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EDITORIAL

Remarkable Increases in Alcohol Use Disorders

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This issue of *JAMA Psychiatry* includes a timely article by Grant et al[1] that makes a compelling case that the United States is facing a crisis with alcohol use, one that is currently costly and about to get worse. The article reminds us that the chilling increases in opioid-related deaths[2] reflect a broader issue regarding additional substance-related problems.

The article by Grant et al[1] describes substantial increases in alcohol use and related problematic behaviors that occurred between the National Epidemiologic Survey on Alcohol and Related Conditions evaluations in 2001-2002 and in 2012-2013. The validity of the results is underscored by the impressive methodology, which at each time applied virtually identical well-validated face-to-face interviews and analytic approaches to about 40 000 nationally representative participants 18 years and older. The concept of high-risk drinking demanded 5 drinks per occasion for men (4 for women) at least weekly, with a standard drink defined as 14 g of ethanol, and alcohol use disorders (AUDs) were defined by the *DSM-IV*.[3]

Related article

The results documented substantial increases in the prevalence of past 12-month drinking, high-risk drinking, and AUDs. The largest increase related to the rate of the most serious problems, AUDs overall, which shot up by 49.4%, from 8.5% in 2001/2002 to 12.7% about a decade later. These figures are limited to the past 12-month, or current, diagnoses and do not include individuals who are in potentially temporary remissions. Respondents with lifetime but not current AUDs are also likely to carry future health care costs through enhanced vulnerabilities for cancers, cardiac disease, and other serious disorders associated with histories of heavy drinking.

The overall changes in prevalence over the decade were even greater for several population subgroups including women (an 83.7% increase in AUDs over the 11 years), African American individuals (a 92.8% increase in AUDs), individuals aged 45 years to 64 years and 65 years and older (with 81.5% and 106.7% increases in AUDs, respectively), those with only high school educations (a 57.8% increase in AUDs), and individuals with incomes less than $20 000 (a 65.9% increase in AUDs). During that same period, high-risk drinking, described using the previously mentioned criteria, increased from 9.7% to 12.6% (a change of 29.9%), with similar subgroups as reported for AUDs demonstrating the greatest increases. The proportion of drinkers increased from 65.4% to 72.7% (an enhancement of 11.2%). Similar results have been reported in other national surveys, indicating that the National Epidemiologic Survey on Alcohol and Related Conditions findings are not anomalies.

As noted by the authors,[1] in 2010, the cost to society for alcohol-related problems was estimated at $250 billion per year.[4] It may be too early to precisely identify future costs associated with the higher rates of problematic drinking and AUDs because most do not become apparent for years after heavier drinking begins. However, there are already signs that the changes in drinking observed since 2001-2002 may be associated with increases in alcohol-related health consequences. As highlighted by Grant et al,[1] data already indicate increases in alcohol-related cirrhosis and in hypertension as well as a levelling off of previous decreases in cardiovascular and stroke-related deaths.[5,6]

The higher rate of increase in high-risk drinking and AUDs in groups less likely to have adequate health coverage is particularly alarming. I am especially concerned about the 106% increase in AUDs for older individuals because they are likely to carry multiple preexisting medical disorders that can be exacerbated by heavier drinking. These older drinkers are also likely to be taking multiple medications that can interact adversely with alcohol, with resulting significant and costly health consequences. It is worth noting the greater-than-average increases in AUDs and related conditions in individuals with less education and lower incomes because these individuals who drink often cannot afford insurance or might have policies that severely limit or do not cover alcohol-related treatments. The 16% increase in the proportion of women who drink alcohol, 58% increase in their high-risk drinking, and the 84% higher 12-month prevalence of AUDs among women are likely to foreshadow future increases in lost time at work, suboptimal child-rearing practices, and children with fetal alcohol spectrum disorders, with potential lifelong impairments in functioning.[7] The higher rate of alcohol problems in subgroups with lower financial resources are cause for concern for humanitarian reasons alone. But even if those are set aside, the absence of easier access to medical care for individuals with long-term, often severe medical problems associated with heavier drinking is likely to result in these individuals turning to emergency departments for their treatment. That will produce subsequent increased costs to taxpayers both directly and through higher insurance rates.

This brings us to the $64-million question of what can be done to mitigate the problems and costs in the future. First, some good news. Several studies have demonstrated that it is possible to decrease the risk for future alcohol-related problems in 18-year-old students by focusing on risk factors for heavy drinking.[8] Our group delivered an intervention to 500 university freshmen through four 50-minute internet-based videos that helped students recognize their vulnerability toward heavy drinking related to a low level of response to al-

cohol and taught them how to change environmental and attitudinal mediators of how a low level of response affects future drinking quantities. The effects on drinking quantities were still significant 6 and 12 months after students viewed the last video. Other studies have identified programs that help diminish drinking during pregnancy,[9] and others have documented significant reductions in alcohol consumption after treatments.[10] These are only a few examples of ongoing hopeful developments.

There is also some disturbing news. For all the reasons stated previously, the proposed cuts to the National Institutes of Health budget being considered in Washington in 2017 are potentially disastrous for future efforts to decrease alcohol problems and are likely to result in higher costs for us all. Efforts to identify risk factors for substance-related problems and to test prevention approaches take time and money and are less likely to be funded in the current financial atmosphere. If the proposed budget prevails, the National Institutes of Health will have serious problems keeping current research going, and it will be difficult or even impossible to fund new research. In addition, most of the problems raised here will escalate further if as many as 23 million people lose health care benefits under a plan passed by the House of Representatives.

Because this is an editorial, I will close by editorializing. I feel a personal responsibility to do what I can to support politicians, regardless of whether they are Democrats, Republicans, or Independents, who recognize the benefits of research, understand the health care crises we face, and are willing to do something about it. I believe there are people in the United States who are in situations where it is hard for them to mobilize themselves to work toward avoiding future health-related problems and who do not have the financial resources to pay for their care when they need it. My view is that if we ignore these problems, they will come back to us at much higher costs through emergency department visits, impaired children who are likely to need care for many years for preventable problems, and higher costs for jails and prisons that are the last resort for help for many.

ARTICLE INFORMATION

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REFERENCES

1. Grant BF, Chou SP, Saha TD, et al. Prevalence of 12-month alcohol use, high-risk drinking, and *DSM-IV* alcohol use disorder in the United States, 2001-2002 to 2012-2013 [published online August 9, 2017]. *JAMA Psychiatry*. doi:10.1001/jamapsychiatry.2017.2161.

2. Brady KT, McCauley JL, Back SE. Prescription opioid misuse, abuse, and treatment in the United States: an update. *Am J Psychiatry*. 2016;173(1):18-26.

3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Press; 1994.

4. Sacks JJ, Gonzales KR, Bouchery EE, Tomedi LE, Brewer RD. 2010 national and state costs of excessive alcohol consumption. *Am J Prev Med*. 2015;49(5):e73-e79.

5. Yoon YH, Chen CM. *Liver Cirrhosis Mortality in the United States: National, State, and Regional Trends, 2000-2013*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism; 2016.

6. Sidney S, Quesenberry CP Jr, Jaffe MG, et al. Recent trends in cardiovascular mortality in the United States and public health goals. *JAMA Cardiol*. 2016;1(5):594-599.

7. Glass L, Moore EM, Akshoomoff N, Jones KL, Riley EP, Mattson SN. Academic difficulties in children with prenatal alcohol exposure: presence, profile, and neural correlates. *Alcohol Clin Exp Res*. 2017;41(5):1024-1034.

8. Schuckit MA, Smith TL, Clausen P, et al. The low level of response to alcohol-based heavy drinking prevention program: one-year follow-up. *J Stud Alcohol Drugs*. 2016;77(1):25-37.

9. Montag AC, Brodine SK, Alcaraz JE, et al. Preventing alcohol-exposed pregnancy among an American Indian/Alaska Native population: effect of a screening, brief intervention, and referral to treatment intervention. *Alcohol Clin Exp Res*. 2015;39(1):126-135.

10. Witkiewitz K, Hallgren KA, Kranzler HR, et al. Clinical validation of reduced alcohol consumption after treatment for alcohol dependence using the World Health Organization risk drinking levels. *Alcohol Clin Exp Res*. 2017;41(1):179-186.