Managing Unhealthy Alcohol Use in Clinical Practice: Best Practices

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Continuing Medical Education

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Educational Objectives

At the conclusion of this activity, participants should be better able to:

- Recall evidence-based approaches in screening adults for the full spectrum of unhealthy alcohol use, from at-risk drinking to alcohol use disorder.
- Utilize the Brief Negotiated Interview to counsel patients with unhealthy alcohol use about behavior change.
- Summarize the role of psychosocial and behavioral therapies for treating patients with alcohol use disorder.
- Summarize the benefits and risks of pharmacologic treatments for treating patients with alcohol use disorder.

Additional Information

CME, AAFP, NCPD, ACPE, and Social Work credit are all available for this program. Please see the home page for information about obtaining credit.

Funded by an unrestricted educational grant from Alkermes.

First visit with Tom Stewart

- 40 years old
- High blood pressure
- First visit with new primary care clinician

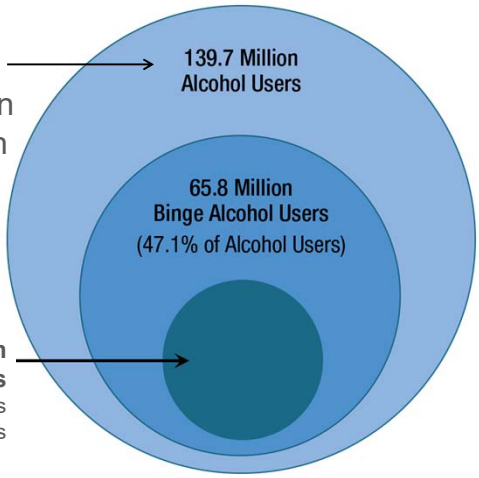
First visit with Tom Stewart

What did we just see?

- The screening element of Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Provider building engagement and establishing partnership
- Normalization of process
- Validated questions

Current, Binge and Heavy Alcohol Use Among Adults

51%
of US adults drank alcohol in the past month



Binge alcohol users:
≥5 drinks for men
≥4 drinks for women
- on the same occasion
- on at least 1 day
- in the past 30 days

Heavy alcohol users:
- binge drinking ≥5 days
- in the past 30 days

SAMHSA. 2019 Survey: National Survey on Drug Use and Health; September 2020.

U.S. Alcohol-related Deaths

10% of Deaths
in working-age adults (20 to 64 years of age) is attributable to unhealthy alcohol use[1]

95,158
ALCOHOL-RELATED
Deaths
Annually[2]

ARDI
ALCOHOL-RELATED DISEASE IMPACT APPLICATION

1. Stahre M, et al. *Prev Chronic Dis*. 2014 Jun 26;11:E109.
2. Alcohol-Related Disease Impact (ARDI) Application announcement September 3, 2020. https://www.cdc.gov/alcohol/ARDI/announcement.html

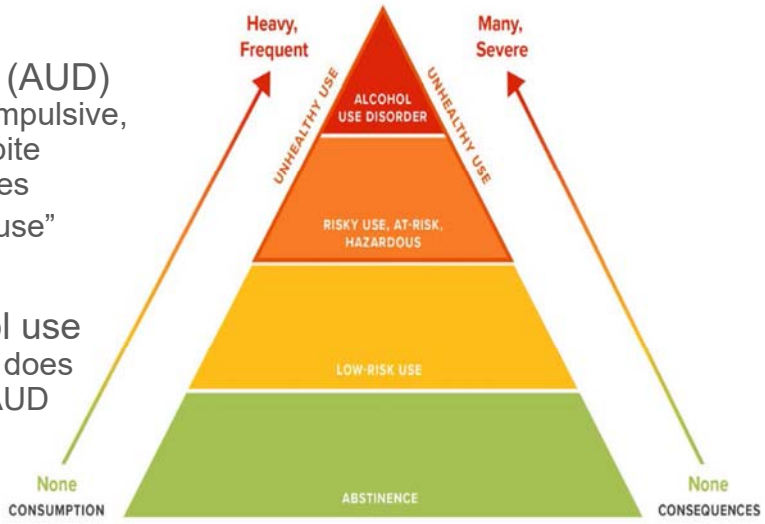
Unhealthy Alcohol Use

Alcohol Use Disorder (AUD)

- Clinical diagnosis: compulsive, uncontrolled use despite negative consequences
- Replaces "alcohol abuse" "alcohol dependence"

At-risk or risky alcohol use

- Consumption-based, does not meet criteria for AUD



Unhealthy Alcohol Use

1 Drink = 12-oz Beer = 5-oz Wine = 1.5-oz Liquor

Daily Limits	Weekly Limits
• ≥5 drinks/day (men)	• >14 drinks/week (men)
• ≥4 drinks/day (women)	• >7 drinks/week (women)

At Risk for What?

- Accidents, injuries, falls, overdose
- Social problems
  - Vulnerable, decreased alertness
  - Being a target of aggression or taking part in aggression-related events
- Substance use disorders
- Medication interactions
- Health effects…

Are the Risky Limits Too Low?

- Risk for alcohol-related problems rises with the number of heavy drinking days.
- Some problems, like driving while intoxicated or trauma, can occur with single occasion.
- Even if only drink heavily on rare occasions, opportunity to educate about safe drinking limits.

Screening, Brief Intervention, & Referral to Treatment

For Unhealthy Alcohol Use

U.S. Preventive Services Task Force (USPSTF)[1]

Centers for Disease Control and Prevention (CDC)[2]

U.S. Surgeon General[3]

American Society of Addiction Medicine[4]

Screening and brief counseling for risky drinking is considered one of the highest impact preventive services

Second only to childhood immunization and tobacco use screening/counseling[5]

1. USPSTF. *JAMA*. 2018;320(18):1899–1909.
2. CDC. www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf
3. US Surgeon General. www.surgeongeneral.gov /priorities/prevention
4. American Society of Addiction Medicine (ASAM). www.asam.org/docs/default-source/public -policy-statements
5. Maciosek MV, et al. *Ann Fam Med*. 2017;15:14-22.

SBIRT: An Approach

Screening, Brief Intervention, and Referral to Treatment

Screening	Identify unhealthy alcohol use – Assessment of severity (risky vs. AUD)
Brief Intervention **(Brief Negotiated Interview)**	Discuss the diagnosis and treatments
Treat and/or Refer to Treatment	Specialized services

SBIRT
SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT
www.samhsa.gov/sbirt

Screen: 'Single' Item Screening Question

"Do you sometimes drink beer, wine or other alcoholic beverages?"

"How many times in the past year have you had "X" or more drinks in a day?"

(X = 5 for men; 4 for women)

+answer: >0

82% sensitive, 79% specific for unhealthy use

NIAAA. Clinicians Guide to Helping Patients Who Drink Too Much, 2007.
Smith PC, Saitz R. *J Gen Intern Med.* 2009;24:783-8.
Saitz R, et al. *J Studies Alcohol Drugs*. 2014;75(1):153-157.
McNeely J, et al. *J Gen Intern Med*. 2015 Dec;30(12):1757-64.

CAGE to Assess Severity of Unhealthy Alcohol Use

Have you ever felt you should ***C**ut down* on your drinking?

Have people ***A**nnoyed* you by criticizing your drinking?

Have you ever felt bad or ***G**uilty* about your drinking?

Have you ever taken a drink first thing in the morning (***E**ye-opener*) to steady your nerves or get rid of a hangover?

Answer ≥2 indicated likely AUD with sensitivity of 75% to 95% and specificity of 84% to 97%

Mayfield D, et al. *Am J Psych.* 1974;131:1121.
Cherpitel CJ. *Ann Emerg Med.* 1995;26:158–166.

Alcohol Use Disorder Identification Test (AUDIT) to Assess Severity of Unhealthy Alcohol Use

- 10 questions
- Score ≥8: harmful/ hazardous alcohol use
- Likely AUD:
  - Score of ≥13 in women
  - Score of ≥15 in men

Scoring:	0 points per question	1 point per question	2 points per question	3 points per question	4 points per question
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
Add the score for each column:		+	+	+	+
Total Score (add column scores) =					

First visit with Tom Stewart

Still the first visit with new primary care clinician

Brief Negotiated Interview in action

First visit with Tom Stewart

What did we just see?

- Example of Brief Intervention: Brief Negotiated Interview
- Asking permission to discuss
- Exploring ambivalence
- Using a readiness scale
- Establishing goals

Brief Negotiated Interview (BNI): Definition

Brief	Negotiated	Interview
• Based upon well researched "brief interventions" • Goals are different for at risk vs use disorder	• Recognizes patients as equal partners • Patient is decision maker, change involves ambivalence	• Elicit patient's perception and reasons (or not) and ways to change

Bernstein E, Bernstein J, Levenson S. *Annals Emerg Med*. 1997;30(2):181-9.

Brief Negotiated Interview (BNI): Steps

Seven Steps:

- Build Rapport
- Explore Pros and Cons
- Review Health Risks
- Summarize and Ask Key Question
- Explore Readiness
- Negotiate Goals
- Explore Confidence

Step 1: Build Rapport

Seven Steps:

- Build Rapport
- Explore Pros and Cons
- Review Health Risks
- Summarize and Ask Key Question
- Explore Readiness
- Negotiate Goals
- Explore Confidence

"Before we start, I'd like to learn a little more about you. Would you mind telling me a little bit about yourself?"

"What is a typical day like for you? What are the most important things in your life right now?"

"How does your [X] use fit in?"

Step 2: Explore Pros and Cons

Seven Steps:

- Build Rapport
- **Explore Pros and Cons**
- Review Health Risks
- Summarize and Ask Key Question
- Explore Readiness
- Negotiate Goals
- Explore Confidence

"Is it okay if we talk about your use of [X]?"

"What do you enjoy/like about [X]? What else?"

"What do you enjoy less (or regret) about your [X] use? What else?"

Explore problems mentioned in screening, if done.
"You mentioned … Can you tell me more about that situation?"

Step 3: Review Health Risks: Elicit-Provide-Elicit

Seven Steps:

- Build Rapport
- Explore Pros and Cons
- **Review Health Risks**
- Summarize and Ask Key Question
- Explore Readiness
- Negotiate Goals
- Explore Confidence

Elicit "What do you know about the health effects and/or risks of [X]?"

Provide "Would it be okay if I shared some additional information with you?"
- Link any medical problems with [X] use
- For alcohol, review lower risk drinking levels

Elicit "What do you think about what I just told you?"

Step 4: Summarize and Ask Key Question

Seven Steps:

- Build Rapport
- Explore Pros and Cons
- Review Health Risks
- **Summarize and Ask Key Question**
- Explore Readiness
- Negotiate Goals
- Explore Confidence

"So on the one hand, you said *[pros]*, AND on the other hand you said *[cons]* and *[risks]."*

"Where does that leave you with your [X] use?"

Change Talk

Self-Motivating Speech

- Disadvantages of Status Quo
- Advantages of Change
- Optimism for Change
- Intention for Change

Step 5: Explore Readiness

Seven Steps:

- Build Rapport
- Explore Pros and Cons
- Review Health Risks
- Summarize and Ask Key Question
- **Explore Readiness**
- Negotiate Goals
- Explore Confidence

"To help me understand how you feel about making a change in your [X] use,

on a scale of 0-10, how ready are you to change your [X] use, with 0 not ready and 10 completely ready."

"Why did you choose a [X] and **not a lower number** like a 1 or 2?"

If they choose "0": "What would need to happen in your life to consider making a change?"

Step 6: Negotiate Goals

Seven Steps:

- Build Rapport
- Explore Pros and Cons
- Review Health Risks
- Summarize and Ask Key Question
- Explore Readiness
- **Negotiate Goals**
- Explore Confidence

"You mentioned some reasons to change. What type of changes might you make?"

"I have a few suggestions that might be helpful. Is it OK if I shared them with you?"

Cut back to NIAAA Lower Risk Amounts, if:

- Risky drinking amounts without reported negative consequences

Further assessment and discussion with a Primary Care Provider and/or referral to addiction treatment, if:

- Negative consequences from [X] use
- Known medications that interact with or medical conditions that are worsened by [X] use
- Pregnant or trying to conceive

" What are your thoughts about that?"

Step 7: Explore Confidence

"On a scale of 0 – 10, how **confident** are you to change your use of [X]?

"What are some challenges to reaching your goal(s)?"

"How can you overcome those challenges?"

"Can I suggest other strategies that have helped other patients?

- Recommend 1-2 strategies that may help

"Thanks for being so open with me today."

Brief Negotiated Interview (BNI)

Seven Steps:

- Build Rapport
- Explore Pros and Cons
- Review Health Risks
- Summarize and Ask Key Question
- Explore Readiness
- Negotiate Goals
- Explore Confidence

Second visit: Tom Stewart and his wife

- Six months since first appointment

Second visit: Tom Stewart and his wife

What did we just see?

- History now consistent with more severe unhealthy alcohol use with continued use despite negative consequences
- Patient is self-medicating stress
- Provider asked pros and cons, summarized and asked a key question
- Patient brought up AA as a treatment option

DSM-5 Criteria for Alcohol Use Disorder (AUD)

Uncontrolled Use	More consequences…continued use despite:
1. Using in larger amounts or for longer than intended 2. Repeated unsuccessful efforts to cut back or control use	1. Social problems caused/exacerbated by use 2. Being in physically hazardous settings 3. Physical or psychological problems caused or worsened by use

More time	"Biological"	Symptoms
1. Great deal of time spent using, obtaining, recovering 2. Important things given up or reduced by use 3. Failure to fulfill major obligations due to substance use	1. Craving 2. Tolerance 3. Withdrawal	Mild 2-4 Moderate 4-5 Severe ≥ 6

DSM-5 Task Force. C2013. Diagnostic And Statistical Manual Of Mental Disorders, Fifth Edition. Washington, D.C.: American Psychiatric Association.

AUD Background

14.5 Million
(5.3%)
of U.S. ADULTS have
AUD[1]

20% to 36%
prevalence in primary care[2,3]

Only 8% received treatment
in the last year[4]

1. SAMHSA. 2019 National Survey on Drug Use and Health. 2020
2. Fiellin DA, Reid MC, O'Connor PG. *Am J Med*. 2000;108(3):227-37.
3. Institute of Medicine. Improving the Quality of Health Care for Mental and Substance-Use Conditions. National Academy Press. 2006.
4. NIAAA. Alcohol Facts and Statistics. NIH; February 2020.

Alcohol Withdrawal Syndrome

Withdrawal symptoms occur in **~50%** of persons with AUD when alcohol is reduced or discontinued

Complicated withdrawal occurs in up to **20%** of cases (i.e. seizures, delirium tremens)

Seizures and hallucinations can occur early in the withdrawal period *even without autonomic dysfunction*

Symptoms of alcohol withdrawal generally begin within **6 to 24 hours** of the last alcohol use

Alcohol-related withdrawal seizures occur in 10-30% of patients in alcohol withdrawal

Seizures and delirium tremens are **LIFE THREATENING**

Goodson CM, Clark BJ, Douglas IS. *Alcohol Clin Exp Res*. 2014 Oct;38(10):2664-77.
Schuckit MA. *N Engl J Med*. 2014 Nov 27;371(22):2109-13.

Management of AUD

"Detoxification" is not treatment

Treatment:

- In primary care or by specialist, outpatient or inpatient
- Psychosocial and behavioral
- Pharmacotherapy

Medical Management:

- Education regarding AUD and medications for treatment
- Medication adherence and treatment
- Strength based approach to encourage patient
- Care plan recommendations
- Address medical and psychiatric co-morbidities

Friedmann PD, Saitz R, Samet JH. *JAMA*. 1998;279(15):1227-31.

Treatment Goals

- Study looked at long term treatment outcomes at 2.5 and 5 years after treatment entry
- Patients selected from the following:
  - ❑ Abstinence
  - ❑ Low risk drinking
  - ❑ No goal
- Findings suggest that patients with AUD who **identify abstinence as their goal** showed favorable treatment outcomes vs those who selected low risk or no goal.

Berglund KJ, et al. *Alcohol Alcoholism.* 2019;54(4):439-445.

Psychosocial and Behavioral Interventions

- All patients with AUD should be encouraged to participate in some type of psychosocial treatment, including counseling ***and*** participation in a mutual help group
- Evidence of efficacy of these interventions in AUD is unclear
  - Randomized trials have multiple methodologic problems and heterogeneous outcomes
- Up to 70% of individuals return to heavy drinking after psychosocial treatment ***alone***

UpToDate, 2020. Approach to treating alcohol use disorder. Author: Richard Saitz, MD, MPH, FACP, DFASAM; current through Aug 2020.

Examples of Psychosocial Treatments

Motivational Interviewing

An evidence-based counseling technique for eliciting behavior change by helping the patient explore and resolve ambivalence about change

Cognitive-behavioral Therapy (CBT)

A structured goal-directed form of psychotherapy in which patients learn how their thought processes contribute to their behavior

Combined Behavioral Intervention

Integration of CBT, motivational interviewing and techniques to enhance mutual help group participation

Mutual Help Groups

Including 12-step programs (e.g. Alcoholics Anonymous) and other models, are a common component of treatment and although there are differences among them, they commonly emphasize achieving abstinence through group sharing and support

Weiss RD, Kueppenbender KD. *J Clin Psychopharmacol*. 2006 Dec;26 Suppl 1:S37-42.
Anton RF, et al. *JAMA*. 2006;295(17):2003–2017.

COMBINE Trial

- Evaluate efficacy of medication, behavioral therapies and their combinations for treatment of AUD
- Groups:
  - Medical Management (naltrexone or acamprosate, both, and/or both placebos, with or without Combined Behavioral Intervention (CBI)
  - CBI Only (no medication)
- Results:
  - All groups demonstrated substantial reduction in drinking
  - No combination produced better efficacy than naltrexone or CBI alone in the presence of medical management

Anton RF, et al. *JAMA*. 2006;295(17):2003–2017.

What is Alcoholics Anonymous (AA)?

- Anonymous fellowship of members with a desire to stop drinking
- Founded in 1939 by Bill W. and Dr. Bob
  - Reaching out to others to help stay sober
- Always available, free of charge
- Online virtual meetings are available
- Patients should try 4-5 different groups until they find the one that feels most comfortable

Similar Groups:

Narcotics Anonymous

Overeaters Anonymous

Al-Anon

AA: Therapeutic Elements

- 12 Steps: spiritual basis/necessary actions (principles)
- 12 Traditions: guidelines for meetings
- Peer support, role modeling (sponsorship)
- Built in social support network and structure
- Forum for sharing stories with no judgment
- Hope
- Practical problem solving advice

AA: Process

- Admitting lack over control over addiction
- Recognizing that higher power can give strength to achieve sobriety
- Examining past mistakes
- Making amends
- Learning to live new life with new code
- Helping others

Other Mutual Support Groups

- SMART Recovery
  - Self Management And Recovery Training
- Refuge Recovery
- Al-Anon
  - Support for families and friends with AUD
- Women for Sobriety
- Secular Organization for Sobriety
- Celebrate Recovery

Second visit: Tom Stewart and his wife

Additional treatment options, including medications

Second visit: Tom Stewart and his wife

What did we just see?

- Provider brought up medications as a treatment for patients moderate to severe AUD
- Provider discussed realistic expectations
- Provider also referred for psychosocial treatment and suggested keeping mind open to AA

Pharmacotherapy

- Medications can be used to treat AUD, leading to reduced heavy drinking and increased days of abstinence
- Indications
  - Patients with moderate to severe alcohol use disorder
  - Current, heavy use and ongoing risk for consequences from use
  - Motivation to reduce alcohol intake
  - Preference for medication along with or instead of a psychosocial intervention
  - No medical contraindications to the individual medication

UpToDate, 2020. Approach to treating alcohol use disorder. Author: Richard Saitz, MD, MPH, FACP, DFASAM; current through Aug 2020.

Alcohol Pharmacotherapy Options

FDA-approved Medications:

- **Disulfiram** (Antabuse)
- **Acamprosate** (Campral)
- **Naltrexone** (Revia [PO] and Vivitrol [IM])

Other Options NOT FDA-approved

- **Topiramate** (Topamax)
- **Gabapentin** (Neurontin)

Randomized clinical trials have not found medication combinations to be more effective than the individual medications

UpToDate, 2020. Approach to treating alcohol use disorder. Author: Richard Saitz, MD, MPH, FACP, DFASAM; current through Aug 2020.

Disulfiram (Antabuse)

- Irreversibly inhibits aldehyde dehydrogenase. Alcohol use results in increased serum acetaldehyde, causing diaphoresis, palpitations, facial flushing, nausea, vertigo, hypotension, and tachycardia
- Dose: 250 mg daily
- Randomized placebo-controlled trials have failed to demonstrate a benefit (difficult to do with this type of drug)
- Appears to be effective with compared with no treatment or when administration is supervised
- Side effects: disulfiram reaction, neuropathy
- Contraindications: severe myocardial disease, psychoses

Jorgensen CH, et al. *Alcohol Clin Exp Res.* 2011;35:1749.

Acamprosate (Campral)

- Enhances GABA reception and transmission, which are reduced by chronic alcohol exposure
- Usual Dose: 666 mg (2 pills) TID
- Modestly improves abstinence (risk difference of 9% - NNT = 11)
- Side effects: diarrhea (17%)
- Contraindications: severe renal impairment (CrCl less than 30mL/min)

Rösner S, et al. *Cochrane Database Syst Rev.* 2010:CD004332.
Jonas D, et al. *JAMA.* 2014;311:18:1889.

Naltrexone (Revia/Vivitrol)

- Opioid antagonist, thought to reduce the reinforcing effects of alcohol
- Usual Dose: 50-100 mg po daily
- Long-acting injectable form (380 mg IM q month)
- Modestly reduces return to heavy drinking [risk difference of 9% (48% base rate) - NNT=11]
- Oral vs IM effectiveness?
- Side effects: nausea (14%) and dizziness (12%)
- Contraindications: receiving opioid analgesics

Rösner S, et al. *Cochrane Database Syst Rev.* 2010:CD004332.
Jonas D, et al. *JAMA.* 2014;311:18:1889.

Safety of Injectable Naltrexone

- Generally a safe and well tolerated medication
- Most common adverse effects include: injection site pain, injection site reactions, hepatic enzyme abnormalities, insomnia, and anorexia
- Caution in persons with moderate to severe renal or liver impairment, thrombocytopenia, or any coagulation disorder

Administering Injectable Naltrexone

- One dose, 380 mg (4mL), delivered intramuscularly into gluteal muscle every 4 weeks
- Medication at room temperature prior to administration
- Reconstitute medication after patient arrives for visit and is determined to be appropriate for injectable naltrexone
- There will be 2 needle sizes 1.5” and 2” choose needle that will ensure medication goes into muscle. Do not substitute manufacturer components
- Once mixed, give injection quickly so that the medication does not solidify
- Document location of injection – and alternate sites

Specialty Pharmacy Process: Injectable Naltrexone

- Make sure pharmacy benefit coverage is accepted at pharmacy
- Understand coverage limitations and co-pay implications
  - *Specialty pharmacy can work with the manufacturer’s patient assistance program and other resources to eliminate barriers*
- Send prescription (e.g., e-prescribe, fax, mail) to pharmacy
- Have a process to accept the prescription sent/mailed from specialty pharmacy
  - ***Prescription is never to be provided directly to the patient by pharmacy***
- Be able to store prescription under refrigeration until administration

Co-Occurring Conditions

Liver Disease	Renal Impairment	Opioid Use Disorder
Patients with acute hepatitis, liver enzymes ≥3 to 5X normal, or liver failure, acamprosate preferred over naltrexone – Acamprosate, excreted mostly unchanged by the kidneys rather than metabolized by the liver, can be used safely in patients with liver disease	Patients with renal insufficiency treated for AUD with acamprosate (e.g., when naltrexone is contraindicated or ineffective), a reduced dose is used – Acamprosate, excreted by the kidneys, is contraindicated in patients with severe renal dysfunction *(creatinine clearance ≤30 mL/min)*	In patients treated for both an AUD and an opioid use disorder, naltrexone can be used to treat both conditions

Topiramate (Topamax)

GABA enhancer, thought to reduce the rewarding effects of alcohol; 25 mg/d then increase by 25 to 50 mg/d each week to 300 mg/d max

Systematic review including 6 RCTs and total of 979 participants:
- Fewer drinks/drinking day (-1.6)
- Higher % days abstinent (mean difference 15.5%)
- Less heavy drinking (standardized mean -0.44)

Side effects: Parasthesias (50%), taste perversion (23%), anorexia (20%), difficulty with concentration (15%)

No differences compared to other meds in head to head trials

Pani PP, et al. *Cochrane Database Syst Rev.* 2014;2:CD008544.
Not FDA approved for AUD.

Gabapentin (Neurontin)

Enhances GABA activity

In a 12-week trial (N=150), gabapentin 1800 mg/day was associated with:
- Reduction in heavy drinking (55% vs. 77%; NNT=5)
- Increase in abstinence (17% vs. 4%; NNT=8)

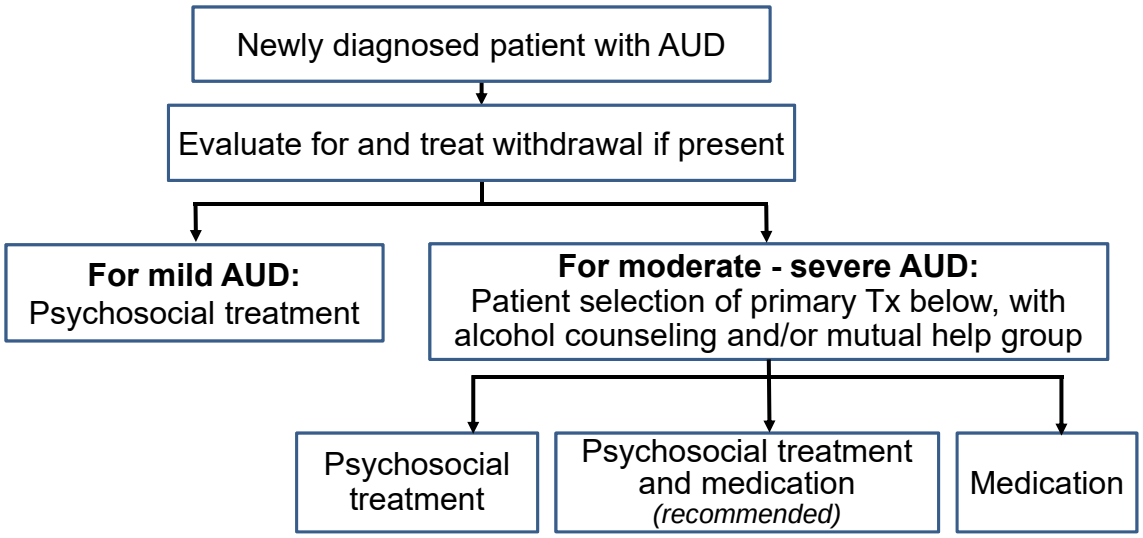
Two other smaller studies (N = 60, 21) with positive results

One study reported that a combination of gabapentin with naltrexone was superior to naltrexone alone (over 6 weeks)

Not FDA approved, potential for misuse

Mason BJ, et al. *JAMA Intern Med.* 2014;174:70.
Leung JG, et al. *Ann Pharmacotherapy.* 2015;49:897.
Not FDA approved for AUD.

Approach to Treating AUD



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