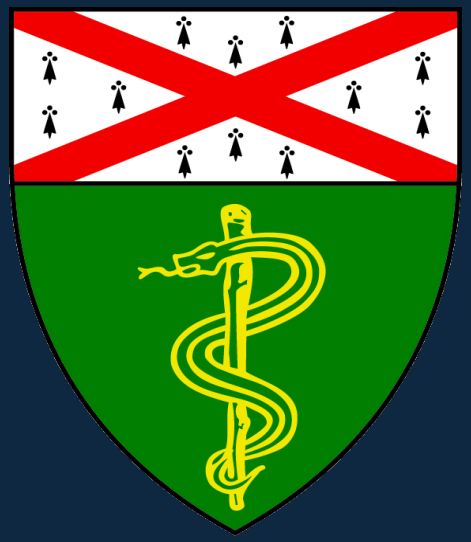
Medications for Alcohol Use Disorder

Srinivas Muvvala, MD MPH

January 16, 2026



Yale SCHOOL OF MEDICINE

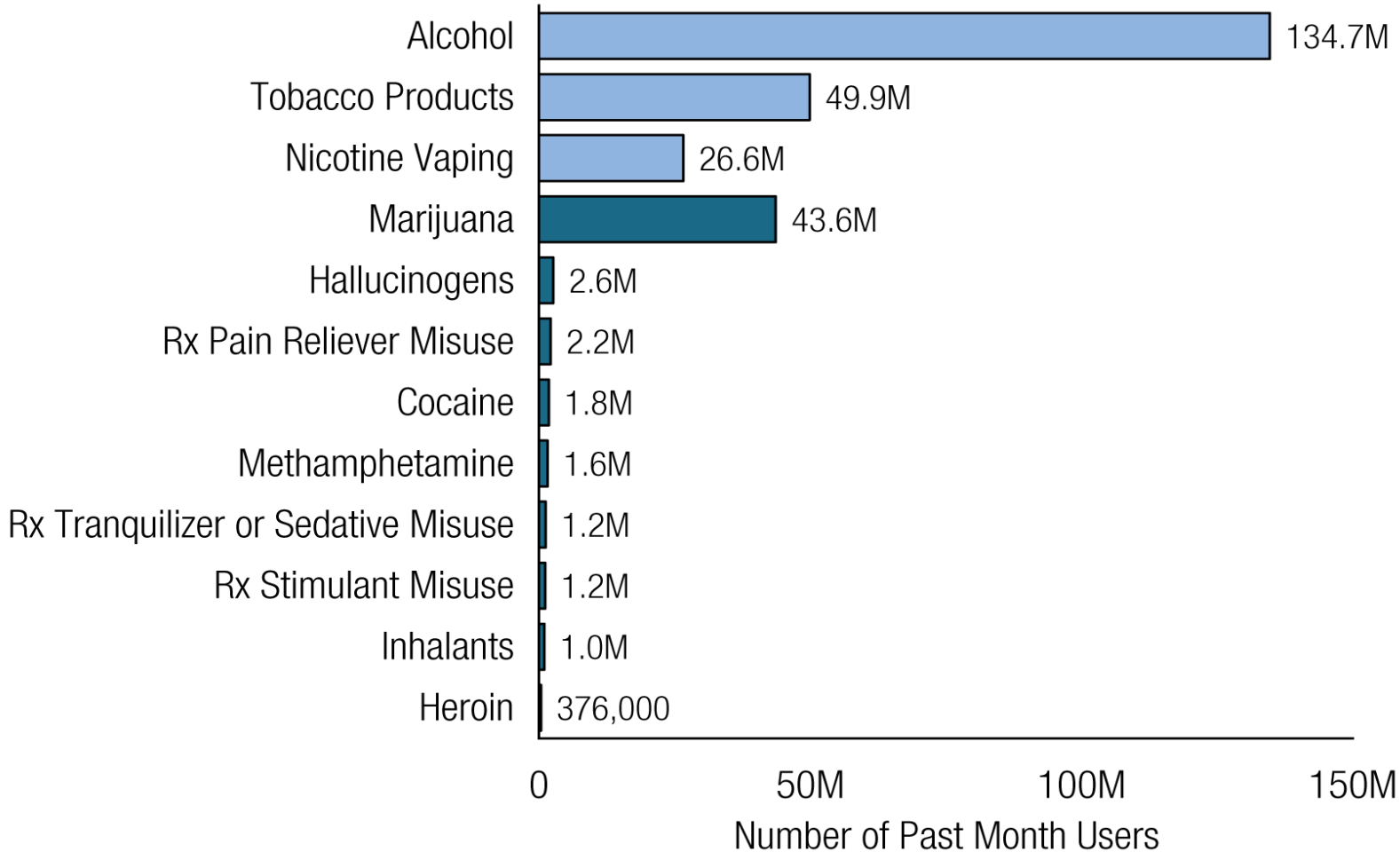
Professional & Financial Disclosures

- No conflicts of interest

Learning Objectives

- At the end of this presentation, participants will be able to:
  - Discuss helpful medications for the treatment of Alcohol Use Disorder (AUD)
  - Enumerate the mechanisms of action and common side effects of medications for AUD
  - Identify the need to integrate AUD treatment into mental health
  - Discuss psychopharmacological interventions for patients with comorbid disorders

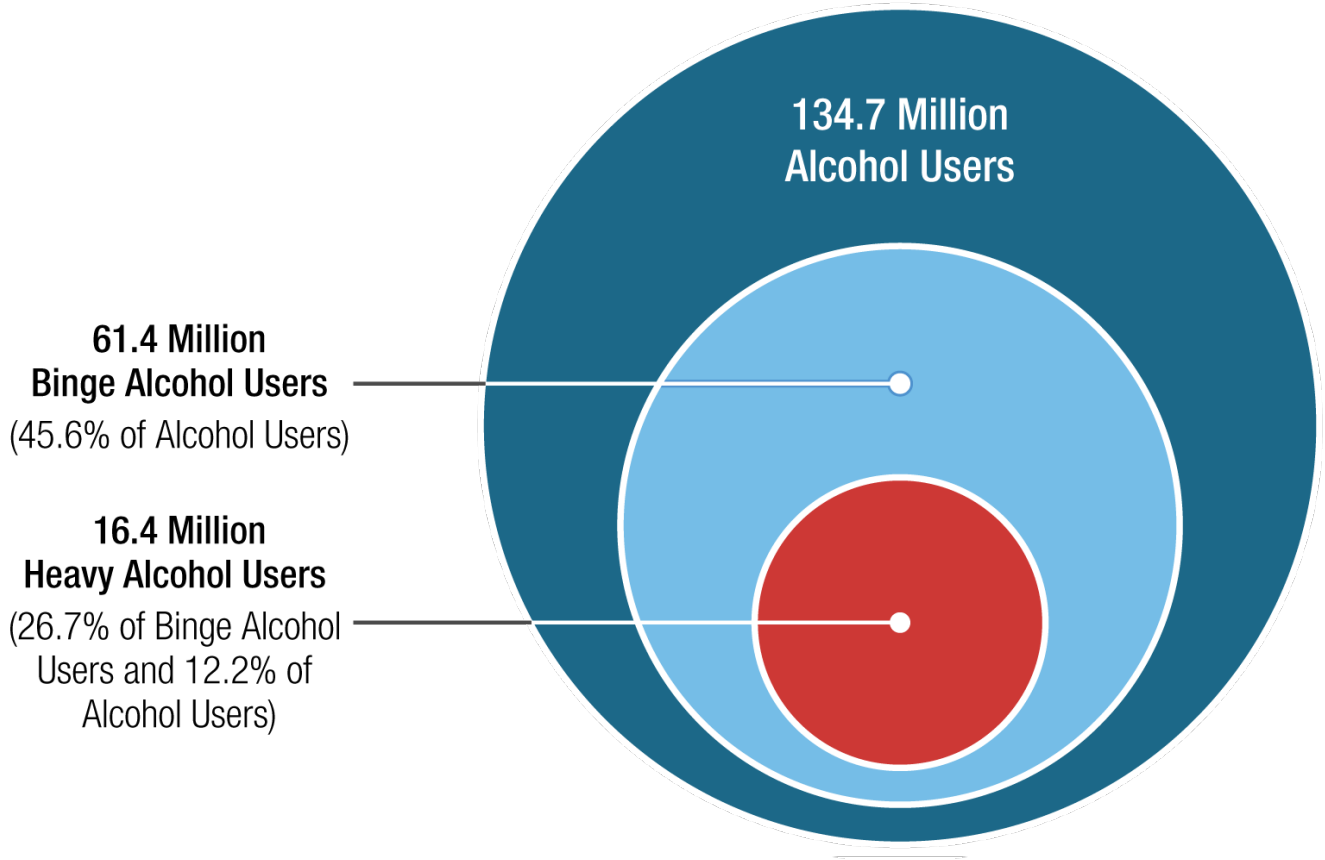
Past Month Substance Use: Among People Aged 12 or Older; 2023 National Survey on Drug Use and Health (NSDUH) annual report



Rx = prescription.

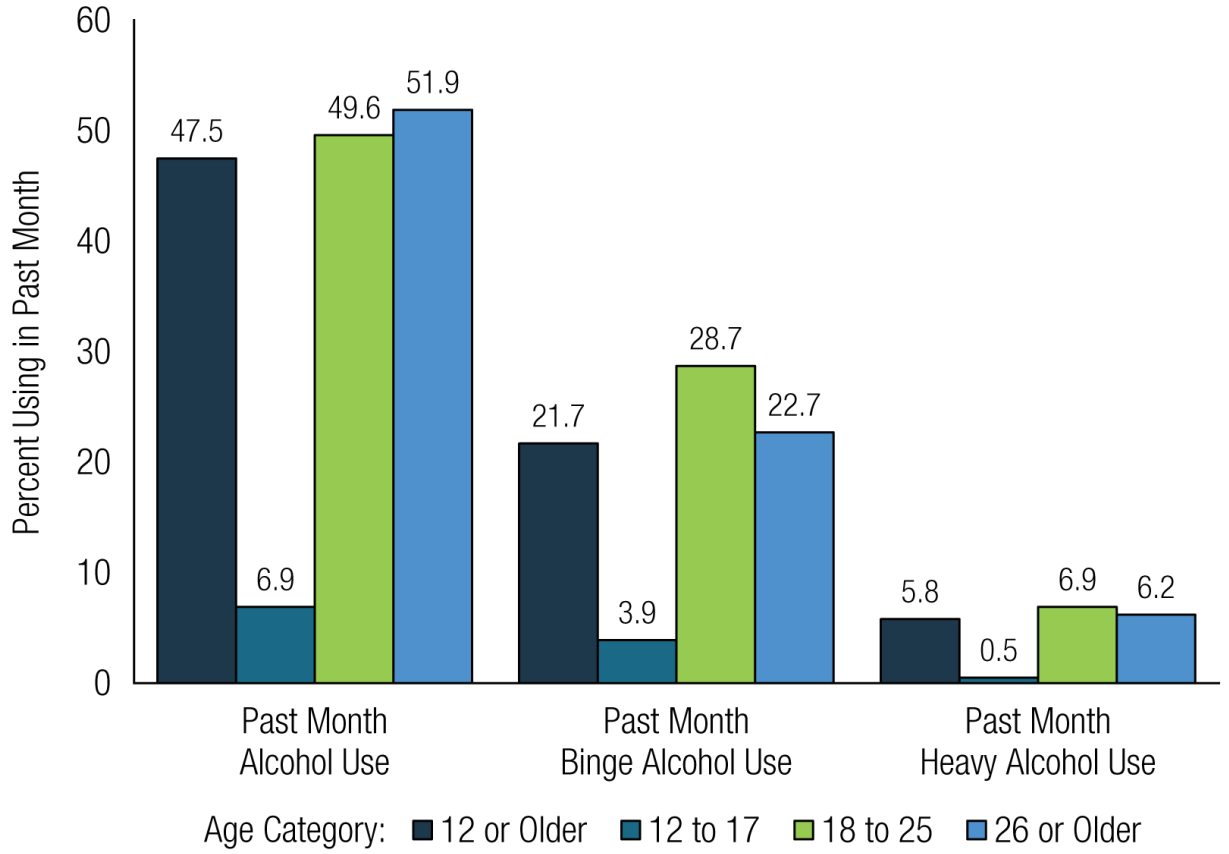
Note: The estimated numbers of current users of different substances are not mutually exclusive because people could have used more than one type of substance in the past month.

Past Month Alcohol Use, Past Month Binge Alcohol Use, or Past Month Heavy Alcohol Use: Among People Aged 12 or Older; 2023 National Survey on Drug Use and Health (NSDUH) annual report



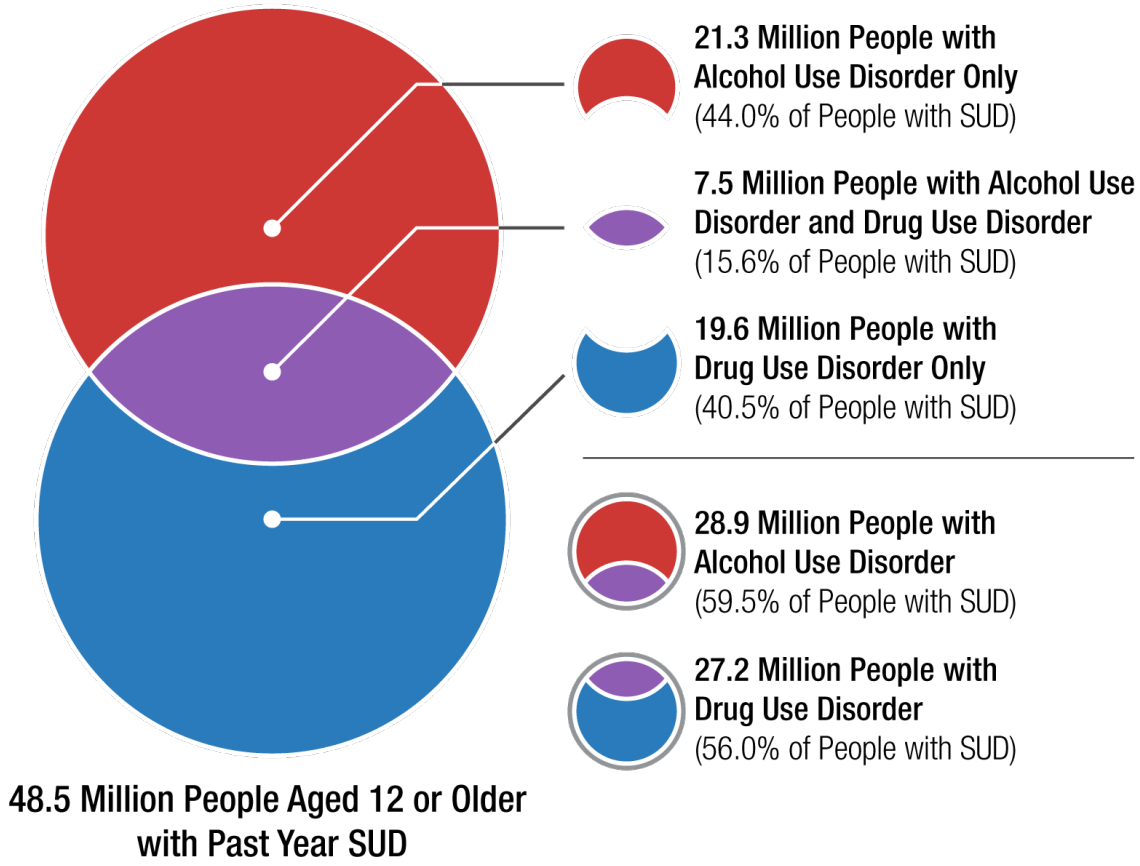
Note: Binge Alcohol Use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as binge drinking on the same occasion on 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Past Month Alcohol Use, Past Month Binge Alcohol Use, or Past Month Heavy Alcohol Use: Among People Aged 12 or Older; 2023 National Survey on Drug Use and Health (NSDUH) annual report



Note: Binge Alcohol Use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion on at least 1 day in the past 30 days.
Heavy Alcohol Use is defined as binge drinking on the same occasion on 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Alcohol Use Disorder or Drug Use Disorder in the Past Year: Among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD);
2023 National Survey on Drug Use and Health (NSDUH) annual report

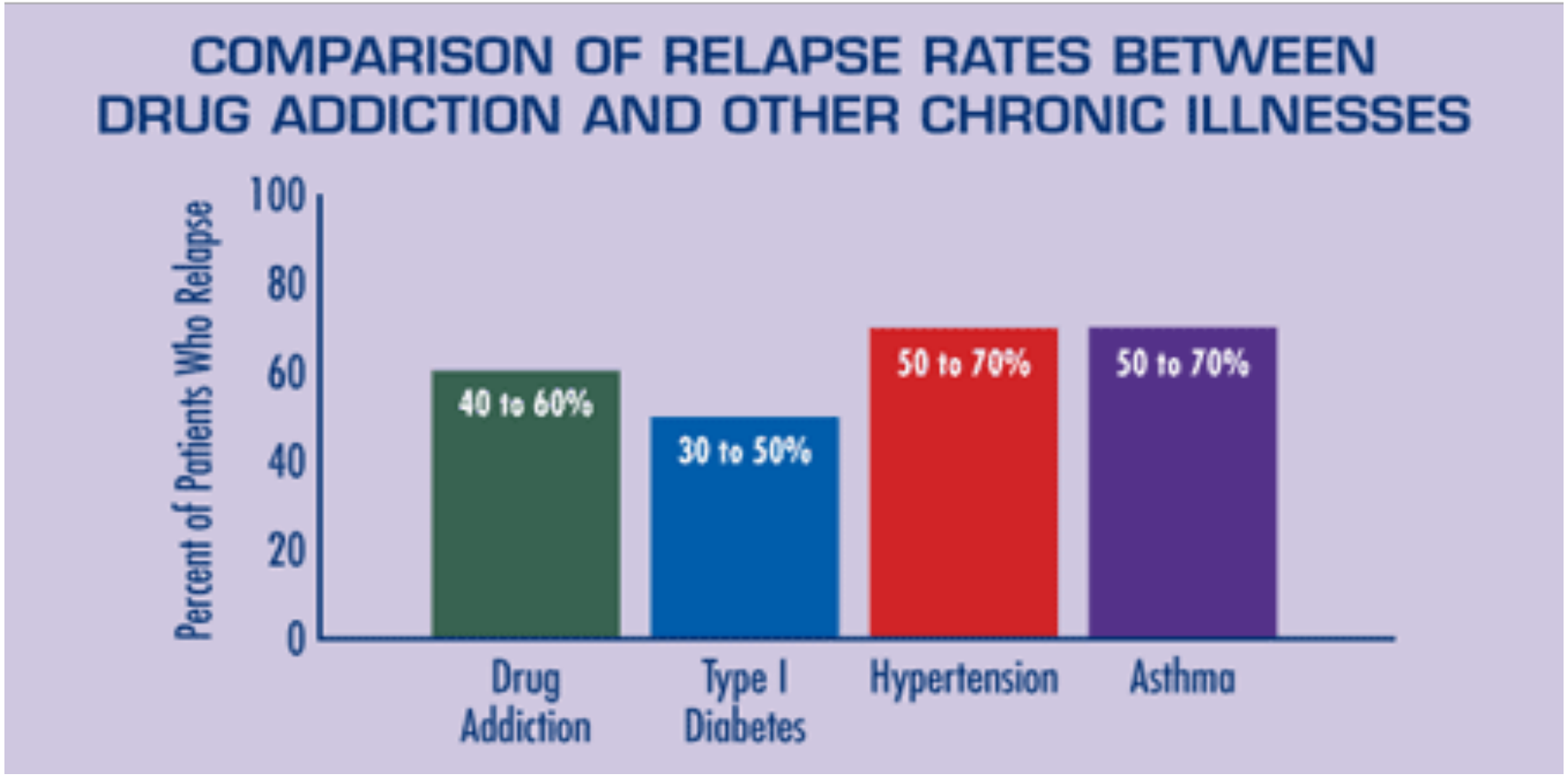


Note: Drug Use Disorder includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives).

The Problem

- Only one in ten people with addiction receive care
- 5.7% with AMI and SUD receive both treatments

SAMSHA 2021



McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA. 2000 Oct 4;284(13):1689-95.

CNN health Life, But Better Fitness Food Sleep Mindfulness Relationships

1 in 5 deaths of US adults 20 to 49 is from excessive drinking, study shows

By Madeline Holcombe, CNN
Published 3:56 PM EDT, Tue November 1, 2022

JAMA Network Open

Original Investigation | Substance Use and Addiction

Estimated Deaths Attributable to Excessive Alcohol Use Among US Adults Aged 20 to 64 Years, 2015 to 2019

Marissa B. Esser, PhD; Gregory Leung, PhD; Adam Sherk, PhD; Michele K. Bohm, MPH; Yong Liu, MD; Hua Lu, MS; Timothy S. Naimi, MD

Abstract

IMPORTANCE Alcohol consumption is a leading preventable cause of death in the US, and death rates from fully alcohol-attributable causes (eg, alcoholic liver disease) have increased in the past decade, including among adults aged 20 to 64 years. However, a comprehensive assessment of alcohol-attributable deaths among this population, including from partially alcohol-attributable causes, is lacking.

Key Points

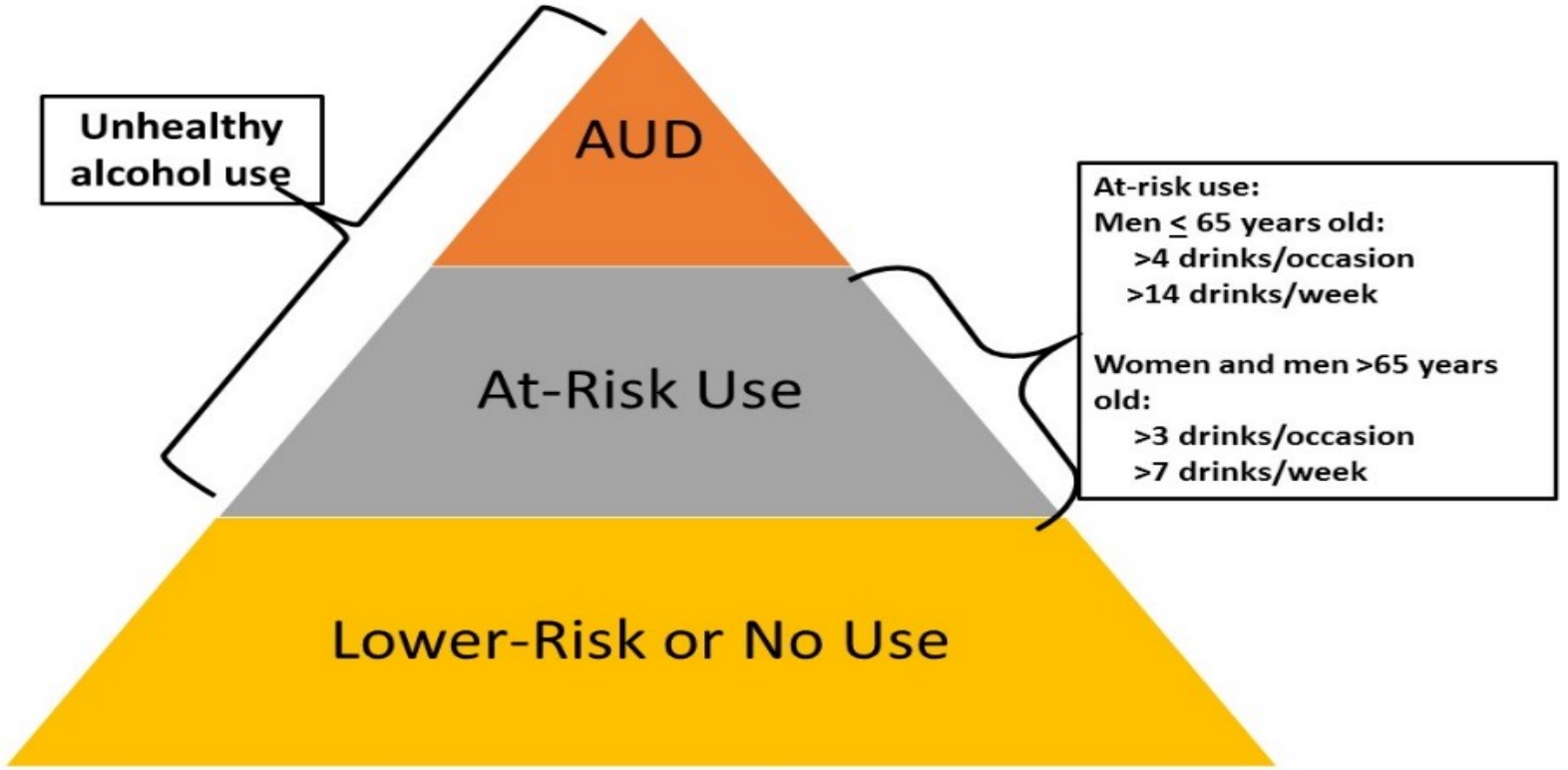
Question What is the estim
proportion of deaths among
aged 20 to 64 years attribu
excessive alcohol consump
there differences by sex, ag
US state?

What defines at-risk alcohol use?

	Drinks/ day	Drinks/ week
Men	> 4	> 14
Women	> 3	> 7
All Age >65	> 3	> 7

1 drink =

Spectrum of Alcohol Use



Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Alcohol brief intervention, specialty treatment and drinking outcomes at 12 months: Results from a systematic alcohol screening and brief intervention initiative in adult primary care

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ARTICLE INFO

Keywords:
Unhealthy alcohol use
Alcohol brief intervention
Systematic primary care-based SBIRT
Electronic health records
Causal inference
Effect heterogeneity

ABSTRACT

Background: Alcohol screening, brief intervention and referral to treatment (SBIRT) in adult primary care is an evidence-based, public health strategy to address unhealthy alcohol use, but evidence of effectiveness of alcohol brief intervention (ABI) in real-world implementation is lacking.

Methods: We fit marginal structural models with inverse probability weighting to estimate the causal effects of ABI on 12-month drinking outcomes using longitudinal electronic health records data for 312,056 adults with a positive screening result for unhealthy drinking between 2014 and 2017 in a large healthcare system that implemented systematic primary care-based SBIRT. We examined effects of ABI with and without adjusting for receipt of specialty alcohol use disorder (AUD) treatment, and whether effects varied by patient demographic characteristics and alcohol use patterns.

Results: Receiving ABI resulted in significantly greater reductions in heavy drinking days (mean difference [95% CI] = −0.26 [−0.45, −0.08]), drinking days per week (−0.04 [−0.07, −0.01]), drinks per drinking day (−0.05 [−0.08, −0.02]) and drinks per week (−0.16 [−0.27, −0.04]). Effects of ABI on 12-month drinking outcomes varied by baseline consumption level, age group and whether patients already had an AUD, with better improvement in those who were drinking at levels exceeding only daily limits, younger, and without an AUD.

Conclusions: Systematic ABI in adult primary care has the potential to reduce drinking among people with unhealthy drinking considerably on both an individual and population level. More research is needed to help optimize ABI, in particular tailoring it to diverse sub-populations, and studying its long-term public health impact.

Key Treatment Steps & Principles:

1. **Comprehensive Assessment:** Evaluate alcohol/substance use patterns, severity, co-occurring mental health/medical conditions, and social factors.
2. **Collaborative Goal Setting:** Clinician and patient agree on individualized goals, which can be complete abstinence or moderate drinking (harm reduction), documented in the record.
3. **Evidence-Based Therapies:**
    1. **Behavioral Therapies: Cognitive Behavioral Therapy (CBT) for coping skills, Motivational Enhancement Therapy (MET) to build motivation, and 12-Step Facilitation (12-SF) for community support.**
    2. **Pharmacotherapy: FDA-approved medications like naltrexone and acamprosate, often combined with therapy, can significantly help.**
4. **Person-Centered Planning:** Develop a plan integrating non-pharmacological (therapy) and pharmacological treatments, adjusting as needed.
5. **Address Co-occurring Conditions:** Treat any other psychiatric or medical disorders alongside AUD.
6. **Promote Lifestyle Changes:** Encourage healthy habits, build supportive social networks, and find alcohol-free activities.

APA Recommendations Highlight:

- **Individualization:** Goals and treatment approaches must fit the patient's needs and preferences.
- **Harm Reduction:** Acknowledges that reducing drinking, not just stopping, can improve health for some individuals.
- **Integration:** Combines therapy, medication, and peer support for comprehensive care.

Reus VI, Fochtmann LJ, Bukstein O, Eyler AE, Hilty DM, Horvitz-Lennon M, Mahoney J, Pasic J, Weaver M, Wills CD, McIntyre J, Kidd J, Yager J, Hong SH. The American Psychiatric Association Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder. Am J Psychiatry. 2018 Jan 1;175(1):86-90. doi: 10.1176/appi.ajp.2017.1750101. PMID: 29301420.

Screening: AUDIT-C

Scored on scale of 0-12

Men- 4 or more = positive

Women – 3 or more = positive

1. How often do you have a drink containing alcohol?

- A. never
- B. monthly or less
- C. 2-4 times a month
- D. 2-3 times a week
- E. 4 or more times a week

2. How many standard drinks containing alcohol do you have per week?

- A. 1 or 2
- B. 3 or 4
- C. 5 or 6
- D. 7 or 9
- E. 10 or more

3. How often do you have six or more drinks on one occasions?

- A. never
- B. less than monthly
- C. monthly
- D. weekly
- E. daily or almost daily

Bush K, Kivlahan DR, McDonell MB, Fihn SD, Bradley KA. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Alcohol Use Disorders Identification Test. Arch Intern Med. 1998 Sep 14;158(16):1789-95.

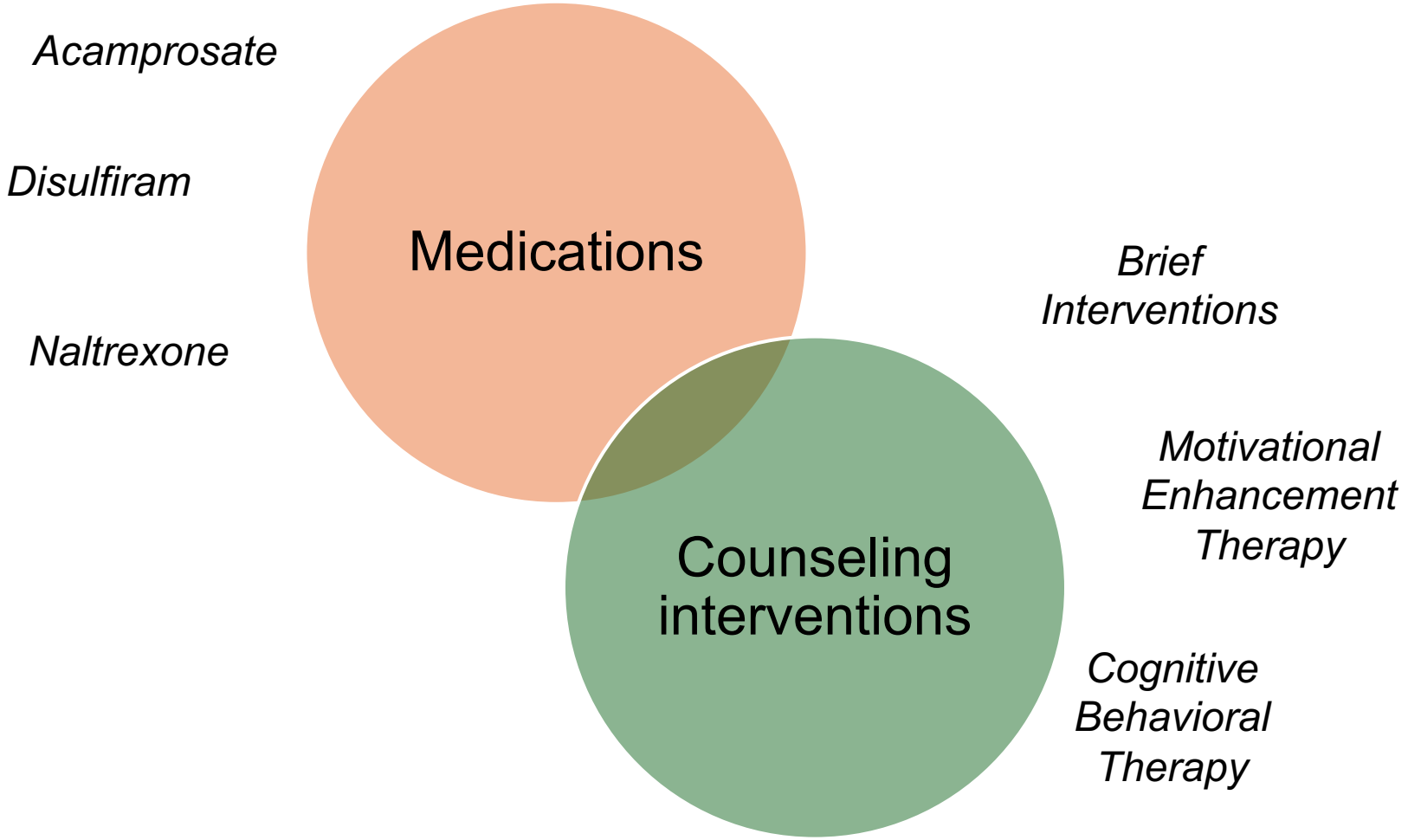
If screen positive, assess for Alcohol Use Disorder

	Characteristics
Substance Use Disorder	At least 2 of the following criteria over the past year: •Recurrent use in hazardous situations •Loss of control of use (quantities or duration) •Trying to cut down •Much time spent using or recovering from use •Use despite interpersonal problems •Failing obligations in work, home or school •Activities given up to use •Use despite physical/psychological problems related to use •Withdrawal •Tolerance •Craving

Note: Mild: 2-3 criteria; Moderate: 4-5 criteria; Severe: 6-11 criteria

DSM-5 criteria

Interventions for unhealthy alcohol use

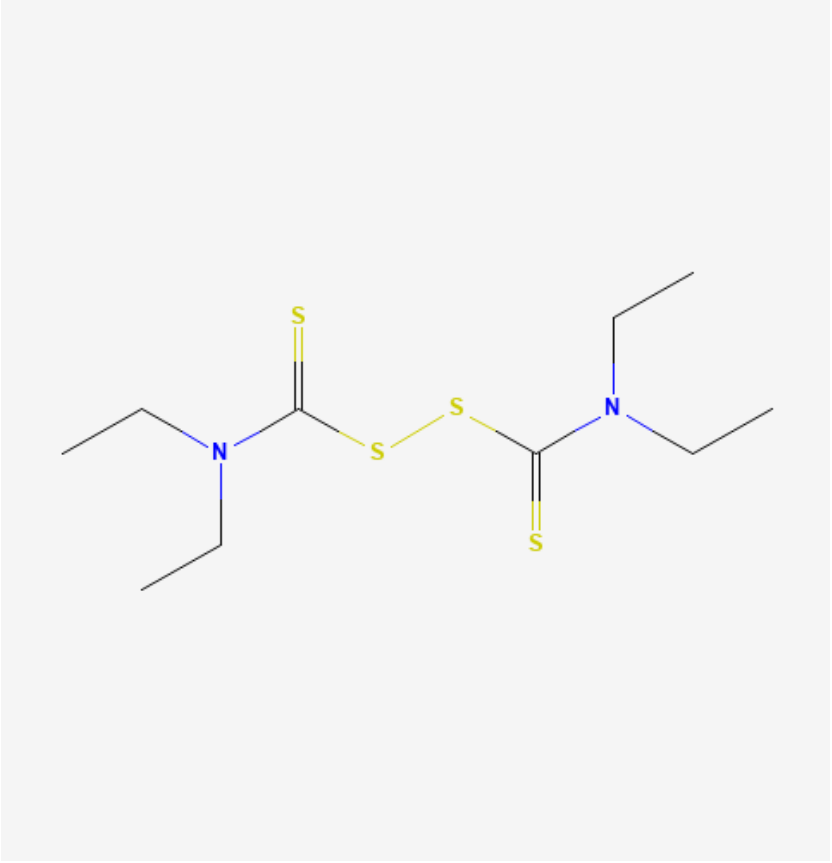


Alcohol Use Disorder

- FDA Approved Medications
  - Naltrexone – Mu opioid antagonist
  - Vivitrol – Long-acting Naltrexone injec
  - Acamprosate
  - Disulfiram
- Non-FDA Approved Medications
  - Topiramate
  - Gabapentin
  - Baclofen
  - Others

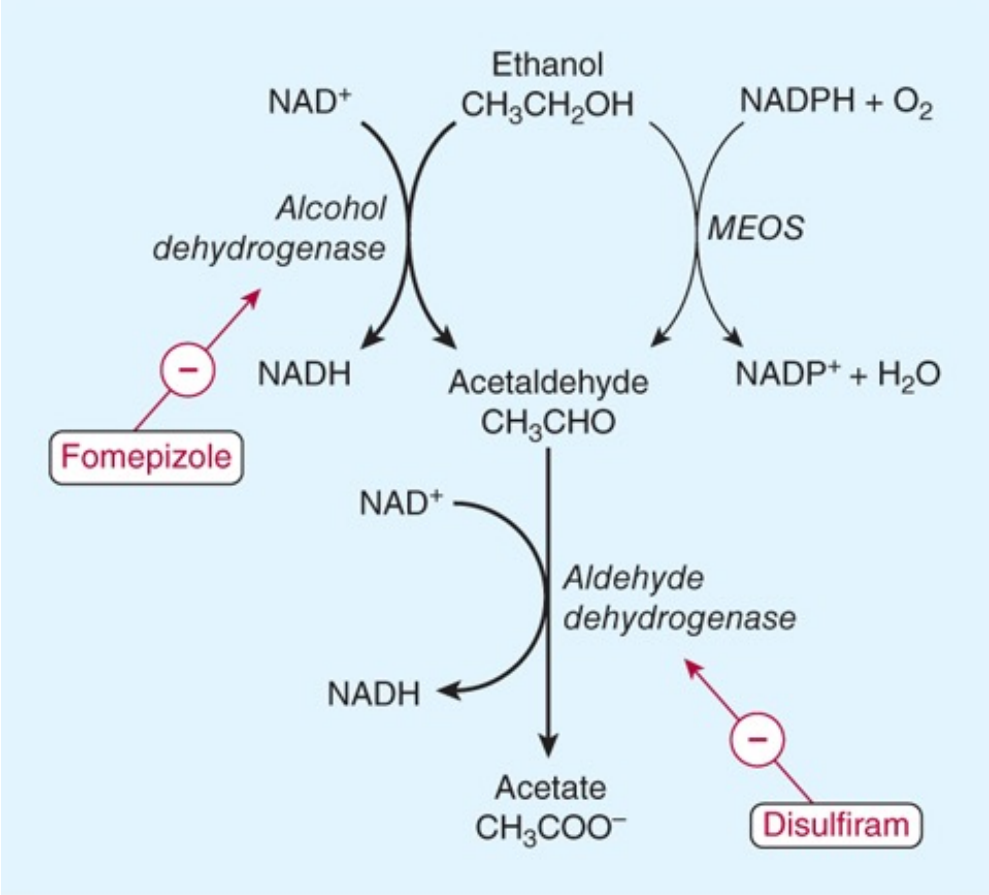
Alcohol sensitizing agent: Disulfiram

- Antabuse
- FDA approved for alcohol use disorder in 1949.
- Disulfiram inhibits the enzyme aldehyde dehydrogenase, which catalyzes the oxidation of acetaldehyde to acetic acid.
- The ingestion of alcohol while this enzyme is inhibited elevates the blood acetaldehyde concentration, resulting in the disulfiram–ethanol reaction (DER).



Mechanism of action

- Disulfiram works via negative reinforcement, precipitating an unpleasant physical reaction when alcohol is consumed while on the medication as it irreversibly binds to ALDH.
- ALDH enzyme activity requires the synthesis of new enzyme, so that the potential exists for a DER to occur at least 2 weeks from the last ingestion of disulfiram.
- Avoid alcohol 2 weeks after disulfiram ingestion.
- Disulfiram also inhibits dopamine beta-hydroxylase, increasing dopamine levels thus theoretically could increase psychotic symptoms in patients with psychosis.



Metabolism of ethanol by alcohol dehydrogenase and the microsomal ethanol-oxidizing system (MEOS). Alcohol dehydrogenase and aldehyde dehydrogenase are inhibited by fomepizole and disulfiram, respectively. NAD^+, nicotinamide adenine dinucleotide; NADPH, nicotinamide adenine dinucleotide phosphate.

Disulfiram–Ethanol Reaction (DER)

- Symptoms and signs of the DER include warmth and flushing of the skin, usually of the upper chest and face; tachycardia; palpitations; and hypotension.
- Other symptoms include nausea, vomiting, shortness of breath, sweating, dizziness, blurred vision, and confusion. Most DERs are self-limited (30 minutes).
- But DER may be severe, with marked tachycardia, hypotension, or bradycardia; may result in cardiovascular collapse, congestive heart failure, and convulsions.

Disulfiram: Adverse Effects and monitoring

- Disulfiram adverse effects include drowsiness, lethargy, and fatigue.
- More serious adverse effects include optic neuritis, peripheral neuropathy, and hepatotoxicity.
- Avoid in patients with severe cardiovascular disease, pregnant women and psychosis.
- Liver enzymes should be monitored monthly or at more frequent intervals during the first 3 months of treatment and quarterly thereafter to identify hepatotoxic effects.

Disulfiram dosing

- Patient must be abstinent abstinent from alcohol for at least 48 hours prior to first administration of disulfiram.
- There is a correlation between the risk of adverse effects and dosage, although the risk of hepatic injury does not appear to be related to dose.
- This concern about dosage-related adverse events has resulted in the daily dosage prescribed in the United States being limited to 250-500 mg/d.
- Before starting patients on disulfiram, make them aware of the hazards of the medication, including the need to avoid over-the-counter preparations with alcohol and drugs that can interact with disulfiram and the potential for a DER to be precipitated by alcohol used in food preparation.

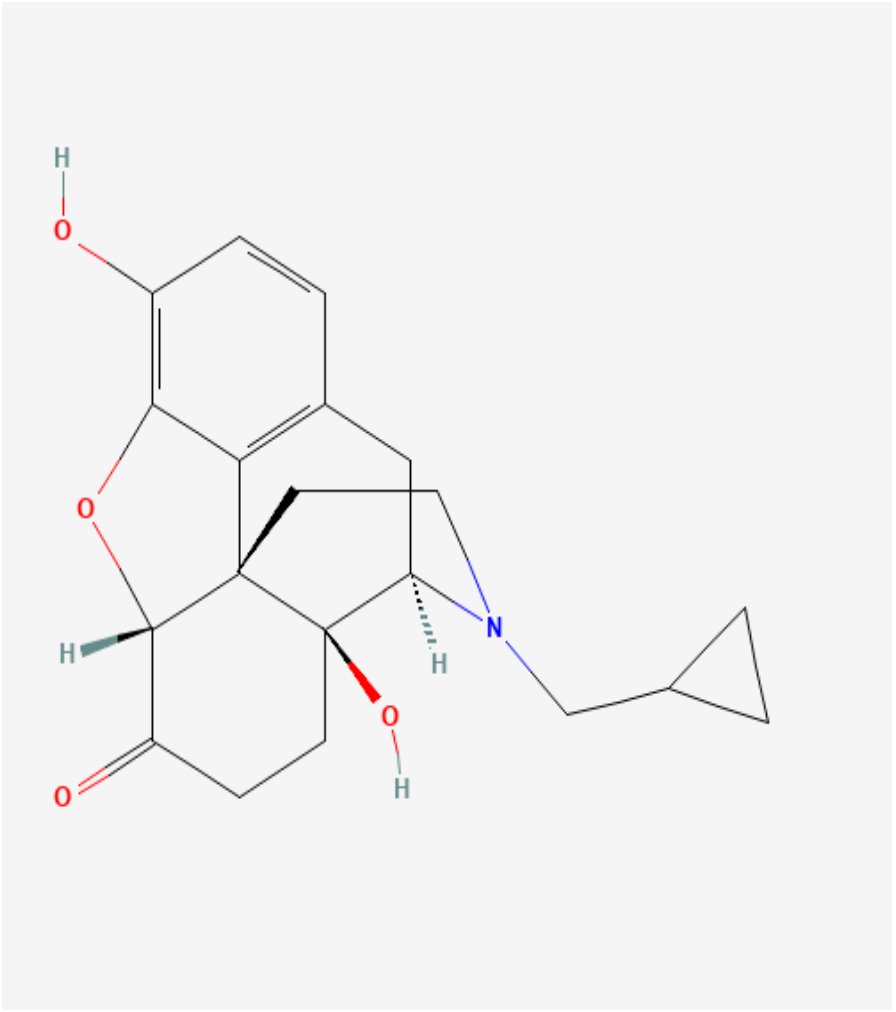
Naltrexone

ReVia/Vivitrol

Oral naltrexone FDA approved for the treatment of opioid dependence in 1984 but approved for the treatment of alcohol dependence in 1994.

Injectable naltrexone was FDA approved for AUD in 2006 and OUD in 2010.

The approval for alcohol dependence was based on the results of two single-site studies.



Volpicelli JR, Alterman AI, Hayashida M, et al. Naltrexone in the treatment of alcohol dependence. *Arch Gen Psychiatry.*1992;49:876-880.

O'Malley SS, Jaffe AJ, Chang G, et al. Naltrexone and coping skills therapy for alcohol dependence. A controlled study. *Arch Gen Psychiatry.* 1992;49:881-887.

Naltrexone reduces:

- craving for alcohol
- alcohol’s reinforcing properties
- the experience of intoxication
- the chances of continued drinking following a slip
- number of drinking days and heavy drinking days

Mechanism of action

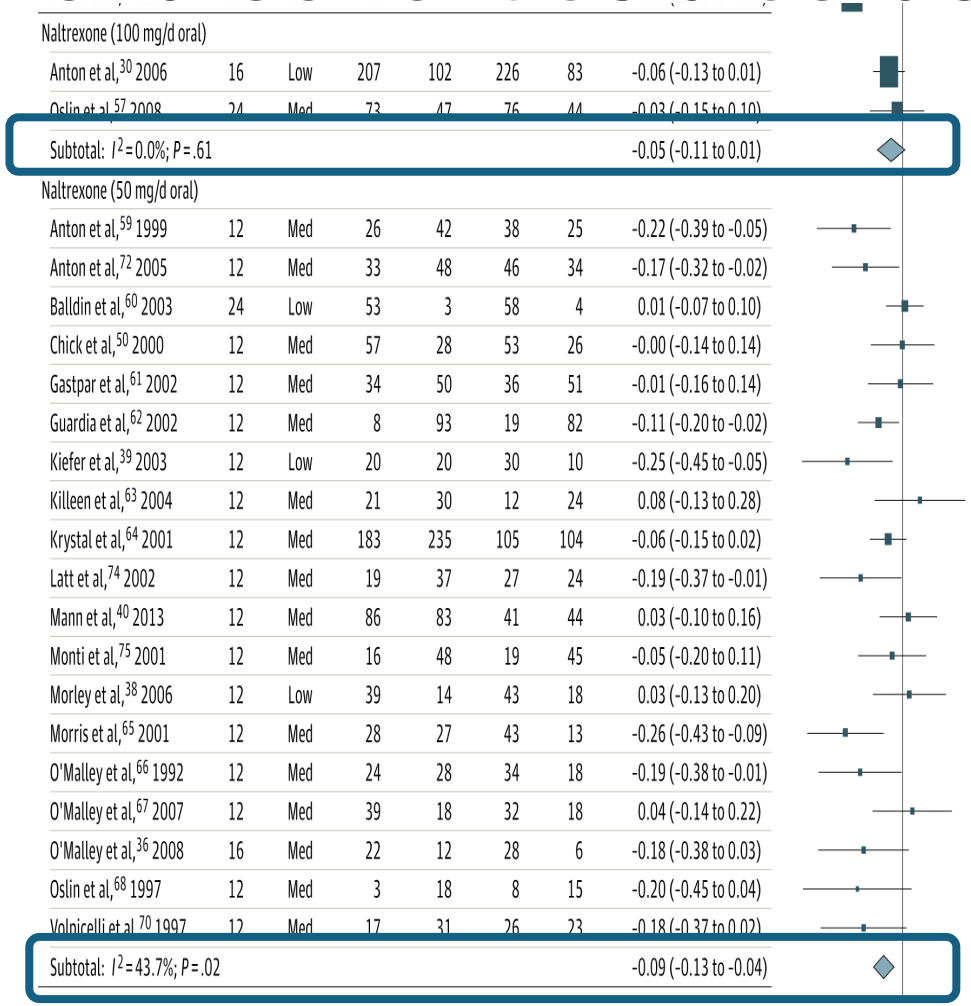
- Naltrexone exerts its effects via mu-opioid receptor blockade thus reducing the reinforcing effects of alcohol.
- Patients experience less euphoric effects of alcohol, suggesting that the blocked endogenous opioid system contributes to alcohol's "priming effect".
- Avoid initiating if at risk for opioid withdrawal

Relapse Prevention

- Meta-analysis by Bouza et al. showed a 38% lower likelihood of relapse with naltrexone treatment ($p < 0.00001$).
- Secondary outcomes: time to relapse, percentage of drinking days, number of drinks per drinking day, days of abstinence, total alcohol consumption during treatment, and levels of gamma-glutamyl transpeptidase and aspartate aminotransferase, all showed a significant advantage for naltrexone.

- Bouza C, Angeles M, Munoz A, et al. Efficacy and safety of naltrexone and acamprosate in the treatment of alcohol dependence: a systematic review. *Addiction*. 2004;99: 811-828.

Strong data to support use of naltrexone for alcohol use disorder



Naltrexone (100 mg/d oral)							
Anton et al,[30] 2006	16	Low	207	102	226	83	-0.06 (-0.13 to 0.01)
Oslin et al,[57] 2008	24	Med	73	47	76	44	-0.03 (-0.15 to 0.10)
Subtotal: I^2=0.0%; P=.61							-0.05 (-0.11 to 0.01)
Naltrexone (50 mg/d oral)							
Anton et al,[59] 1999	12	Med	26	42	38	25	-0.22 (-0.39 to -0.05)
Anton et al,[72] 2005	12	Med	33	48	46	34	-0.17 (-0.32 to -0.02)
Balldin et al,[60] 2003	24	Low	53	3	58	4	0.01 (-0.07 to 0.10)
Chick et al,[50] 2000	12	Med	57	28	53	26	-0.00 (-0.14 to 0.14)
Gastpar et al,[61] 2002	12	Med	34	50	36	51	-0.01 (-0.16 to 0.14)
Guardia et al,[62] 2002	12	Med	8	93	19	82	-0.11 (-0.20 to -0.02)
Kiefer et al,[39] 2003	12	Low	20	20	30	10	-0.25 (-0.45 to -0.05)
Killeen et al,[63] 2004	12	Med	21	30	12	24	0.08 (-0.13 to 0.28)
Krystal et al,[64] 2001	12	Med	183	235	105	104	-0.06 (-0.15 to 0.02)
Latt et al,[74] 2002	12	Med	19	37	27	24	-0.19 (-0.37 to -0.01)
Mann et al,[40] 2013	12	Med	86	83	41	44	0.03 (-0.10 to 0.16)
Monti et al,[75] 2001	12	Med	16	48	19	45	-0.05 (-0.20 to 0.11)
Morley et al,[38] 2006	12	Low	39	14	43	18	0.03 (-0.13 to 0.20)
Morris et al,[65] 2001	12	Med	28	27	43	13	-0.26 (-0.43 to -0.09)
O'Malley et al,[66] 1992	12	Med	24	28	34	18	-0.19 (-0.38 to -0.01)
O'Malley et al,[67] 2007	12	Med	39	18	32	18	0.04 (-0.14 to 0.22)
O'Malley et al,[36] 2008	16	Med	22	12	28	6	-0.18 (-0.38 to 0.03)
Oslin et al,[68] 1997	12	Med	3	18	8	15	-0.20 (-0.45 to 0.04)
Volpicelli et al,[70] 1997	12	Med	17	31	26	23	-0.18 (-0.37 to 0.02)
Subtotal: I^2=43.7%; P=.02							-0.09 (-0.13 to -0.04)

- Number needed to treat (NNT) with naltrexone
  - **20** people to prevent return to any drinking
  - **12** to prevent return to heavy drinking

- By comparison:
  - SSRIs for depression: NNT=7-9
  - Statins for primary prevention of one non-fatal MI: NNT=104
  - DVT prophylaxis for one non-fatal PE: NNT=345

Jonas *JAMA* 2014; slide data courtesy S. Holt

> Am J Addict. 2021 Jan;30(1):55-64. doi: 10.1111/ajad.13089. Epub 2020 Aug 17.

Multiple Psychiatric Morbidity and Continued Use of Naltrexone for Alcohol Use Disorder

Srinivas B Muvvala [1], Stephanie S O'Malley [1], Robert Rosenheck [1 2 3]

Affiliations + expand

PMID: 32805083 DOI: 10.1111/ajad.13089

Abstract

Background and objectives: Despite substantial evidence of the efficacy of naltrexone in treating alcohol use disorder (AUD), naltrexone is used infrequently and often for short durations. Understanding factors related to the initiation and continued use of naltrexone could identify targets for improving its use in clinical practice.

Methods: We used the Fiscal year 2012 national data from the Veterans Health Administration to identify the proportion of veterans diagnosed with AUD who initiated and then continued to receive naltrexone for AUD over a 6-month period (N = 67,788). We further examined correlates of any use and continued use, and patterns of use in inpatient and outpatient mental health services and psychotropic prescription fills. Comparisons were made using bivariate analyses and multinomial logistic regression.

Results: Among the veterans diagnosed with AUD, 2.02% initiated treatment with naltrexone. Naltrexone initiation was associated with recent homelessness, concurrent psychiatric disorders, receipt of psychiatric outpatient services, psychotropic prescription fills, residential treatment, and psychiatric and medical-surgical hospitalization. Of the 1,366 patients initiating naltrexone, 43.2% (590) received 2 to 5 prescriptions and 16.3% (223) received more than 5 prescriptions for naltrexone. Use of naltrexone beyond one prescription was associated with homelessness, major depressive disorder, schizophrenia, psychotropic medication use, and psychiatric hospitalization.

Conclusion: Veterans with AUD who used and continued naltrexone were primarily those with multimorbidity and extensive involvement in psychiatric treatment.

Protracted withdrawal after cessation

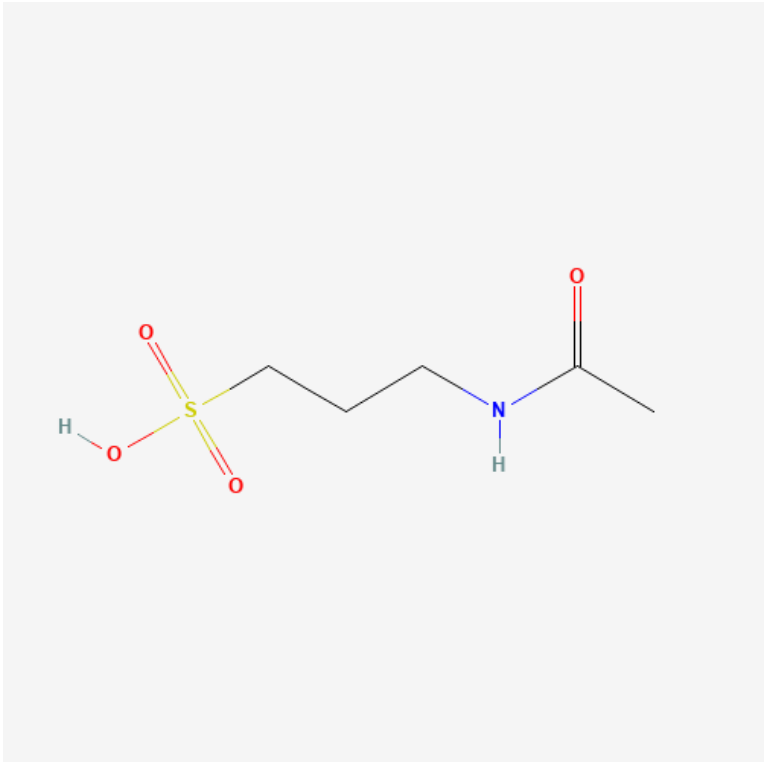
- There is clinical interest in combining naltrexone with medications (such as gabapentin) that might influence other aspects of alcohol use (such as protracted withdrawal)
- Protracted withdrawal observed after alcohol cessation: insomnia difficulty, anxiety, irritability, decreased concentration, and depressed mood. These symptoms may lead to return to use.

Naltrexone dosing and Adverse Effects

- Oral naltrexone 50mg daily
- Additional dose (Sinclair method)
- Extended-release naltrexone – Vivitrol 380 mg Q28 days
- AE- GI symptoms including nausea (most common- >30%), vomiting, decreased appetite, abdominal pain.
- Other reaction- headache, insomnia, arthralgia
- Vivitrol- injection site symptoms including injection site nodule and swelling (most common 69%), tenderness and pain.

Acamprosate

- Campral
- Acamprosate is an amino acid derivative that increases gamma-aminobutyric acid (GABA) neurotransmission.
- It also has complex effects on glutamate neurotransmission likely the effect that is important for its therapeutic effects in alcohol use disorder.
- FDA approved for alcohol use disorder in 2004.



Effects

- Shown to provide beneficial effect in the prevention of relapse to drinking and in the reduction of drinking among patients who relapse.
- However, based on the COMBINE (Combining Medications and Behavioral Interventions for Alcoholism) study acamprosate failed to show an advantage over placebo on an intent-to-treat basis.

Dosing and AE

- Acamprosate is FDA approved at a dosage of 1998 mg/d (i.e., two 333-mg capsules three times per day) in patients who are abstinent from alcohol and receiving psychosocial treatment.
- The most common adverse effects are generally mild and transient including gastrointestinal (e.g., diarrhea, bloating) and dermatological (e.g., pruritus).
- In contrast to disulfiram and naltrexone, which are metabolized in the liver, acamprosate is excreted unmetabolized (dose adjustment required in renal failure).

Monitoring

- Evaluation of renal function prior to initiation of the drug is warranted, particularly in individuals who have a history or are otherwise at risk of renal disease and in the elderly.
- Baseline Creatinine.

Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence

The COMBINE Study: A Randomized Controlled Trial

N=1,383 participants

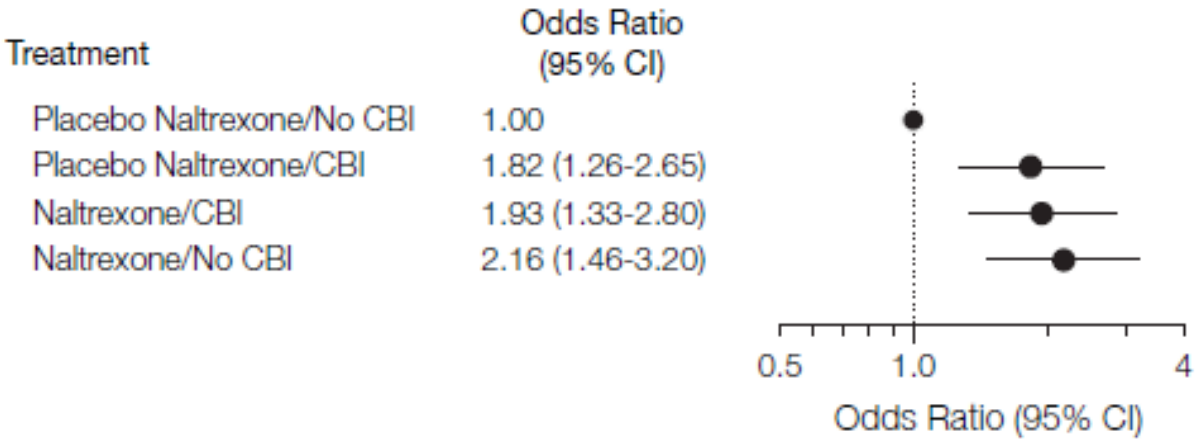
Nine treatment arms:

- -naltrexone 100mg/d + MM
- -acamprosate 3g/d + MM
- -both medications + MM
- -placebo only + MM

+/- CBT

- -one arm CBT only (no pills)

Figure 4. Odds Ratios for Good Composite Clinical Outcome at End of Treatment Compared With Placebo Naltrexone/No Combined Behavioral Intervention (CBI)



MM=medical management, CBT=cognitive behavioral therapy

Anton *JAMA* 2006

Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence

The COMBINE Study: A Randomized Controlled Trial

Conclusions Patients receiving medical management with naltrexone, CBI, or both fared better on drinking outcomes, whereas acamprosate showed no evidence of efficacy, with or without CBI. No combination produced better efficacy than naltrexone or CBI alone in the presence of medical management. Placebo pills and meeting with a health care professional had a positive effect above that of CBI during treatment. Naltrexone with medical management could be delivered in health care settings, thus serving alcohol-dependent patients who might otherwise not receive treatment.

Anton *JAMA* 2006

Topiramate and Gabapentin

- Topiramate antagonizes kainite glutamate receptors and has activity at GABA receptors.
- Topiramate reduces alcohol use in patients with severe AUD.
- AE: cognitive dulling, weight loss, avoid in pregnant woman.
- Gabapentin blocks voltage gated calcium channels (alpha-2-delta-1 subunit) thus modulating neurotransmitter release.
- It results in improvement in rates of abstinence, reduction in heavy drinking and improved sleep.

Alcohol use disorder and metabolic comorbidities

- Steatohepatitis
- Overweight or obese
- Other Metabolic side effects

Leggio L, Farokhnia M, Kenny PJ, Pepino MY, Simmons WK. Crosstalk between alcohol use disorder and obesity: two sides of the same coin? Mol Psychiatry. 2025 Dec;30(12):5938-5952.

Picture: Created using Google Gemini

Hendershot ET AL., JAMA Psychiatry, 2025

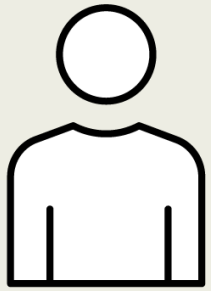
- Phase 2, double-blind, randomized, parallel-groups trial
- 48 patients with AUD received 9 Weeks of outpatient treatment with semaglutide or placebo at weekly clinic visits:
- 0.25 mg/week for 4 Weeks
- 0.5 mg/week for 4 Weeks
- 1.0 mg for 1 Week
- At pre-treatment and post-treatment, patients completed alcohol self-administration lab studies

JAMA Psychiatry

RCT: Once-Weekly Semaglutide in Adults with Alcohol Use Disorder

POPULATION

14 Men, 34 Women



Non–treatment-seeking adults meeting criteria for alcohol use disorder

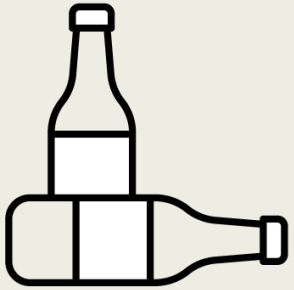
Mean (SD) age, 39.9 (10.6) y

SETTINGS / LOCATIONS

1 US academic medical center

INTERVENTION

48 Participants randomized and analyzed



24 Semaglutide
Once-weekly semaglutide

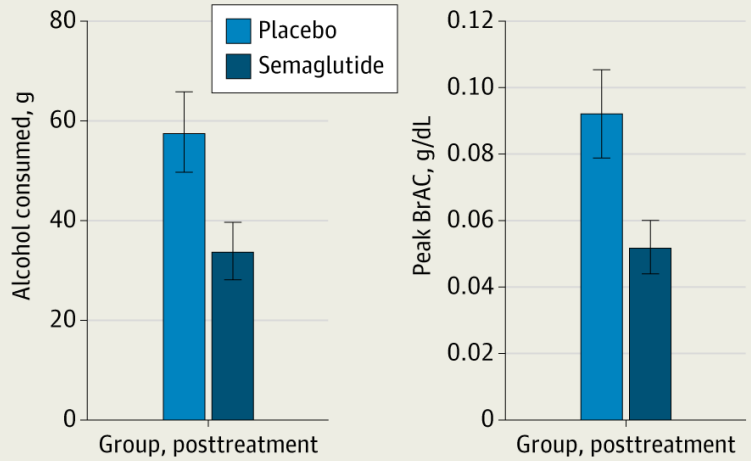
24 Placebo
Placebo injections

PRIMARY OUTCOME

Estimated alcohol consumed over 120 min during laboratory self-administration (estimated alcohol consumed in grams and peak breath alcohol concentration [BrAC] in g/dL)

FINDINGS

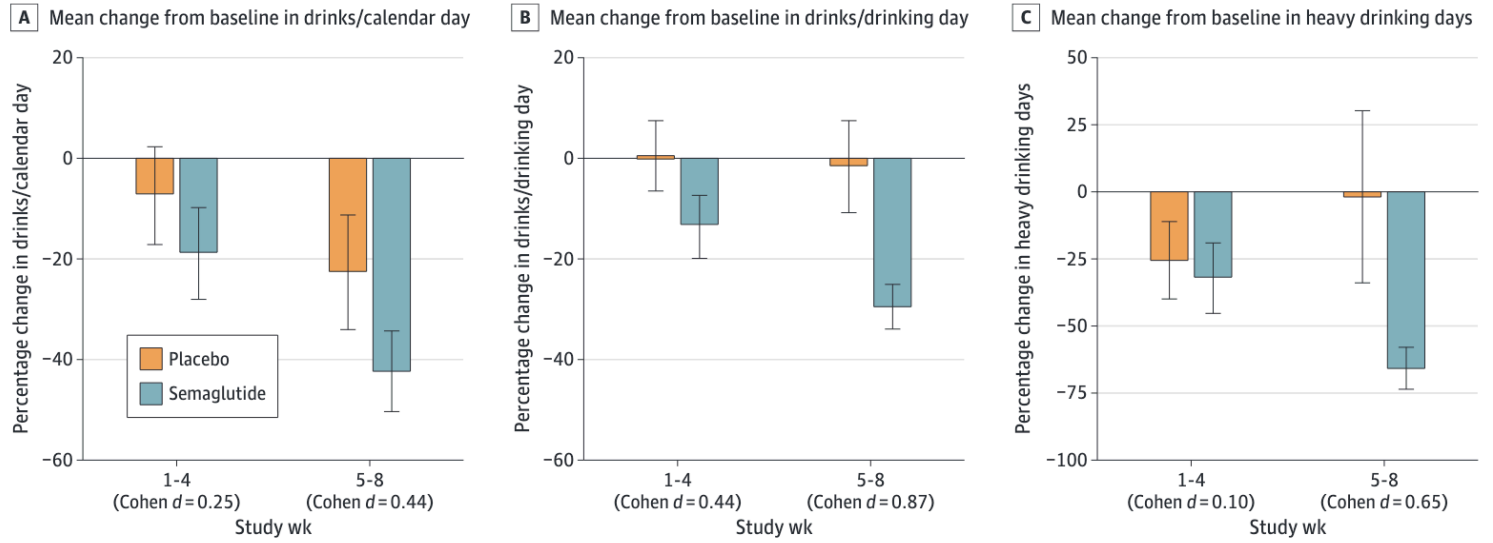
Among participants consuming alcohol in a laboratory session following 8 wk of treatment, those in the semaglutide group drank significantly less alcohol than those in the placebo group



Mean (SD) alcohol consumed: Semaglutide: 33.62 (20.72) g; placebo: 57.19 (28.15) g
Mean (SD) peak BrAC: Semaglutide: 0.052 (0.029) g/dL; placebo: 0.092 (0.046) g/dL
Effect sizes: Alcohol consumed: β, −0.48; 95% CI, −0.85 to −0.11; *P* = .01; peak BrAC: β, −0.46; 95% CI, −0.87 to −0.06; *P* = .03

Hendershot ET AL., JAMA Psychiatry, 2025

Figure 4. Medication Group Differences in Weekly Drinking and Craving as a Function of Treatment Period



Practical strategies in patients with comorbid psychiatric disorders

Practical strategies in patients with comorbid psychiatric disorders

- Integrated treatment
- Evaluating and treating comorbid alcohol, substance use and psychiatric conditions
- Clinician is a collaborator in the recovery process
- Partnership
- Motivational engagement
- Skills training

Epidemiology of COD: National Comorbidity Survey

(Kessler et al, 2004)

- Using data from the National Comorbidity Survey (NCS), individuals with any lifetime psychiatric disorder were 2.4 times more likely to have any lifetime SUD.
- 51.4% of participants in the NCS who reported a lifetime alcohol or SUD, also met criteria for at least one lifetime psychiatric disorder.
- 50.9% of those with a lifetime psychiatric disorder also had a history of SUD.

Siloed treatments

- About half of adults aged 18 or older in 2020 with a co-occurring SUD and AMI in the past year received either substance use treatment at a specialty facility or mental health services in the past year (50.5%), but only **5.7% received both services.**
- About two thirds of adults aged 18 or older with a co-occurring SUD and SMI in the past year received either substance use treatment at a specialty facility or mental health services in the past year (66.4%), but only **9.3% received both services.**

- Studies of clinical samples have shown that patients with co-occurring disorders had more:
  - Severe symptoms, poorer treatment outcomes, greater risks of homelessness, involvement with law enforcement and more frequent utilization of inpatient and emergency department (ED) services than patients with either a psychiatric disorder or an SUD alone.
- Siloed treatments are potential barriers to effective outpatient mental health and substance use treatment

Jegede et al., 2022; McCrone et al., 2000; Osher and Drake, 1996; Schütz et al., 2019; Trude and Stoddard, 2003; Cunningham, 2009; Walker et al., 2015; Moulin et al., 2018; Painter et al., 2018.

Integrating Addiction Treatment

SAMSHA 2009

JOURNAL OF
Addiction Medicine
The Official Journal of the American Society of Addiction Medicine

COMMENTARIES

Integrating Ambulatory Addiction Consultation Service Into a Community Mental Health Center

Jegede, Oluwole MD, MPH; Muvvala, Srinivas MD, MPH; Cahill, John MD, PhD; Wade, Ryan MD; Jordan, Ayana MD, PhD

Author Information

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Abstract

Despite the escalation in substance related overdose mortality—culminating in more than 100,000 deaths in each of the first 2 years of the COVID-19 pandemic—healthcare systems have not kept up with the demands for care among people who use drugs. There remains a significant gap in access to evidence-based treatment. The addiction consult services has served to address this gap, as a critical intervention that engages mostly hospitalized patients and initiate addiction treatment in acute settings, but little is known about addiction consult services in ambulatory settings. This model of care could potentially serve to scale up the care for people who use drugs in the community by embedding the limited number of addiction professionals within existing ambulatory systems, thus extending their reach. We describe here an innovative, yet simple and potentially replicable model for an ambulatory addiction consultation service in a large, advanced community mental health center.

Objectives of the MAT consultation clinic

1. To bridge the gap in the treatment of individuals with severe mental illness (SMI) and SUD (Co-occurring Disorders).
2. To provide support for physicians and clinicians (who may not be comfortable with or lack the expertise to treat SUD).
3. To create a **low barrier system** for addiction treatment using the **harm reduction** model, thus fostering an avenue for patients who may be contemplative about seeking treatment or want information on how to optimize safety during drug use, to have contact with an addictions specialist.

Service activities

1. Addiction-specific consultation for staff (Academic detailing)
2. SUD-specific assessment and evaluation
3. Comprehensive addiction treatments (MAT, harm reduction, MI, CM)
4. Education and Training
    - Monthly center-wide addiction seminar series
    - Yale medical student rotation
    - Psychiatry residents

Community Ambulatory MAT consultation clinic in brief

- Innovative model of addiction treatment in ambulatory settings.
- Integrates SUD treatment into general psychiatry setting.
- Fidelity to consultation framework, harm reduction and open access models (**No wrong doors**)
- Provide support to psychiatric providers who may not be willing or unable to treat SUDs
- Likely easy to replicate and scalable.

Source: Don’t Judge Me Until You’ve Walked In My Shoes http://sumo.ly/yS6I via @tonyfahkry. Accessed 10/12/17

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Summary

CHANGE the NARRATIVE

Common provider barrier: “One more thing to do when we are already busy”

Change the narrative: “What can we do to provide better quality care for our patients?”