Illegal Drug Use

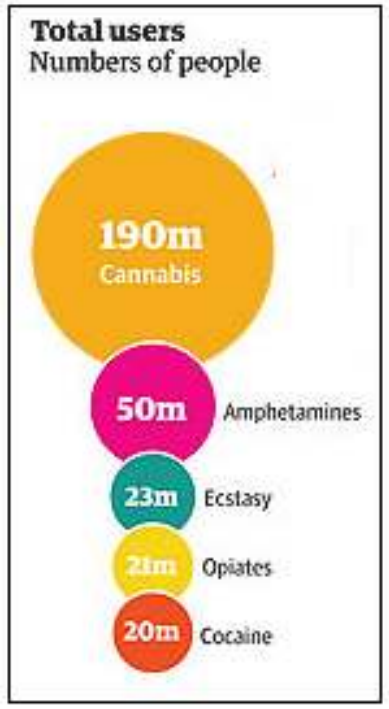
Classification

- Legal drug abuse
  - Substance abuse
    - Prescription drugs
      - Sedatives/hypnotics
    - Alcohol
    - Tobacco
    - Volatile solvents
  - Non-substance abuse
    - Gambling addiction
    - Internet addiction
    - Work addiction
    - Sex addiction
    - Shopping addiction

- Illegal drugs
  - Substance abuse
    - Stimulants
      - Amphetamine
      - Cocaine
      - Ecstasy
    - Depressants
    - Hallucinogens
      - Cannabinoids
      - LSD
      - PCP
      - Psilocybin Mushrooms
    - Opioids
      - Opium
      - Heroine
    - New Psychoactive Substances (NPS)

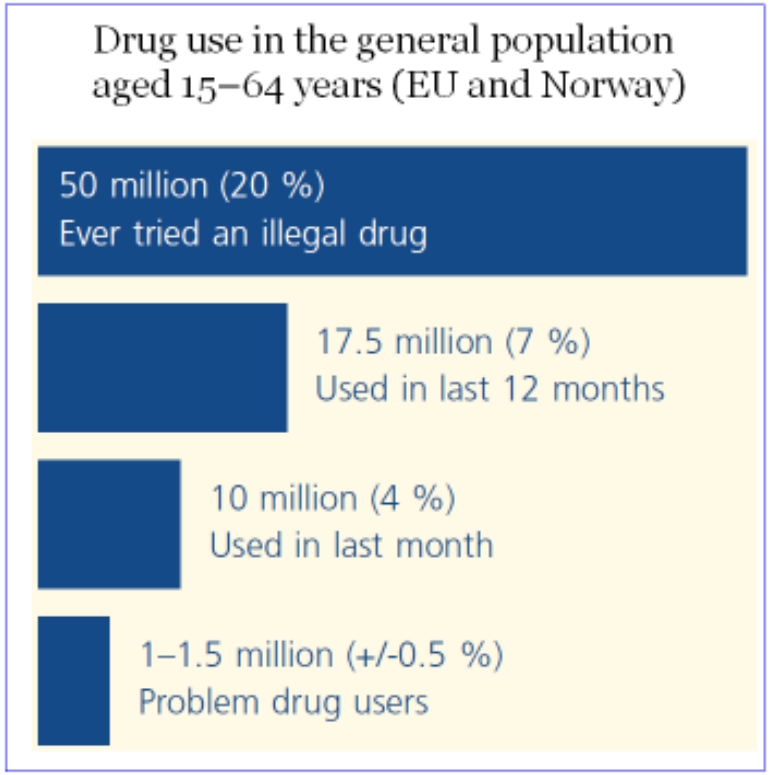
Epidemiology of drug use

- While there has been some increase in the estimated total number of users of any illicit substance, estimates show that the number of drug users with dependence or drug use disorders has remained stable.
- In 2011, 14.0 million persons between the ages of 15 and 64 were estimated to be injecting drugs. In the same year, the number of drug-related deaths was estimated at 211,000.



Indicators for characterizing drug use

- Lifetime prevalence
  - Lifetime prevalence is a cumulative indicator of the total number of people who have ever tried drugs.
  - Lifetime prevalence tends to increase because with the aging of the population those reaching the age of 65 fall out of the given population (usually 15-64). These people were young before the surge of drug use and are replaced by a generation with higher rates of use.
  - Prevalence is much more accurate if examined in the last year or month, instead of a lifetime.



Continuation Rate

- When dealing with figures related to drug use, it must be kept in mind that the highest continuation rates are for cigarettes (over half who ever smoke continue) and especially alcohol where the figure is over three-quarters. Continuation rates for illegal drugs are considerably lower, 20 % or less, so with age many will stop.

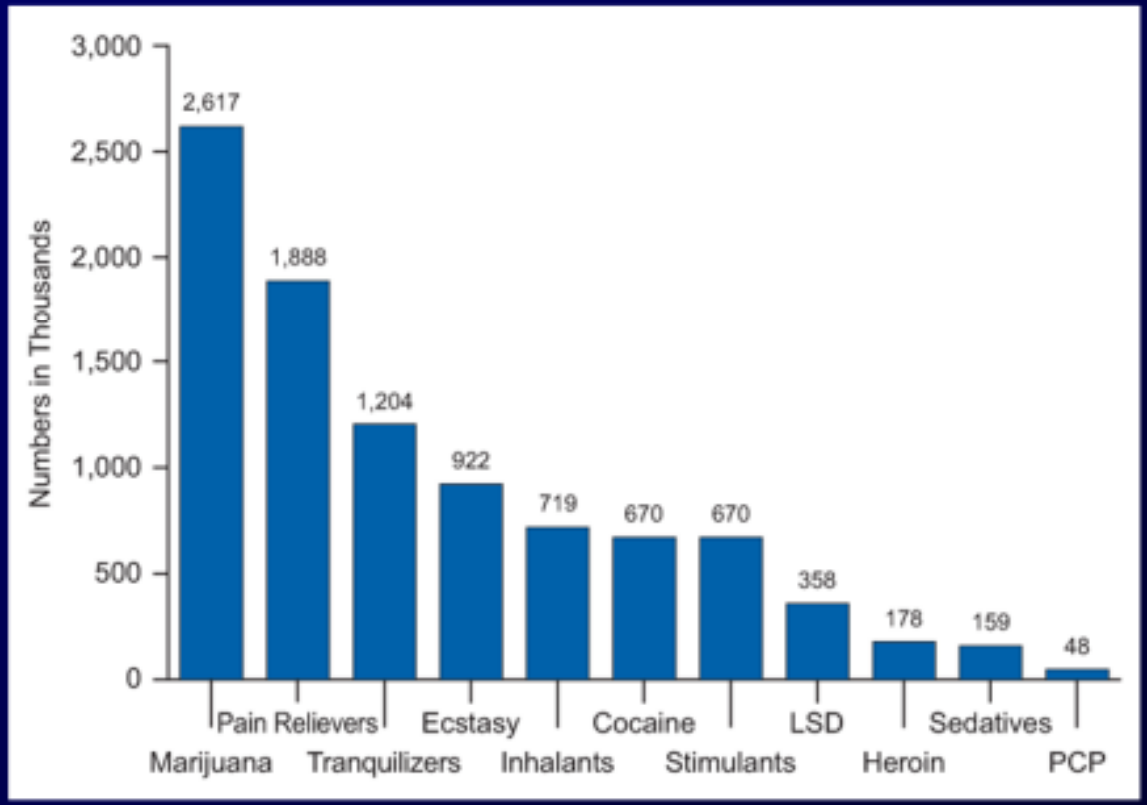
The process of dependence

- Early abuse often includes such substances as tobacco, alcohol, inhalants, marijuana, and prescription drugs such as sleeping pills and anti-anxiety medicines. If drug abuse persists into later adolescence, abusers typically become more heavily involved with marijuana and then advance to other drugs, while continuing their abuse of tobacco and alcohol. Studies have also shown that abuse of drugs in late childhood and early adolescence is associated with greater drug involvement

Risk factors

- Family history, such as having a parent with drug or alcohol problem
- Affiliation with drug-abusing peers
- Biological causes like gender, race or geographic location
- high levels of risk factors and low levels of protective factors (see later)

Most Frequently Used Substances



1. Methamphetamine

- Methamphetamime, popularly shortened to meth or ice, is a psychostimulant and sympathomimetic drug.
- Methamphetamine enters the brain and triggers a cascading release of norepinephrine, dopamine and serotonin.
- Since it stimulates the mesolimbic reward pathway, causing euphoria
- Withdrawal is characterized by excessive sleeping, eating and depression-like symptoms, often accompanied by anxiety and drug-craving. excitement, it is prone to lead to abuse and addiction.

2. Cocaine

- Cocaine is a crystalline tropane alkaloid that is obtained from the leaves of the coca plant.
- It is both a stimulant of the central nervous system and an appetite suppressant, giving rise to what has been described as a euphoric sense of happiness and increased energy.
- The initial signs of stimulation are hyperactivity, restlessness, increased blood pressure, increased heart rate and euphoria.
- The euphoria is sometimes followed by feelings of discomfort and depression and a craving to experience the drug again.
- Side effects can include twitching, paranoia, and impotence, which usually increases with frequent usage.

3. Ecstasy

- Ecstasy (MDMA) is a semisynthetic psychedelic substance of the phenethylamine family that is much less visual with more stimulant-like effects than most all other common “trip” producing psychedelics.
- The primary effects of MDMA include an increased awareness of the senses, feelings of openness, euphoria, empathy, love, happiness, heightened self-awareness, feeling of mental clarity and an increased appreciation of music and movement.
- Tactile sensations are enhanced for some users, making physical contact with others more pleasurable. Other side effects, such as jaw clenching and elevated pulse, are common.

5. LSD

- Lysergic acid diethylamide, LSD, LSD-25, or acid, is a semisynthetic psychedelic drug of the tryptamine family.
- LSD's psychological effects (colloquially called a "trip") vary greatly from person to person, depending on factors such as previous experiences, state of mind and environment, as well as dose strength. They also vary from one trip to another, and even during a single trip.
- An LSD trip can have long term psycho-emotional effects; some users cite the LSD experience as causing significant changes in their personality and life perspective.

6. PCP

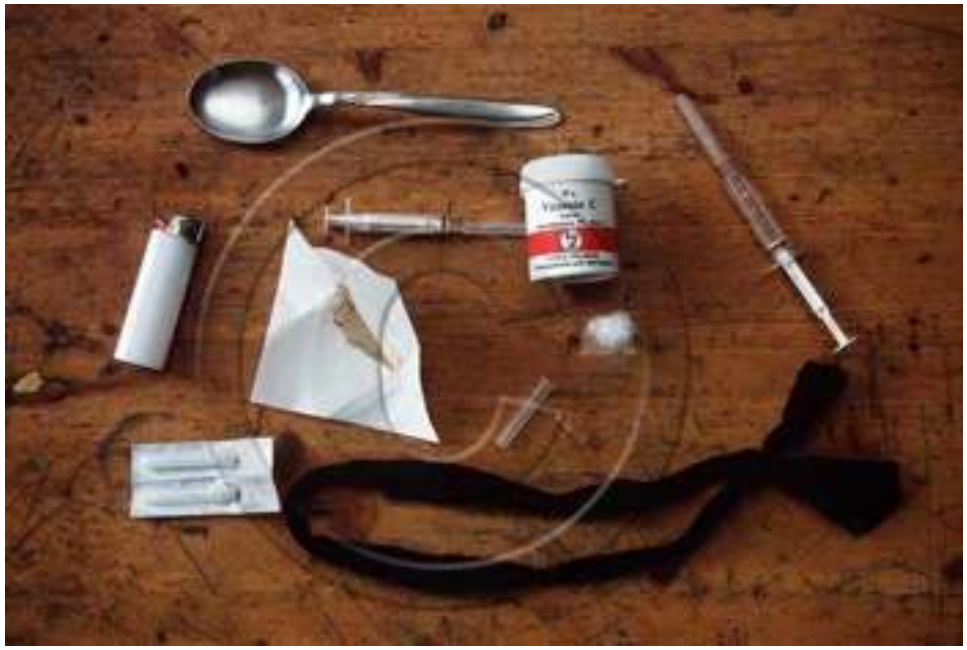
- PCP (Phencyclidine) is a dissociative drug formerly used as an anesthetic agent, exhibiting hallucinogenic and neurotoxic effects. It is commonly known as Angel Dust.
- PCP has potent effects on the nervous system altering perceptual functions (hallucinations, delusional ideas, delirium or confused thinking), motor functions (unsteady gait, loss of coordination, and disrupted eye movement or nystagmus), and autonomic nervous system regulation (rapid heart rate, altered temperature regulation).

7. Psilocybin Mushrooms

- Psilocybin mushrooms are fungi that contain the psychedelic substances psilocybin and psilocin, and occasionally other psychoactive tryptamines
- The experience is typically inwardly oriented, with strong visual and auditory components. Visions and revelations may be experienced, and the effect can range from exhilarating to distressing. There can be also a total absence of effects, even with large doses.

8. Opium and Heroin

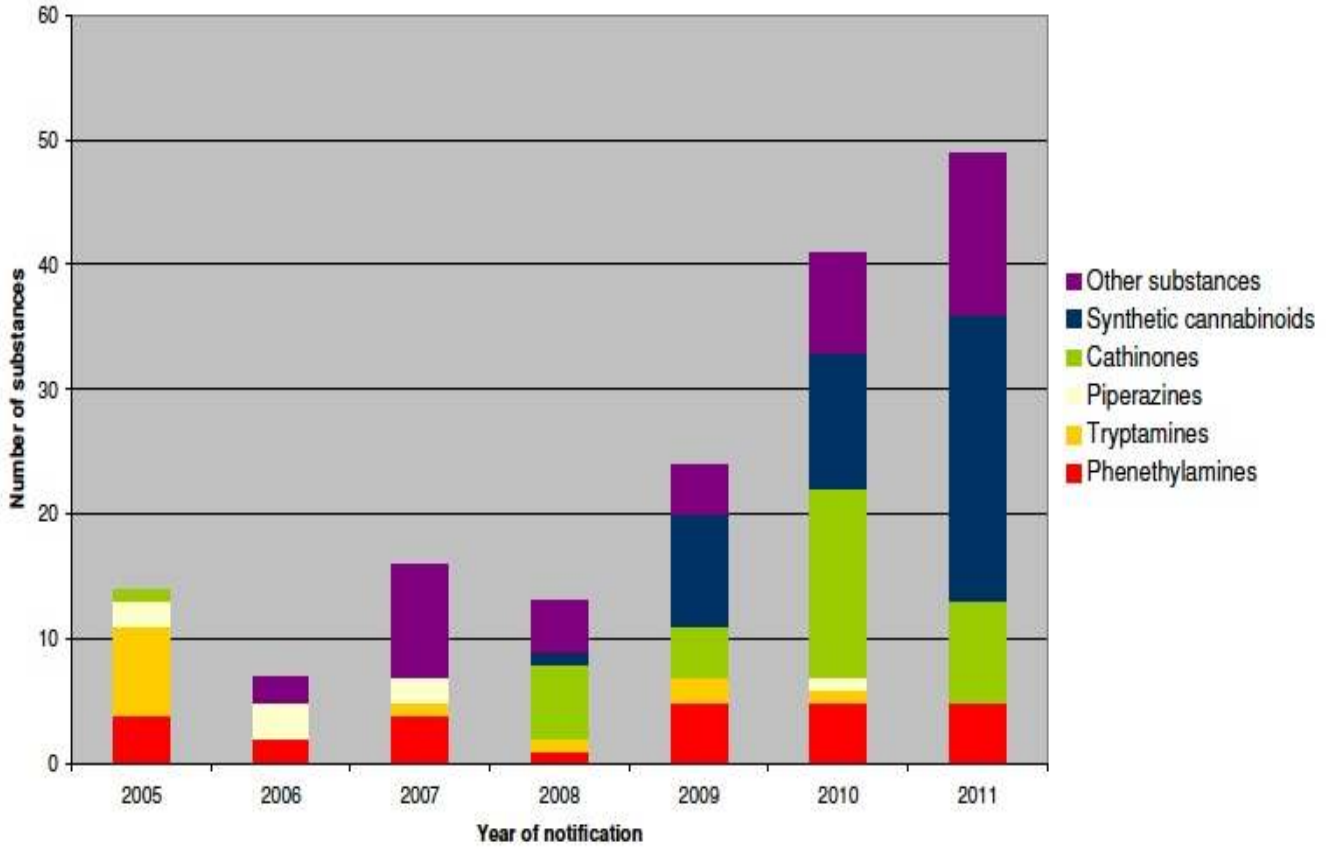
- Opium is a resinous narcotic formed from the latex released by lacerating the immature seed pods of opium poppies (Papaver somniferum).
- Heroin was originally created to help cure people of addiction to morphine.
- Upon crossing the blood-brain barrier, which occurs soon after introduction of the drug into the bloodstream, heroin is converted into morphine, which mimics the action of endorphins, creating a sense of well-being; the characteristic euphoria has been described as an “orgasm” centered in the gut.



9. New Psychoactive Substances (NPS)

- NPS are substances of abuse, either in a pure form or a preparation, that are not controlled by international drug conventions, but which may pose a public health threat.
- In general, NPS is an umbrella term for unregulated (new) psychoactive substances or products intended to mimic the effects of controlled drugs.
- Countries in nearly all regions have reported the emergence of NPS. The number of identified NPS in the European Union rose from 14 in 2005 to 236 by the end of 2012.

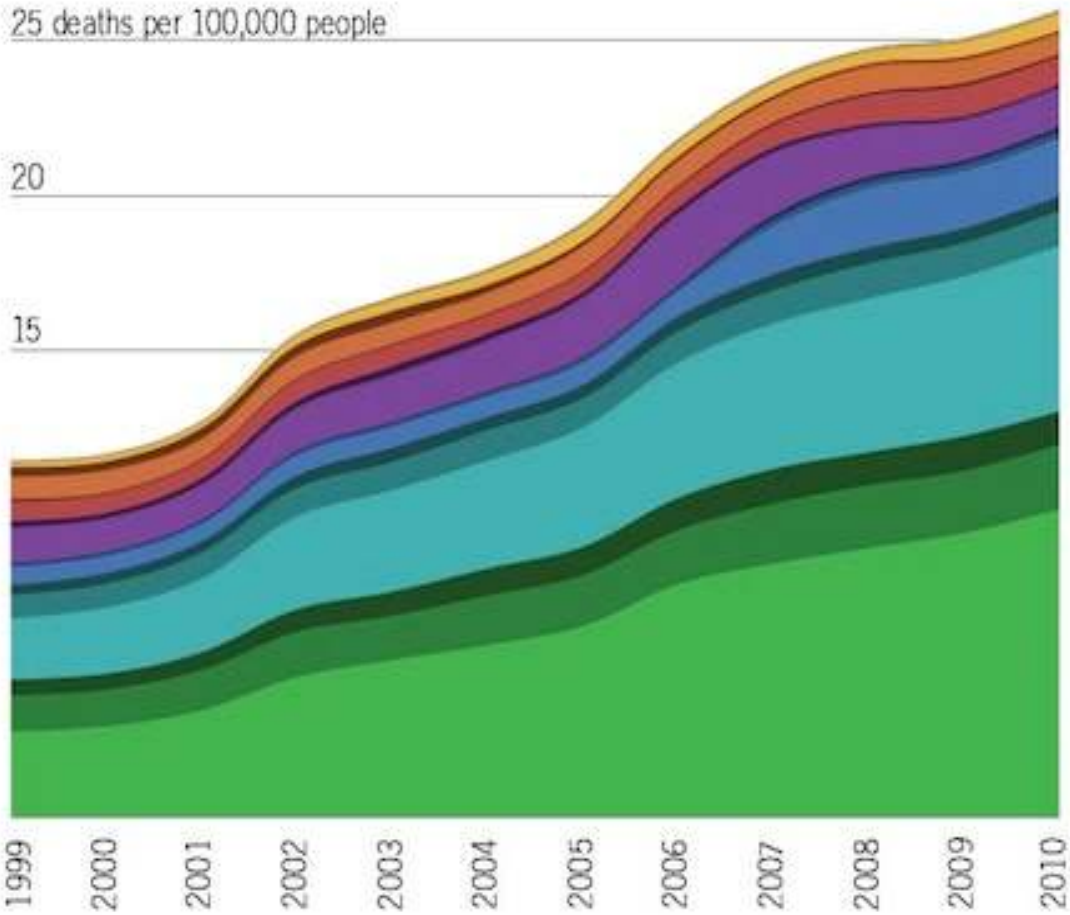
Graph 1. Number of new psychoactive substances notified in 2005–11, by year



NPS

- It has generally been observed that, when a NPS is controlled or scheduled, its use declines shortly thereafter, which has a positive impact on health-related consequences and deaths related to the substance.
- While most widespread in Europe and North America, NPS seem to originate nowadays primarily in Asia (East and South Asia), notably in countries known for their advanced chemical and pharmaceutical industries.
- For more information visit the following website: http://www.unodc.org/wdr/index.html

U.S. DRUG OVERDOSES



Other*
Psychostimulants**
Narcotics other than heroin and cocaine
Heroin
Cocaine
Alcohol

Unspecified
Drug name not identified on death certificate

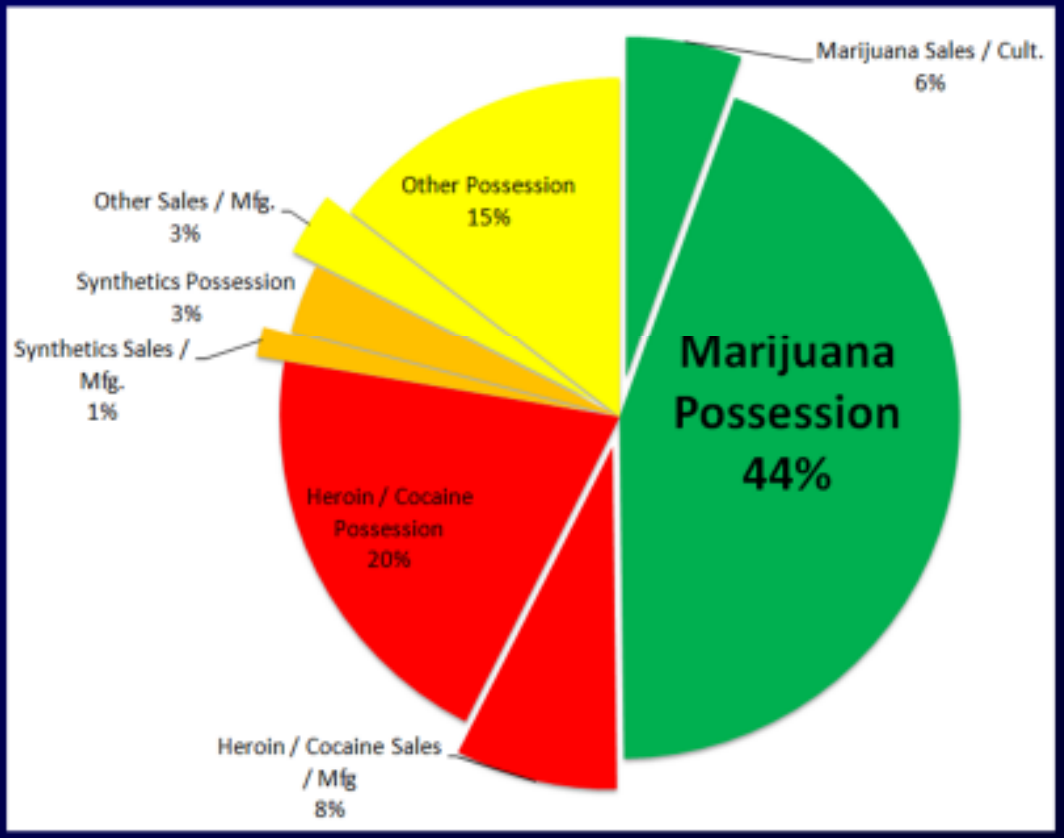
Pharmaceuticals
Undetermined intent
Intentional self-harm
Unintentional self-harm

***Includes** cannabis, LSD, opium, mescaline, mushrooms, and all cases of overdose by assault

****Includes** methamphetamines, MDMA (ecstasy), and caffeine

Drug overdose data from the CDC National Center for Health Statistics's multiple cause of death database (WONDER). Compiled by Popular Science.

Distribution of drug arrests



Drugs and HIV

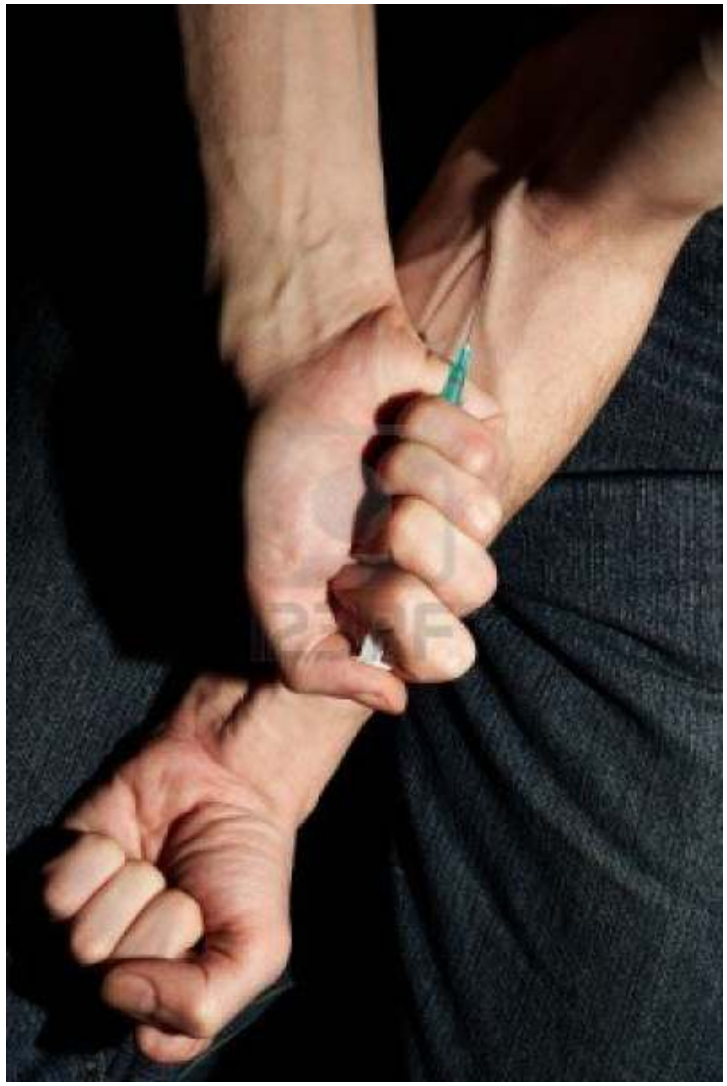
- In 2011, 1.6 million people who injected drugs were living with HIV. In comparison with the previous years, this represents a 46% decline. This puts the global prevalence of HIV at 11.5% among people who inject drugs.
- The total number of people who inject drugs and are living with HIV in a particular region is influenced by three variables:
  - the prevalence of HIV among people who inject drugs;
  - the prevalence of people who inject drugs; and
  - the total population in the region aged 15-64.

Drugs and HIV

- Overall, the Russian Federation, the United States and China account for 46% of the global number of people who inject drugs that are living with HIV (21%, 15% and 10%, respectively).
- The region with the highest prevalence of HIV among people who inject drugs is the Near and Middle East/ South-West Asia (24%). This is driven primarily by high rates of HIV among people who inject drugs in Pakistan (37%) and Iran (15.1%).
- Almost 30% of the global population injecting drugs and are living with HIV are in Eastern and South-Eastern Europe. Similar to Pakistan, Ukraine has a large share of population who injects drugs, with a very high prevalence of HIV (22%).

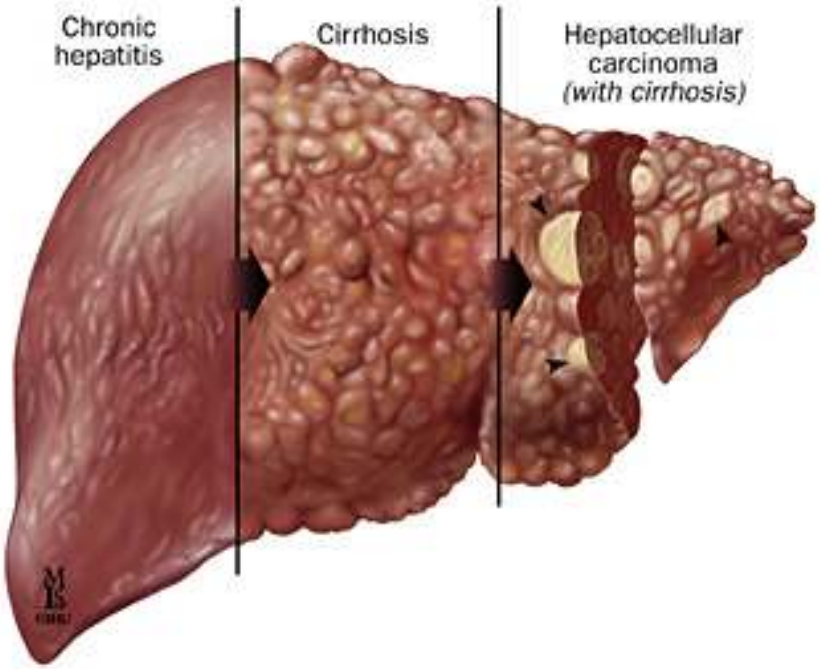
Drugs and Hepatitis C

- Another major global public health concern is hepatitis C, which can lead to liver diseases such as cirrhosis and cancer. Infection with the hepatitis C virus (HCV) is highly prevalent among people who inject drugs.
- UNODC estimates that the global prevalence of HCV among people who inject drugs is 51%, meaning that 7.2 million people who inject drugs were living with HCV in 2011.



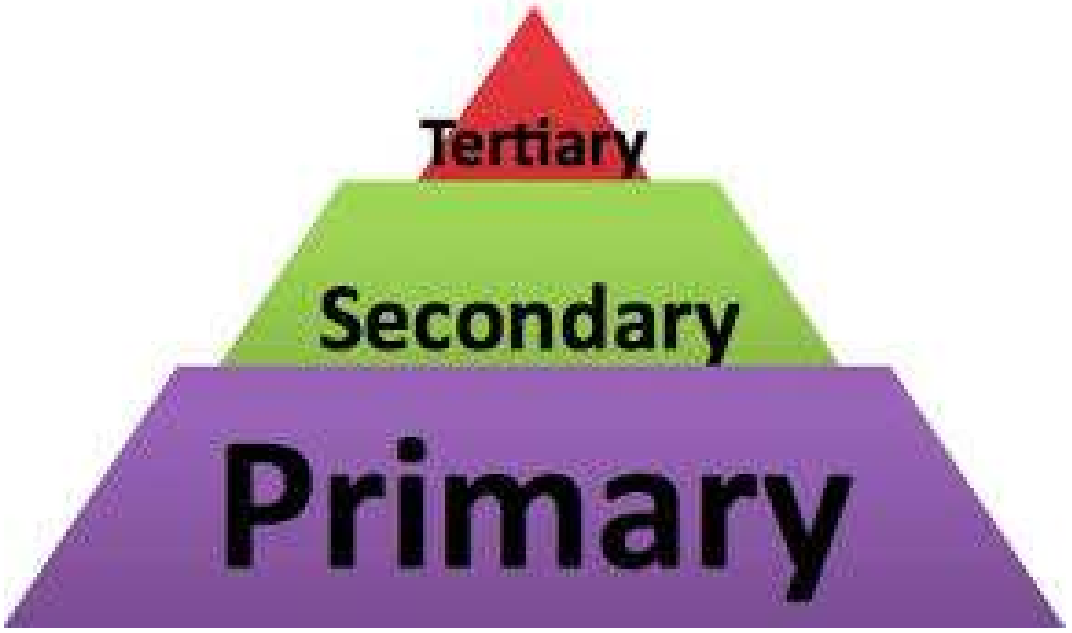
Drugs and Hepatitis B

- The global prevalence of the hepatitis B virus (HBV) in 2011 among people who inject drugs is estimated at 8.4%, or 1.2 million people, based on reporting from 63 countries.
- The highest prevalence of HBV among people who inject drugs is found in the Near and Middle East/South West Asia (22.5%) and Western and Central Europe (19.2%).



Prevention

- The most important goal in prevention is to decrease the risk factors and increase the protective factors. The main scenarios for this are family, education and community. The needle exchange program does not lead to the decline of number of users however it decreases the transmission of infectious diseases.



Risk factors associated with drug use

- Age: increasing use until mid-20s, then decreasing
- Gender: usually higher in males, though not always much difference
- Outgoing lifestyles: bars, discos, parties
- Precocity: younger-than-average initiation into “adult” behavior in general: sex, smoking, drinking and drugs
- Higher disposable income (in some studies, unemployment is also a risk factor)
- Urban settings: higher for illegal drugs but not for alcohol, tobacco, medicines, solvents; less so for cannabis in countries with longer histories of use
- High-prevalence areas and drug availability
- Positive images of drug use among peers
- Alcohol or tobacco use
- Parental substance use

Protecting factors

- Self-control
- Parental monitoring
- Academic competence
- Anti-drug use policies
- Strong neighborhood attachment

The three areas of drug prevention

- Family
- School
- Community

Family

- Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information.

School

- Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout.
- Prevention programs for middle or junior high and high school students should increase academic and social competence.
- Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community.

Community

- Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.
- Community prevention programs reaching populations in multiple settings (for example, schools, clubs, faith-based organizations, and the media) are most effective when they present consistent, community-wide messages in each setting.

Needle exchange program

- A needle and syringe program (NSP) is a social policy based on the philosophy of harm reduction where injecting drug users can obtain hypodermic needles and associated injection equipment at little or no cost.
- The possession of a syringe without prescription is/was illegal for a long time in many places around the world. Legislation was usually amended to allow needle and syringe programs to operate when governments realized the need to provide sterile injecting equipment to reduce the spread of HIV and hepatitis C. Generally, each state and territory allows authorized NSP and pharmacies to provide needles and syringes. Police can enter NSP facilities at any time and are able to approach or apprehend clients. However, discretion is used to ensure that the NSP can operate effectively.

Needle exchange program

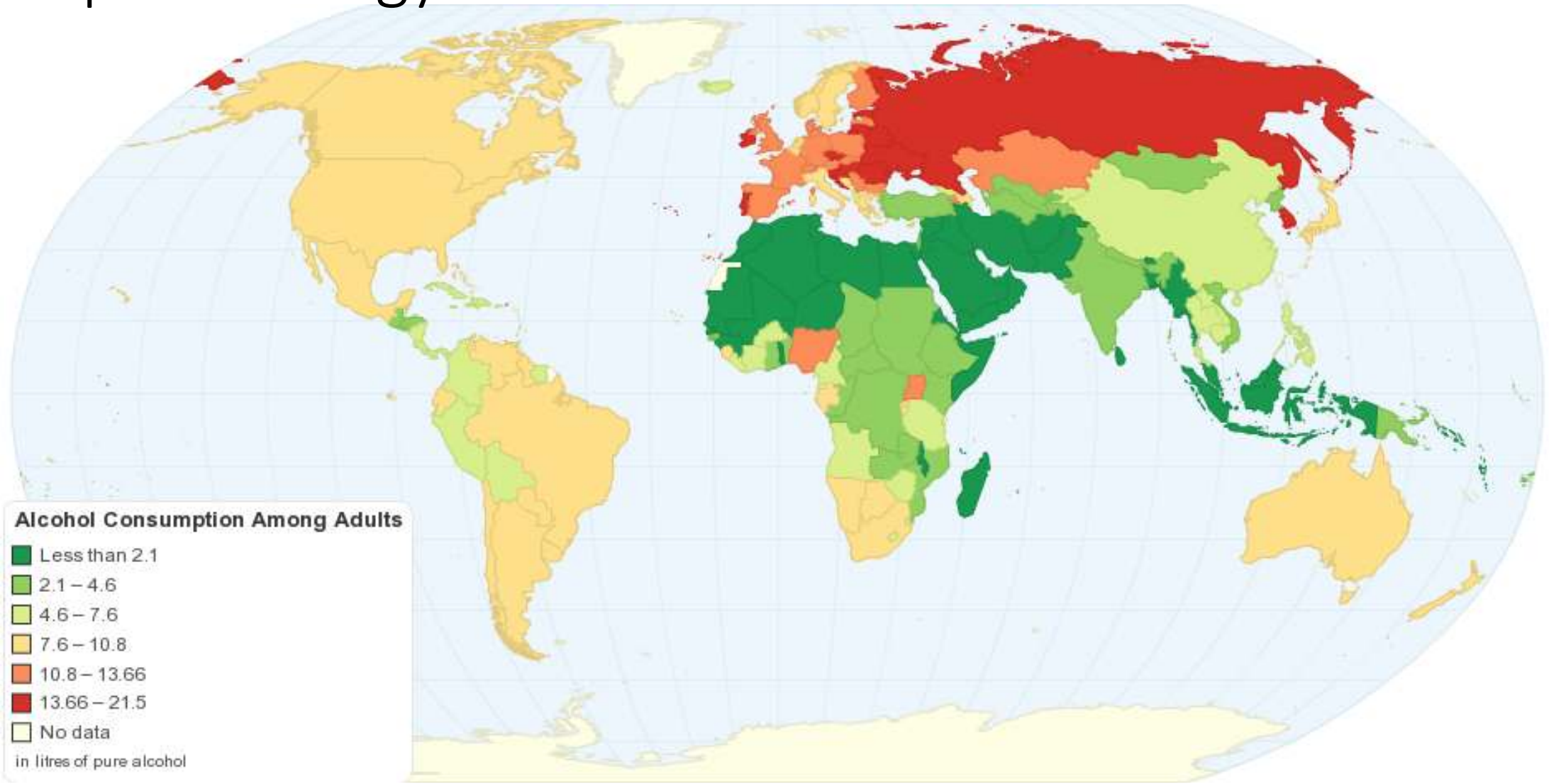
- Government and non-government organizations provide people who inject drugs with access to needles and syringes to prevent the transmission of HIV and hepatitis C infections. Australian Governments invested $130 million in Needle and Syringe Programs between 1991 and 2000. This resulted in the prevention of an estimated 25,000 cases of HIV and 21,000 cases of hepatitis C. The savings to the health system in avoided treatment costs over a lifetime are estimated to be between $2.4 and $7.7 billion.

Alcohol

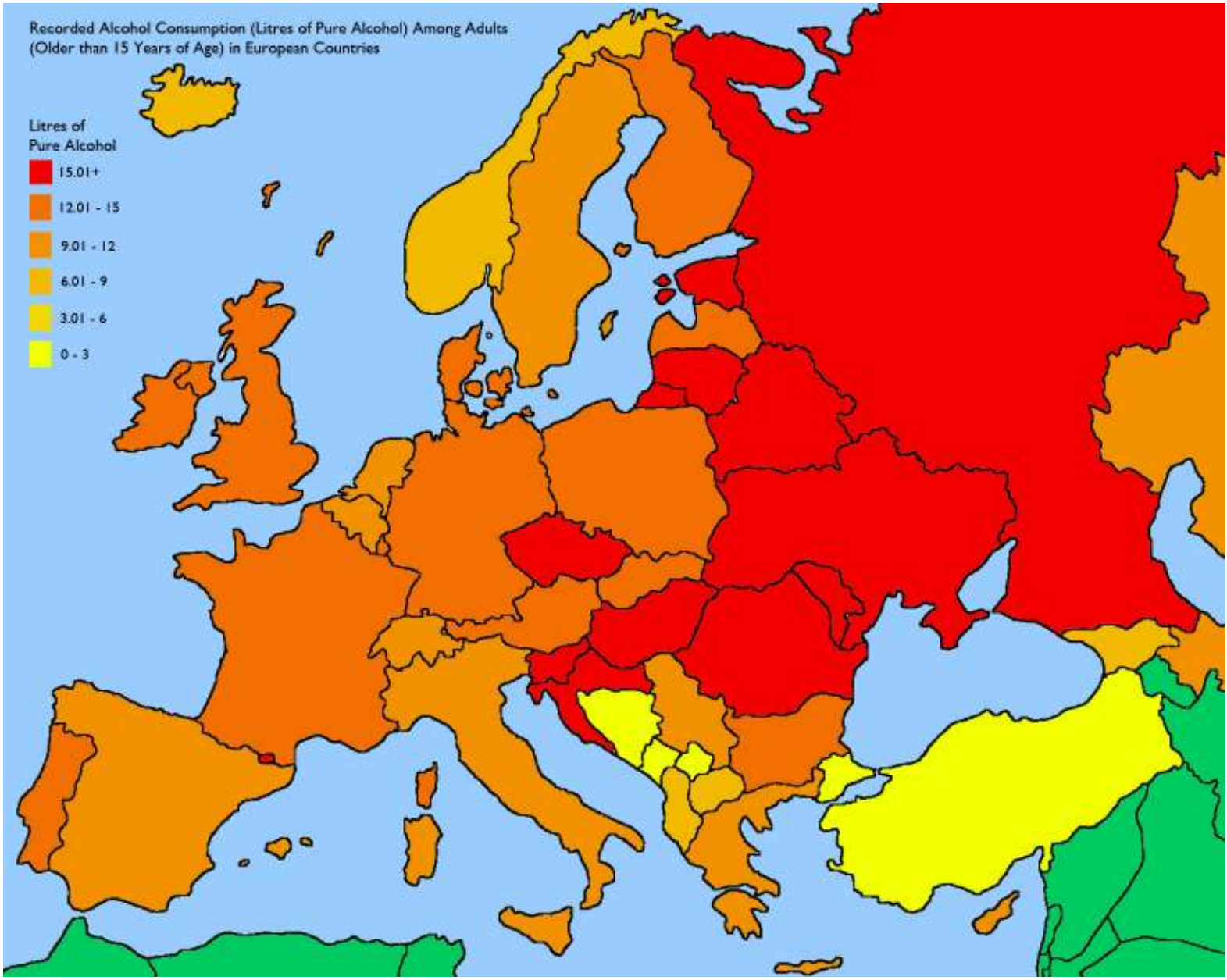
HOW MUCH DO PEOPLE DRINK?

- The true picture of alcohol consumption is often shrouded in myths and assumptions. A statistical presentation and mapping of the level and patterns of global, regional and country alcohol consumption by adults 15 years and older provides a sound basis for the analysis of problems related to alcohol.
- Worldwide per capita consumption of alcoholic beverages in 2005 equaled 6.13 litres of pure alcohol consumed by every person aged 15 years or older. A large portion of this consumption – 28.6% or 1.76 litres per person – was homemade and illegally produced alcohol or, in other words, unrecorded alcohol.

Epidemiology



Alcohol consumption in Europe



ALCOHOL CONSUMPTION AMONG YOUNG PEOPLE

- In the WHO Global Survey on Alcohol and Health (2008), the five-year trend of under-age drinking was assessed: out of 73 responding countries, 71% indicated an increase, 4% a decrease, 8% were stable and 16% showed inconclusive trends. The five-year trend of drinking among 18–25 year olds indicated that, out of 82 responding countries, 80% showed an increase, 11% a decrease, 6% were stable and 12% showed inconclusive trends.

TRENDS IN ADULT PER CAPITA CONSUMPTION SINCE 1990

- Worldwide recorded per capita consumption has remained stable at around 4.3–4.7 litres of pure alcohol since 1990, including relative stability in all WHO regions.
- After a slight decrease at the beginning of the 1990s, alcohol use in the European Region increased again to around the same level of 9.5 litres. The initial decline in the 1990s in the Region of the Americas stabilized in the new millennium at about 6.7 litres.
- There was an increase at the end of the last century in the Western Pacific Region, but recorded consumption then stabilized at around 4.7 litres

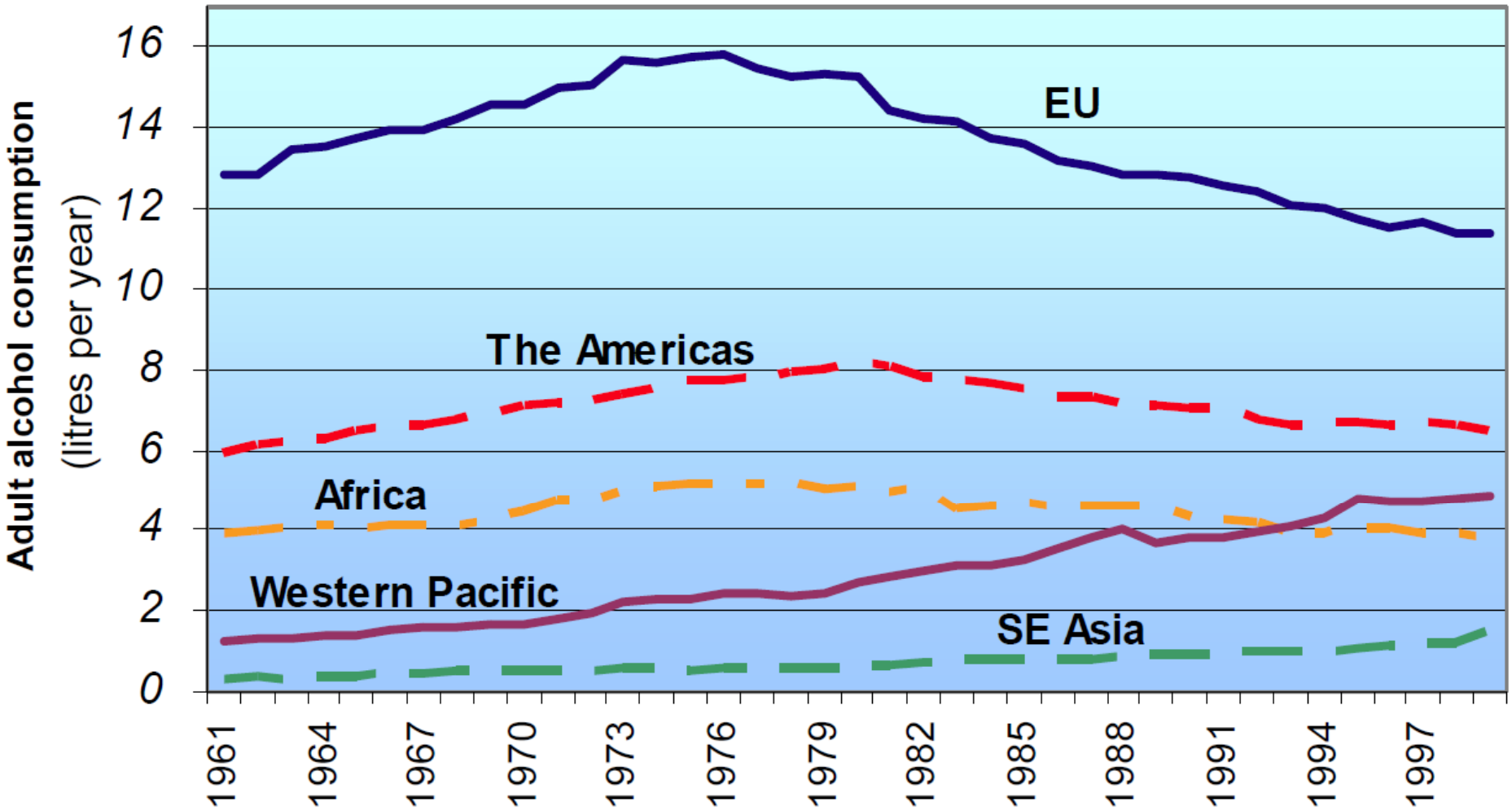


Figure 4.1 Europe and the world's drinking *Sources: Global Status Report on Alcohol (WHO 2004); EU figures are taken from WHO Health for All Database and WHO Global Alcohol Database (as below). Averages are population-weighted.*

UNRECORDED ALCOHOL CONSUMPTION

- The consumption of unrecorded alcohol (see Box 4) is a significant issue in all WHO regions, and poses a difficult dimension for measuring the true nature of global alcohol consumption. Data must be culled from many sources to accurately estimate this sector of consumption, which accounts for nearly 30% of total worldwide adult consumption.

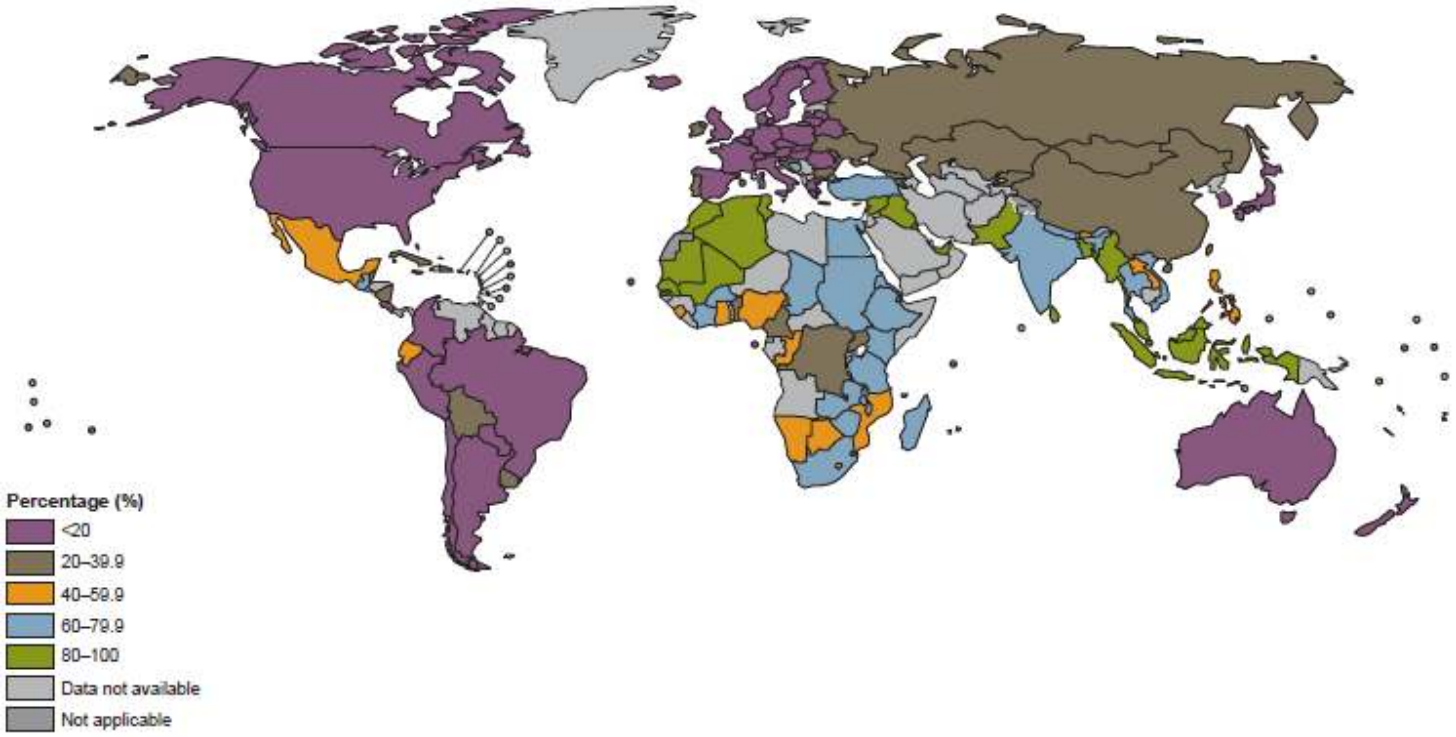
Total adult per capita consumption (APC), unrecorded APC and proportion of unrecorded APC of total APC, in litres of pure alcohol, by income group

Income	Total APC	Unrecorded APC	Proportion of unrecorded APC of total APC (%)
Low	2.97	1.42	47.9
Lower middle	4.41	1.71	38.9
Upper middle	9.46	2.88	30.5
High	10.55	1.18	11.2
World	6.13	1.76	28.7

[a] Best estimates of 2005 using average recorded alcohol consumption 2003–2005 (minus tourist consumption, see Appendix IV) and unrecorded alcohol consumption 2005.

ABSTENTION

Figure 6. Lifetime prevalence of abstention (%), 2004[a]

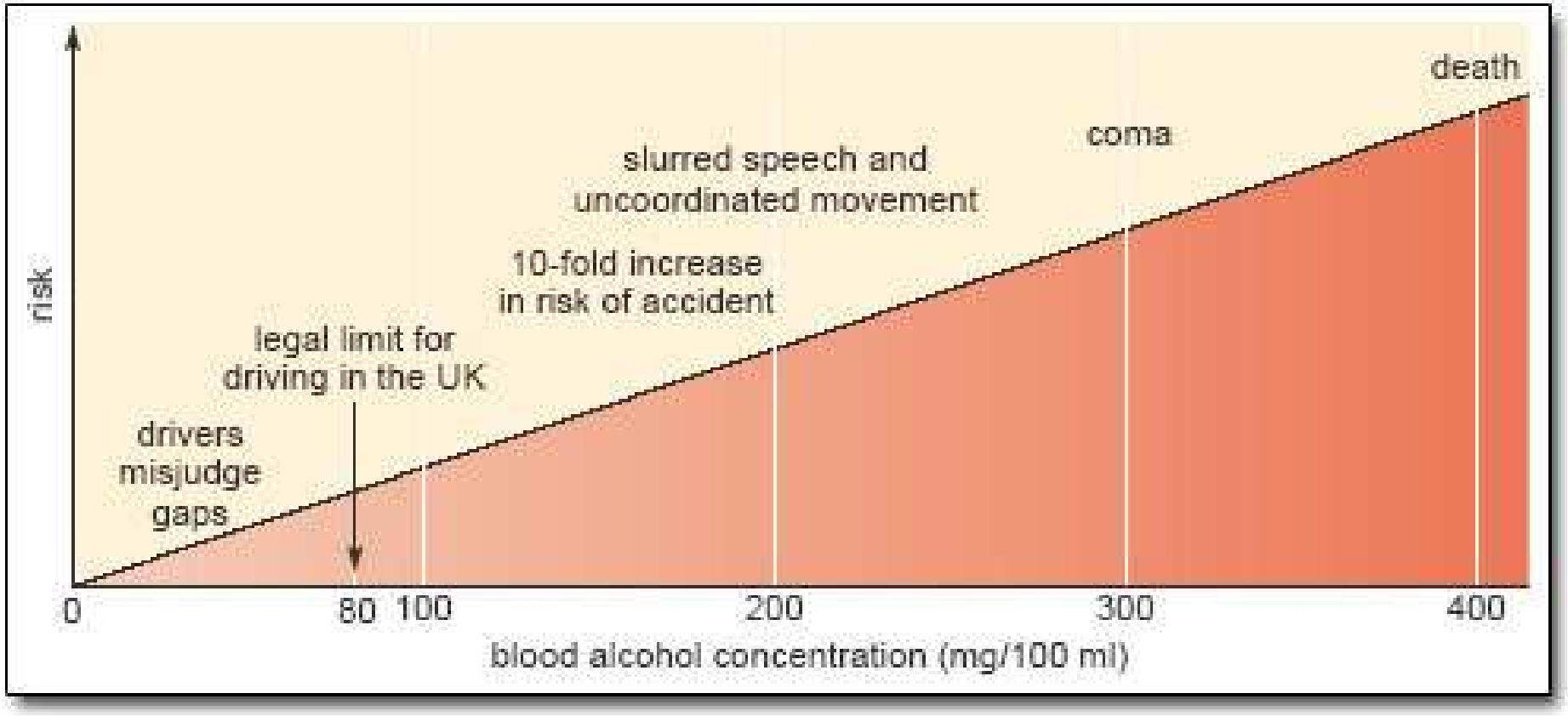


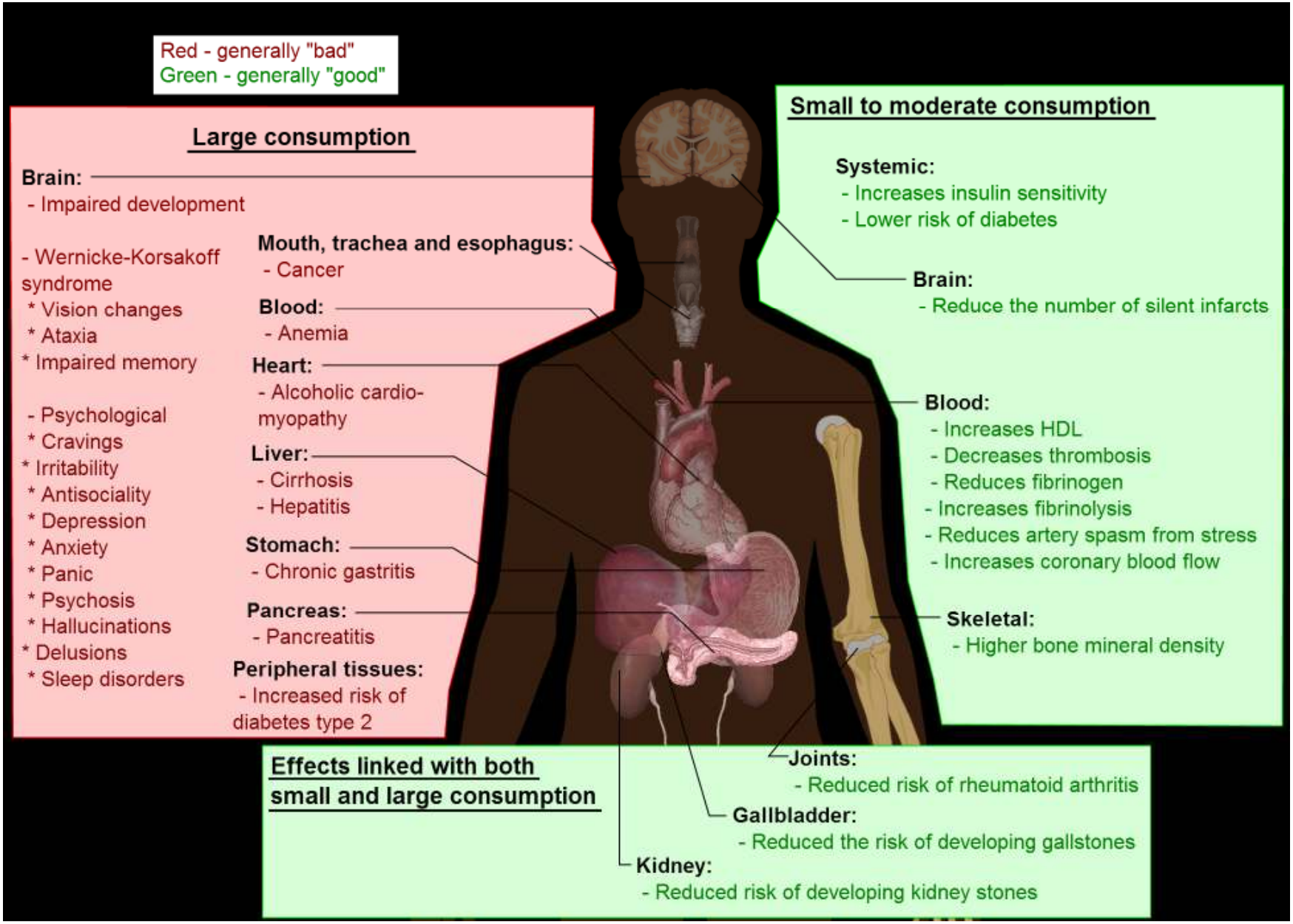
[a] Best estimates for abstention rates in 2004 based on surveys carried out within the time period 1993–2009.

Alcohol use disorder

- **Alcohol use disorders:** for the purposes of the WHO Global Burden of Disease (GBD) Study, the group of “alcohol use disorders” comprises not only diagnostic categories of the harmful use of alcohol and alcohol dependence, but also of alcohol psychoses.
- **Harmful use of alcohol** (also often referred to as “alcohol abuse”) is defined as “a pattern of alcohol use that is causing damage to health”
- **Alcohol dependence** (also known as alcoholism or alcohol dependence syndrome) is defined as “a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated alcohol use and that typically include a strong desire to consume, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to alcohol use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state”
- **Alcohol psychosis** is defined as a cluster of psychotic phenomena that occur during or following alcohol use but that are not explained on the basis of acute intoxication alone and do not form part of a withdrawal state (ICD-10).

Acute effects of alcohol




Red - generally "bad"
Green - generally "good"
Large consumption
Brain:
- Impaired development
- Wernicke-Korsakoff syndrome
* Vision changes
* Ataxia
* Impaired memory
- Psychological
* Cravings
* Irritability
* Antisociality
* Depression
* Anxiety
* Panic
* Psychosis
* Hallucinations
* Delusions
* Sleep disorders
Mouth, trachea and esophagus:
- Cancer
Blood:
- Anemia
Heart:
- Alcoholic cardio-myopathy
Liver:
- Cirrhosis
- Hepatitis
Stomach:
- Chronic gastritis
Pancreas:
- Pancreatitis
Peripheral tissues:
- Increased risk of diabetes type 2
Small to moderate consumption
Systemic:
- Increases insulin sensitivity
- Lower risk of diabetes
Brain:
- Reduce the number of silent infarcts
Blood:
- Increases HDL
- Decreases thrombosis
- Reduces fibrinogen
- Increases fibrinolysis
- Reduces artery spasm from stress
- Increases coronary blood flow
Skeletal:
- Higher bone mineral density
Effects linked with both small and large consumption
Joints:
- Reduced risk of rheumatoid arthritis
Gallbladder:
- Reduced the risk of developing gallstones
Kidney:
- Reduced risk of developing kidney stones

Alcohol poisoning

- The signs and symptoms of acute alcohol poisoning include:
  - severe confusion, unpredictable behavior and stupor
  - sudden lapses into and out of unconsciousness or semi-consciousness (with later alcoholic amnesia)
  - vomiting while unconscious or semi-conscious
  - seizures
  - respiratory depression (fewer than eight breaths a minute)
  - pale, bluish, cold and clammy skin due to insufficient oxygen

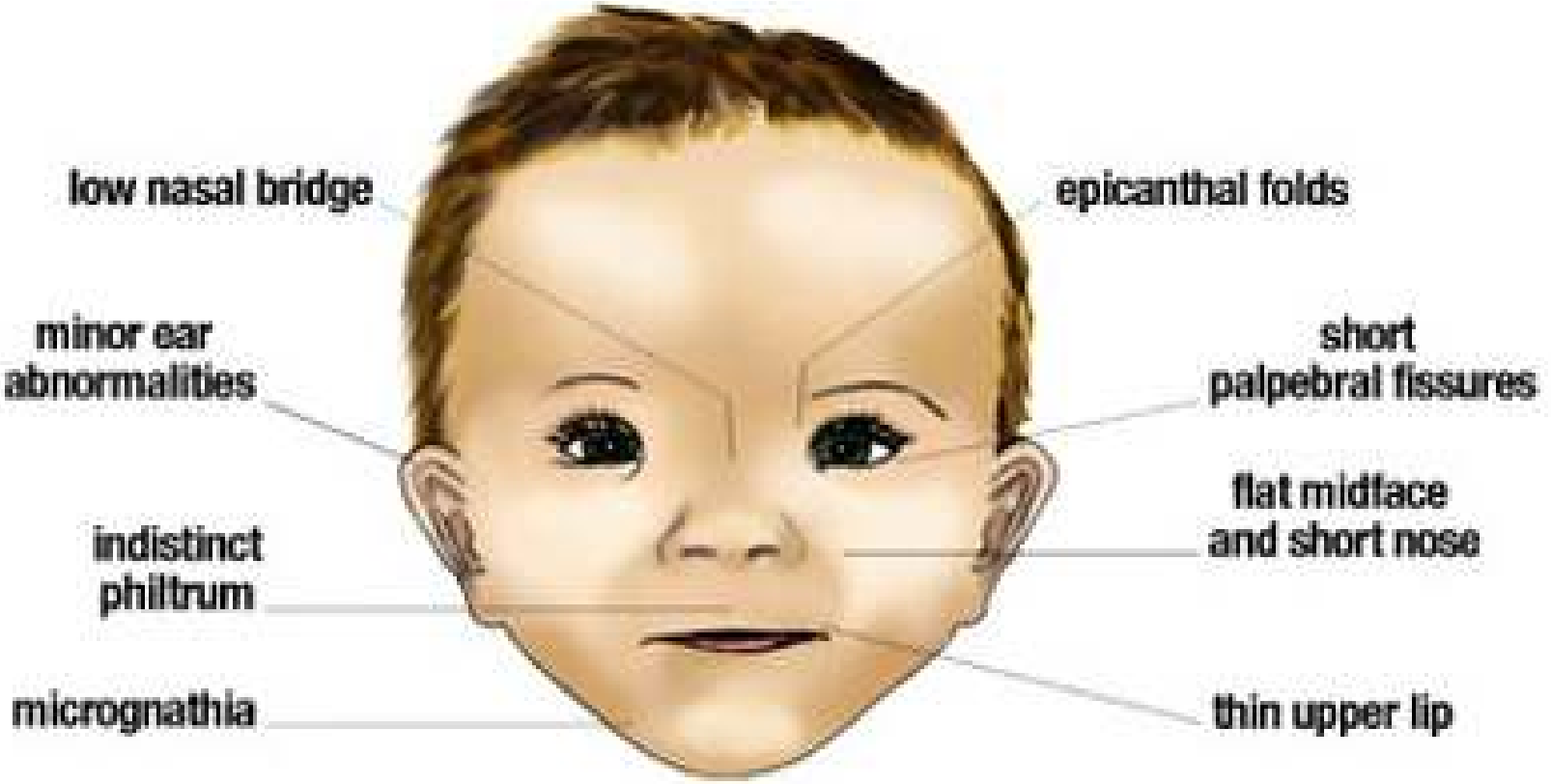
Alcohol poisoning management

- Acute alcohol poisoning is a medical emergency due to the risk of death from respiratory depression and/or inhalation of vomit if emesis occurs while the patient is unconscious and unresponsive. Emergency treatment for acute alcohol poisoning strives to stabilize the patient and maintain a patent airway and respiration, while waiting for the alcohol to metabolize.
- Treat hypoglycaemia (low blood sugar) with 50ml of 50% dextrose solution and saline flush, as ethanol induced hypoglycaemia is unresponsive to glucagon.
- Administer the vitamin thiamine to prevent Wernicke-Korsakoff syndrome, which can cause a seizure (more usually a treatment for chronic alcoholism, but in the acute context usually co-administered to ensure maximal benefit).
- Apply haemodialysis if the blood concentration is dangerously high (>400 mg%), and especially if there is metabolic acidosis.
- Provide oxygen therapy as needed via nasal cannula or non-rebreather mask.
- Additional medication may be indicated for treatment of nausea, tremor, and anxiety.

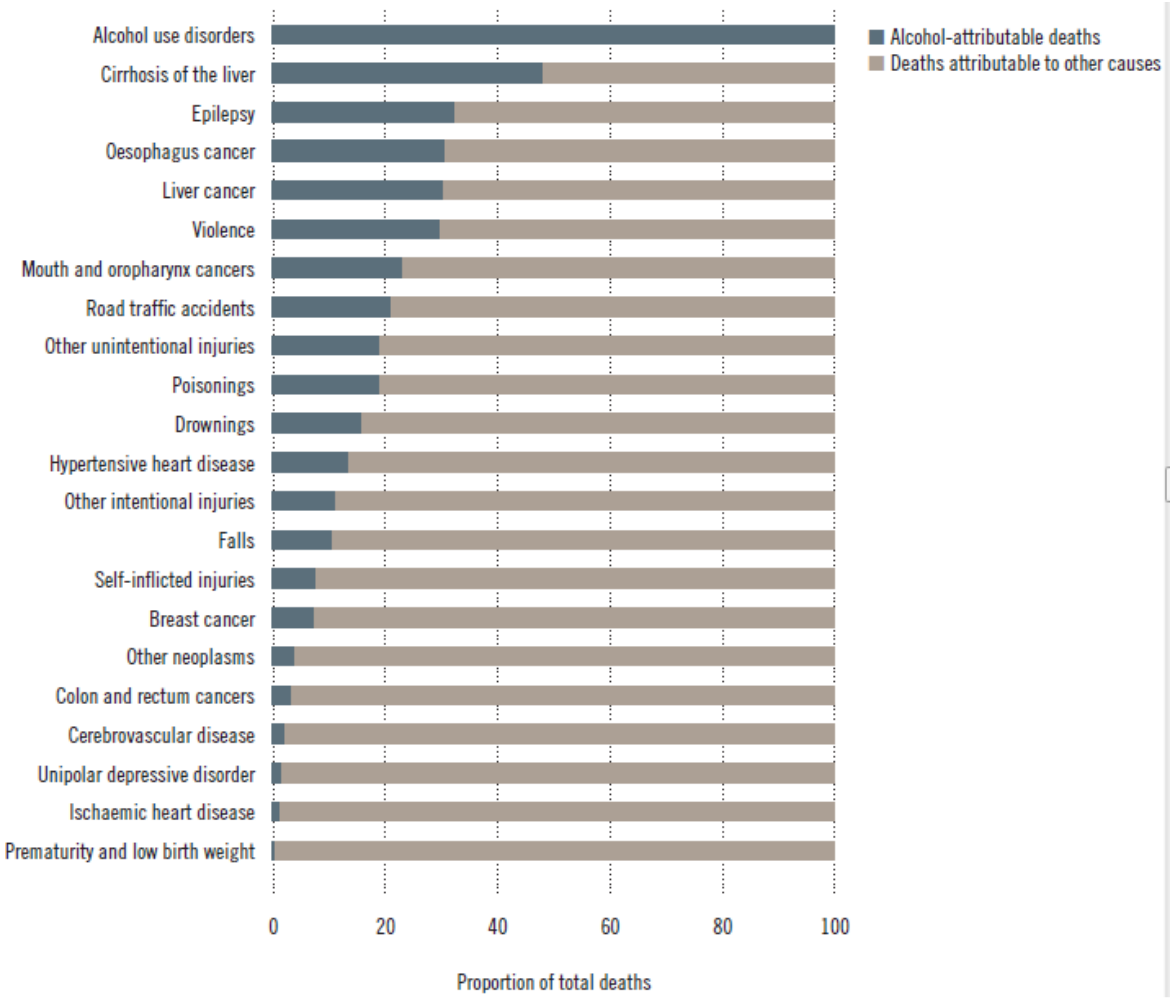
Alcohol poisoning prognosis

- A normal liver detoxifies the blood of alcohol over a period of time that depends on the initial level and the patient's overall physical condition. An abnormal liver will take longer but still succeed, provided the alcohol does not cause liver failure.
- People who have been drinking heavily for several days or weeks may have withdrawal symptoms after the acute intoxication has subsided.[15]
- A person who consumes a dangerous amount of alcohol persistently can develop memory blackouts and idiosyncratic intoxication or pathological drunkenness symptoms.
- Long-term persistent consumption of excessive amounts of alcohol can cause liver damage and have other deleterious health effects.

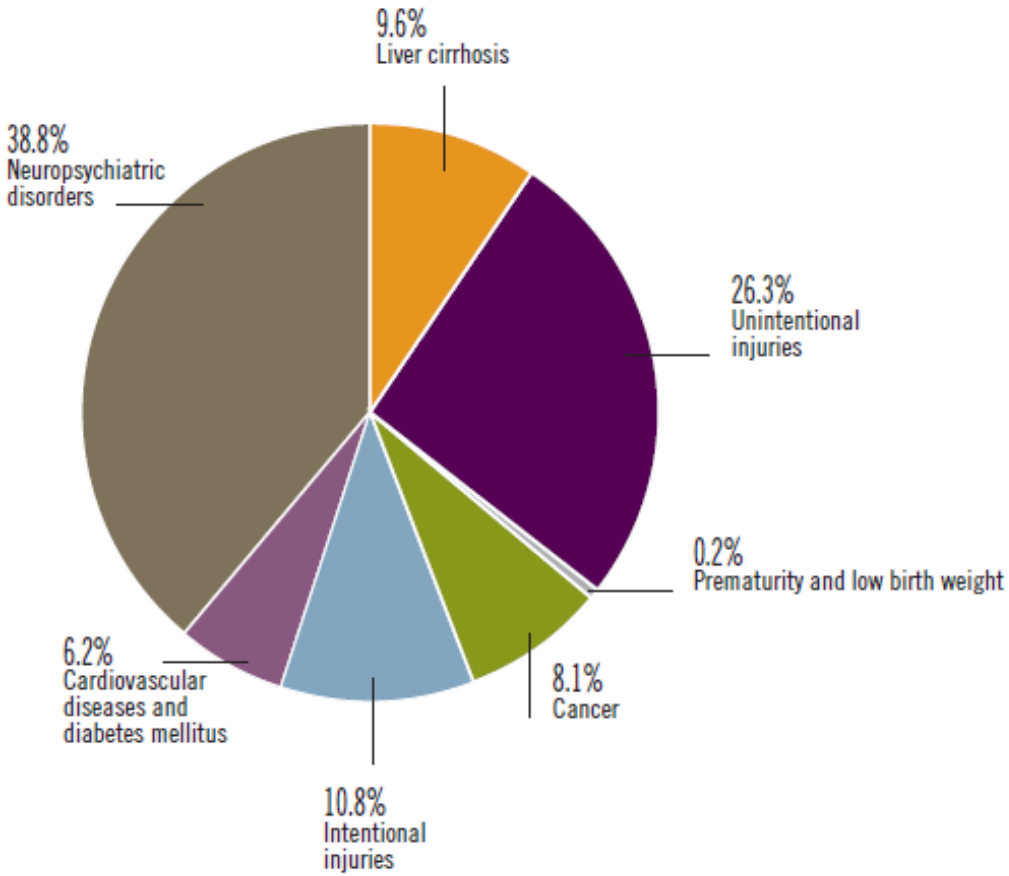
FETAL ALCOHOL SYNDROME



Alcohol-attributable deaths



Global distribution of all alcohol-attributable DALYs by disease or injury



HARM TO OTHER PEOPLE

- Social harm from drinking can be classified in terms of how they affect important roles and responsibilities of everyday life: work, family, friendship and public character. Intoxication interferes to a greater or lesser extent with most productive labour. The drinker's own productivity is reduced, and there may be adverse social consequences for the drinker, including loss of their job. The productivity of others around the drinker may be diminished if they have to take time out of their work to cover for the drinker's mistakes, absences or lateness.

HARM TO OTHER PEOPLE

- Drinking and intoxication can also adversely affect intimate and family relations, and friendships.
- There may be serious adverse immediate and long-term effects for the children because of neglect or abuse by the drinker.
- Besides the adverse social impact on family members, relatives, friends and co-workers, people's drinking can also impact on strangers, who can be victims of road traffic accidents caused by a drunk driver or be assaulted by an intoxicated person.

Range and magnitude of alcohol's harm to others in Australia in 2008

Records based

Deaths due to another's drinking	367
Hospitalizations due to another's drinking	13 699
Substantiated child protection cases involving a caregiver's drinking	19 443
Alcohol-related domestic assault in police records	24 581
Alcohol-attributable assaults in police records	69 433

HARM TO SOCIETY AT LARGE

- The studies typically do not try to disentangle who within society is paying the costs, although some separate out costs that are paid by various levels of government. In a recent analysis pulling together cost studies from four high-income countries and two middle-income countries, the total costs attributable to alcohol ranged from 1.3% to 3.3% of GDP (Rehm et al., 2009).

PREVENTIVE POLICIES AND INTERVENTIONIONS

- LEADERSHIP
- AVAILABILITY OF ALCOHOL
- PRICES AND TAXES
- DRINKING AND DRIVING
- ALCOHOL ADVERTISING AND MARKETING

LEADERSHIP

- The implications of the legal definition of an alcoholic beverage are that they set the limit for when alcohol-related restrictions on production, distribution, sales and advertising laws apply. Hence, the definition of an alcoholic beverage is an integral part of the legislation on alcohol.
- The minimum alcohol content necessary to be considered an alcoholic beverage varies from 0.0% in the Eastern Mediterranean Region, 0.7% in the South-East Asia Region, 1.1% in the Region of the Americas, 1.4% in the Western Pacifi c Region and the European Region to 1.6% in the African Region.

AVAILABILITY OF ALCOHOL

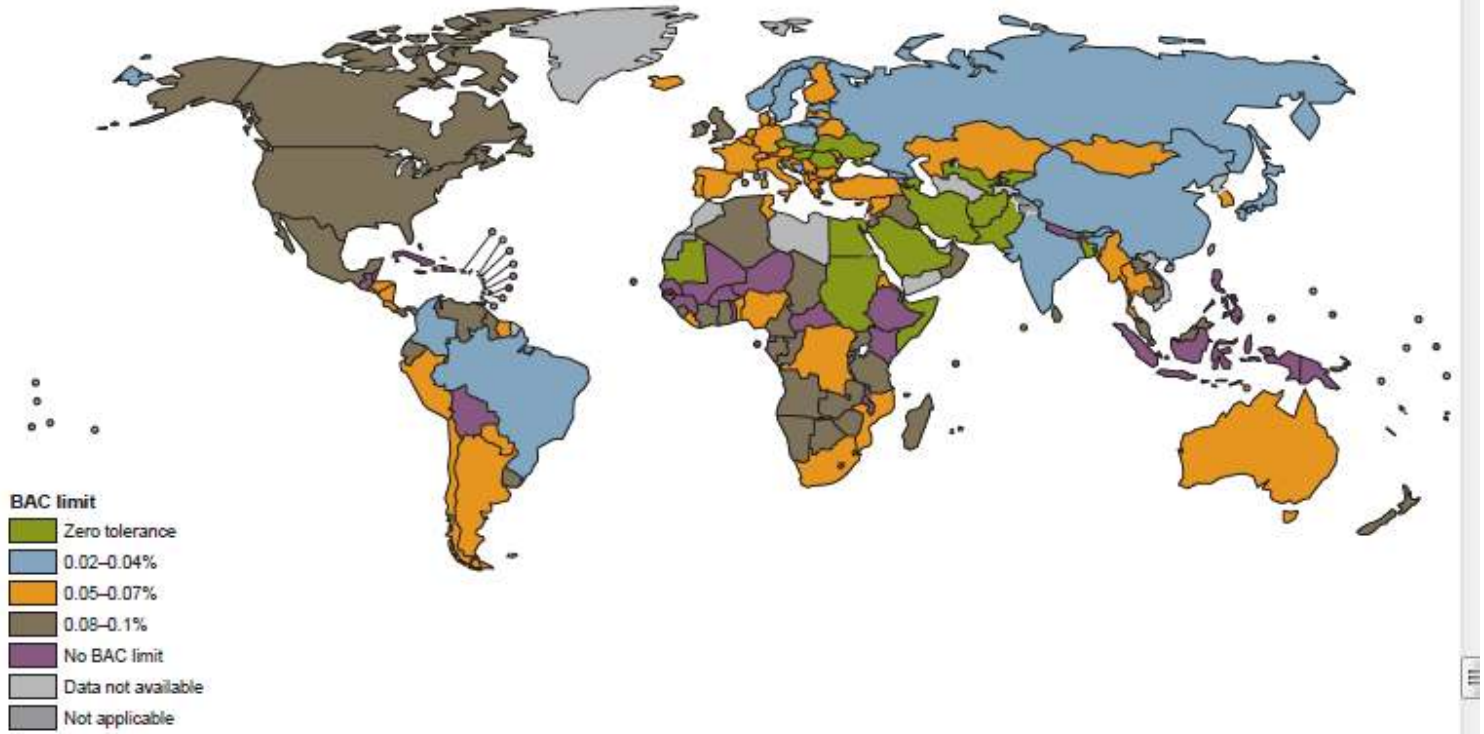
- Age limits for serving or selling alcohol by major classes of alcoholic beverages.
- Territorial restriction (pl. Sweden)
- Time restriction (after 10 pm)

PRICES AND TAXES

- One of the most effective strategies for reducing consumption of alcohol at the population level is through increasing alcohol prices, usually accomplished by raising alcohol taxes. A recent review of 112 studies of the effects of alcohol tax affirmed that when alcohol taxes go up, drinking goes down – including among problem drinkers and youth (Wagenaar et al., 2009). However, such steps can only be effective if the illegal alcohol market is under control (Room et al., 2002).

DRINKING AND DRIVING

Figure 25. Blood alcohol concentration (BAC) limits for drivers, by countries, 2008



ALCOHOL ADVERTISING AND MARKETING

- Countries use a wide range of policies to control alcohol advertising and marketing. The most common is self-regulation or co-regulation, in which the primary responsibility for regulating alcohol marketing lies with the alcoholic beverage industry itself.
- Other areas in which countries have moved to restrict alcohol marketing include bans on product placement, either on public or private television; complete or partial restrictions on industry sponsorship of sporting events; and restrictions on sales promotion in the form of sales below cost.

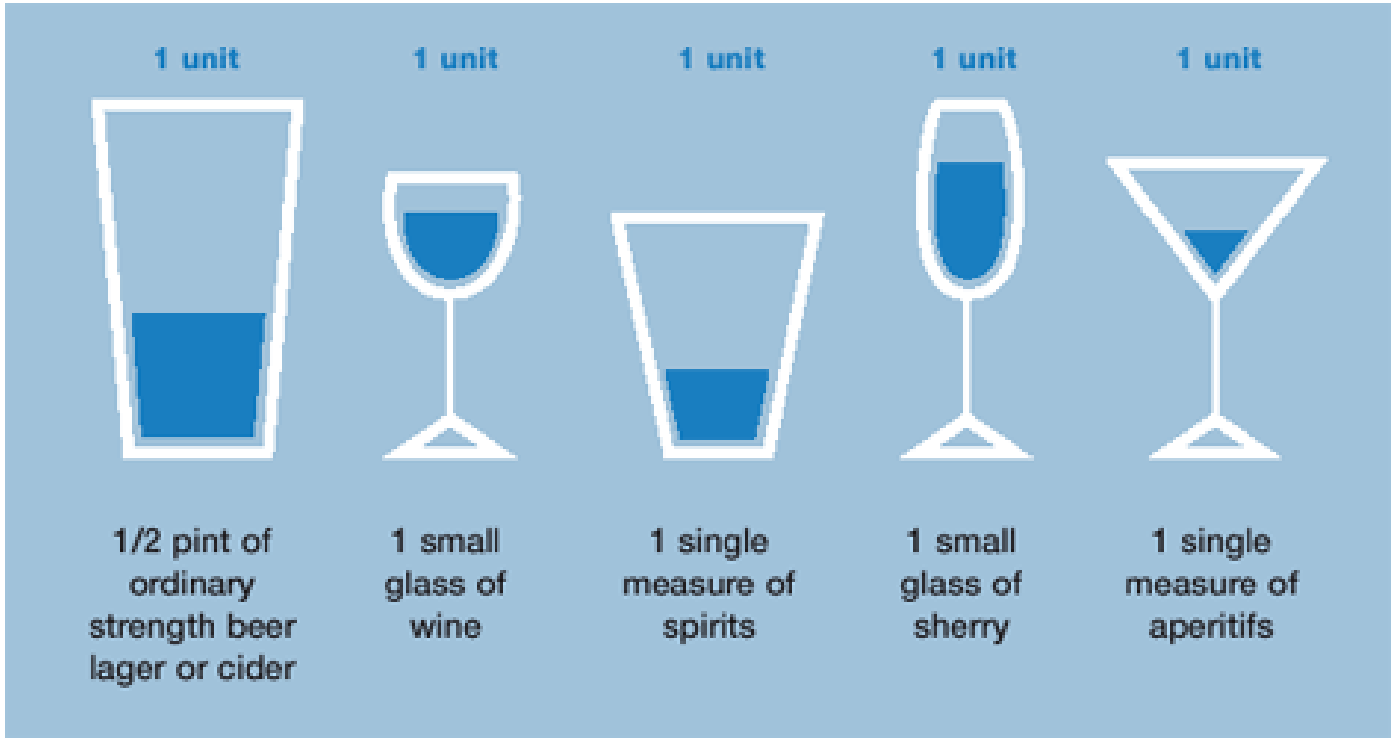
RAISING AWARENESS

- The focus of these campaigns is most frequently on drink–driving, youth drinking, alcohol and health, and social harm related to alcohol use. The “other” category most commonly included in campaigns focuses on domestic or family violence, and alcohol use.

THE DAILY LIMITS

COUNTRY	MEN	WOMEN
UK	4 units	3 units
Australia	5	5
France	5	3.75
Italy	5	5
Czech Republic	3	2
Spain	5	5
Portugal	4.6	2.3
Netherlands	5	2.5
Sweden	2.5	2.5
Canada	3.4	3.4
USA	3.5	1.75
New Zealand	7.5	5
Japan	5	5

How much is a unit?



Advices for anyone who wants to stop:

- Commit to stop drinking
- Set goals and prepare for change
- Find new meaning in life
- Handle triggers and cravings
- Get support

Commit to stop drinking

- Most people with alcohol problems do not decide to make a big change out of the blue or transform their drinking habits overnight. Recovery is usually a more gradual process. In the early stages of change, denial is a huge obstacle. Even after admitting you have a drinking problem, you may make excuses.
- Make a list of pros and cons

Set goals and prepare for change

- **Do you want to stop drinking altogether or just cut back? When do you want to stop drinking or start drinking less?**
- **Announce your goal.** Let friends, family members, and co-workers know that you're trying to stop drinking. If they drink, ask them to support your recovery by not doing so in front of you.
- **Get rid of temptations.** Remove all alcohol, barware, and other drinking reminders from your home and office.

Find new meaning in life

- **Take care of yourself.** To prevent mood swings and combat cravings, concentrate on eating right and getting plenty of sleep. Exercise is also key: it releases endorphins, relieves stress, and promotes emotional well-being.
- **Build your support network.** Surround yourself with positive influences and people who make you feel good about yourself. The more you're invested in other people and your community, the more you have to lose—which will help you stay motivated and on the recovery track.
- **Develop new activities and interests.** Find new hobbies, volunteer activities, or work that gives you a sense of meaning and purpose. When you're doing things you find fulfilling, you'll feel better about yourself and drinking will hold less appeal.
- **Continue treatment.** Your chances of staying sober improve if you are participating in a support group like Alcoholics Anonymous, have a sponsor, or are involved in therapy or an outpatient treatment program.

Handle triggers and cravings

- **Avoid the things that trigger your urge to drink.**
- **Practice saying “no” to alcohol in social situations.**
- When you’re struggling with alcohol cravings, try these strategies:
  - **Talk to someone you trust**
  - **Distract yourself until the urge passes**
  - **Remind yourself of your reasons for not drinking**

Get support

- Whether you choose to go to rehab, rely on self-help programs, get therapy, or take a self-directed treatment approach, support is essential. Don’t try to go it alone. Recovering from alcohol addiction is much easier when you have people you can lean on for encouragement, comfort, and guidance.
- Support can come from family members, friends, counselors, other recovering alcoholics, your healthcare providers, and people from your faith community.