Co-Occurring Disorder-Related Quick Facts:
ALCOHOL

Alcohol: Worldwide, alcohol contributes to approximately one out of every 30 deaths. Alcohol use produces four percent of the total Disability-Adjusted Life Years (DALY), a summary measure that combines the impact of illness, disability, and mortality on population health. In developed countries, alcohol consumption is the third largest risk factor for disease burden. About one fourth of esophageal and liver cancers, cirrhosis, homicides, seizures, and motor vehicle accidents are estimated to be caused by alcohol.[1]

In the United States, about two out of every three adults (18 years of age or older) report having had at least one drink in the past year. Of these adults, roughly 62 percent report light drinking (three or fewer drinks per week on average), 21 percent report moderate drinking (more than three drinks per week on average -- up to seven for women and up to 14 for men), and 16 percent report heavy drinking (averaging more than one drink per day for women and two drinks per day for men).[2]

Every member of a family will experience the negative consequences of alcohol in some way at some point—from the effects of drinking during pregnancy to the higher risks of violent crimes, economic loss, depression, and adult dementia.[3]

Epidemiology: Conducted a decade apart, two national surveys (the National Longitudinal Alcohol Epidemiologic Survey and the National Epidemiologic Survey on Alcohol and Related Conditions [NESARC]), suggest that the 12-month prevalence rates for adult alcohol abuse and dependence rose from 7.41 percent in the early 1990s to 8.46 percent 10 years later.[4] The National Comorbidity Survey Replication (NCS-R), conducted in the early 2000s on adults ages 18 years and older, found a 12-month abuse and dependence prevalence rate of 3.1 percent and a lifetime prevalence rate of 13.2 percent (N=5692).[5] Rate differences between NCS-R and NESARC may be attributable to the differences in survey methodologies and definitions. However, it is clear that the use, misuse, abuse, and dependence on alcohol present considerable challenges for the health care system.

Numerous studies have attempted to estimate the rates of alcohol use disorders (AUDs) in homeless populations, with rates for men reported as high as 68 percent and as low as 29.3 percent and for women as high as 41 percent and as low as 19 percent.[6] However, given the difficulty of reaching and/or diagnosing people who are homeless, most studies are dependent on convenience samples. The setting has a large impact on the rates found (e.g., the low lifetime prevalence rate of 29.3 percent found in a presumably drug and alcohol-free sheltered facility for the homeless in Rhode Island is much lower than the 48.4 percent found among homeless youth in California).[6] Further, among homeless individuals, the use of a particular drug (alcohol or any other) is likely to be more dependent upon local availability. For many of the homeless persons also suffering from mental disorders and other medical problems, almost any substance use would constitute abuse. The studies of Carol North and her colleagues show that the rate of homeless persons with both an SUD and an Axis I disorder increased from the 1990's to the

2000's at an astounding rate (14.3% in 1990 to 36.7% in 2000 for women; 23.2% in 1990 to 32.2% in 2000 for men).[7]

Rates of regular heavy drinking (five or more drinks for men or four or more for women in a single day, on 12 or more days during the past year) were also found to be high for respondents who had a past year major depression (9%) or specific phobia (8.3%). Respondents with lifetime antisocial, obsessive-compulsive, and paranoid personality disorders also showed regular heavy drinking patterns (8.7%, 8.9%, and 7%, respectively).[2] In general, the national estimates for those adults with a co-occurring SUD and a mental disorder range from 5.2 million to 6.6 million.[8]

Treatment: Treatment for alcohol ranges from emergency care for acute alcohol poisoning and other alcohol-related medical conditions (including detoxification) to inpatient and outpatient psychosocial modalities. Self-help groups and other community and social support networks (from drug courts to spiritual resources) play significant roles in influencing alcohol use and fostering recovery. Major developments within the alcohol treatment community include the focus on evidence-based decisionmaking and psychopharmacological adjuvants.

The National Institute on Alcohol Abuse and Alcoholism's (NIAAA's) Project MATCH (Matching Alcoholism Treatments to Client Heterogeneity) showed that cognitive-behavioral, motivational enhancement, and 12-step facilitation treatment were all effective in reducing drinking and that results were sustained over the three-year follow-up. Project MATCH gave rise to additional studies of 12-step facilitation and the role of Alcoholics Anonymous (AA) attendance in terms of outcomes. One Veterans Affairs (VA) study that assigned patients (without random assignment) to either 12-step, cognitive–behavioral, or a mixture of the two found that after one year, 25 percent of the 12-step, and 18 and 20 percent, respectively, of the other two approaches were abstinent. Another study found that five patient characteristics were associated with stronger affiliation with AA and better outcomes: self-efficacy, commitment to abstinence, cognitive coping, behavioral coping, and primary appraisal of harm due to drinking.[3]

Several studies have examined new pharmacological agents used as part of a holistic approach with traditional psychosocial treatments. Dozens of studies assessed the role of medications in the care of people with co-occurring disorders (COD), especially alcohol use disorders and mood disorders, but including substance use disorders (SUDs) co-occurring with schizophrenia or with anxiety disorders, such as posttraumatic stress disorders. Although there is some evidence that adjuvant medications might help reduce cravings and/or improve drinking-related outcome measures, the use of such medications (except for disulfiram) is relatively new in alcohol use disorder treatment and so far fairly limited. According to Schuckit: "…more studies will be required evaluating larger numbers of individuals over a longer period of time before final conclusions can be drawn regarding the general applicability of opioid antagonists in treating alcohol dependence."[9]

Major SAMHSA Activities/Resources:

- U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Report to Congress on the Prevention and Reduction of Underage Drinking,* Terry L. Cline, Ph.D., Administrator, SAMHSA, Publications Date To Be Determined.

- 2007 Surgeon General's Report on Alcohol—Underage Drinking: http://www.surgeongeneral.gov/topics/underagedrinking/calltoaction.pdf

- SAMHSA OAS Alcohol Studies on Alcohol:
    - http://www.oas.samhsa.gov/

- NCADI List of Publications on Alcohol: http://ncadistore.samhsa.gov/catalog/results.aspx?topic=3&h=

- SAMHSA Fetal Alcohol Spectrum Disorder:
    - http://www.fasdcenter.samhsa.gov/

- SAMHSA Campaign to Stop Underage Drinking: http://www.stopalcoholabuse.gov/

- SAMHSA Treatment Improvement Protocol (TIP) Series:
    - http://kap.samhsa.gov/products/manuals/tips/index.htm

- SAMHSA TAP Series list http://kap.samhsa.gov/products/manuals/taps/index.htm

- SAMHSA NREPP Alcohol Related Programs: http://nrepp.samhsa.gov/listofprograms.asp?textsearch=alcohol&ShowHide=1&Sort=A1

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