HARM REDUCTION SOCIETY
KENYA
Saving lives through Harm Reduction.

ALCOHOL HARM REDUCTION
Evidence Based Science
(Excerpts)

1. Demand Reduction, which involves preventing and/or delaying alcohol use, reducing the misuse of alcohol, and using evidence-informed treatment to support recovery from dependence.
2. Supply Reduction, which involves reducing the production and supply of illicit alcohol and regulating the supply of legal alcohol.
3. Harm Reduction, which involves reducing the risk of adverse alcohol-related consequences.

FROM MODERATION TO MINDFULNESS

PRACTICAL STRATEGIES FOR ALCOHOL HARM REDUCTION

Here are some key strategies for reducing alcohol-related harm:

- **Moderation Strategies:** Set specific limits on how much and how often you drink. For example, only drink in social settings or on certain days of the week. The CDC recommends no more than 1 drink per day for women and 2 drinks per day for men.
- **Eat and Drink Water:** Avoid drinking on an empty stomach. Eating before consuming alcohol and drinking water between alcoholic beverages can help prevent blackouts and alcohol poisoning. Hydration is key to reducing the negative effects of alcohol.
- **Nurse Drinks:** Take small sips of your drink instead of consuming it quickly. This helps you drink more slowly and reduces the risk of overconsumption. Drinking slowly also allows your body to process alcohol more effectively.
- **Measure and Count Drinks:** A standard drink is 150ml of wine, 350ml of beer, or 45ml of hard alcohol. Keep track of how many drinks you consume to avoid excessive drinking. Use measuring tools to ensure accurate portions.
- **Medications:** Use medications like acamprosate, disulfiram, and naltrexone to reduce cravings and block the "buzz" caused by alcohol. These medications are often prescribed as part of a comprehensive treatment plan for alcohol dependence.
- **Avoid Mixing Substances:** Do not mix alcohol with other substances, such as prescription drugs or illicit substances, as this can increase the risk of harmful effects, including overdose and organ damage.
- **Drinks with Less Alcohol Content:** Choose beverages with lower alcohol content, such as light beer or wine spritzers, to reduce the overall amount of alcohol consumed. This can help you stay within safe drinking limits.
- **Arrange Safe Transportation:** Always plan for a safe way to get home if you plan to drink, such as a designated driver, ride-sharing service, or public transportation. Never drink and drive.
- **Abstinence Days:** Designate days where you do not consume alcohol to give your body a break and reduce dependency. This can also help you reassess your drinking habits and make healthier choices.
- **Understand Alcohol Poisoning:** Be aware of the signs of alcohol poisoning, such as vomiting, confusion, slow breathing, and seizures. Seek medical help immediately if these symptoms occur. Alcohol poisoning can be life-threatening and requires urgent attention.
- **Breastfeeding Mothers:** Use breast milk test strips to check for alcohol content before breastfeeding if you have consumed alcohol. This ensures the safety of your baby.
- **Limit Alcohol at Home:** Reduce the amount of alcohol kept at home to minimize temptation and encourage moderation.

For more information on treatment and recovery plans, visit our ***Recovery Resource Center.***

Cochrane Library

Cochrane Database of Systematic Reviews

Alcoholics Anonymous and other 12-step programs for alcohol use disorder (Review)

Kelly JF, Humphreys K, Ferri M

Kelly JF, Humphreys K, Ferri M.
Alcoholics Anonymous and other 12-step programs for alcohol use disorder.
Cochrane Database of Systematic Reviews 2020, Issue 3. Art. No.: CD012880.
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[Intervention Review]

Alcoholics Anonymous and other 12-step programs for alcohol use disorder

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A B S T R A C T

Background

Alcohol use disorder (AUD) confers a prodigious burden of disease, disability, premature mortality, and high economic costs from lost productivity, accidents, violence, incarceration, and increased healthcare utilization. For over 80 years, Alcoholics Anonymous (AA) has been a widespread AUD recovery organization, with millions of members and treatment free at the point of access, but it is only recently that rigorous research on its e< ectiveness has been conducted.

Objectives

To evaluate whether peer-led AA and professionally-delivered treatments that facilitate AA involvement (Twelve-Step Facilitation (TSF) interventions) achieve important outcomes, specifically: abstinence, reduced drinking intensity, reduced alcohol-related consequences, alcohol addiction severity, and healthcare cost o< sets.

Search methods

We searched the Cochrane Drugs and Alcohol Group Specialized Register, Cochrane Central Register of Controlled Trials (CENTRAL), PubMed, Embase, CINAHL and PsycINFO from inception to 2 August 2019. We searched for ongoing and unpublished studies via ClinicalTrials.gov and the World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) on 15 November 2018.

All searches included non-English language literature. We handsearched references oftopic-related systematic reviews and bibliographies of included studies.

Selection criteria

We included randomized controlled trials (RCTs), quasi-RCTs and non-randomized studies that compared AA or TSF (AA/TSF) with other interventions, such as motivational enhancement therapy (MET) or cognitive behavioral therapy (CBT), TSF treatment variants, or no treatment. We also included healthcare cost o< set studies. Participants were non-coerced adults with AUD.

Data collection and analysis

We categorized studies by: study design (RCT/quasi-RCT; non-randomized; economic); degree of standardized manualization (all interventions manualized versus some/none); and comparison intervention type (i.e. whether AA/TSF was compared to an intervention with a di< erent theoretical orientation or an AA/TSF intervention that varied in style or intensity). For analyses, we followed Cochrane methodology calculating the standard mean di< erence (SMD) for continuous variables (e.g. percent days abstinent (PDA)) or the relative risk (risk ratios (RRs)) for dichotomous variables. We conducted random-e< ects meta-analyses to pool e< ects wherever possible.

Main results

We included 27 studies containing 10,565 participants (21 RCTs/quasi-RCTs, 5 non-randomized, and 1 purely economic study). The average age of participants within studies ranged from 34.2 to 51.0 years. AA/TSF was compared with psychological clinical interventions, such as
MET and CBT, and other 12-step program variants.

We rated selection bias as being at high risk in 11 of the 27 included studies, unclear in three, and as low risk in 13. We rated risk of attrition bias as high risk in nine studies, unclear in 14, and low in four, due to moderate (> 20%) attrition rates in the study overall (8 studies), or in study treatment group (1 study). Risk of bias due to inadequate researcher blinding was high in one study, unclear in 22, and low in four.
Risks of bias arising from the remaining domains were predominantly low or unclear.

AA/TSF (manualized) compared to treatments with a di3 erent theoretical orientation (e.g. CBT) (randomized/quasi-randomized evidence)

RCTs comparing manualized AA/TSF to other clinical interventions (e.g. CBT), showed AA/TSF improves rates of continuous abstinence at 12 months (risk ratio (RR) 1.21, 95% confidence interval (CI) 1.03 to 1.42; 2 studies, 1936 participants; high-certainty evidence). This e< ect
remained consistent at both 24 and 36 months.

For percentage days abstinent (PDA), AA/TSF appears to perform as well as other clinical interventions at 12 months (mean di< erence (MD) 3.03, 95% CI -4.36 to 10.43; 4 studies, 1999 participants; very low-certainty evidence), and better at 24 months (MD 12.91, 95% CI 7.55 to 18.29; 2 studies, 302 participants; very low-certainty evidence) and 36 months (MD 6.64, 95% CI 1.54 to 11.75; 1 study, 806 participants; very low-certainty evidence).

For longest period of abstinence (LPA), AA/TSF may perform as well as comparison interventions at six months (MD 0.60, 95% CI -0.30 to 1.50; 2 studies, 136 participants; low-certainty evidence).

For drinking intensity, AA/TSF may perform as well as other clinical interventions at 12 months, as measured by drinks per drinking day (DDD) (MD -0.17, 95% CI -1.11 to 0.77; 1 study, 1516 participants; moderate-certainty evidence) and percentage days heavy drinking (PDHD) (MD -5.51, 95% CI -14.15 to 3.13; 1 study, 91 participants; low-certainty evidence).

For alcohol-related consequences, AA/TSF probably performs as well as other clinical interventions at 12 months (MD -2.88, 95% CI -6.81 to 1.04; 3 studies, 1762 participants; moderate-certainty evidence).

For alcohol addiction severity, one study found evidence of a di< erence in favor of AA/TSF at 12 months ($P < 0.05$; low-certainty evidence).

AA/TSF (non-manualized) compared to treatments with a di3 erent theoretical orientation (e.g. CBT) (randomized/quasi□randomized evidence)

For the proportion of participants completely abstinent, non-manualized AA/TSF may perform as well as other clinical interventions at three to nine months follow-up (RR 1.71, 95% CI 0.70 to 4.18; 1 study, 93 participants; low-certainty evidence).

Non-manualized AA/TSF may also perform slightly better than other clinical interventions for PDA (MD 3.00, 95% CI 0.31 to 5.69; 1 study, 93 participants; low-certainty evidence).

For drinking intensity, AA/TSF may perform as well as other clinical interventions at nine months, as measured by DDD (MD -1.76, 95% CI -2.23 to -1.29; 1 study, 93 participants; very low-certainty evidence) and PDHD (MD 2.09, 95% CI -1.24 to 5.42; 1 study, 286 participants; low-certainty evidence).

None oftheRCTs comparing non-manualized AA/TSF to other clinical interventions assessed LPA, alcohol-related consequences, or alcohol addiction severity.

Cost-e3 ectiveness studies
In three studies, AA/TSF had higher healthcare cost savings than outpatient treatment, CBT, and no AA/TSF treatment. The fourth study found thattotal medical care costs decreased for participants attending CBT, MET, and AA/TSF treatment, butthat among participants with worse prognostic characteristics AA/TSF had higher potential cost savings than MET (moderate-certainty evidence).

Authors' conclusions
There is high quality evidence that manualized AA/TSF interventions are more e< ective than other established treatments, such as CBT, for increasing abstinence. Non-manualized AA/TSF may perform as well as these other established treatments. AA/TSF interventions, both manualized and non-manualized, may be at least as e< ective as other treatments for other alcohol-related outcomes. AA/TSF probably produces substantial healthcare cost savings among people with alcohol use disorder.

PLAIN LANGUAGE SUMMARY

Alcoholics Anonymous (AA) and other 12-step programs for alcohol use disorder

Review question
This review summarized research comparing the Alcoholics Anonymous (AA) and similarTwelve-Step Facilitation (TSF) programs (AA/TSF) to other treatments to see if they help people with drinking problems to stay sober, or reduce alcohol consumption and drinking-related consequences. We also examined whether AA/TSF reduces healthcare costs relative to other treatments.

Background
Alcohol use disorder (i.e. alcoholism) is a concerning individual and public health problem worldwide. Treatment is expensive. AA is a widespread and free mutual-help fellowship that helps people to recover from alcoholism and to improve their quality of life.

Search date
The evidence is current to 2 August 2019.

Study characteristics
We identified 27 relevant studies that had included 10,565 participants. The studies varied in design; and whether treatments were delivered according to standardized procedures (i.e. manualized); and whether AA/TSF was compared to a treatment that had a di< erent theoretical basis (e.g. cognitive behavioral therapy (CBT)), or to a di< erent type of TSF (i.e. one that varied in style or intensity from the AA TSF).

Study funding sources
The included studies were funded through one or more grants from the United States National Institutes of Health (18 studies), the USA Department of Veterans A< airs (8 studies), and other organizations (e.g. private foundations or academic institutions; 8 studies). Two studies did not report their source of funding.

Key results
Manualized AA/TSF interventions usually produced higher rates of continuous abstinence than the other established treatments investigated. Non-manualized AA/TSF performed as well as other established treatments. AA/TSF may be superior to other treatments for increasing the percentage of days of abstinence, particularly in the longer-term. AA/TSF probably performs as well as other treatments for reducing the intensity of drinking (of alcohol). AA/TSF probably performs as well as othertreatments for alcohol-related consequences and addiction severity. Four ofthe five economics studies found substantial cost-saving benefits for AA/TSF, which indicate that AA/TSF interventions probably reduce healthcare costs substantially.
In conclusion, clinically-delivered TSF interventions designed to increase AA participation usually lead to better outcomes over the subsequent months to years in terms of producing higher rates of continuous abstinence. This e< ect is achieved largely by fostering increased AA participation beyond the end of the TSF intervention. AA/TSF will probably produce substantial healthcare cost savings while simultaneously improving alcohol abstinence.

Certainty of evidence
Our certainty in the evidence ranged from very low to high for the di< erent outcomes. Most of the high-certainty evidence was based on the results from studies with reliable study designs (randomized controlled trials) and good measurement methods. We considered some evidence to be of low certainty, partly because of inadequate methods for deciding which treatment each person in the study was to receive, which can allow factors other than the treatments to a< ect the results.There was some inconsistency in the evidence across studies that could be due to variation in the clinical characteristics of the participants, times of follow-up, error in participant recall of certain outcomes, and di< erences in intervention durations, or therapist e< ects. Some studies had small sample sizes, which led to less precise estimates of the longest periods of abstinence, and high variability around estimates of drinks per drinking day

What is the 12-Step AA Program?

The 12-Step program, first developed and used by Alcoholics Anonymous, is a 12-Step plan in order to overcome addictions and compulsions. The basic premise of this model is that people can help one another achieve and maintain abstinence from substances, but that healing cannot come about unless people with addictions surrender to a higher power. This higher power doesn't need to be a traditional Christian version of God—it can be as simple as the community of the 12-Step meetings, the universe, or a different version of a higher power.

The 12-Step movement can be a powerful and helpful force for many people, but some people struggle with what they interpret as a strong religious element in the program. Many addiction treatment programs offer alternatives to 12-Step methodology for those who prefer a more secular foundation for treatment.

Twelve-Step programs remain a commonly recommended and used treatment modality for various types of addiction. According to the Substance Abuse and Mental Health Services Administration (SAMSHA) in its National Survey of Substance Abuse Treatment Services from 2020, 12-Step models are utilized by approximately 65.5% of treatment centers nationwide.1

What are the 12 Steps of AA?

The 12 Steps, as outlined in the original Big Book and presented by Alcoholics Anonymous, include the following:2

1.We admitted we were powerless over alcohol—that our lives had become unmanageable.
2.Came to believe that a Power, greater than ourselves, could restore us to sanity.
3.Made a decision to turn our will and our lives over to the care of God as we understood Him.
4.Made a searching and fearless moral inventory of ourselves.
5.Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6.Were entirely ready to have God remove all these defects of character.
7.Humbly asked Him to remove our shortcomings.
8.Made a list of all they persons we had harmed, and became willing to make amends to them all.
9.Made direct amends to such people wherever possible, except when to do so would injure them or others.
10.Continued to take personal inventory and when we were wrong, promptly admitted it.
11.Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12.Having had a spiritual awakening as a result of these steps, we tried to carry this message to those with an alcohol use disorder, and practice these principles in all our affairs.

The History of the 12 Steps of AA

Alcoholics Anonymous (AA) originated the idea for the 12-Step model in 1938, when founder Bill Wilson wrote out the ideas that he had been developing through his experience with alcohol use. He wrote about the positive effects experienced when people struggling with alcohol use disorder shared their stories with one another.

Wilson wrote his program in what has become known as the Big Book. The steps were developed through synthesizing concepts from a few other teachings he had encountered, including a program espoused by an organization called the Oxford Group.3

In their original form, the 12 Steps came from a spiritual, Christian inspiration that sought help from a greater power as well as from peers suffering with the same addiction struggles.3

The Big Book was originally written as a guide for people who couldn't attend AA fellowship meetings, but it soon became a model for the program in general. It has since been adopted as a model for a wide range of addiction mutual-help and self-help programs designed to help drive behavioral change. In addition to the original Alcoholics Anonymous (AA) group, various others now exist, such as Narcotics Anonymous (NA) and Cocaine Anonymous (CA).

The 12-Step Practice

The basic premise of the 12-Step model is that people can help one another achieve and maintain abstinence from the substances to which they are addicted. They can do this through meetings in which they share their experiences with one another and support each other in the ongoing effort of maintaining abstinence.

The 12-Step philosophy emphasizes certain fundamentals, including:4

- The importance of accepting addiction as a disease that can be stopped but never eliminated.
- Enhancing individual maturity and spiritual growth.
- Minimizing self-centeredness.
- Providing help to others who are addicted by sharing recovery stories in group meetings, sponsoring new members, etc.

How Long Do the 12 Steps Take?

The average length of time it takes for someone to work through the 12 steps varies. Many 12-Step sponsors encourage sponsees and newcomers in AA and other 12-Step programs to attend 90 meetings in 90 days, or at least one meeting a day for three months. Overall, the focus of working through the 12 steps in any 12-Step program shouldn't be on the amount of time it takes to get through the steps once, but on how thoroughly you are doing your step work and how you are using the steps to positively impact your everyday life.

How Effective is the 12-Step AA Program?

Alcoholics Anonymous and other 12-Step programs regularly conduct surveys to assess demographic characteristics and to determine the length of its members' abstinence. These studies indicate that participation in AA, NA, or CA is associated with a greater likelihood of abstinence, improved psychosocial functioning, and greater levels of self-efficacy.4

Research shows that beginning 12-Step participation while in treatment, is associated with better outcomes. Additionally, consistent, early, and frequent attendance/involvement is associated with better substance use outcomes. Active engagement—(e.g. doing service at meetings, reading 12-Step literature, doing "step work," or getting a sponsor)—are better indicators of engagement than merely attending meetings, and this more active engagement may help with relapse prevention.4

There is some evidence that individuals with co-occurring substance use and mental health disorders can benefit from 12-Step involvement. However, specialized support groups, such as Dual Recovery Anonymous, may be more beneficial for individuals with co-occurring disorders.4

When Do I Need a 12-Step AA Program?

You may need a 12-Step program if you suffer from a substance use disorder or struggle with substance use of any kind. If you're wondering whether a 12-Step program is right for you, discuss the option with your therapist, doctor, or addiction care specialist, who can provide insight that's specific to you and your needs. That being said, there is never harm in attending a 12-Step meeting, but it's important to note that every meeting is a bit different and some might fit your personality and goals better than others so you'll likely have to attend several before finding the one or ones that are best for you.

Does American Addiction Centers Offer 12-Step AA Programs?

Yes, all American Addiction Centers (AAC) rehab locations offer 12-Step programming as a therapy modality for addiction treatment. To learn more about AAC's various treatment centers throughout the country, call .

Variations of the 12 Steps of AA

Since its origin with AA, the 12-Step model has been adopted and altered by many groups to fit other programs—for addiction treatment and more. Many groups, like Narcotics Anonymous, use the steps

exactly as they were conceived by AA. Others have modified the steps to fit the needs and cultures of the individuals in it. For example, a group specifically for Native American/Alaska Native people combined the 12 Steps with teachings of the the Native American/Alaska Native Medicine Wheel, Cycle of Life, and the Four Laws of Change to create a culturally-appropriate 12-Step program for Native American/Alaska Native men and women.

The 12 Steps with Other Treatments

Many treatment centers, including AAC, offer 12-Step facilitation therapy as part of the interventions utilized in the treatment for addiction. This 12-Step facilitation therapy is an active engagement strategy designed to increase the likelihood that the individuals participating in it during formal treatment continue in aftercare to help sustain recovery.5

Mutual-help groups, like 12-Step groups, can offer an added layer of community-level social support to help individuals in recovery as they transition from the formal treatment setting back to everyday life and beyond.5

Alternatives to the 12-Step Model

Some people don't like or are not interested in the 12-Step model. They don't like basing their recovery on the idea that they cannot control their addiction, when there is evidence that there are ways of practicing internal control over the recovery process.

Some of the programs based on this active control model include groups like SMART Recovery. SMART Recovery and similar groups use a peer-sharing model but don't rely on the idea of surrender. Instead, these groups promote empowerment of the individual to exercise control over the treatment of and recovery from addiction.

What Is SMART Recovery?

SMART Recovery is a group-based, volunteer-led recovery model offering support meetings, skills learning, and scientifically based treatments to help participants overcome addiction.1 Founded in 1994, SMART Recovery, which stands for Self-Management and Recovery Training, is a nationwide, nonprofit organization serving as a secular alternative to AA and NA groups.2,3

SMART Recovery Uses and Goals

SMART Recovery offers online and in-person meetings to help those suffering from substance-based addiction (e.g., substance use disorders related to alcohol, marijuana, opioids, etc.) as well as behavioral-based addictions (e.g., eating disorders, gambling addictions, sex addiction, etc.). SMART Recovery was built around a 4-point recovery program involving self-empowerment and evidence-based practices that include:4

1.Building and maintain the motivation to change.
2.Coping with urges to use.
3.Managing thoughts, feelings, and behaviors in an effective way without addictive behaviors.
4.Living a balanced, positive, and healthy life.

Information taught through SMART recovery is heavily drawn from behavioral therapies such as cognitive behavioral therapy (CBT) and Rational-Emotive Behavior Therapy (REBT), which focus on behavioral changes to help treat addiction.5

SMART Recovery vs AA: How Are They Different?

Both SMART Recovery and AA utilize group dynamics and offer support through a community of peers However, there are some differences between the two programs.

- Philosophy — SMART Recovery's underlying philosophy is a person-centric one, empowering individuals to take control of their recovery. In contrast, one of the basic tenets of AA is to admit powerlessness to addiction and the need to turn to a higher power for support and strength.
- Role of Spirituality — Because one of the foundational principles of AA is reliance on a higher power, people often wonder, "Is SMART Recovery religious-based?" The short answer is no. SMART Recovery is not inherently religious, though anyone, regardless of their spiritual leanings, can benefit

from its secular evidence-based approach.
• Views on Addiction — SMART Recovery views addiction as maladaptive behavior which can be unlearned through evidence-based approaches like cognitive behavioral therapy (CBT). AA views addiction as a disease that can be controlled but never cured.
• Structure of Meetings — Both AA and SMART Recovery use group meetings to support recovery. SMART Recovery meetings tend to be more akin to workshops or group discussions. In contrast, AA meetings tend to have a more formal approach, with a chairperson, readings from literature, and sharing of personal stories of recovery.
• Resources and Tools — AA's resources and tools are simple but effective: the group literature (The Big Book, the 12 Steps and 12 Traditions, and other group readings), which can be read at the individual's pace, meetings, sponsorship, and service. SMART Recovery uses a 4-point program that provides a framework for recovery, CBT and REBT techniques, worksheets and exercises, and a wealth of online resources.
• Flexibility of Approach — AA is more structured in its approach and encourages each member to work through the 12 Steps in order and with the guidance of a sponsor. While meetings are not mandatory, they are strongly encouraged. Additionally, AA emphasizes that abstinence is the only way to manage the disease of addiction. SMART Recovery, on the other hand, has more flexibility. There are no required steps to work through; individuals can choose the tools and techniques that resonate with them and best meet their needs. While abstinence is encouraged, it is not a requirement of SMART Recovery, and the program is open to individuals whose goals may be more aligned with harm reduction or moderating their substance use.

The World Health Organization (WHO) emphasizes that there is no safe level of alcohol consumption that doesn't affect health. They advocate for policies and interventions to reduce the harmful use of alcohol. This includes measures like restricting alcohol availability, addressing drink driving, facilitating access to treatment, and restricting alcohol advertising.
Key Points of WHO's Alcohol Guidelines:
No Safe Level:
The WHO's stance is clear: any amount of alcohol consumption can have health consequences.
Harm Reduction Focus:
The WHO aims to reduce the harmful use of alcohol through various strategies.
1.Policy and Interventions:
This includes policies like restricting alcohol availability, enforcing drink driving countermeasures, and regulating advertising.
2.Treatment and Support:
The WHO also emphasizes the importance of providing access to screening, brief interventions, and treatment for alcohol-related problems.
3.Global Strategy:
The WHO has a global strategy to reduce the harmful use of alcohol, which is supported by local, regional, and global actions.

The SAFER initiative

A world free from alcohol related harm
Every 10 seconds a person dies from alcohol-related causes. WHO, in collaboration with international partners, launched the SAFER initiative in 2018. "SAFER" is an acronym for the 5 most cost effective interventions to reduce alcohol related harm.
The SAFER interventions

Strengthen restrictions on alcohol availability
Enacting and enforcing restrictions on commercial or public availability of alcohol through laws, policies, and programmes are important ways to reduce harmful use of alcohol. Such strategies provide essential measures to prevent easy access to alcohol by young people and other vulnerable and high-risk groups.

Advance and enforce drink driving counter measures
Road users who are impaired by alcohol have a significantly higher risk of being involved in a crash. Enacting and enforcing strong drink-driving laws and low blood alcohol concentration limits via sobriety checkpoints and random breath testing will help to turn the tide.

Facilitate access to screening, brief interventions and treatment
Health professionals have an important role in helping people to reduce or stop their drinking to reduce health risks, and health services have to provide effective interventions for those in need of help and their families.

Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion
Bans and comprehensive restrictions on alcohol advertising, sponsorship and promotion are impactful and cost-effective measures. Enacting and enforcing bans or comprehensive restrictions on exposure to them in the digital world will bring public health benefits and help protect children, adolescents and abstainers from the pressure to start consuming alcohol.

Raise prices on alcohol through excise taxes and pricing policies
Alcohol taxation and pricing policies are among the most effective and cost-effective alcohol control measures. An increase in excise taxes on alcoholic beverages is a proven measure to reduce harmful use of alcohol and it provides governments revenue to offset the economic costs of harmful use of alcohol.


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