Update on Low-Risk Guidelines

Prevention Research Institute™

Key Takeaways:

- PRI's guidelines were created prioritizing mortality risk and risk of acute impairment concerns, rather than for risks of specific diseases.
- 0-1-2-3 is an evidence-based upper bound of the low-risk drinking spectrum, and is just the starting point for creating low-risk guidelines for individuals.
- The terms "low-risk" and "safe" are not synonymous. Some recent headlines are based on "safe" (i.e., "zero-risk") drinking, which we believe requires abstinence.
- Prime programs prompt participants to consider adjusting the low-risk guidelines downward to account for individual differences in biological risk and to align with their values and concerns about chronic disease risk based on available information. This adjustment might be more common for women than for men.
- People must decide for themselves how much risk they are willing to take.

Frequently Asked Questions:

I am seeing increasing amounts of news related to the harms of drinking any amount of alcohol. Why have the Prevention Research Institute (PRI) Low-Risk Guidelines remained the same?

When examining guidelines, it is important to note the intention behind their creation. PRI's low-risk guidelines focus on reducing risk for alcohol-related health and impairment problems. Recent headlines and statements from some researchers and health organizations have, alternatively, focused primarily on "safe" levels of drinking. PRI's guidelines and programs are in alignment with the view that the only "safe" level of drinking (a level indicating the absolute certainty of avoiding alcohol-related harm) is abstinence, though we do not present abstinence as the only "low-risk" option.

Research on the potential harm from low-level drinking is far from definitive. Specifically, almost all the research which suggests there is an increased risk for health problems from low-level drinking is based on averaging people's drinking to an artificial daily amount and/or does not adequately consider the risks created by episodes of drinking greater than three drinks. Studies which have considered frequency of drinking and episodes of heavier drinking have typically not found increased risk for health problems when people consume

amounts within the 0-1-2-3 Guidelines with food. Importantly, we do teach that some people might increase their risk for some health problems even when drinking within the guidelines, and each person is encouraged to evaluate whether to make modifications to these foundational guidelines based on their own values and judgements about types of risk, as is outlined in the Prime For Life (PFL) curriculum.

We believe it is everyone's right to be presented with information about risk as clearly and objectively as possible without predetermining what people should do with that information. PRI honors people's autonomy and recognizes each of us need to decide for ourselves how much risk we are willing to take. Accordingly, we do our best to avoid overstatements or understatements of risks.

What sets PRI's low-risk guidelines for alcohol apart from those developed by other organizations?

In creating these guidelines, Prevention Research Institute (PRI) examines a range of research, including studies on mortality, alcohol impairment, and various drinking outcomes. While there were only a few studies for our team to reference in the early 1980s, there are now several hundred journal articles that inform the development of these guidelines. Due to differences in study methodologies and participants, the results of these evaluations vary, making it challenging to make absolute statements about the quantities and frequencies of drinking that increase relative risk. While data remains incomplete, we believe there are enough quality studies to guide the formation of our guidelines and inform the public. It is crucial to understand that low-risk guidelines are intended for making "low-risk" choices, not "no-risk" or "safe" choices.

Low-risk guidelines are shaped not just by data, but also by judgment calls and values. In regard to the data used to develop the low-risk guidelines for PFL, PRI gave (and continues to give) greater weight to well-conducted studies. Key factors considered include the sample size, the percentage of participants who had died during follow-up, the quality of the assessment of drinking quantity and frequency, and the reference groups used. These factors led to the establishment of the 0-1-2-3 guidelines for both men and women.

PRI also considers low-risk guidelines from other organizations within the United States and other countries. When differences exist, PRI closely examines the research cited by these groups. Of particular importance is that most studies use *average usual consumption* to analyze risk. As alluded to earlier, this approach poses a problem since different consumption patterns can result in the same average. For example, individuals

consuming 14 drinks in one day, 7 drinks on 2 days, and 2 drinks on 7 days would share an identical average of 2 drinks per day, despite representing different consumption patterns. Moreover, many individuals vary their consumption significantly throughout the year and over their lifetime, yet they are typically only asked to report their choices over the previous week or month. In general, we prioritize studies that examine people's actual consumption patterns, which does not appear to be the case in the development of low-risk guidelines by many other groups.

PRI believes that any error should be on the side of being more protective of people's lives and well-being when learning the low-risk guidelines. However, it is important to consider that individuals who could benefit the most from the message of Prime For Life and our additional programs are likely to reject it if they perceive it as overly cautious. We have chosen to balance these factors when choosing specific low-risk guidelines that are within the wider range supported by research. PRI also believes that the guidelines need to be as simple and memorable as possible to increase the likelihood of people recalling and following them.

Why doesn't PRI lower the low-risk alcohol guidelines for women?

Some groups have lower drinking guidelines for women compared to men. For example, from 1985 through 2025, the dietary guidelines for alcohol from the U.S. Department of Agriculture, eventually adopted by NIAAA, listed 7 drinks per week as the upper limit for women and 14 drinks per week for men. The rationale for lower guidelines for women seems to primarily stem from the differential impairment risks between men and women, as well as studies suggesting an increased risk for liver disease and breast cancer among women consuming more than seven drinks per week.

Prime For Life, and other PRI programs, address the issue of increased impairment risk among many women by discussing how females often have less body fluid, making them more likely than men to require downward adjustments in the guidelines to prevent impairment. However, research does not support the notion that most women would be significantly impaired by consuming two drinks slowly over two hours with food in their stomachs. Even for women who might experience impairment, they can prevent it by choosing to drink more slowly than one drink per hour. Unlike how PFL teaches the low-risk guidelines, many other guidelines do not include limits on consumption speed or provide information on as many factors that might necessitate a reduction in the guidelines.

Regarding the risk of individual health problems such as liver disease and breast cancer, to date, these studies have almost exclusively used daily averages based on weekly reports of consumption and often fail to adequately account for the actual pattern of consumption as noted above. Additionally, most studies involving women have not found an increased risk of premature mortality until consumption exceeds 14 drinks per week. As mentioned previously, PRI uses the risk of premature mortality as the main basis for formulating the low-risk guidelines for weekly alcohol limits, rather than small increased risks for individual health problems in some individuals. We also emphasize that anyone concerned about their risk of alcohol-related health problems—especially women with an increased risk of breast cancer and individuals, regardless of gender, with an increased risk for alcohol-related health problems like colorectal cancer and atrial fibrillation—might want to adjust their guidelines downward or consider abstaining from alcohol.

To summarize, research supports that many women (though not all) might need to adjust the low-risk guidelines downward to protect what they value, just as some men might need to do the same. It seems reasonable to have lower limits for women in low-risk guidelines provided outside of prevention programs like PFL, as it is unlikely many people would delve into the specifics on adjusting for individual differences on their own. In PFL, we take the time to teach these essential details to ensure comprehensive understanding and application of the guidelines.

What about the 2026-2030 U.S. Dietary guidelines on alcohol?

PRI has always based its guidelines on an independent review of research and will continue to do so. Nevertheless, we carefully consider the guidelines recommended by others. So far, the research basis for the new dietary guidelines has not been released. If/when released, we will examine all studies cited. In the meantime, our ongoing examination of the research suggests that specific guidelines on alcohol are more useful than general statements about reducing drinking. The message to “drink less” could be useful for those who do not drink heavily. Those who do drink heavily can benefit more from specific guidance, since simply “drinking less” than they currently are could still lead to numerous problems. The science behind any set of low-risk guidelines is not perfect, yet it offers a more effective way to protect what people value most.

Why is zero (0) the only low-risk option for THC?

As non-medical THC use becomes increasingly legal across the US, the lack of corresponding information regarding low-risk consumption levels remains a challenge. Unlike with alcohol, there is a lack of data available on low-risk THC use. Numerous obstacles hinder the acquisition of such knowledge. First, although the labeling of THC content is mandatory on non-medical cannabis products, various studies have revealed inaccuracies in this labeling. Even if the labeling were reliable, determining a standard non-medical-use THC dose that does not pose problems, as is the case with alcohol, presents difficulties. Moreover, the different methods of ingestion contribute to distinct impairment curves. Additionally, THC use almost always results in impairment, which inherently raises the risk of encountering problems. Although the perception of THC risk has diminished with legalization, its legality does not eliminate its health and impairment risks. Consequently, PRI considers all THC use to be high-risk. If future research demonstrates specific low-risk amounts for THC use, PRI will adjust these guidelines accordingly.