includes links to additional information'.

Widespread assumption that knowing more about the harms of alcohol use would impact decision-making.

A large majority of participants said they believe that knowing more about the harms of alcohol use would have an impact on their decision-making (or, among participants who do not consume alcohol, the decision-making of people they know who do consume alcohol) when buying or consuming alcohol. Reasons given to explain why included the following:

- Once such knowledge/awareness occurs it cannot be forgotten or totally ignored, especially because it is difficult to ignore information about things that have negative consequences for people.
- Such information can help people who consume alcohol make more informed (and better) decisions. It can raise fears, doubts, considerations, or apprehensions in people's minds, that factor into their decision-making process.
- Once such information becomes common knowledge it can generate discussions and may even result in a certain amount of peer pressure that influences people's decisions (i.e., encourage them to consider reducing their alcohol consumption).
- Such knowledge is likely to be confirmed/re-enforced by more research over time, making it harder to ignore or deny.
- This knowledge is confirmed by experience because people tend to feel better when they consume less alcohol.
- This information will sink in over time, especially as people get older and re-evaluate/re-assess their lives.
- Harm-related information seems to have been effective regarding cigarette smoking so there is reason to believe the same thing would apply to alcohol consumption.

Participants who think their own decision-making would *not* be impacted by knowing more about the risks and harms associated with alcohol use provided the following types of reasons to explain why: their alcohol consumption is limited/they do not drink too much or too often; they are already well informed about the risks and harms and take care of themselves; and they do not like to have health-related information directed at them.

Participants who do not consume alcohol themselves and who think that people they know who do consume alcohol will *not* be influenced by such knowledge provided the following types of reasons to explain why: knowledge alone is insufficient to get someone to change their habits because behavioural change depends more on will and personality than on knowledge; many people know about the harms of alcohol but ignore them (as is evident in the case of cigarettes); and drinking alcohol is too ingrained in our culture to be significantly impacted by such information.

Alcohol reduction strategies

This section reports on issues related to alcohol reduction strategies, including the following: recollection of education campaigns or public health messaging related to alcohol use, reaction to information from two public education initiatives related to alcohol use, views on messaging that would encourage people their age who drink alcohol to consider its health effects and to reduce their drinking, the perceived effectiveness of labelling, views on what else government can do to encourage people their age to consider reducing their alcohol consumption, and what would make participants who consume alcohol consider changing their drinking behaviour.

Limited recollection of education campaigns or public health messages related to alcohol use.

Recollection of education campaigns or public health messages related to alcohol use was limited. No more than a couple of participants in any group could recall seeing or hearing anything related to either.[19] Those who could recall something identified the following as what was memorable about the education campaign or health message in question:

- new directives concerning drinking/reduced number of drinks per week considered safe
- different directives concerning number of drinks per week suggested for men and women
- encouragement to drink less/consume less alcohol
- a recommendation to drink responsibly
- recommendation of non-alcoholic drinks
- references to 'standard' drinks
- reference to breast cancer
- warning about health risks of drinking alcohol during pregnancy
- reference to the connection between alcohol consumption and liver disease
- reference to the long-term effects of alcohol consumption
- reference to signs/indications that one is drinking too much
- information about how alcohol affects one's body
- a focus on young people/youth
- the message 'why another one?'
- a reference to 'dry February'
- message being sponsored by the Heart and Stroke foundation
- message being sponsored by Éduc'alcool

Places where participants recalled seeing or hearing these messages included the following: in media (YouTube, social media (unspecified), Health Canada ad on social media, radio), in public places (public transit, a billboard), in restaurants, bars/washrooms in bars and liquor stores, in a university residence, via a pamphlet and the new drinking guidance, or through word of mouth.

Parallel between alcohol and smoking, link between alcohol and cancer, as well as statistics resonate.

Participants were shown the following information from two public education initiatives focusing on the link between drinking alcohol and cancer. The one on the left is part of cancer prevention resources and supports provided by the Central East Regional Cancer Program in Ontario and the one on the right is a campaign from the BC Cancer and the BC Ministry of Health. Participants were

[19] In some groups, many participants said they recalled something. However, probing revealed that what they recalled were ads about drunk driving.

asked to take a moment to look at the materials and to share their reactions, with a focus on things they liked or disliked about the messaging.

Aspects of these materials that participants said they liked or that resonated with them routinely included the parallel drawn between alcohol and smoking, the link between cancer and alcohol consumption, and the use of numbers/data, i.e., 7,000 cases of cancer. Other aspects that participants said they liked or that resonated with them included the following:

- the inclusion of a QR code that takes one to a quiz
- emphasis on *any* amount of alcohol increasing the risk of cancer
- emphasis on the risk of cancer increasing with *each* drink
- the wordplay in the line 'The proof speaks for itself'

The aspect that participants most often said they did not like or did not resonate with them was the image of the alcohol container in the campaign material on the right because it does not resemble any alcohol container with which they are familiar. It was sometimes noted that it looks more like a perfume or shampoo bottle than a bottle of liquor, and, as a result, does not depict something that looks like it poses a risk or danger. Related to this, it was sometimes noted that the use of blue lettering on the bottle downplays the risk or danger that the messaging wants to emphasize (the colour blue not being associated with anything dangerous). Finally, it was occasionally noted that the image of the bottle is somewhat attractive, and to that extent, has the effect of depicting alcohol consumption as glamourous. Indeed, it was suggested that at first glance this material looks like advertising for alcohol.

Other aspects that participants did not like or that did not resonate with them included the following:

- The reference to cancer: while the reference to cancer, as noted above, was one of the most frequently identified aspects that participants liked about these materials, it was also sometimes criticized as not very effective for the following reasons:

    - The perceived vagueness of the messaging: This included the reference to cancer in general or several types of cancer as opposed to specific forms of it, the use of indefinite language such as 'can' and 'contributes to', and the use of the line 'The proof speaks for itself', it being suggested that this is a statement rather than proof (e.g., where is this substantiated?, where can one find this information?).
    - The reference to 7,000 cancer cases per year: While this was also one of the most frequently identified aspects that participants liked about these materials, some indicated that the number does not resonate with them, either because it is not high enough to be thought-provoking or shocking, or because they are unable to contextualize it in a meaningful way (e.g., is this high or low?, what else causes a similar number of cancer-related deaths each year?).
    - The impression that a reference to cancer causing substances has become too routine/banal in health campaigns.
- The link to smoking: While the parallel between smoking and the consumption of alcohol was routinely identified as a strength of the material on the left, a few said that this linkage did not resonate with them. Reasons included the impression that references to the dangers of smoking are too routine/banal to be effective, and not knowing any smoker who has died of cancer.
- Depiction of two glasses of hard liquor in the material on the left, because it could leave the impression that other types of liquor, e.g., wine, beer, do not pose a risk or as high a risk as hard liquor.

Most think the campaign materials would get people to consider the health effects of alcohol.

Most participants think these campaigns, or aspects of them, would get people their age to at least consider the health effects of alcohol, though younger participants aged 19-24 were more likely to say this than older ones aged 25-35. Reasons given to explain their effectiveness echoed feedback about aspects of the materials that resonated with participants. This most often included the parallel drawn between alcohol and smoking, the link between cancer and alcohol consumption, and the provision of numbers/data. Other reasons included the inclusion of the QR code, general concern about health among younger people, and the impression that such information can get people to reflect about their lifestyle.

The parallel drawn between alcohol and smoking was described as effective because young people have been raised in an environment in which the health risks posed by smoking have long been known, proven/confirmed, and taken for granted as common sensical. As a result, any parallel between the risk posed by cigarettes and other substances is likely to resonate with young people in general. The link to cancer was described as effective because of the fear factor, and the causal nature of the connection between the two. The use of numbers/data was considered effective because of their concreteness and vividness. The inclusion of a QR code was described as effective because it provides an interactive element that resonates with young people and that will allow them to meaningfully interpret this information by assessing their own personal level of risk.

Participants who did not consider these campaigns effective in this regard tended to focus on the absence of anything particularly attention-grabbing in these materials, with a focus on the following:

- The references to cancer are general and indefinite and not very effective because they provide no actual sense of the level or degree of risk.
- The data/numbers, i.e., 7,000 cancer cases, either lack context or are not high enough to be shocking.
- There is nothing specific that targets or speaks to young people.
- There is nothing really new in these materials.
- There is too much text, and the images are not vivid/captivating enough.
- There is a lack of information/details, e.g., what are the several types of cancer?, where is the 'proof' referred to?
- It might not be immediately evident to people outside a focus group that these campaigns deal with alcohol because of the prominence of the smoking image in one, and the use of a bottle that does not look like an alcohol container in the other.

It was suggested that materials targeting young people need to be attention-grabbing because their attention is typically focused on their phones and because they have many challenges and issues to deal with in their lives and alcohol may not figure prominently on their radar screen.

Most who drink alcohol did not think these campaigns would change their drinking behaviour.

Participants who consume alcohol were asked if these campaigns would change their drinking behaviour in any way and if so how. In response, most of them said no. Reasons volunteered to explain why included the impression that they do not consume alcohol in high quantities or very often, because they are already vigilant regarding their health, and because this is information with which they are already familiar.

Those who said they think these campaigns would change or influence their drinking behaviour pointed to the following to explain why: the link between alcohol consumption and cancer; the information about any amount of alcohol increasing their risk of cancer; the reference to alcohol contributing to 7,000 cancer cases per year; a recently developed concern about their health/level of fitness; and because it reinforces what is known by personal experience, that cutting down on alcohol consumption makes one feel better.

Concrete and meaningful messaging might encourage young people to consider the effects of alcohol and reduce consumption.

Participants collectively identified a number of types of messages that they felt would encourage people their age who drink alcohol to consider the health effects and to reduce their drinking. Effective messaging for young people most often focussed on concrete and meaningful/relevant information about the effects of alcohol consumption, including the following:

- Evidence/data showing the effects of alcohol on the brain, including comparisons of the brain of someone who consumes alcohol to that of someone who does not.
- Data/statistics to help meaningfully interpret the level of risk posed by alcohol consumption, e.g., X number of drinks per week increases the likelihood of Y disease by Z%.
- The number of deaths each year attributed to health conditions linked to alcohol consumption.

- Emphasis on the message that no amount of alcohol consumption is safe or recommended.
- Specific types of cancer associated with alcohol consumption, but also other diseases caused by or linked to drinking, e.g., dementia.
- Imminent or short-term effects of alcohol consumption on people their age/young people (not 30 years down the road).
- Early warning signs of the adverse effect of alcohol consumption, e.g., behavioural signs.
- Effects over time of alcohol consumption, e.g., how a condition will develop/manifest itself.
- Testimonials from young people who are dealing with health issues/problems resulting from alcohol consumption.
- Testimonials from people affected by someone's alcohol consumption, e.g., relatives, friends, colleagues, to show the adverse effect it has on others.
- Visual depictions/images (including graphic ones) of the aesthetic effects of alcohol use, e.g., weight gain, effect on skin or appearance in general.
- Showing how alcohol can adversely affect the kinds of things people their age desire or aspire to, e.g., marriage, children, careers.

In addition to information about the effects of alcohol, it was also suggested that messaging focus on the following:

- use of categorical language whenever possible, e.g., 'will cause' instead of 'can cause'
- appealing to emotions and feelings, not just data and statistics
- dissociating the consumption of alcohol from anything glamourous or positive
- associating the consumption of alcohol with negative things
- specific sources on where to go for help/assistance or information
- messaging that includes access to interactive tools, e.g., personalized assessment tools
- a focus on information that is visual, hard-hitting, simple, and easy to remember
- data on the money that can be saved over time by reducing or ceasing alcohol consumption
- focus on the good effects of not drinking and alternatives to drinking
- how to deal with/reduce peer pressure associated with alcohol consumption
- use of social media as a communications vehicle and social influencers as messengers
- use of shaming guilt, as is sometimes done in the case of cigarettes

Suggestions for ways government can reduce alcohol consumption tended to fall into two categories: regulatory measures and public education.

Aside from sharing health-related information, there were a number of things participants felt government can do to encourage people their age to consider reducing their alcohol consumption. These things tended to fall into two broad categories: regulatory measures and information/public education initiatives.

Regulatory measures included the following:

- increasing the cost of alcohol/taxing it more
- restricting the availability of alcohol, i.e., where it can be sold
- generic packaging, as is the case with cigarettes

- tax incentives for producers of low/non-alcoholic beverages
- tax incentives for non-liquor serving establishments
- limiting/restricting alcohol advertising
- restricting the depiction of alcohol consumption in movies.

Information/public education initiatives included the following:

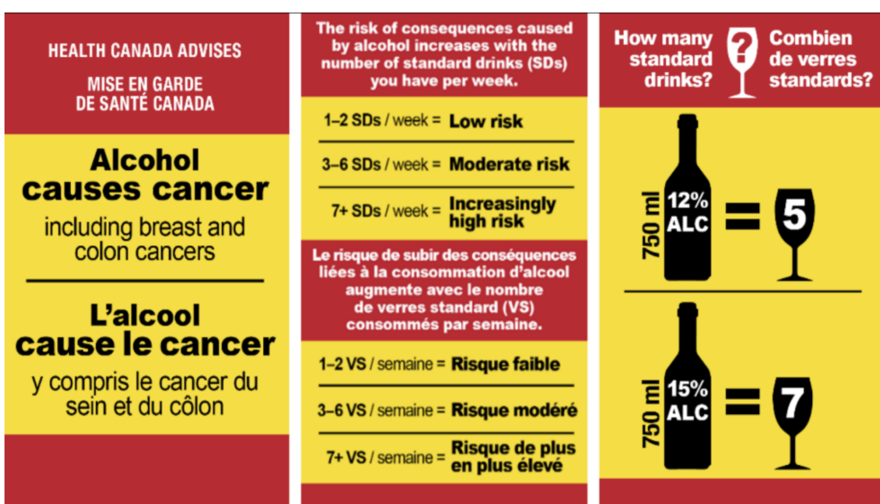
- promoting alternatives, e.g., non-alcoholic beverages, activities that do not involve alcohol
- sponsoring/promoting alcohol-free events with a focus on having fun without drinking
- marketing breathalyzers so that people can monitor themselves/regulate their consumption
- engaging social influencers to promote alcohol reduction
- getting buy-in from bars, restaurants, craft breweries, to share information about alcohol use
- drawing attention to the health effects that could result from reduced alcohol consumption
- providing information on the financial impact/effect of reduced alcohol consumption
- providing information on the social/interpersonal costs of alcohol consumption
- putting in place supports for people who want to reduce their consumption or quit
- emphasizing the connection between alcohol and mental health issues
- publicizing the caloric content/count of alcoholic beverages
- using social media as a vehicle to reach younger people

It was occasionally noted that reducing alcohol consumption would require a cultural or societal shift in perceptions about alcohol. One suggestion along these lines was to explore why people drink. Another was to consider lowering the legal age for consuming alcohol. The rationale was that if people are introduced to alcohol consumption early on, they would be less likely to view it as something new and exciting or to associate it with having fun/letting loose. As a result, they would be less likely drink heavily.

Most believe labelling will get people to think about the potential harms of alcohol.

Labelling of alcoholic products was raised by some participants in the context of discussing information that would be helpful to understand the risks and consequences of alcohol consumption, as well as ways they would like to receive such information. When the topic was explicitly introduced as a theme, it was noted that some countries are introducing alcohol labels to provide health and other information at the point of sale, and participants were shown the following example of labelling[20].

[20] It should be kept in mind that participants' feedback on the effectiveness of labelling was provided in the context and on the basis of the example of labelling that they were shown.



When asked specifically if alcohol labelling would be an effective way to get people to think about the potential harms of alcohol, there was widespread agreement that it would, mainly because of the visibility of such information at the point of sale. Specifically, emphasis was placed on the following:

- information labels on products are difficult to avoid/ignore
- health-related information is something people tend to notice/pay attention to
- the health information provided i.e., the causal connection between alcohol and cancer, specific types of cancer caused by alcohol, and risk levels associated with number of drinks per week, is attention-grabbing
- the colour scheme and bold text are eye catching/noticeable
- people tend to notice/pay attention to numbers/quantifiable data
- people often read labels on alcoholic products/products in liquor stores so they will encounter the health information in the context of something they do habitually

In addition to the visibility of such information, it was also routinely noted that such information would induce people to think about potential harms/risks because it allows them to contextualize it in a personalized way. Specifically, information about the number of standard drinks in a bottle and the number of drinks per week associated with various risk levels allows people to gauge their own consumption habits and reflect on them, e.g., does my weekly consumption place me at a low, medium, or high-risk level?

Additional reasons given to explain the perceived effectiveness of labelling in getting people to think about the potential harms of alcohol consumption included the following:

- labelling makes it clear that drinking alcohol is not something without negative effects
- such information would serve as a constant reminder/keeps this information top-of-mind
- the information is readily available, i.e., people do not have to look for it
- the information may prompt/motivate people to go look for additional information
- people are familiar/acquainted with health information on labels and take it for granted, so there is reason to think they will be receptive to receiving it on alcohol products
- being aware of something is a precondition to doing anything about it, so simply being given the information is useful

- the information provided is simple and easy to remember

A few participants specified that they felt labelling would be effective in this regard if accompanied by graphic images, e.g., showing the harmful effects of alcohol consumption. It is worth noting that two of the main reasons identified, i.e., risk levels associated with the amount of alcohol consumed and specific forms of cancer linked to alcohol consumption, were among the most frequently identified sorts of messages that participants felt would encourage people their age who drink alcohol to consider the health effects and reduce their drinking.

The main reason given to explain why labelling would *not* be effective in getting people to think about the potential harms of alcohol consumption was the impression that people are purchasing alcohol to consume it. The fact that a product contains health information will be of limited effectiveness if people have already taken the decision to purchase the product. Other reasons given to explain why labelling would not be effective were variations on the theme that information alone is not effective. Specifically,

- If people are going to think about the potential harms of alcohol it is more likely to be as a result of personal experience than as a result of reading health-related information on a label.
- Labelling does not really work unless it is accompanied by an act of will or desire, i.e., information alone will not be effective.
- This kind of information is not really new/most people probably already know that alcohol is not good for one's health.

Finally, it was occasionally suggested that many people will simply not read the labels.

Most believe labelling will get people to consider reducing their alcohol consumption.

Most participants also indicated that they believe that labelling would be an effective way to get people to consider reducing their consumption of alcoholic drinks. The most frequently given reason to explain why was that the information about the number of drinks per week associated with various risk levels allows people to gauge their own consumption habits and adjust them in such a way to reduce the level of risk, e.g., reducing one's weekly consumption so as to place them at a low as opposed to a medium or high risk level in terms of their health. Other reasons included what was described as the 'fear factor', i.e., the link between alcohol consumption and cancer, and the impression that labelling associates the consumption of alcohol with negative or harmful things, something which over time can reduce the desire or motivation to drink.

Those who felt that labelling would not be an effective way to get people to consider reducing their consumption of alcoholic drinks focused on one reason to explain why, the same reason offered to explain why labelling would not be effective in getting people to think about the potential harms of alcohol consumption: the impression that information alone is not effective. Participants who took this position sometimes pointed to what they considered to be the limited effectiveness of labelling on cigarette packages in getting people to stop smoking.

A few participants specified that labelling would be an effective way to get people to consider reducing their consumption of alcoholic drinks if they are not addicted to alcohol.

A variety of factors might encourage participants to reduce their own consumption of alcohol.

Following the discussion of the effectiveness of labelling in getting people to consider reducing their consumption of alcoholic drinks, participants who consume alcohol were asked what would make them consider changing their own drinking behaviour. In response, the following factors were routinely identified:

- financial considerations/an increase in the price of alcohol
- increased focus on health/fitness
- evidence of negative effects on their health, temperament, or behaviour
- adverse/negative effects on their personal and/or professional relationships
- no longer enjoying the experience

Other factors that were identified included the following:

- reduced/limited availability of alcohol/more difficult access
- a physician's recommendation to reduce consumption
- access to an array of enjoyable alternatives, e.g., mocktails
- pressure or concern from loved ones
- a reduction in peer pressure to drink
- peer pressure to drink less
- labelling with clear information/data about risks and risk levels, e.g., so many drinks per week increases your risk of X by Y%

Low and non-alcoholic beverages

This section reports on issues related to reduced alcohol consumption. This includes participants' reasons or motivations for reducing their own alcohol consumption in the past year, their awareness and impressions of trends promoting alcohol reduction, and whether they have purchased low or non-alcoholic beverages over the past year and if so why.

Many participants decided to drink less alcohol in the last year, for a variety of reasons.

At least one participant in almost every group (and typically between two to three participants in most groups) said they decided to drink less alcohol during the past year. The most frequently identified reasons or motivations for doing so included the following: health issues/concerns; a greater focus on health and fitness; the requirements/demands of work or studies; being tired of the after-effects of drinking; and financial considerations.

Other reasons were provided by individuals or no more than a few participants. They included the following:

- curiosity at first, but then noticed that one felt better
- seeing the effects of alcohol dependence on friends
- not liking oneself under the influence of alcohol
- concerns about one's behaviour when intoxicated
- growing tired of it/not enjoying it as much as before
- involvement in a new social circle with people who do not consume alcohol
- routinely taking on the role of designated driver
- being subject to less peer pressure to consume alcohol
- the realization that one was drinking too much, especially during holidays
- feeling the effects/impacts more with age
- no longer going out as much in the aftermath of the pandemic
- because of MADD ads

Widespread awareness of trends promoting alcohol reduction.

There was widespread awareness of trends such as 'sober curious', 'dry January' and 'sober October', though relatively few of the participants have taken part in them. Perceptions of these trends were typically positive, with participants routinely focusing on their potential influence or impact. This included the following:

- their capacity to help people accomplish something they might not be able to do on their own by providing peer support and encouragement
- providing people with the opportunity to test their resolve and gauge their degree of dependence on alcohol
- providing an opportunity to feel the positive effects of reduced alcohol consumption
- potentially leading one to a permanent reduction in alcohol consumption

On a positive note, it was also suggested that these trends periodically reduce the pressure on young people who do not consume alcohol, and that they can be a good vehicle for raising money for various causes. While impressions tended to be positive, there was also a sense among some

that these campaigns can have a 'boomerang effect', meaning that people who take part in them might compensate for their reduced alcohol consumption during one month by increasing it in the month(s) after. While not a criticism, it was also noted that these trends are targeted towards people who consume a lot of alcohol.

Perception that alcohol reduction campaigns are driven mainly by health and wellness considerations.

There was a widespread impression among participants that what is driving these kinds of trends is health and wellness considerations. Other factors identified as influencing these trends included the following:

- the desire for a post-holiday reset, i.e., a reprieve after a period of festivities
- a desire to take charge of part of one's life
- financial considerations/the cost of alcohol
- social media influencers and the ability to brag on social media about having taken part
- the opportunity to raise funds for a variety of causes
- the pervasiveness of alcohol consumption in our society/culture
- personal or family issues/problems involving alcohol

Many participants have purchased low or non-alcoholic beverages in the past year.

At least one participant in almost every group (and a few in most groups) said they have purchased low or non-alcoholic beverages in the past year. Reasons included the following:

- curiosity about the taste
- liking the taste
- liking the artistry of the cocktails
- simply for a change
- their lower cost/financial considerations
- being designated driver/driving a vehicle
- occasionally preferring an alternative to alcohol
- having to work the next day
- because the consumption of alcohol is not permitted in one's work environment
- ability to socialize and drink something without it being alcohol and to avoid being asked why one is not drinking.
- because others did
- to confirm that one does not have to drink alcohol to have fun
- being past the 'rite of passage' phase during which one feels pressured to drink alcohol

Concluding observations

Young people involved in this study had some awareness of general harms and risks associated with the consumption of alcohol. At the same time, a large majority said that knowing more about the specific harms of alcohol use would have an impact on decision-making when buying or consuming alcohol. These findings suggest that young people are receptive to communications/messaging about the harmful effects of alcohol consumption and that such communications/messaging *could* impact their behaviour. Consequently, a communications strategy targeting young people would not face the challenge of having to overcome resistance to the basic message that there are risks and harms linked to the consumption of alcohol.

That being said, findings from this study suggest that a communications strategy targeting young people on the topic of alcohol consumption needs to be mindful of the following in order to be successful:

- The social dimension of alcohol consumption. Alcohol consumption is inextricably linked to socializing and fuelled, at least to some extent, by peer pressure. Any communications strategy that ignores this is unlikely to be very effective with members of this demographic.
- Messaging that resonates. While receptivity to messaging removes the challenge of convincing young people of the validity of the message, this receptivity also involves a challenge. A communications strategy is less likely to be effective if it enunciates generalities that young people already know or believe, i.e., 'alcohol consumption poses risks to your health', 'alcohol consumption is linked to cancer'. In order to resonate, messaging must provide concrete and relevant information about the effects of alcohol consumption, including things they do not know or might not think about.
- Reaching young people where they are. The use of social media is a sine qua non of any effective communications strategy designed to reach young people.

In addition, it is noteworthy that differences in opinions based on age were not widespread, suggesting that similar health-related messages will resonate with young adults. For example, participants, regardless of age, observed that there is peer pressure or expected behaviour when it comes to drinking. What differed by age cohort was that 19-to-24-year-olds tended to focus on not wanting to miss out on social activities where alcohol would be consumed and 25-to-35-year-olds tended to focus on drinking as a social expectation associated with fitting-in. Communications centred on addressing the normative or prescriptive character of alcohol, therefore, can be expected to resonate with younger and older young adults.

Appendix

Technical specifications

A set of 20 online focus groups was conducted with Canadians aged 19 to 35. Four 90-minute sessions were conducted with participants living in each of the following five regions:[21] Atlantic Canada, Quebec (French), Ontario, the Prairies, and British Columbia. In each region, two sessions were conducted with 19- to 24-year-olds, one with men and one with women, and two sessions were conducted with 25- to 35-year-olds, one with women and one with men. The platform used to conduct the focus groups was MS Teams.

The table below presents the distribution of the focus groups:

Date	Session	Region	Audience	Language	Local Time
January 31	Group 1:	Ontario	**Women 19-24**	English	18h00 [Eastern]
	Group 2:	Ontario	**Men 19-24**	English	19h45 [Eastern]
February 5	Group 3:	Ontario	**Men 25-35**	English	18h00 [Eastern]
	Group 4:	Ontario	**Women 25-35**	English	19h45 [Eastern]
	Group 5:	British Columbia	**Men 19-24**	English	18h00 [Pacific]
	Group 6:	British Columbia	**Women 19-24**	English	19h45 [Pacific]
February 6	Group 7:	Atlantic Canada	**Women 19-24**	English	18h00 [Atlantic]
	Group 8:	Atlantic Canada	**Men 19-24**	English	19h45 [Atlantic]
	Group 9:	British Columbia	**Women 25-35**	English	18h00 [Pacific]
	Group 10:	British Columbia	**Men 25-35**	English	19h45 [Pacific]
February 7	Group 11:	Atlantic Canada	**Men 25-35**	English	18h00 [Atlantic]
	Group 12:	Atlantic Canada	**Women 25-35**	English	19h45 [Atlantic]
February 8	Group 13:	Prairies	**Men 19-24**	English	18h00 [Central]
	Group 14:	Prairies	**Women 19-24**	English	19h45 [Central]
February 12	Group 15:	Prairies	**Women 25-35**	English	18h00 [Central]
	Group 16:	Prairies	**Men 25-35**	English	19h45 [Central]
	Group 17:	Quebec	**Women 19-24**	***French***	18h00 [Eastern]
	Group 18:	Quebec	**Men 19-24**	***French***	19h45 [Eastern]
February 13	Group 19:	Quebec	**Men 25-35**	***French***	18h00 [Eastern]
	Group 20:	Quebec	**Women 25-35**	***French***	19h45 [Eastern]

Recruitment adhered to the Government of Canada's *Standards for the Conduct of Government of Canada Public Opinion Research – Qualitative Research*. Participants were recruited by telephone and online methods using CRC Research's opt-in database of 450,000 adults aged 18+ as well as social media (in Atlantic Canada only). The identity of the client was revealed (i.e., the Government of Canada) during recruitment. All individuals recruited were fluent in the language in which the focus group was conducted. For the groups held with those residing in Quebec, the primary language of all recruited individuals was French and elsewhere it was English.

Eight individuals were recruited for each group, with the expectation that six would attend the session. For all but two sessions, the target of six participants was exceeded. In total, 145 individuals took part in this research. Participants included those who consume alcohol as well as those who

[21] Residents of Nunavut were eligible for the groups in Ontario, residents of the Northwest Territories for the groups in the Prairies, and residents of the Yukon Territory for the groups in British Columbia.

have never, or no longer, consume alcohol. All groups included a mix of participants by age (within the recruitment parameters), education, household income, and cultural backgrounds, including those from racialized communities. The table on the next page provides a profile of participants by age, gender, racial background, province or territory of residence, household income and education level.

The fieldwork took place between January 31 and February 13, 2024. The first two focus groups (held January 31, 2024, with 19–24-year-olds residing in Ontario) were treated as a pretest of the moderator's guide. Following the pretest, several questions were removed to streamline the moderator's guide and it was decided that examples of labels for alcohol containers should be shared with participants to help ground the discussion. All participants were paid an honorarium of $125 to thank them for taking part in the research.

The data analysis included a review of the video-recordings of each session, the transcripts, as well as the notes taken by the moderators during each session. First, common words and concepts in the videos, transcripts and notes were identified for each area of investigation. Following the content analysis, the same approach was used to identify patterns or broader themes in the qualitative data. Unlike the content analysis, however, the moderators were looking for patterns across questions and by audience. The intent was to find similarities (majority views) and differences (minority views) in the data that yielded insights for Health Canada on appropriate methods of raising awareness about the risks and harms of alcohol use among young people in Canada. No data analytical software was used as part of this analysis. All data were reviewed and analyzed by members of the research team.

Table 1: Profile of Research Participants

Characteristics	Number of Participants
Age range	
19-24 years	73
25-34 years	72
Racial Background	
Caucasian or White	86
Another racial background*	59
Annual Household Income	
Under $60,000	58
$60,000 and above	87
Education	
Completed up to a college diploma	90
Completed a university degree	55
Region	
British Columbia	31
Prairies	28
Ontario	26
Quebec	31
Atlantic Canada	29
Gender	
Man	71
Woman	74

*This includes participants who are Indigenous or Métis or from the following backgrounds: Black African, Black Caribbean, Asian, Middle Eastern.

Research instruments

1. Recruitment Screener

A. Eligibility

INTRODUCTION:

Hello/Bonjour, my name is [INSERT]. I'm calling from Phoenix Strategic Perspectives, a Canadian public opinion research firm. Would you prefer to continue in English or French? / Préférez-vous continuer en français ou en anglais?

[RECRUITER NOTE: FOR ENGLISH GROUPS, IF THE INDIVIDUAL WOULD PREFER TO CONTINUE IN FRENCH, PLEASE CONTINUE IN FRENCH AND RECRUIT FOR THE FRENCH GROUPS IN QUEBEC. FOR THE FRENCH GROUPS, IF THE INDIVIDUAL WOULD PREFER TO CONTINUE IN ENGLISH, PLEASE CONTINUE IN ENGLISH AND RECRUIT FOR AN OPEN ENGLISH GROUP [BUT, FOR GROUPS OUTSIDE OF ONTARIO/THE EASTERN TIME ZONE, FIRST CONFIRM THAT THE SESSION TIME IS ACCEPTABLE].

We are organizing a series of discussion groups on issues of importance to Canadians, on behalf of the Government of Canada. We are looking for people aged 19 to 35 who would be willing to participate in an online discussion group. Is there anyone in your household who is aged 19 to 35? If so, may I speak with this individual?

01. No [THAND AND DISCONTINUE]
02. Yes
    a. Same person CONTINUE WITH "INFORMATION"
    b. Someone else 1. ASK TO SPEAK TO INDIVIDUAL
        i. REPEAT "INTRODUCTION"
        ii. GO TO "INFORMATION"
    c. Not available SCHEDULE CALL-BACK

INFORMATION:

The objective of these focus groups is to understand Canadians' attitudes towards alcohol and collect opinions on approaches to address the risks and harms associated with the consumption of alcohol. Participation is completely voluntary and your decision to participate or not will not affect any dealings you may have with the Government of Canada. We are interested in hearing your opinions; no attempt will be made to sell you anything or change your point of view. The information collected will be used for research purposes only and handled according to the Privacy Act of Canada.* The format is an online discussion with up to 8 participants led by a research professional from Phoenix Strategic Perspectives. All opinions will remain anonymous and views will be grouped together to ensure that no particular individual can be identified. Those who participate will receive an honorarium to thank them for their time.

May I continue?

01. Yes [CONTINUE]
02. No** [THANK AND DISCONTINUE]

RECRUITER NOTES:

A. *IF ASKED: The personal information you provide is governed in accordance with the Privacy Act and will not be linked with your name on any document including the consent form. In addition to protecting your personal information, the Privacy Act gives you the right to request access to and correction of your personal information. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly. The final report written by Phoenix SPI will be available to the public from Library and Archives Canada (http://www.bac-lac.gc.ca/).]

B. **IF A POTENTIAL PARTICIPANT INDICATES THAT PARTICIPATING ONLINE IS NOT POSSIBLE FOR THEM (E.G., DUE TO LACK OF COMFORT, NO INTERNET ACCESS, NO COMPUTER, ETC.), SAY: Thank you for letting us know. You yourself do not need to have a computer and internet connection to participate. If you have a friend or family who could provide you with access to a computer, a high-speed Internet connection, and a Webcam for the online session, you would be able to participate. Would this be possible?

C. IF ANYONE QUESTIONS THE VALIDITY OF THE RESEARCH, INVITE THEM TO GO ONLINE TO CRIC RESEARCH VERIFICATION SERVICE AND ENTER PROJECT NUMBER: 20240109-PH545.

EN: https://www.canadianresearchinsightscouncil.ca/rvs/home/
FR: https://www.canadianresearchinsightscouncil.ca/rvs/home/?lang=fr

D. WHEN TERMINATING A CALL WITH SOMEONE, SAY: Thank you for your cooperation. We already have enough participants who have a similar profile to yours, so we are unable to invite you to participate.

The focus group will take place online on the (**INSERT DATE/TIME**) and will last up to **an hour and a half (1.5 hours)**.

1. Would you be interested in taking part in this study?

   01 Yes [CONTINUE]
   02 No [THANK AND TERMINATE]

2. Before we invite you to attend, I need to ask you a few questions to ensure that we get a good mix of participants. This will take 5 minutes. May I continue?

   01 Yes [CONTINUE]
   02 No [THANK AND TERMINATE]

3. We've been asked to speak to participants from all different ages. May I have your age please?

   RECORD: __________. [RECRUIT A MIX BY AGE WITHIN STUDY SPECIFICATIONS.]

   01 18 and under [THANK AND TERMINATE]
   02 19 to 24 [CONTINUE]
   03 25 to 35 [CONTINUE]
   04 36 and older [THANK AND TERMINATE]

99 DK/NR [THANK AND TERMINATE]

4. Which gender do you identify as?

01 Female
02 Male
03 Other; please specify ______________________ [TEXT]
99 DK/NR [THANK AND TERMINATE]

5. Do you or anyone in your immediate family/household work or have ever worked…? [READ LIST]

a. A marketing research, public relations firm, or advertising agency
b. The media (i.e., radio, television, newspapers, magazines, etc.)
c. A federal or provincial government department or agency
d. A brewery, vineyard, or distillery of alcoholic beverages

01 Yes [THANK AND TERMINATE]
02 No [CONTINUE]
99 DK/NR [THANK AND TERMINATE]

6. Do you sometimes drink alcoholic beverages, like beer, wine, or hard liquor either on your own or *in a group context, such as with friends or at an event*?

01 Yes [DRINKER]
02 No [SKIP TO Q8]
99 DK/NR [THANK AND TERMINATE]

7. [ASK IF Q6=01] On average, how often do you have a drink containing alcohol? Would you say…? [READ LIST; STOP WHEN THE RESPONDENT MAKES A SELECTION]

01 A few times a year
02 Once a month
03 2-4 times a month
04 Once a week
05 2-4 times a week
06 5 or more times a week
99 DK/NR [THANK AND TERMINATE]

8. [ASK IF Q6=02] Have you ever consumed alcoholic beverages either on your own or *in a group context, such as with friends or at an event*? This does not include having a few sips of wine for religious or other purposes.

01 Yes [PREVIOUS DRINKER]
02 No [NON-DRINKER]
99 DK/NR [THANK AND TERMINATE]

9. What is your racial background? [WATCH QUOTAS; 02 THROUGH 11 = RACIALIZED OR INDIGENOUS]

I identify as: _______________

01. Caucasian or White
02. Indigenous
03. South Asian (e.g., Indian, Pakistani, Sri Lankan, Bangladeshi, etc.)
04. East Asian (e.g., Chinese, Korean, Japanese, Taiwanese, etc.)
05. Southeast Asian (e.g., Filipino, Vietnamese, Cambodian, Indonesian, etc.)
06. Middle Eastern, West and Central Asian (e.g., Israeli, Iranian, Lebanese, Afghan, Palestinian, etc.)
07. North African (e.g., Egyptian, Moroccan, Algerian, etc.)
08. Black Caribbean (e.g., Jamaican, Haitian, Trinidadian/Tobagonian, etc.)
09. Black African (e.g., Nigerian, Ethiopian, Congolese, etc.)
10. Latinx (e.g., Colombian, Salvadorian, Peruvian, etc.)
11. Multiracial, please specify: ______________
99. DK/NR

10. The focus groups are going to be online sessions held over the Internet**.** Participants will need to have access to a computer, a high-speed Internet connection, and a Webcam to participate in the group. The Webcam will need to be turned on for the duration of the session. Would you be able to participate under these conditions?

    03. Yes
    04. No [THANK AND TERMINATE]
    99 DK/NR [THANK AND TERMINATE]

11. In which province or territory do you live? This information is needed to make sure you are assigned to a focus group that takes place in your time zone. [DO NOT READ LIST] [FOR THE GROUPS IN ATLANTIC CANADA AND THE PRAIRIES, AIM FOR A MIX OF PARTICIPANTS FROM EACH OF THE PROVINCES/TERRITORIES.]

01 Newfoundland & Labrador	[RECRUIT TO ATLANTIC CANADA]
02 Prince Edward Island	[RECRUIT TO ATLANTIC CANADA]
03 Nova Scotia	[RECRUIT TO ATLANTIC CANADA]
04 New Brunswick	[RECRUIT TO ATLANTIC CANADA]
05 Quebec	[RECRUIT TO QUEBEC]
06 Ontario	[RECRUIT TO ONTARIO]
07 Manitoba	[RECRUIT TO PRAIRIES]
08 Saskatchewan	[RECRUIT TO PRAIRIES]
09 Alberta	[RECRUIT TO PRAIRIES]
10 British Columbia	[RECRUIT TO BRITISH COLUMBIA]
11 Nunavut	[RECRUIT TO ONTARIO]
12 Northwest Territories	[RECRUIT TO PRAIRIES]
13 Yukon	[RECRUIT TO BRITISH COLUMBIA]
99 DK/NR	[THANK AND TERMINATE]

12. Which of the following best describes your total household income last year, before taxes, from all sources for all household members? [READ LIST; STOP WHEN A SELECTION IS MADE; ENSURE A GOOD MIX]

01 Under $20,000
02 $20,000 to just under $40,000
03 $40,000 to just under $60,000
04 $60,000 to just under $80,000
05 $80,000 to just under $100,000
06 $100,000 to just under $150,000
07 $150,000 and above
99 DK/NR

13. What is the highest level of education that you have completed? [ENSURE GOOD MIX WITHIN STUDY SPECIFICATIONS.]

01 Some high school
02 High school diploma or equivalent
03 Some college, university, or apprenticeship
04 Registered apprenticeship or other trades certificate or diploma
05 College, CEGEP or other non-university certificate or diploma
06 University certificate or diploma below bachelor's level
07 Bachelor's degree
08 Post graduate degree above bachelor's level
09 DK/NR [THANK AND TERMINATE]

B. Industry Screening and Consent

WHEN TERMINATING A CALL WITH SOMEONE, SAY: Thank you for your cooperation. We already have enough participants who have a similar profile to yours, so we are unable to invite you to participate.

14. Have you ever attended a discussion group or taken part in an interview on any topic that was arranged in advance and for which you received money for your participation?

01 Yes [CONTINUE]
02 No [SKIP TO Q18]
09 DK/NR [THANK AND TERMINATE]

15. When did you last attend one of these discussion groups or interviews?

01 Within the last 6 months [THANK AND TERMINATE]
02 Over 6 months ago [CONTINUE]
09 DK/NR [THANK AND TERMINATE]

16. Thinking about the groups or interviews that you have taken part in, what were the main topics discussed?

RECORD: ________________ [THANK/TERMINATE IF RELATED TO ALCOHOL]

17. How many discussion groups have you attended in the past 5 years?

01 Fewer than 5 [CONTINUE]
02 5 or more [THANK AND TERMINATE]

18. The discussion group will be recorded. The recordings will be used only by the research professional to assist in preparing a report on the findings and they will be destroyed once the report is final. Do you agree to be recorded for research purposes only?

    01 Yes [SKIP TO Q20]
    02 No [CONTINUE]
    09 DK/NR [CONTINUE]

19. It is necessary for the analysis process for us to record the session as the moderator needs this material to complete the report. The recordings will be used solely to assist with writing the report and will not be shared. Now that I've explained this, do I have your permission for recording?

    01 Yes [CONTINUE]
    02 No [THANK AND TERMINATE]
    09 DK/NR [THANK AND TERMINATE]

20. There may be some people from the Government of Canada observing the groups. They will not take part in the discussion. They will be attending to hear your opinions firsthand although they may take their own notes and confer with the moderator to discuss additional questions to ask the group. Do you agree to be observed by employees of the Government of Canada?

    01 Yes [CONTINUE]
    02 No [THANK AND TERMINATE]
    09 DK/NR [THANK AND TERMINATE]

C. Invitation to Participate

You qualify to participate in one of our virtual discussion groups. The discussion will be led by a researcher from the public opinion research firm, Phoenix Strategic Perspectives. The group will take place on [**DAY OF WEEK**], [**DATE**], at [**TIME**], and will last **an hour and a half** [1.5 hours]. You will receive an honorarium of **$125** for your time.

21. Are you willing to attend?

    01 Yes [CONTINUE]
    02 No [THANK AND TERMINATE]
    09 DK/NR [THANK AND TERMINATE]

22. We will provide the focus group moderator with a list of participants' names so that they can sign you into the group. We will provide your first name and the first letter of your last name as well as your responses to this questionnaire. Do we have your permission to do this? I assure you it will be kept strictly confidential.

    01 Yes [SKIP TO Q24]
    02 No [CONTINUE]
    09 DK/NR [CONTINUE]

23. We need to provide the focus group moderator with the names of the people attending the focus group because only the individuals invited are allowed in the session and the moderator must have this information for verification purposes. Your first name will be visible when you join the focus group session. Now that I've explained this, do I have your permission to provide your name and profile to the moderator?

    01 Yes [CONTINUE]
    02 No [THANK AND TERMINATE]
    09 DK/NR [THANK AND TERMINATE]

24. May I have your email address so that we can also send you an email message with the information you will need about the focus group?

    ENTER EMAIL ADDRESS: ____________________

Information regarding how to participate will be sent to you by email in the coming days. The email will come from Phoenix SPI and the address will be research@phoenixspi.ca. You will be asked to log into the online session 10 minutes prior to the start time. **If you do not log in on time, you may not be able to participate and you will not receive an honorarium.**

As we are only inviting a small number of people to attend, your participation is very important to us. If for some reason you are unable to attend, please call us so that we can get someone to replace you. You can reach us at [INSERT NUMBER] at our office. Please ask for [INSERT NAME].

Someone will call you the day before to remind you about the session. So that we can call you to remind you about the focus group or contact you should there be any changes, can you please confirm your name and contact information for me?

First name: ___________________________
Last Name: ___________________________
Daytime phone number: _______________
Evening phone number: _______________

Thank you very much for your time and willingness to participate in this research.

2. Moderator's Guide

Introduction	5 minutes

⟶ Introduce moderator/firm and welcome participants to the focus group.

TECHNICAL CHECK; CONFIRM SOUND AND VIDEO QUALITY.

- Thank you for attending/value your being here.
- Tonight, we're conducting research on behalf of Health Canada.
- We'll be asking for your opinions on various aspects of alcohol consumption.
- The discussion will last up to 90 minutes.
- I'd like you to leave your camera on for the duration of the session. Cameras turning on and off is distracting.

⟶ Describe focus group.

- This is a "virtual" organized discussion.
- My job is to facilitate the discussion, keeping us on topic and on time.
- Your job is to offer your opinions. There are no right or wrong answers.
- I'd like to hear from everyone, so we have a range of opinions.
- Please be considerate and try not to interrupt others.
- Feel free to use the "raise hand" function to let me know that you'd like to say something.

⟶ Explanations.

- Comments treated in confidence.
  - Anything you say during these groups will be kept anonymous.
  - Our report summarizes the findings but does not mention anyone by name.
  - We encourage you to not provide any identifiable information about yourself.
  - The final report will be available through Library and Archives Canada.
- The session is being video recorded.
  - Recording is for report writing purposes/verify feedback.
  - Recordings remain in our possession and will not be released to anyone, even to the Government of Canada, without your written consent.
- There are people involved in this project who will be observing tonight's online session.
  - Purpose: oversee the research process and see your reactions first-hand
  - They may also take their own notes on tonight's session, but these again will not mention anyone by name.

⟶ Any questions?

⟶ Roundtable introduction: Let's start with everyone introducing themselves, first name only, please.

Context/Alcohol use	15 minutes

As I mentioned, tonight we're going to be discussing alcohol consumption and related issues.

1. I'd like to start by asking a fairly broad question…Why do you think people your age drink alcohol?

   Probe:

   - What influences drinking patterns in your age group? [MODERATOR: WAIT FOR TOP-OF-MIND RESPONSES AND THEN PROMPT] What about things like social norms, peer pressure, or alcohol marketing?

2. How many drinks per week would you say is reasonable for people your age? Would these drinks be spread across the week? If so, on how many days per week is it reasonable for someone to drink alcohol?

When you were recruited, some of you said you drink alcohol and some of you do not.

3. For those of you who drink alcohol: Can you describe your typical drinking habits and patterns?

   - When you drink alcohol, what do you typically drink?
   - Where, when and with whom do you typically drink alcohol?
   - What or who influences your choices about how much and how often you drink?
   - Have you ever felt like you needed to reduce your consumption?
   - What factors led you to consider reducing your alcohol consumption?

4. For those of you who don't drink alcohol:

   - Are there people in your social circle who drink alcohol?
   - What factors influenced your decision to stop drinking alcohol or never start drinking at all?

Knowledge of Alcohol-related Harms and Information Needs	20 minutes

Now we're going to change the focus,

5. We often encounter health information in our everyday lives, whether we're actively looking for it or not. Based on what you've heard or read, what risks and harms are associated with alcohol use? And where did you learn this information? Probe: short-term and long-term effects, physical and mental health effects.

6. Has anyone heard of the new drinking guidance released last year by the Canadian Centre for Substance Use and Addiction? PROMPT IF NEEDED: The 2011 Low-Risk Alcohol Drinking Guidelines were updated and rebranded Canada's Guidance on Alcohol and Health by the Canadian Centre on Substance Use and Addiction. You may have heard them referred to in the media. What have you heard about them?

NOTE TO MODERATOR: In January 2023, the Canadian Centre on Substance Use and Addiction released *Canada's Guidance on Alcohol and Health***,** which provides updated evidence on the health risks of alcohol use. To minimize the risk associated with drinking, the guidance recommends that people consider reducing their alcohol consumption to decrease their risk of experiencing alcohol-related harms and that some groups, such as people who are pregnant or trying to conceive or breastfeeding, should avoid drinking alcohol entirely. It cautions that consuming alcohol even at low levels can increase the risk of developing certain cancers, heart disease and stroke.

7. When it comes to understanding alcohol guidance are there aspects of this information that are unclear or confusing to you?

8. [ADJUST AS NEEDED IF MENTIONED AT Q7] Just a quick show of hands, how many of you have heard the term "standard drink"? Do you know how many standard drinks are in different containers of alcohol? I know container sizes can vary by product, so let's keep this focussed on typical containers. How many standard drinks are in a bottle of [ASK EACH SEPARATELY: wine/beer/spirits/coolers/ciders]?

9. Drinking alcohol increases your risk of cancer, even at low levels of drinking. For how many of you is this new information? Does it surprise you?

10. Do you think there's enough health information available on alcohol? If not, what specific information do you think would be most helpful in understanding the potential risks and consequences associated with alcohol consumption among people your age?

11. If you wanted information about the risks and harms associated with alcohol use, where would you go and why? PROMPT IF NEEDED: alcoholic beverage companies, health professionals, government agencies, non-profit organizations, etc. FOLLOW-UP: If credibility is mentioned as a reason for choosing a source, ask what makes the source credible.

12. How would you like to receive information about the risks and harms associated with alcohol use? Are there particular platforms or formats, like websites, apps, or social media, that you find most engaging and effective for learning about this topic? PROMPT IF NEEDED: Social media (which platforms), apps, TV, radio, internet, billboards….

13. Do you think that knowing more about the harms of alcohol use would have any impact on your decision, or for those who don't drink, on the decision of people you know, when buying or consuming alcoholic drinks? Why is that?

Alcohol Reduction Strategies	**30 minutes**

14. Does anyone recall seeing or hearing any education campaigns or public health messages specifically related to alcohol use? [MODERATOR: If MADD Canada ads are mentioned, refocus the discussion on campaigns about alcohol use and health risks.]

15. For those of you who can… [KEEP BRIEF]

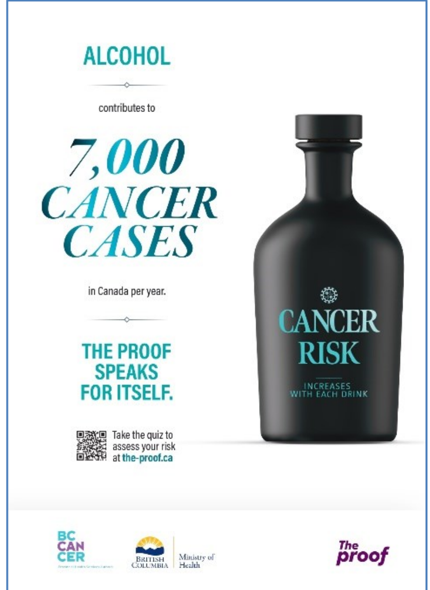
    a. What do you recall about these campaigns?

        i. PROMPT IF NEEDED: the subject, the message, the sponsor?

b. Where did you see or hear these campaigns?
    i. PROMPT IF NEEDED: TV, radio, billboards, social media?
c. What, if anything, was memorable about these campaigns? Why is that?

16. Now I'm going to show you information from two public education initiatives, and I'd like your opinion. Both campaigns focus on the link between drinking alcohol and cancer. Here they are.

The one on the left is part of cancer prevention resources and supports put together by the Central East Regional Cancer Program in Ontario and the one on the right is a campaign from the BC Cancer and the BC Ministry of Health. Take a minute to look at the material.



17. What's your reaction to these campaigns? [MODERATOR: KEEP BRIEF. FOCUS ON LIKES/DISLIKES AND WHY]

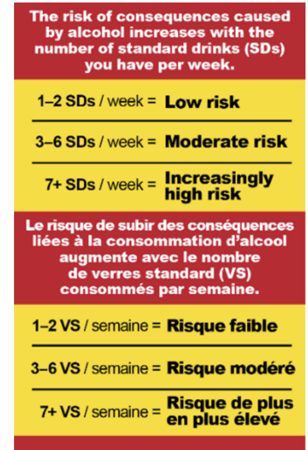
18. If you came across those campaigns on your own outside of this focus group, do you think they would get people your age to consider the health effects of alcohol? Why/why not?

19. For those of you who drink alcohol, would these campaigns change your drinking behaviour in any way? If so, how?

20. This question is for everyone… What sort of messages *would* encourage people your age who drink alcohol to consider the health effects and reduce their drinking?

21. Aside from sharing health-related information, what else can government do to encourage people your age to consider reducing their alcohol consumption? [MODERATOR: IF NO SUGGESTIONS ARE OFFERED, DO NOT PROMPT AND MOVE ON].

22. [ADJUST IF LABELLING WAS MENTIONED AT Q21] What about labelling? Some countries are introducing alcohol labels to provide health and other information at the point of sale. I'm going to share my screen again to show you an example.



- Would alcohol labelling be an effective way to get people to think about the potential harms? Why do you say that? Probe: reasons why/why not.
- And what about to consider reducing their consumption of alcoholic drinks? Why do you say that? Probe: reasons why/why not.

[MODERATOR: IF ASKED ABOUT LABELLING, SAY: This might include labels that tell you how many standard drinks are contained in each can or bottle, the level of risk associated with how much you are drinking, and the health impacts, such as cancer, or fetal alcohol spectrum disorder.]

23. For those of you who do drink alcohol, what, if anything, would make you consider changing your drinking behaviours? PROMPT IF NEEDED: the cost of alcohol, information about the risks and harms, warning labels…

Low and non-alcoholic beverages	15 minutes

24. In the past year, has anyone decided to drink less alcohol? What motivated this? [MODERATOR: IF NEEDED, REMIND PARTICIPANTS TO NOT SHARE ANYTHING TOO PERSONAL.]

25. Just a quick show of hands, how many of you have heard about the "sober curious" trend or "dry January" or "sober October" campaigns? What do you think about them and why? Has anyone taken part in dry January or sober October?

MODERATOR: IF NEEDED, OFFER THESE DESCRIPTIONS: ***Sober curiosity*** involves being mindful of your drinking habits and examining social influences and pressures around alcohol. This often means cutting back, but it could also mean attending social events without drinking, going to sober bars, or avoiding alcohol for periods of time. The ***campaigns*** similarly promote sober curiosity in that they're designed to get people to think about their drinking and be sober for a month.

26. What do you think is driving these trends? Do you think it's health and wellness considerations or something else?

27. For some people, choosing low or non-alcoholic beverages (or "NoLos") is a way to reduce the risks associated with drinking alcohol. To start with, has anyone purchased low or non-alcoholic beverages in the past year?

For those who have:

28. What motivated you to explore or choose these alternatives over alcoholic drinks? Probe: general lifestyle preference, health reasons, to reduce alcohol consumption.

Conclusion	5 minutes

We've covered a lot tonight and I really appreciate you taking the time to share your opinions.

29. Does anyone have any last thoughts or feedback to share with the Government of Canada about the topic?

On behalf of Health Canada, I would like to thank you for your time and participation today. The honorarium will be available through the recruiter.

You can all log out now. Have a great evening!