In search of better solutions for alcohol problems

Poland has a long history of well-organized action against insobriety since first half of XIX century and currently among the many people involved in prevention is a feeling of continuation of long history of efforts for sobriety. Polish level of alcohol consumption is at 2002 estimated as 8 ltr/100 percent per capita. Changes has appeared-excise taxes on spirits was decreased at 2002, prices went down 25% and after one year consumption of vodka drop up on 25%.

The main kind of alcohol related problems in Poland are: Self-destruction of alcoholics (700,000 – 800.000 people), Health problems of abusers (1-1.2 million people), Youth drinking (high risk group is 20-25 per cent of teen population), Alcohol threat to family life (2-3 million children and co-dependent adults, domestic violence, Alcohol threat to workplace and for public safety, Illegal activity of producers and sellers of alcohol

For the each five years period the Polish government approves a program of action for public administration, which is elaborated by the State Agency for Prevention of Alcohol Problems (PARPA), and each year the Polish Parliament receives a special report on its implementation, PARPA is a professional institution for alcohol policy of the Polish government. Main field of polish policy development include

a) Modernization of treatment for dependent and codependent patients
b) Development of family violence counteraction system
c) Development of psychosocial treatment and care centers system for children of alcoholics
d) Development of school and family prevention programs
e) Development of local community systems of action

During preparation of Poland for entry into the European Union, we have met some dilemmas for our alcohol policy - these concern regulations on drink driving, alcohol advertising, and alcohol prices. Our polish experiences, collected during past ten years induce us to introduction following priorities for future discussions and actions in Poland and international cooperation in EU:

a). High level of youth drinking appeal for serious changes in prevention
b) Improvement of treatment effectiveness and availability should not be neglected
c) Defense of safety and support for alcoholic families should be more developed
d) Free market economy and alcohol policy should be better harmonized

We see as an important to continue close cooperation with II European Alcohol Action Plan and national counterparts network. European Charter on Alcohol should be treated as base for future policy and actions. European policy should give more balanced priority for help for people with alcohol problems, and on control of alcohol consumption. It means that may be a more justified name for EU policy should be ALCOHOL PROBLEMS and ALCOHOL POLICY.
THE RISK OF ALCOHOL IN EUROPE

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The more alcohol an individual drinks, the greater the harm
For all types of alcohol-related harm, including social harms, accidents and violence, alcohol dependence, cirrhosis of the liver, cancers, and cardiovascular diseases, the more an individual drinks, the greater the risk of harm. The risks are due to alcohol and come from all beverage types, including wine.

Alcohol reduces the risk of heart disease; a large amount increases the risk
One drink every second day gives almost all the protection that alcohol has on reducing the risk of a heart attack. This protective effect is not relevant for people who are at low risk of heart disease, which includes young people everywhere. Above two drinks a day the risk of heart disease goes up, with the more alcohol drunk, the greater the risk. The biochemical changes that might reduce the risk of heart disease result equally from beer, wine or spirits; they do not result equally from grape juice or red wine from which the alcohol has been removed.

The less a country drinks, the less the harm
The lower the average alcohol consumption of a country, the less harm there is from alcohol. For example, European countries with a male adult per capita consumption of about 14 litres of alcohol have about twice the death rate from liver disease (a sensitive indicator of alcohol-related harm) than countries with a per capita consumption of about 7 litres of alcohol. Also, the lower the average alcohol consumption of a population, the proportion of heavier drinkers is smaller.

A country that reduces its consumption reduces its harm
As a country reduces its alcohol consumption, alcohol-related harm also reduces. On average, as European countries in the middle range of alcohol consumption reduce their average male alcohol consumption by 1 Litre per person, the risk of male death from accidents is reduced by 4%, from cirrhosis of the liver by 9%, from homicide by 11% and from heart disease by 2%.

Alcohol causes nearly 1 in 10 of the burden of ill-health in Europe
The World Health Organization’s Global Burden of Disease Study finds that alcohol is the third most important risk factor for European ill-health and premature death, after smoking and raised blood pressure. Alcohol is more important than high cholesterol levels and overweight, three times more important than diabetes and five times more important than asthma. It causes nearly 1 in 10 of all ill-health and premature death in Europe.
THE FINANCIAL COSTS AND BENEFITS OF ALCOHOL

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What are the costs and benefits?
The costs of alcohol fall on the individual as private costs and others as external costs. Consumers have private benefits of alcohol consumption but there is little evidence of external benefits. Industry claims of the benefits of alcohol related jobs are not counted in most studies. If people reduced drinking they would switch expenditure to other goods and services and replacement jobs would be created in these sectors.

Cost of illness studies
Different costing studies address different questions. Cost of illness studies are designed to address the question what are the costs of alcohol misuse compared to the hypothetical alternative that no alcohol existed. A number of studies have included allowance for the health benefits of low alcohol consumption. The total sums calculated in these studies are substantial, equivalent to 1 to 5% of Gross Domestic Product. While there are a number of studies available comparisons between them are difficult because of different methodologies adopted and different coverage of the effects of alcohol. In a recent study of England, costs were estimated to be €30 billion, far in excess of the total alcohol revenue for the UK. These estimates would be higher still if lives lost were valued for their intrinsic worth rather than in terms of future lost earnings, a ten fold difference. In this study crime costs accounted for nearly 60% of the total much higher than recent Australian estimates at 12%.

Externality studies
This methodology has not been used in the alcohol field but provides strong market driven arguments for including more than the external costs in addressing whether current government policies are sufficient in response to the size of alcohol related problems.

Cost effectiveness of alcohol policies
More evidence has become available on the cost-effectiveness of different alcohol interventions and several databases exist or are being developed e.g. WHO-CHOICE programme. For many treatment programmes, effective interventions have been found to more than pay for their initial outlay in reduced health, crime and other impacts. However, the most cost effective programmes are not necessarily the cheapest. Gathering further economic evidence can be done in a number of ways from very expensive but rigorous evaluative studies, such as the UK Alcohol Treatment trial to more local modelling of available data based on systematic reviews of the literature. A recent study for the Scottish Executive was able to produce a range of estimates of alternative alcohol treatment compared to basic counselling for heavy drinkers at a modest cost!

While data in some areas are still scarce, there is a growing evidence base that could be used to make sure there is economic evidence to support policy makers and counter often misleading economic arguments from industry.
THE LOI EVIN – A FRENCH EXCEPTION

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‘Loi Evin’ - an alcohol policy law controlling advertising – was voted in France in 1991. The severity of the law can be understood better through the European context. The former French law on advertising discriminated against foreign products. France was condemned by the European Court of Justice and asked to change the law. This history explains why - unlike most European countries - the advertising for alcohol does not depend on self regulation or voluntary codes of practice. In this law, a clear definition of alcoholic drinks is given, places and media of authorized advertising are defined and when advertising is permitted, its content is controlled. The sponsorship is not permitted.

Since 1991, many advertisements infringing the law have been condemned by the French courts of justice. As a consequence, we can observe a real change in alcohol advertising: the law has modified the language of advertising which has lost most of its seductive character. The ‘Loi Evin’ had also an important side effect in Europe causing trouble in the field of sports, advertisements for alcohol being forbidden on French television and problems appeared about TV retransmission of international sports events. The effect of the law on average consumption is difficult to assess because of the steady decline of consumption in France, but the symbolic effect is clear. The restrictiveness of the ‘loi Evin’ was the only way to change the basic, easy seductive language used by advertisers.

A European legislative framework covering the advertising of alcohol should be enacted for two reasons:

- Internationalisation of life styles, particularly those of the younger generation,
- Development of marketing strategies by the drinks industry with easy transmission of products and images of alcohol across borders.

The French experience should be considered to propose basic measures, acceptable by all, in order to limit the influence of advertising, especially to the young:

- control forms of communications (advertising, public relations, sponsorship, patronage…) using sporting and cultural international events.
- forbid all advertisements shown on television.

The loi Evin has been constantly challenged but these attacks have not been successful. In France, these attacks were concluded in 2004 by several proposals of new legislations to withdraw wine from the law. This came after the adjudications of advertisements for Burgundy and Bordeaux wines, the “stars” of French agriculture and culture. In an unstable political situation, we can be apprehensive about these proposals, whilst at the same time cheered by some good news arriving from the EU. On the 11th of March 2004, the Advocate General published his opinion in the two cases against ‘Loi Evin’ in discussion before the European Court of Justice. He asserts that French legislation achieves the objective of protection of public health and that the French rules are not disproportionate to their objective.
COMMUNICATING ABOUT ALCOHOL: EDUCATIONAL AND REGULATORY POLICIES

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This paper describes two ways in which communications about alcohol have been used in the service of alcohol policy. The first is education and persuasion strategies, which are among the most popular approaches to the prevention of alcohol-related problems. The second is regulatory policies to protect vulnerable populations from efforts by the alcohol industry to promote their products through television, radio and print advertisements, point of sale promotions, and the internet.

Based on the results of an extensive review of the research literature, the expected effect is low for education and for public service messages about drinking. Although evidence shows that education strategies can change attitudes and knowledge, these strategies have a relatively high cost and the population impact of these programs on drinking and problem rates is negligible. Education alone may be too weak a strategy to counteract other forces, such as ready available, that pervade the environment.

The second type of communication policy is regulating alcohol promotion. Advertising bans show some evidence of effectiveness, and are not expensive to implement. Unfortunately, the evidence for advertising content controls, which are often subject to industry self-regulation codes, is too limited to draw any firm conclusions.

Nevertheless, there still may be grounds for using some of these strategies, based on the "precautionary principle," a public health concept that encourages policymakers to take preventive action even in the face of uncertainty. When applied to alcohol policy, the precautionary principle implies that decision-making by policymakers in areas like the marketing of new alcohol products (e.g., high alcohol content malt beverages) and the promotion of alcohol through advertising, should be guided by the likelihood of risk, rather than the potential for industry profits.
TOWARDS ALCOHOL-FREE ROADS IN EUROPE

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Comparable statistics
The statistics describing the role of alcohol in traffic is so deficient that no real comparisons between countries can be made. This is very unfortunate because it also means that the decision makers are led to make the wrong prioritizations.

A major problem
Even in countries with the highest degree of road safety in the world, alcohol accounts for more than 25% of the fatalities on the road.

Tools, used
Alcohol policy: close correlation between the level of total alcohol consumption in a society and drunk driving and alcohol related accidents.
Enforcement: sobriety checkpoints and random breath testing has been proven to be very effective in reducing the toll.
Information/education: difficult to prove its efficiency but deemed to be necessary for "inoculation" of adolescents.
Legislation: four European countries still have a 0.08% BAC limit. There is ample evidence that lowering the legal limit leads to reductions in the death toll.
License suspension/revocation: license restrictions is a justified method of punishment, control and rehabilitation of drinking drivers.
Relicensing: some countries require that the drunk driver provides medical proof that he is not dependent upon alcohol.
Rehabilitation: there is evidence that a high proportion of drunk drivers are alcohol dependent. Therefore, it is important that sanctions focus on rehabilitation.

Tools which could be used
Alcohol Ignition Interlock Devices, AIID: there is little doubt that AIID in all cars would almost eliminate the problem of drunk driving from our roads. The first areas that will see compulsory AIID are probably transportation of hazardous goods and school buses.
Designated driver programs: little evidence of efficiency in formal programs. However, informal application seems to be successful.
Electronic Driving License: license suspension/revocation does not prevent unlicensed driving. EDL could solve this problem and add a powerful motivating tool.
Graduated licensing: driving restrictions during the first years of driving reduce the involvement of young drivers in road accidents.
Raising the drinking age: increasing the legal drinking age to 21 has clear positive effects.
Vehicle sanctions: little used in Europe but proven effective in the USA.

Finally
Effective measures which diminish the role of alcohol in traffic will also give public health a helping hand. Tremendous need for a pan-European monitoring and reporting system.
Disputes regarding the dogma of abstinence or the claim that it is possible to revert to controlled drinking illustrate a deep-seated lack of belief in the individual’s chances of changing without treatment. However, when people do change from substance misuse, most of them change on their own. Canadian population surveys have suggested that about 78% of interviewees with alcohol problems had overcome them without professional treatment. A considerable proportion reverted to moderate, controlled consumption. Intensive case studies in smaller samples highlight, among other things, the role of social support and control and the influence of life events or stress factors in the motivation to overcome problem use, and point to an impressively creative potential of individual coping strategies. In general, the hypothesis of "spontaneous recovery" challenges the concept of addiction as a disease that is in principle irreversible and progressive. The speaker will briefly outline conceptual aspects and then address treatment and policy implications of the area of self-change research. The core question is how to promote a self-change friendly society. Policy planners in the addiction field find themselves faced with growing criticism of the increasing and costly impact of professional therapy and the abstinence dogma in various spheres of life. Under-utilisation of the resources of numerous treatment services also raises questions about the reasons for “treatment rejection” and supports the view that, from the study of clinical populations only, it is not possible to understand the needs of the much more important hidden population of problem drinkers. In this context the concepts of “assisted natural remission” and “stepped care” are introduced. Self-help, lay help, primary care and specialist help therefore can be seen on a continuum. Psychological models and perspectives on change need to be complemented by a sociological approach. The latter views the societal climate of opinion (discrimination, judgements of different types of deviance in the general population and in the media) and objective features of the treatment system (barriers to treatment and perceptions of available programs) as key parameters which can promote or impede individual chances for change.
Primary health care has a preventive role
Prevention is the best way to reduce the suffering due to different diseases. Among the medical disciplines especially academic general practice (family medicine) has taken the preventive role. People have right to know what their drinking means to their health; primary health care is a natural and easy-access place for this information.

Brief interventions are easy to do and effective, also in primary health care
Brief intervention includes alcohol consumption assessment, information on health hazards and short, individual counselling related to current drinking levels. There are good tools to identify risky drinking, and the skills needed are easy to learn. Brief intervention can be incorporated in a normal clinical work by physicians and nurses. Hitherto, more than 10 000 subjects have been included in randomised controlled brief intervention studies and several systematic reviews and meta-analyses have been published. According to the latest meta-analysis in primary health care by Ballesteros et al., brief interventions clearly outperform usual care.

Cost effectiveness is clear
According to Fleming et al. the cost-effectiveness is almost six-fold. Based on a Finnish example, screening and brief intervention of a population with 1600 adults makes a cost similar to the treatment of one complicated alcohol-related pancreatitis.

Implementation is possible, but may take time
Implementation is possible but time, key-persons and political goodwill are needed. Networks are helpful, as are guidelines and continuous education and training in changing the attitudes and strengthening the therapeutic commitment of the staff. Given the brief interventions’ preventive potential the cost-effectiveness, if systematically done in primary health care, would be huge.
Alcohol related problems move along a continuum
Alcohol problems appear as a continuum, ranging from hazardous drinking to severe dependence. Patients move along this continuum through their life. Health systems should be organized to guarantee a continuity of care.

General Practitioners see at their practices all kinds of alcohol related problems
GPs can deal effectively with hazardous and harmful drinkers, but they need specialized support to provide effective treatment to drinkers with higher levels of severity. This support must permit shared care options and adequate referral when needed.

There is a gap between PHC and specialized treatment services in most of the countries
Transition from PHC to specialized centres is not easy. This results in patients being referred less and later than needed, which makes treatment more difficult and worsens their prognosis. NGO’s are doing a remarkable effort to reduce this gap.

A number of causes can be identified to explain why this gap exists
Obstacles can be identified in PHC (lack of time & training, unwillingness of patients), in specialized settings (focus on dependence, long waiting lists, scarce number of centres, lack of resources, etc), and in the Health System itself: alcohol dependence appears as a ‘second class’ illness, and specialized centres are often not fully integrated in the Health System, thus making coordination more difficult.

Structural and organizational changes are needed in order to bridge this gap
Specialized services should be fully integrated into the Health Systems, which would facilitate coordination between specialists and PHC. There is preliminary evidence that training of PHC professionals by alcohol specialists is well received by GPs, and can lead to increased rates of referrals.
TOWARDS A COMPREHENSIVE TREATMENT STRATEGY: THE ROLE OF SPECIALIST SERVICES

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1. Specialist services are needed for the care of severe case of alcohol related disorders, but are often not adequately linked with other professional and nonprofessional help options

Specialist services on an outpatient, day care or inpatient basis are needed for the help of patients with severe alcohol related disorders. In most cases patients with ICD 10 dependence diagnosis (F 10.2) are treated, with additional comorbidic disorders for inpatient services. Lack of cooperation between general and specialist services is a major problem in most countries which leads to inadequate early screening, diagnosis and treatment of hazardous and harmful alcohol use in educational, general health care and social fields.

2. Specialist services differ in many aspects

Specialist services differ in many aspects, like setting and ownership, patient and disorder profiles, staff characteristics and education, treatment modalities and financing issues.

3. Well designed specialist services are effective but expensive and have only low impact

Well designed treatment for alcohol dependents in specialist services is effective but expensive: Inpatient treatment of about 3 to 4 month will cost about € 10.000 to 15.000, and result in an average one year follow up abstinence rate of about 40 % to 50 % in Europe. But the impact is low: about 2 – 4 % or less of the population with harmful or dependent use will receive such a treatment.

4. Scientific evidence requires improvements in major treatment aspects

Scientific studies suggest the implementation of some major improvements: referral to specialist services on the basic of severe disorder profiles and negative social conditions only, less referral to inpatient facilities, individualised, on the average shorter inpatient treatment duration, more evidence based treatment modalities.

5. The challenge to specialist services: cooperation and quality improvement

Specialist services are needed but should be conceptionalized within a public health oriented national and European alcohol policy. This requires (1) close cooperation between general and specialist services to support early screening, diagnosis and intervention for cases with hazardous or harmful alcohol use in general facilities and (2) evidence based and cost effective interventions for cases with severe disorder profiles in specialist services.
ALCOHOL AND THE FAMILY IN EUROPE

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Abstract
Across the European Region, tens of millions of adults and children are adversely effected by the drinking problems of a member of their family. However, in most countries, the contribution of alcohol to family problems such as divorce and child abuse and neglect is not normally ascertained or recorded; treatment and helping services for family members are poorly developed, and relatively little attention is paid to family alcohol problems in preventative programmes.

These are among the findings of the research project `Alcohol Problems in the Family: A Report to the European Union' undertaken by EUROCARE and COFACE, and funded by the European Commission.

The project examined the variety of ways in which family problems are related to alcohol. One aspect is that family influences such as disharmony and break-ups can encourage alcohol problems in both children and adults. Equally, alcohol can cause family problems. The project focused mainly on the effects of problem drinking on spouses and children. It was estimated that at up to 9.2 million children in the European Union are growing up in families impaired by parental alcohol problems.

Internationally, the evidence is consistent in regard to the effects of parental problem drinking on children, who report social isolation and being forced to take on adult roles and responsibilities, caring for younger siblings or indeed their parents. Such children are at increased risk of a wide range of psychological and health problems, as are the partners of problem drinkers.

While the situation varies greatly from one country to another, there are two main features that seem to apply generally:

- There is a lack of national focus on the family aspects of alcohol problems, and this is accompanied by a lack of factual information about their nature and extent.

- There is uncertainty regarding who is responsible for helping family members affected by alcohol problems. In most countries, children and other family members tend to slip through the gaps between helping agencies: alcohol treatment agencies may not provide help to the family of the drinker, while agencies providing treatment and help to families may not be equipped to deal with alcohol problems. Even where help is offered to family members, this is normally dependent upon the problem drinker first being identified and offered treatment. Where this does not happen, which is in the majority of cases, the children and other family members may well be left without recourse to any expert help or support.

Clearly, across the whole European Region there are large areas of unmet need that require attention from a wide range of agencies, governmental and non-governmental.
Alcohol policies targeted at young people, while ignoring the wider population, are doomed to failure: Young people inherit the drinking culture from the adults in their society. Therefore, reshaping the attitudes, behaviours and environments of the whole society is necessary to provide a safer social climate for young people to lead healthy and productive lives. The most effective alcohol policies, relevant for young people, include setting a minimum age for the purchase of alcohol, alcohol control enforcement, seller liability, alcohol taxes, lower BAC for young drinkers and random breath testing. The next level of policy effectiveness includes community mobilisation, on-premise regulation and brief intervention with at risk drinkers.

Young people are not all the same: All young people have a right to be heard and participate when policies, services and programmes are being developed to meet their needs. However, when discussing alcohol, the broad term ‘young people’ can be divided into three main groups with differing needs, children (under 15), teenagers (15-17 years) and young adults (18-30 years). Given that alcohol use poses serious risks for children and teenagers still developing and maturing, the main focus is to keep children alcohol-free.

Lessons to be learned from the Irish experience: Rapid economic growth can trigger an increase in alcohol consumption and related harm with a range of health, social and economic negative consequences. Ignoring the problem or making poor policy choices can contribute further to the problem. Taking action, based on the scientific evidence of effective polices, and gaining public support can influence and begin to turn the tide. The challenge is to build on the progress made by implementing additional integrated measures to reduce alcohol related problems in Ireland.

Alcohol is a global product, but no ordinary commodity: A better balance is needed at European level between public health policy and other policy areas. Recent EU proposals (excise duty and sales promotion) illustrate divergent views and risk increasing alcohol harm, if implemented. European policies should complement and reinforce Member States strategies to reduce alcohol related harm.

The alcohol industry is lukewarm on the public health approach: The alcohol industry exists to sell alcohol. Their aim, like all commercial businesses, is for a better bottom line not for better health for the citizens of Europe. Therefore, it is inevitable that effective public health measures will continue to be opposed by the drinks industry if they impact on profits. While the drinks industry says it is committed to reducing alcohol related harm, the continuing call by the industry for education as the lead strategy rings hollow given the research evidence, which shows that education is a supportive rather than a lead strategy.
Table 1 Alcohol Policy Effectiveness in reducing alcohol related harm

<table>
<thead>
<tr>
<th>Policy Measure</th>
<th>Proven High Effectiveness ***</th>
<th>Proven effectiveness **</th>
<th>Some effect *</th>
<th>No effect 0</th>
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<tbody>
<tr>
<td>Regulating physical availability</td>
<td>• Minimum legal purchase age</td>
<td>• Hours and days of sales restrictions</td>
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<td></td>
<td>• Government monopoly of retail sales</td>
<td>• Restrictions on density of outlets</td>
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<td></td>
<td>• Server liability</td>
<td>• Different availability of alcohol strength</td>
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<td>• Alcohol control enforcement</td>
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<td>Taxation and pricing</td>
<td>• Increased taxes</td>
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<tr>
<td>Modifying the drinking context</td>
<td>• Enforcement of on-premise regulations and legal requirements</td>
<td>• Outlet policy to not serve intoxicated customers</td>
<td>• Voluntary codes of bar practice</td>
<td>• Promoting alcohol-free activities &amp; events</td>
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<td></td>
<td>• Community mobilisation</td>
<td>• Training of bar staff &amp; managers to prevent &amp; better manage aggression</td>
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<td>Education and persuasion</td>
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<td>• Alcohol education in schools</td>
<td>• College student education</td>
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<td></td>
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<td>• Public service messages</td>
<td>• Warning labels</td>
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<td>Regulating alcohol promotion</td>
<td>• Advertising bans</td>
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<td>Drink Driving countermeasures</td>
<td>• Random breath testing</td>
<td>• Sobriety check points</td>
<td>• Designated drivers and ride services</td>
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<td></td>
<td>• Lowered BAC limits</td>
<td>• Administrative license suspension</td>
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<td>• Lower BAC for young drivers</td>
<td>• Graduated license for novice drivers</td>
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<td>Treatment and early intervention</td>
<td>• Brief intervention with at risk drinkers</td>
<td>• Alcohol problems treatment</td>
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<td>• Mutual self-help attendance</td>
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<td></td>
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<td>• Mandatory treatment of repeat drinking drivers</td>
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Source: Babor et al (2003) Alcohol no ordinary commodity research and public policy