America's Most Common Drug Problem? Unhealthy Alcohol Use

Few patients know about evidence-based treatment—or have or seek access to it

Overview

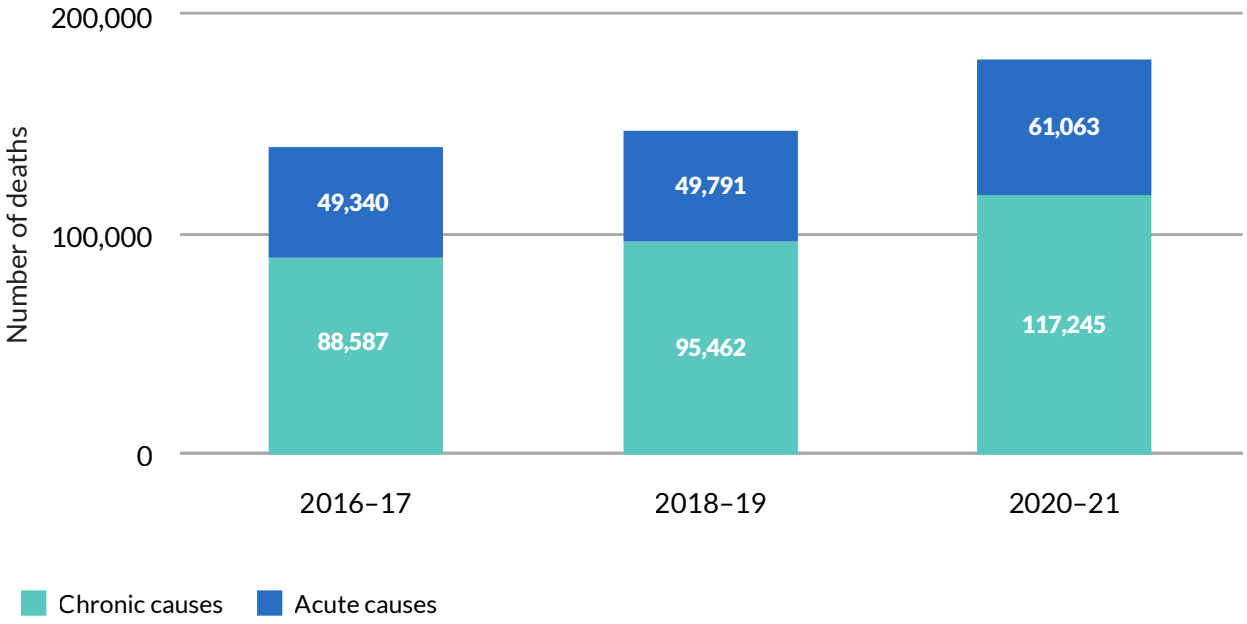
Alcohol is the leading driver of substance use-related fatalities in America: Each year, frequent or excessive drinking causes approximately 178,000 deaths.[1] Excessive alcohol use is common in the United States among people who drink: In 2022, of the 137 million Americans who reported drinking in the last 30 days, 45% reported binge drinking (five or more drinks in a sitting for men; four for women).[2] Such excessive drinking is associated with health problems such as injuries, alcohol poisoning, cardiovascular conditions, mental health problems, and certain cancers.[3]

In 2020, many people increased their drinking because of COVID-19-related stressors, including social isolation, which led to a 26% increase in alcohol-related deaths during the first year of the pandemic.[4]

Figure 1

Alcohol-Related Deaths Have Increased Since 2016

Growth is driven by increases in both acute and chronic causes of death



Notes: Chronic causes of death include illness related to excessive alcohol use such as cancer, heart disease, and stroke, and diseases of the liver, gallbladder, and pancreas. Acute causes include alcohol-related poisonings, car crashes, and suicide.

Source: Marissa B. Esser et al., "Deaths From Excessive Alcohol Use—United States, 2016-2021," *Morbidity and Mortality Weekly Report* 73, no. 8154-61, https://www.cdc.gov/mmwr/volumes/73/wr/mm7308a1.htm#T1_down

Nationwide, nearly 30 million people are estimated to have alcohol use disorder (AUD); it is the most common substance use disorder. AUD is a treatable, chronic health condition characterized by a person's inability to reduce or quit drinking despite negative social, professional, or health effects.[5] While no single cause is responsible for developing AUD, a mix of biological, psychological, and environmental factors can increase an individual's risk, including a family history of the disorder.[6]

There are well-established guidelines for AUD screening and treatment, including questions that can be asked by a person's health care team, medications approved by the U.S. Food and Drug Administration (FDA), behavioral therapies, and recovery supports, but these approaches often are not put into practice.[7] When policies encourage the adoption of screening and evidence-based medicines for AUD, particularly in primary care, the burden of alcohol-related health problems can be reduced across the country. [8]

The Spectrum of Unhealthy Alcohol Use

For adults of legal drinking age, U.S. dietary guidelines recommend that they choose not to drink or drink in moderation, defined as two drinks or fewer in a day for men, and one drink or fewer in a day for women.[9] One drink is defined as 0.6 ounces of pure alcohol—the amount in a 12-ounce beer containing 5% alcohol, a 5-ounce glass of wine containing 12% alcohol, or 1.5 ounces of 80-proof liquor.[10]

Consumption patterns exceeding these recommended levels are considered:

- **Heavy drinking,** defined by the number of drinks consumed per week: 15 or more for men, and eight or more for women.[11]
- **Binge drinking,** defined by the number of drinks consumed in a single sitting: five or more for men, and four or more for women.[12]

Alcohol use disorder is defined by *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) as having symptoms of two or more diagnostic criteria within a 12-month period.[13] The diagnostic criteria assess behaviors such as trying to stop drinking but being unable to, alcohol cravings, and the extent to which drinking interferes with an individual's life.[14] AUD can be mild (meeting two or three criteria), moderate (meeting four or five criteria), or severe (six or more criteria).[15]

Identifying and preventing AUD

Primary care providers are well positioned to recognize the signs of unsafe drinking in their patients. The U.S. Preventive Services Task Force recommends that these providers screen adults 18 years and older for alcohol misuse.[16] One commonly used evidence-based approach, SBIRT—or screening, brief intervention, and referral to treatment—is a series of steps that help providers identify and address a patient's problematic substance use.[17]

Using a screening questionnaire, a provider can determine whether a patient is at risk and, if so, can deliver periodic brief behavioral interventions in an office setting. Such interventions have been shown to reduce heavy alcohol use among adolescents, adults, and older adults.[18] When a patient meets the criteria for AUD, providers can offer medication, connect them to specialty treatment, refer them to recovery supports such as Alcoholics Anonymous or other mutual-help groups, or all of the above, depending on a patient's needs and preferences.[19] When these interventions are used in primary care settings, they can reduce heavy alcohol use.[20]

While screening for AUD is common, few providers follow up when a patient reports problematic alcohol use. From 2015 to 2019, 70% of people with AUD were asked about their alcohol use in health care settings, but just 12% of them received information or advice about reducing their alcohol use.[21] Only 5% were referred to treatment.[22]

Emergency departments (EDs) are another important setting for identifying AUD, and to maintain accreditation they are required to screen at least 80% of all patients for alcohol use.[23] Alcohol is the most common cause of substance-related ED visits, meaning many people in these settings are engaged in excessive or risky alcohol consumption and could be linked to care.[24]

The use of SBIRT in the ED can also reduce alcohol use, especially for people without severe alcohol problems.[25] Providers who use SBIRT can help patients reduce future ED visits and also some negative consequences associated with alcohol use, such as injuries.[26]

Commonly cited barriers to using SBIRT in these health care settings include competing priorities and insufficient treatment capacity in the community when patients need referrals. Conversely, SBIRT use increases with strong leadership and provider buy-in, collaboration across departments and treatment settings, and sufficient privacy to discuss substance use with patients.[27]

Jails and prisons should also screen for AUD, as well as other SUDs, to assess clinical needs and connect individuals with care. However, screening practices may not be evidence based. A review of the intake forms used to screen individuals in a sample of jails in 2018-19 found that some did not ask about SUD at all, and of those that did, they did not use validated tools accepted for use in health care and SUD treatment settings.[28]

Withdrawal management

Up to half of all people with AUD experience some withdrawal symptoms when attempting to stop drinking.[29] For many, common symptoms such as anxiety, sweating, and insomnia are mild.[30] For a small percentage, however, withdrawal can be fatal if not managed appropriately.[31] These individuals can experience seizures or a condition called alcohol withdrawal delirium (also referred to as delirium tremens), which causes patients to be confused and experience heart problems and other symptoms; if untreated, it can be fatal.[32] People with moderate withdrawal symptoms can also require medical management to address symptoms such as tremors in addition to anxiety, sweating, and insomnia.[33]

To determine whether a patient with AUD is at risk of severe withdrawal or would benefit from help managing symptoms, the American Society of Addiction Medicine recommends that providers evaluate patients with positive AUD screens for their level of withdrawal risk.[34] Based on this evaluation, providers can offer or connect patients to the appropriate level of withdrawal management.[35]

At a minimum, high-quality withdrawal management includes clinical monitoring and medications to address symptoms.[36] Providers may also offer behavioral therapies.[37] Depending on the severity of a patient's symptoms and the presence of co-occurring conditions such as severe cardiovascular or liver disease that require a higher level of care, withdrawal management can be provided on either an inpatient or an outpatient basis.[38]

According to the U.S. Department of Justice's Bureau of Justice Assistance and the National Institute of Corrections, jails should also use evidence-based standards of care to address alcohol withdrawal. These standards include screening and assessing individuals who are at risk for withdrawal and, if the jail cannot provide appropriate care, transferring them to an ED or hospital.[39]

Withdrawal management on its own is not effective in treating AUD, and without additional services after discharge, most people will return to alcohol use.[40] Because of this, providers should also connect people with follow-up care, such as residential or outpatient treatment, after withdrawal management to improve outcomes. Continued care helps patients sustain abstinence, reduces their risk of arrests and homelessness, and improves employment outcomes.[41]

Patients face multiple barriers to this follow-up care, however. For example, withdrawal management providers from the Veterans Health Administration cited long wait times for follow-up care, inadequate housing, and lack of integration between withdrawal management and outpatient services as reasons patients couldn't access services.[42] Patients have also cited barriers such as failure of the withdrawal management provider to arrange continued care, lengths of stay that were too short to allow for recovery to begin, insufficient residential treatment capacity for continued care, and inadequate housing.[43]

Promising practices for improving care continuity include: providing peer recovery coaches—people with lived expertise of substance use disorder who can help patients navigate treatment and recovery; psychosocial services that increase the motivation to continue treatment; initiating medication treatment before discharge;

reminder phone calls; and "warm handoffs," in which patients are physically accompanied from withdrawal management to the next level of care.[44]

Treating AUD

In 2023, 29 million people in the U.S. met the criteria for AUD, but less than 1 in 10 received any form of treatment.[45] Formal treatment may not be necessary for people with milder AUD and strong support systems.[46] But people who do seek out care can face a range of barriers, including stigma, lack of knowledge about what treatment looks like and where to get it, cost, lack of access, long wait times, and care that doesn't meet their cultural needs.[47]

For those who need it, AUD treatment can include a combination of behavioral, pharmacological, and social supports designed to help patients reach their recovery goals, which can range from abstaining from alcohol to reducing consumption.[48]

While for many the goal of treatment is to stop using alcohol entirely, supporting non-abstinence treatment goals is also important, because reduced alcohol consumption is associated with important health benefits such as lower blood pressure, improved liver functioning, and better mental health.[49]

Services for treating AUD—including medication and behavioral therapy—can be offered across the continuum of care, from primary care to intensive inpatient treatment, depending on a patient's individual needs.[50]

Medications

Medications for AUD help patients reduce or cease alcohol consumption based on their individual treatment goals and can help improve health outcomes.[51] Medications can be particularly helpful for people experiencing cravings or a return to drinking, or people for whom behavioral therapy alone has not been successful.[52] But medications are not often used: Of the 30 million people with AUD in 2022, approximately 2% (or 634,000 people) were treated with medication.[53]

The FDA has approved three medications to treat AUD:

- **Naltrexone** reduces cravings in people with AUD.[54] This medication is also approved to treat opioid use disorder, and because it blocks the effects of opioids and can cause opioid withdrawal, patients who use these substances must be abstinent from opioids for one to two weeks prior to starting this treatment for AUD.[55] It can be taken daily or as needed in a pill or as a monthly injection.[56] Oral naltrexone is effective at reducing the percentage of days spent drinking, the percentage of days spent drinking heavily, and a return to any drinking.[57] Injectable naltrexone can reduce the number of days spent drinking and the number of heavy drinking days.[58] Additionally, naltrexone can reduce the incidence of alcohol-associated liver disease—an often-fatal complication of heavy alcohol use—and slow the disease's progression in people who already have it.[59]
- **Acamprosate** is taken as a pill.[60] It reduces alcohol craving and helps people with AUD abstain from drinking.[61] It reduces the likelihood of a return to any drinking and number of drinking days.[62]
- **Disulfiram** deters alcohol use by inducing nausea and vomiting and other negative symptoms if a person drinks while using it.[63] It is also taken as a pill.[64] There is insufficient data to determine whether a treatment is more effective than a placebo at preventing relapses in alcohol consumption or other related issues.[65] However, for some individuals, knowing they will get sick from consuming alcohol while taking disulfiram can increase motivation to abstain.[66] As medication adherence is a challenge for patients, supervised administration of disulfiram by another person—for example, a spouse—can improve outcomes in patients who are compliant.[67]

Additionally, some medications used "off-label" (meaning they were approved for treating other conditions) have also effectively addressed AUD. A systematic review found that topiramate, a medication approved for treating epilepsy and migraines, had the strongest evidence among off-label drugs for reducing both any drinking and heavy drinking days.[68] Like naltrexone, it can reduce the incidence of alcohol-related liver disease.[69]

Despite the benefits that medications provide, they remain an underutilized tool for a variety of reasons—such as lack of knowledge among patients and providers, stigma against the use of medication, and failure of pharmacies to stock the drugs.[70]

Behavioral therapies

Behavioral therapies can also help individuals manage AUD, and they support medication adherence:

- **Motivational enhancement therapy** focuses on steering people through the stages of change[71] by reinforcing their motivation to modify personal drinking behaviors.[72]
- **Cognitive behavioral therapy** addresses people's feelings about themselves and their relationships with others and helps to identify and change negative thought patterns and behaviors related to drinking, including recognizing internal and external triggers. It focuses on developing and practicing coping strategies to manage these triggers and prevent continued alcohol use.[73]
- **Contingency management** uses positive reinforcement to motivate abstinence or other healthy behavioral changes.[74] It can help people who drink heavily to reduce their alcohol use.[75]

All of these approaches can help address AUD, and no one treatment has proved more effective than another in treating this complicated condition.[76] Combining behavioral therapies with other approaches such as medication and recovery supports, as described below, can improve their efficacy.[77]

Recovery supports

Peer support specialists and mutual-help groups can also help people achieve their personal recovery goals:

- **Peer support specialists** are individuals with lived expertise in recovery from a substance use disorder who provide a variety of nonclinical services, including emotional support and referrals to community resources.[78] The inclusion of peer support specialists in AUD treatment programs has been found to significantly reduce alcohol use and increase attendance in outpatient care.[79]
- **Mutual-help groups,** such as Alcoholics Anonymous (AA) and Self-Management and Recovery Training (SMART), support individuals dealing with a shared problem. People may seek out these groups more than behavioral or medication treatment for AUD because they can join on their own time and at no cost, and they may better cater to people's needs related to varying gender identities, ages, or races.[80] Observational research shows that voluntary attendance at peer-led AA groups can be as effective as behavioral treatments in reducing drinking.[81]

People with AUD can use recovery supports on their own, in combination with behavioral treatment or medication, or as a method to maintain recovery when leaving residential treatment or withdrawal management.[82]

Disparities in alcohol-related deaths and treatment access

While the U.S. records more than 178,000 alcohol-related deaths each year, some populations have a higher risk of alcohol-related deaths, and others face greater barriers to treatment.[83]

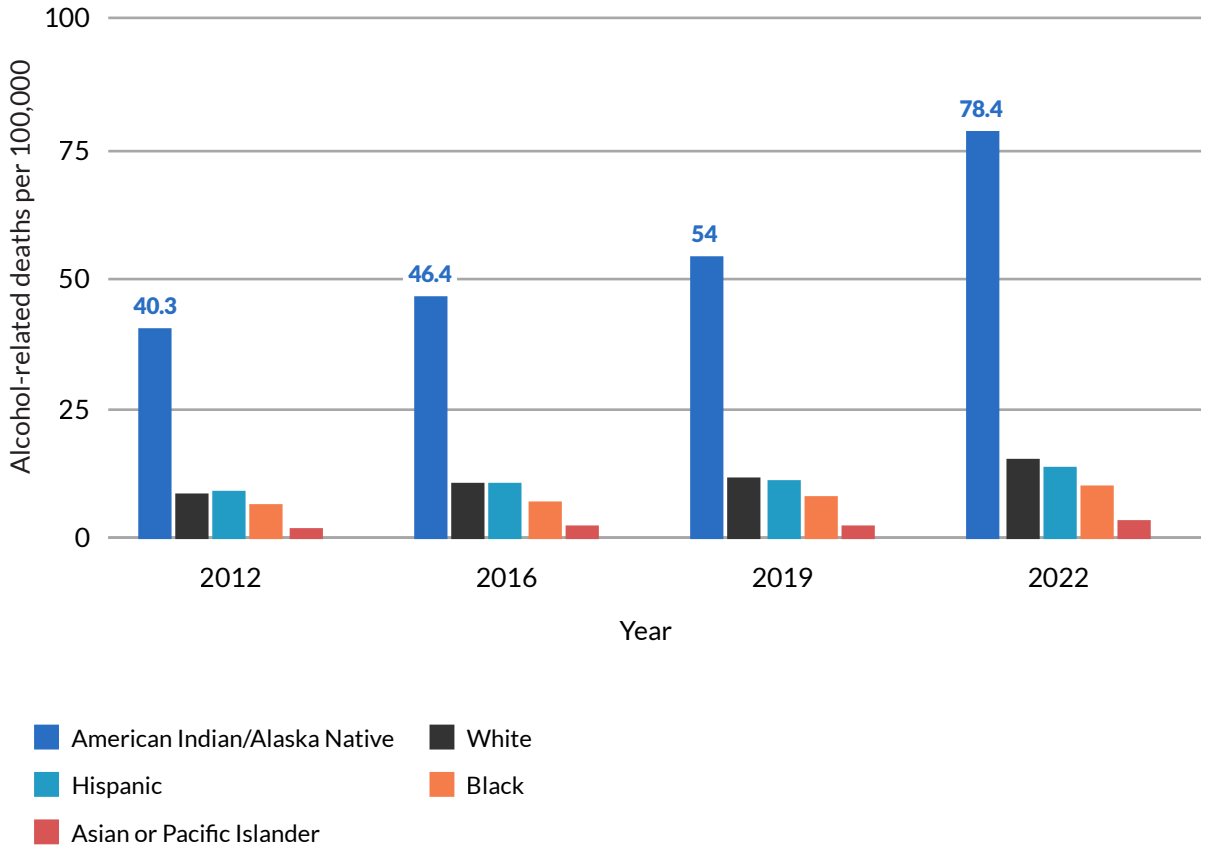
American Indian and Alaska Native communities

Despite seeking treatment at higher rates than other racial/ethnic groups, American Indian and Alaska Native people have the highest rate of alcohol-related deaths.[84]

Figure 2

American Indian and Alaska Native Individuals Have Persistently Higher Alcohol-Related Death Rates Compared With Other Racial and Ethnic Groups

Alcohol-related deaths per 100,000 people



Source: KFF analysis of CDC National Center for Health Statistics Multiple Cause of Death 1999-2020, 2018-2022, https://www.kff.org/mental-health/issue-brief/a-look-at-the-latest-alcohol-death-data-and-change-over-the-last-decade/

Risk factors that impact these communities and can contribute to these deaths include historical and ongoing trauma from colonization, the challenges of navigating both native and mainstream American cultural contexts, poverty resulting from forced relocation, and higher rates of mental health conditions than in the general population.[85] Substances, including alcohol, are sometimes used to cope with these challenges.[86]

However, American Indian/Alaska Native communities also have rich protective factors such as their cultures, languages, traditions, and connections to elders, which can help reduce negative outcomes associated with alcohol use, especially when treatment services incorporate and build on these strengths.[87]

For example, interviews with American Indian/Alaska Native patients with AUD in the Pacific Northwest revealed that many participants preferred Native-led treatment environments that incorporated traditional healing practices and recommended the expansion of such services.[88]

To improve alcohol-related outcomes for American Indians and Alaska Natives, policymakers and health care providers must develop a greater understanding of the barriers and strengths of these diverse communities and support the development of culturally and linguistically appropriate services. The federal Department of Health and Human Services Office of Minority Health defines such an approach as "services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients."[89]

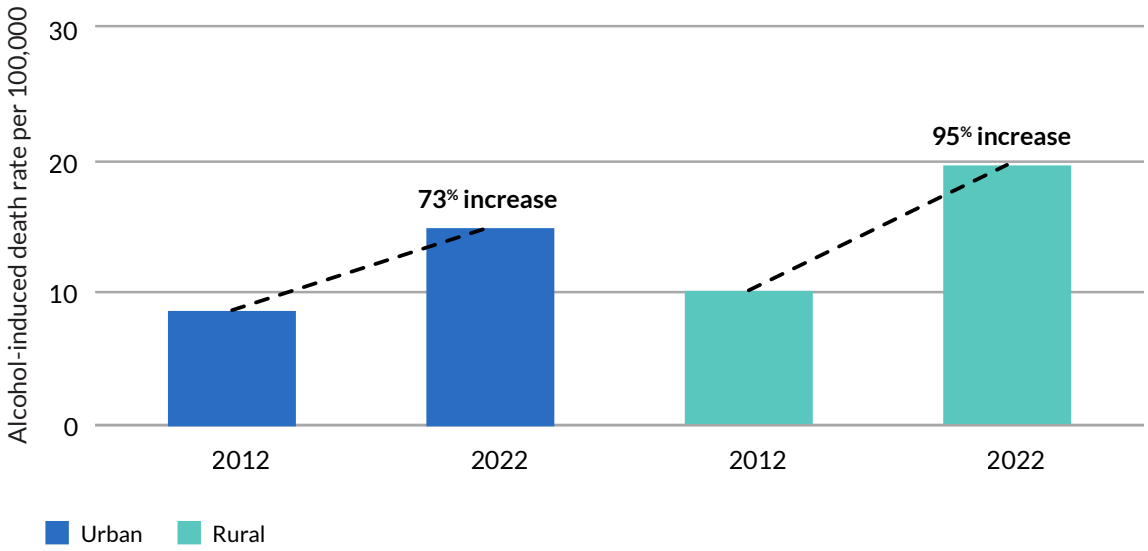
People living in rural areas

Rural communities are another group disproportionately affected by AUD. People living in rural areas have higher alcohol-related mortality rates than urban residents but are often less likely to receive care.[90] They face treatment challenges including limited options for care; concerns about privacy while navigating treatment in small, close-knit communities; and transportation barriers.[91]

Figure 3

Alcohol-Related Deaths Have Increased Faster in Rural Areas

2012-22 change in alcohol-induced death rate per 100,000 by urban and rural areas



Source: KFF analysis of CDC National Center for Health Statistics Multiple Cause of Death 1999-2020, 2018-22, https://www.kff.org/mental-health/issue-brief/a-look-at-the-latest-alcohol-death-data-and-change-over-the-last-decade/

Telemedicine can help mitigate these barriers to care.[92] Cognitive behavioral therapy and medications for AUD can be delivered effectively in virtual settings.[93] People with AUD can also benefit from virtual mutual-help meetings, though some find greater value in face-to-face gatherings.[94]

Despite the value of virtual care delivery, people living in rural areas also often have limited access to broadband internet, which can make these interventions challenging to use.[95] Because of this, better access to in-person care is also needed.

Next steps

To improve screening and treatment for patients with AUD, policymakers, payers, and providers should consider strategies to:

- **Conduct universal screenings for unhealthy alcohol use and appropriately follow up when those screenings indicate a problem.** Less than 20% of people with AUD proactively seek care, so health care providers shouldn't wait for patients to ask them for help.[96]
- **Connect people with continued care after withdrawal management so that they can begin their recovery.** People leaving withdrawal management settings should have a treatment plan that meets their needs—whether that's behavioral treatment, recovery supports, medication, or a combination of these approaches.
- **Further the use of medications for AUD.** With just 2% of people with AUD receiving medication, significant opportunities exist to increase utilization and improve outcomes.[97]
- **Address disparities through culturally competent treatment and increased access in rural areas.** The populations most impacted by AUD should have access to care that meets their needs and preferences.

AUD is a common and treatable health condition that often goes unrecognized or unaddressed. Policymakers can improve the health of their communities by supporting providers in increasing the use of evidence-based treatment approaches.[98]

If you are concerned about your alcohol consumption, you can use the Check Your Drinking tool created by the Centers for Disease Control and Prevention to assess your drinking levels and make a plan to reduce your use.

Endnotes

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