Jackson Care Connect 2026 Virtual Learning Series

Advancing Health Equity, Access & Quality Care

jacksoncareconnect.org

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A dynamic, free virtual learning series designed to empower professionals in physical and behavioral health and community-based organizations. Enhance your skills and **earn Continuing Education Units (CEUs) and Continuing Medical Education credits (CMEs)** in support of providing members with high-quality, compassionate, informed care

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JCC Learning Series Core Values

- **Valuable sessions** on timely topics for professionals in physical and behavioral health, health equity, and community engagement.
- **Practical tools and strategies** to improve access, outcomes, and culturally connected care.
- **Cultivating network connections** to build collaboration across systems of care

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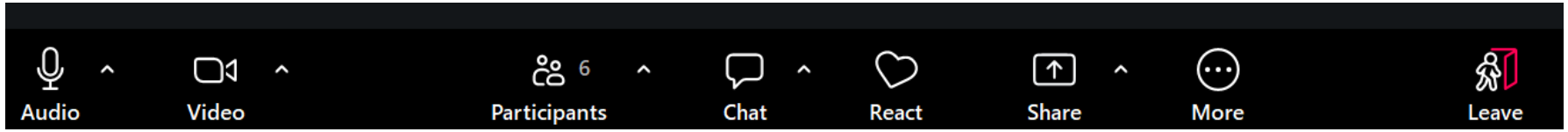
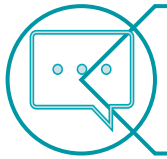
Joining us via Zoom today!

Using the toolbar

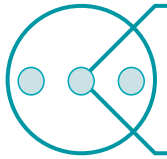


Please mute yourself, during the session

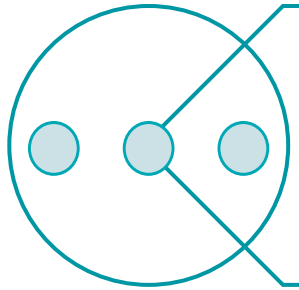


You can pop questions for the presenters into the chat.

You can visually signal a question by using the reactions and “raise your hand”



Hover over your own image and use the three dots on the top right to change how you are viewing the screen.



Use the three dots to access captions and the session transcript.

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Setting the space

- Speak from your own experience
- Engage – use chat, raise hand, ask questions
- Listen for understanding, be open to new perspectives
- Speak appreciations

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CEUs Requirements

- ✓Participate in the entire length of the session.
- ✓By doing so, your name will be included in a session roster that will be submitted to NASW.
- ✓Complete the required evaluation within 10 days of the session. You will receive this via email.

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American Academy of Family Physicians (AAFP) CME

The AAFP has reviewed Understanding Alcohol Use Disorder and Treatment Options and deemed it acceptable for up to 2.00 Live AAFP Prescribed credit(s).

Term of Approval is from 04/29/2026 to 04/29/2026. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Understanding alcohol use disorder and treatment options

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Alcohol Use Disorder 101

Jackson Care Connect Virtual Learning Series

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Learning Objectives

I. Understand the fundamentals of alcohol use disorder

II. Identify treatments and supports available to those with alcohol use disorder

III. Apply rapport building techniques to foster connections with those with alcohol use disorder

IV. Recognize safer drinking habits

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Answer in the chat:

Why do people drink alcohol?

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Why Do People Drink Alcohol?

- Fun
- Coping with stress
- Part of a social, religious, or spiritual ritual
- Fitting in
- Regulating emotions
- Culture/social norms
- Curiosity

(Abbey, Smith, and Scott, 1993;CDC and Prevention, 2024; Gilman, et al., 2008)

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SUBSTANCE USE SPECTRUM

People use substances, such as **controlled and illegal drugs**, **cannabis**, **tobacco/nicotine** and **alcohol** for different reasons, including medical purposes; religious or ceremonial purposes; personal enjoyment; or to cope with stress, trauma or pain. Substance use is different for everyone and can be viewed on a spectrum with varying stages of benefits and harms.

NON-USE

Avoiding use of substances (abstinence)

Example: No drugs, tobacco or alcohol

BENEFICIAL USE

Use that can have positive health, social, or spiritual effects

Example: Taking medication as prescribed, ceremonial/ religious use of tobacco (such as smudging)

LOWER-RISK USE

Use that has minimal impact to a person, their family, friends and others

Example: Drinking following the **low-risk alcohol drinking guidelines**, cannabis use according to the **lower-risk cannabis use guidelines**

HIGHER-RISK USE

Use that has a harmful and negative impact to a person, their family, friends and others

Example: Use of illegal drugs, impaired driving, binge drinking, combining multiple substances, increasing frequency, increasing quantity

ADDICTION
(Substance use disorder)

A treatable medical condition that affects the brain and involves compulsive and continuous use despite negative impacts to a person, their family, friends and others

Example: When someone cannot stop using drugs, tobacco or alcohol even if they want to

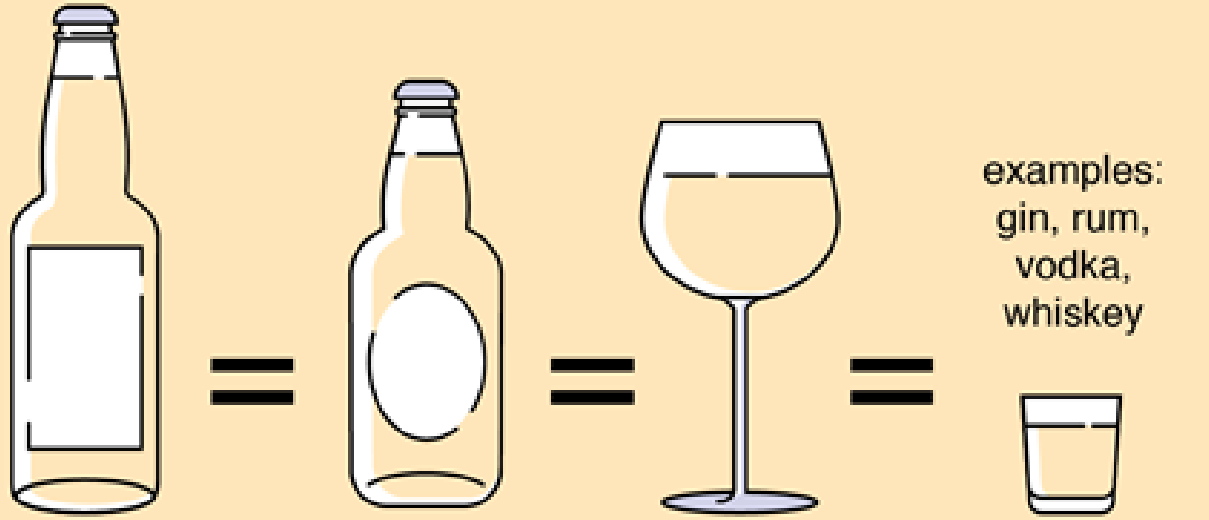
A person may move back and forth between the stages over time

(Health Canada, 2022)

Standard Drink Definition

What is considered a "drink"?

U.S. Standard Drink Sizes



12 ounces	8 ounces	5 ounces	1.5 ounces
5% ABV beer	7% ABV malt liquor	12% ABV wine	40% ABV (80 proof) distilled spirits

examples: gin, rum, vodka, whiskey

(CDC and P, 2024; NIAAA, n.d.)

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What is a Binge?

- Assigned Female at Birth: 4+ drinks
- Assigned Male at Birth: 5+ drinks
- Why differences based on sex assigned at birth?

(CDC and P, 2025; NIAAA, n.d.)

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A Note on Blood Alcohol Content (BAC)

Female

Approximate Blood Alcohol Content (BAC) In One Hour

Source: National Highway Traffic Safety Administration

Drinks	Body Weight In Pounds								Influenced
	100	120	140	160	180	200	220	240	
1	.05	.04	.03	.03	.03	.02	.02	.02	Possibly
2	.09	.08	.07	.06	.05	.05	.04	.04	
3	.14	.11	.11	.09	.08	.07	.06	.06	Impaired
4	.18	.15	.13	.11	.10	.09	.08	.08	
5	.23	.19	.16	.14	.13	.11	.10	.09	Legally Intoxicated
6	.27	.23	.19	.17	.15	.14	.12	.11	
7	.32	.27	.23	.20	.18	.16	.14	.13	
8	.36	.30	.26	.23	.20	.18	.17	.15	
9	.41	.34	.29	.26	.23	.20	.19	.17	
10	.45	.38	.32	.28	.25	.23	.21	.19	

Subtract .015 for each hour after drinking.

BAC	Effects
.02 - .04%	Lightheaded
.05 – 0.7%	"Buzzed"
.08 - .10%	Legally impaired
.11 - .15%	Drunk
.16 - .19%	Very drunk
.20 - .24%	Dazed and confused
.25 - .30%	Stupor
.31% and up	Coma – death by respiratory arrest in 50% of those who drink

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(Alcohol.org, n.d.; Alcoholic Beverage Control, n.d., The University of Toledo, 2024)

Possible Consequences of Drinking

- Reduced inhibitions
- Confusion
- Memory problems
- Concentration problems
- Slurred speech
- Motor impairment
- Breathing problems
- Coma
- Death is possible

(Prevention Conversation, 2015)

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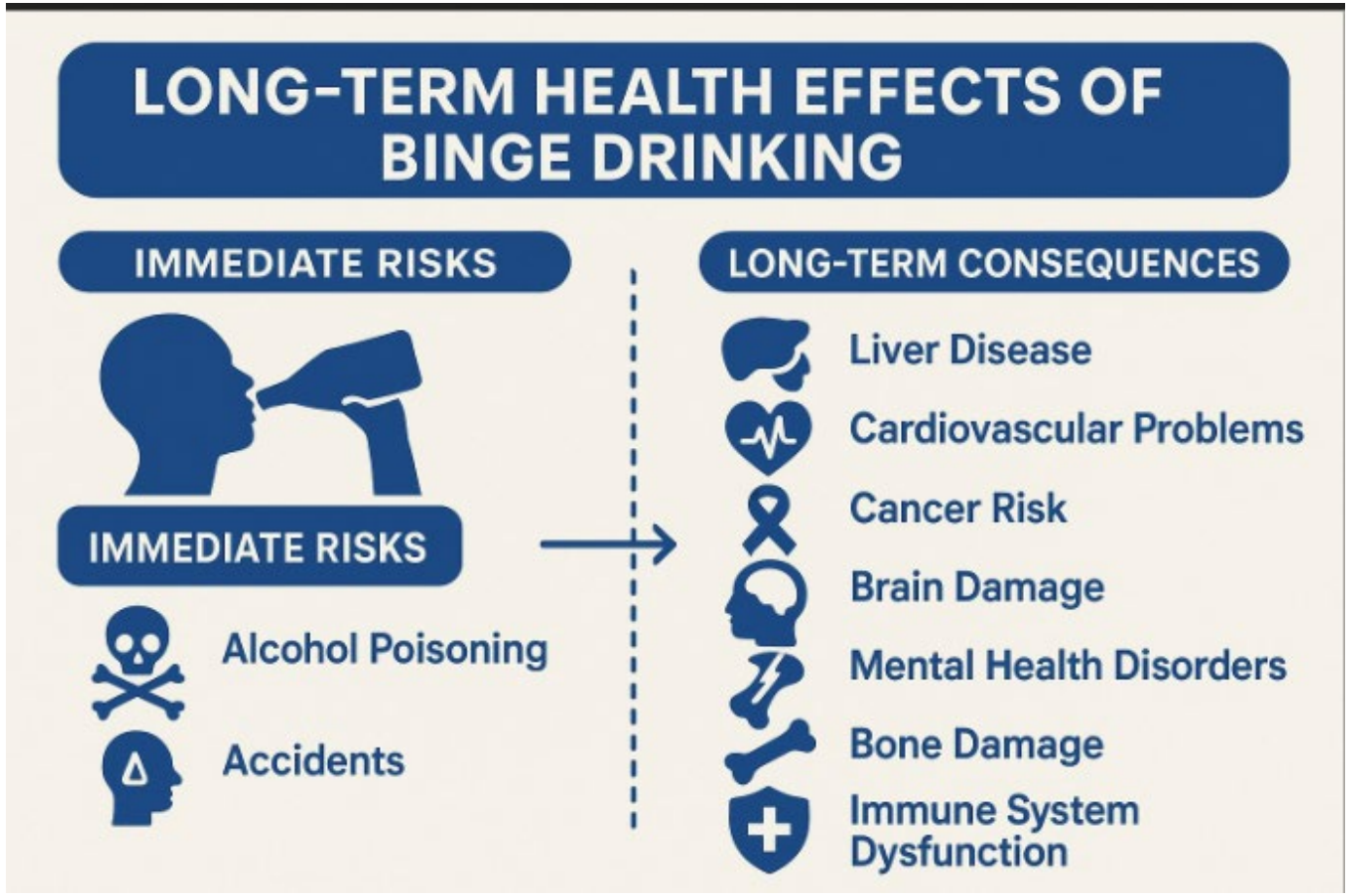
Long Term Effects of Drinking



(The Freedom Room, n.d.)

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Withdrawal Effects

Severe alcohol withdrawal is an **emergency** and **requires medical attention**!

(Prevention Conversation, 2015)

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Alcohol Use Disorder Diagnostic Criteria

1. Larger amounts and longer periods than intended
2. Unsuccessful efforts to cut down or quit
3. Spending a lot of time getting, using, or recovering from alcohol
4. Craving
5. Inability to fulfill work, school, or home duties
6. Social and interpersonal problems
7. Reduced or abandoned social, occupational, or recreational activities
8. Use when it is physically dangerous
9. Persistent physical or psychological problems
10. Tolerance (needing more over time/having a diminished effect)
11. Withdrawal (physical symptoms when stopping or using substances to relieve withdrawal symptoms

- **Mild** = meet 2-3
- **Moderate** = meet 4-5
- **Severe** = meet 6 or more

(APA, 2018)

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Remember the Three C's…

- **C**raving
- **C**ompulsions
- **C**onsequences ignored

(Public Safety Medicine, n.d)

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How prevalent is alcohol use disorder (AUD)?

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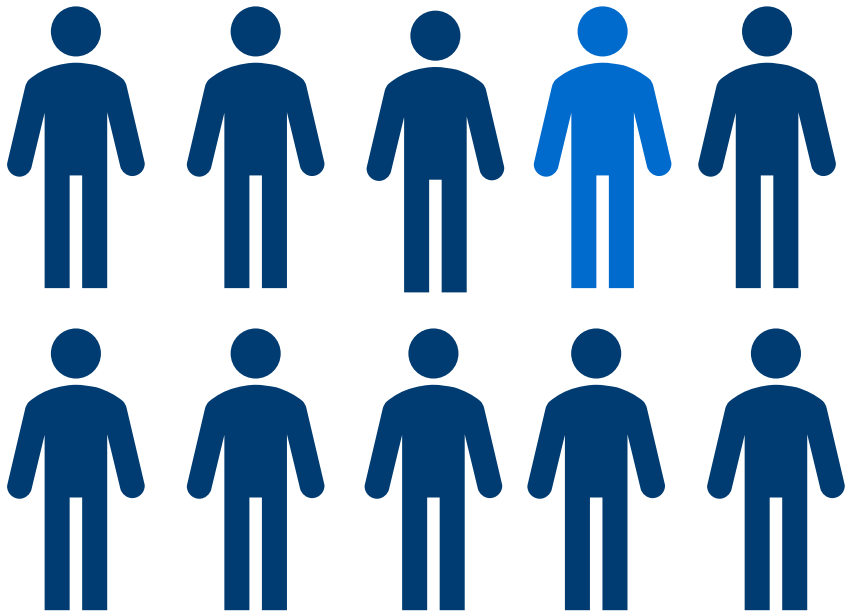
National Prevalence of AUD

- Roughly 10% of those ages 12+ in the United States have AUD
  - Reduced from 10.6% in 2021 to 9.7% in 2024!



(SAMHSA, 2025)

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Oregon Alcohol Use in Past Month 2023-2024

- For those aged 12+, **52.14%** reported past month alcohol use
  - **54.79%** for those aged 18-25
  - **56.16%** for those aged 26+

- For those aged 12+, **19.92%** reported past month binge drinking
  - **30.42%** of those aged 18-25
  - **20.11%** of those aged 26+

(SAMHSA, 2024)

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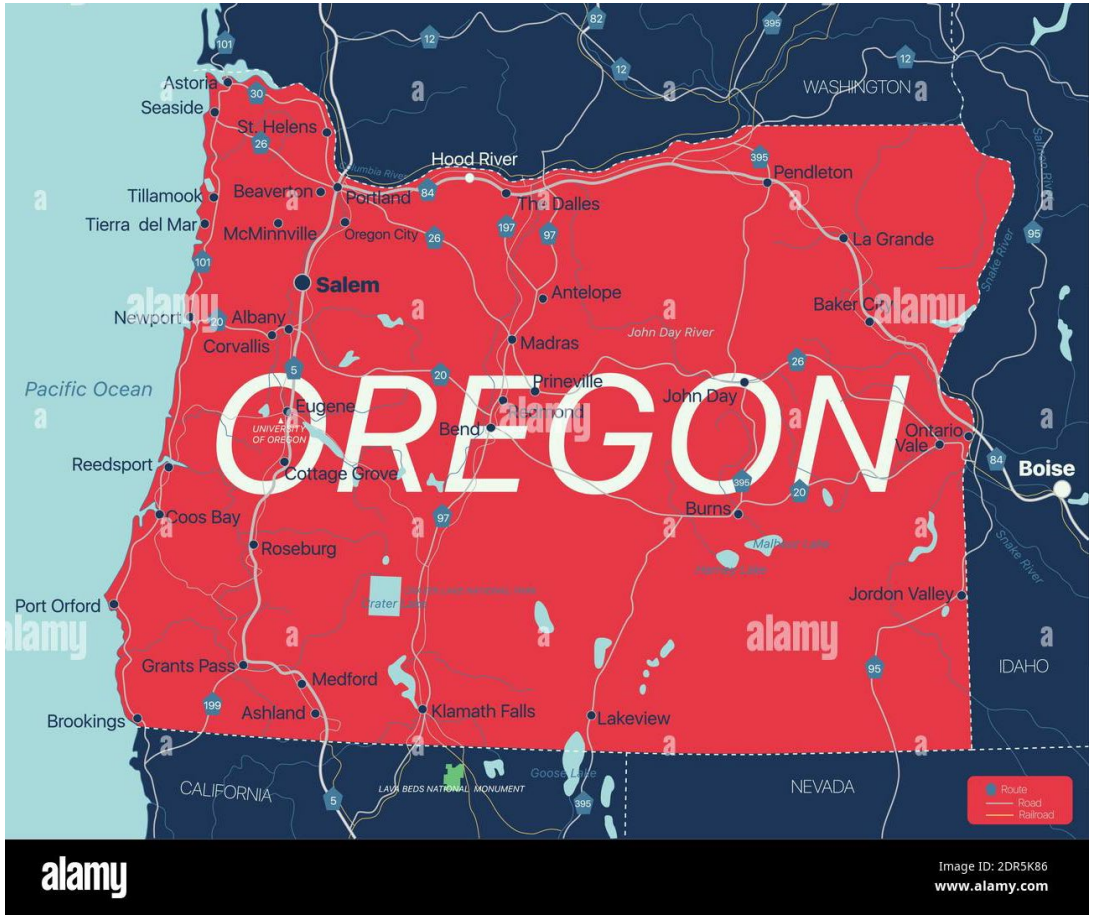
Past Year Alcohol Use Disorder in Oregon



- For those 12+, **11.69%**
  - **17.17%** for those aged 18-25
  - **11.71%** for those aged 26+

(SAMHSA, 2024)

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Ages of First Drink

70.7% begin before age 21

29.3% begin after 21

Relatively few begin drinking after age 25

(NIAAA, , 2025)

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Emerging Trends

- National alcohol use has been declining for the past three years
- Young people are embracing idea that drinking is detrimental
- Community and public health messaging
  - Rethink the Drink
  - NIAAA College AIM and Alcohol Interventions for Young Adults
  - World Health Organization's "No Safe Level"

(Gallup, 2025; NIAAA, 2025)

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What Treatment and Supports Exist?

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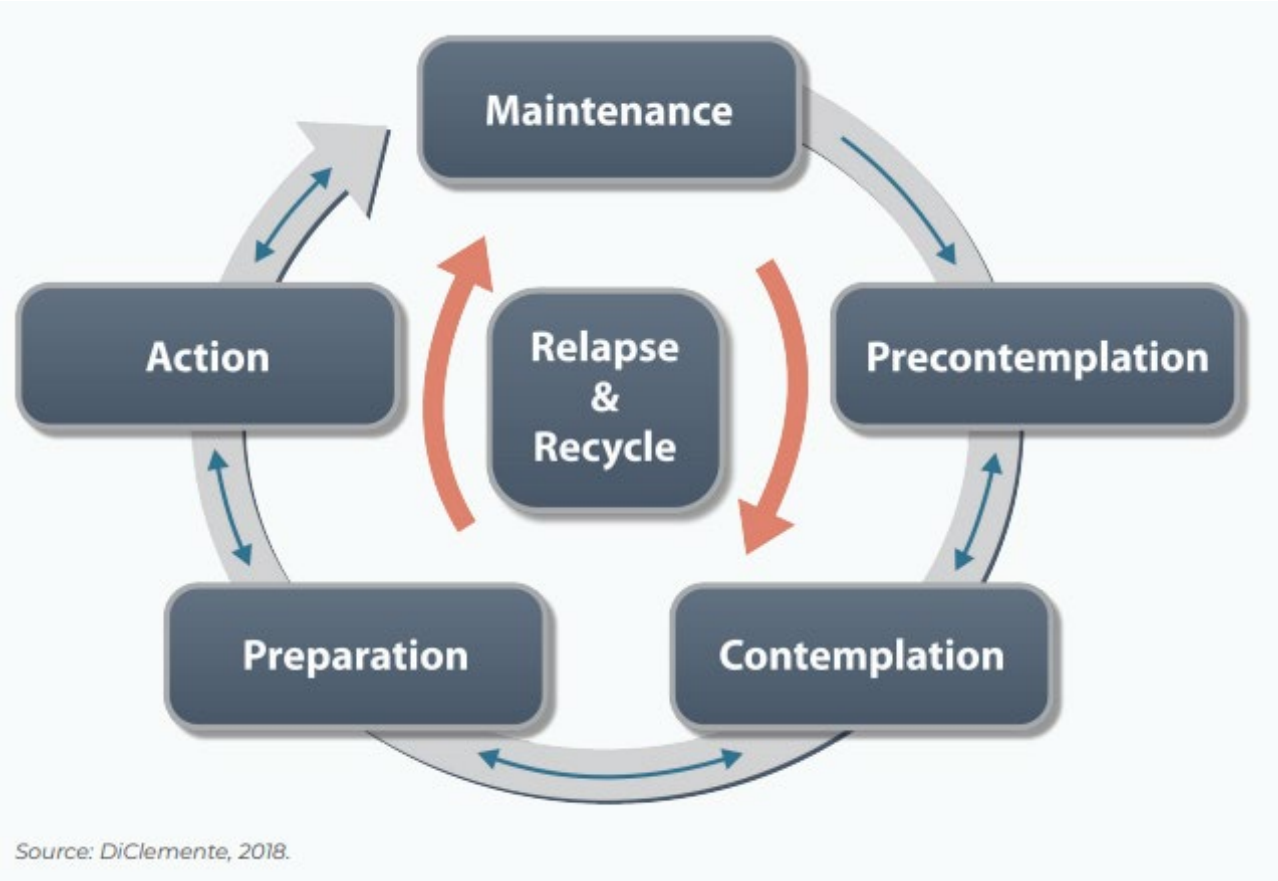
Stages of Change



Note: The Stages of Change don't always follow one path.

It's normal and expected for someone to move back and forth or all around the cycle.

(Prillo, 2023; SAMHSA, 2019)

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Where Can I Receive AUD Services?

- Primary Care
- Specialty Behavioral Health
  - Level 1: Outpatient treatment
  - Level 2: Intensive Outpatient/High-Intensity Outpatient treatment
  - Level 3: Residential Treatment
  - Level 4: Medically Managed Inpatient Treatment
- Community based
- Emergency departments

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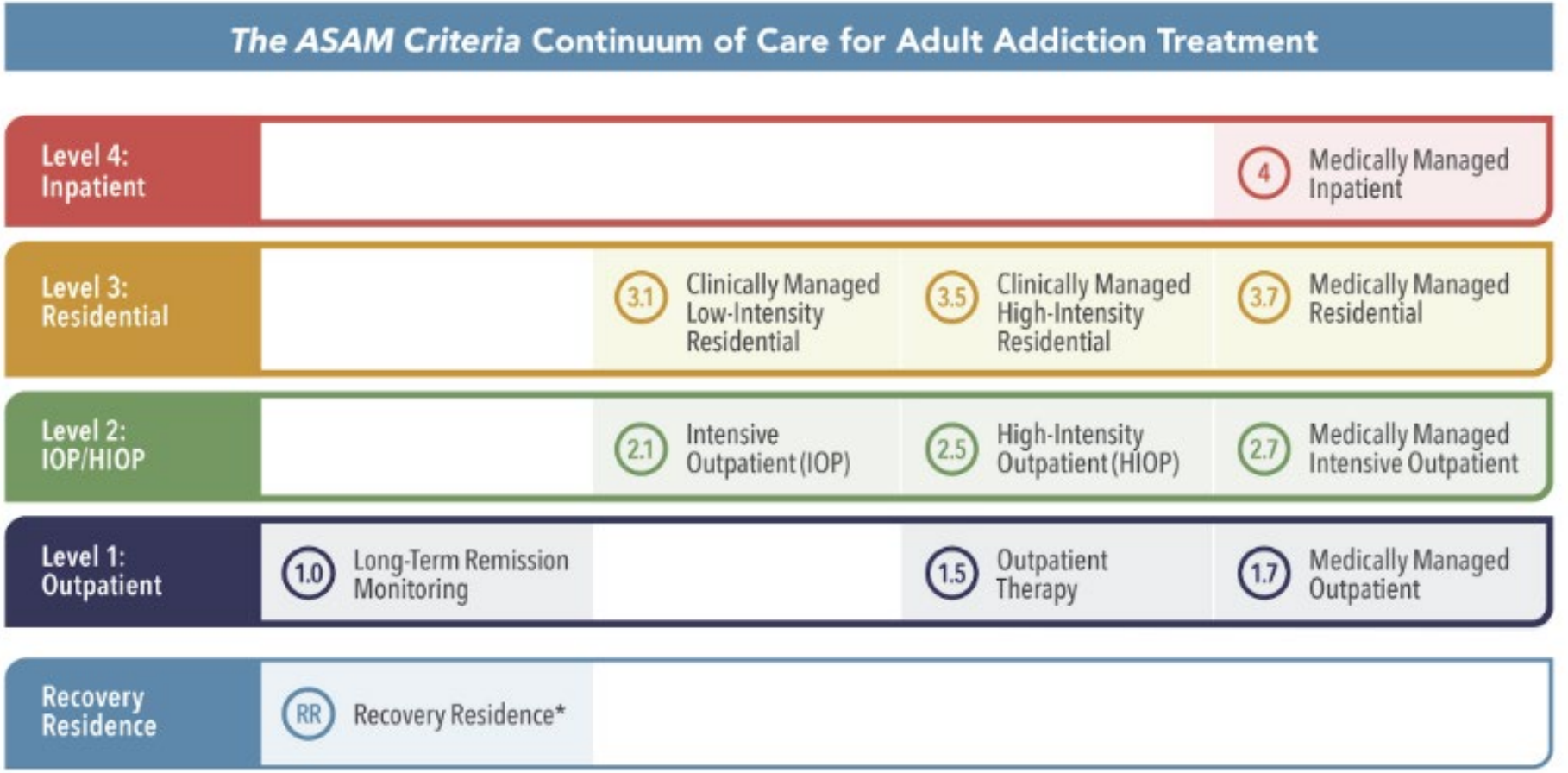
ASAM Continuum of Care



(ASAM, n.d.)

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Examples of Engagement and Support for AUD

- Primary Care
- Medications for substance use disorders only
- Reducing harms related substance use
- Intensive inpatient
- Medically managed withdrawal management (“detox”)
- Residential or inpatient treatment
- Intensive outpatient therapy
- Outpatient therapy
- Sober living
- 12-step or peer-support groups
- Prevention and education

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Medications for Alcohol Use Disorder

3 FDA-Approved Medications for Alcohol Use Disorder

- Naltrexone (oral medication: Revia® and injectable: Vivitrol®)
  - Works by dampening the pleasant sensations of drinking and lowers cravings.
  - Can be prescribed while still drinking
- Acamprosate (Campral®)
  - Works by easing the negative effects of withdrawal
- Disulfiram (Antabuse®)
  - Makes people nauseous when combined with alcohol. Not frequently prescribed anymore
- All available in primary care

(U.S. Department of Health and Human Services, n.d)

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Person-First Language

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What is Person-First Language?

- Emphasizes an individual's **humanity** before their condition.

- In context of SUD, it is someone who has a disorder, not someone who is disordered.
  - Examples:
    - "Person with a Substance Use Disorder"
    - "Person who uses substances"
    - "Person in recovery"

(ASAM, n.d)

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Why Use Person-First Language?

- Encourages and empowers people to seek care
- Communicates respect
- Promotes dignity
- Reduces stigma

(ASAM, n.d.; Bartholow, 2023)

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Language Matters:

A person is a person first, and a behavior is something that can change – terms like "drug addict" or "user" imply someone is "something" instead of someone

Perceived stigma is a barrier to care and we want people to feel comfortable when accessing services

People are more than their drug use and harm reduction focuses on the whole person

(ASAM, n.d)

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Engage Directly with the Person Using Alcohol

- Ask permission
  - "Would now be a good time to talk to you about resources?"
- Build the relationship and trust
  - "How can I make this easier for you?"
  - "You seem to have a good idea on what has worked for you."
  - "I appreciate you taking the time to talk with me today. Your time is important."
  - "We are here to help you reach your identified goal or next step"
- Ask about past experiences to move forward
  - "Have you had SUD treatment in the past?
  - "What was your experience like?"
  - "Would you like to learn more about treatment or resources?"

(Hartney, 2025)

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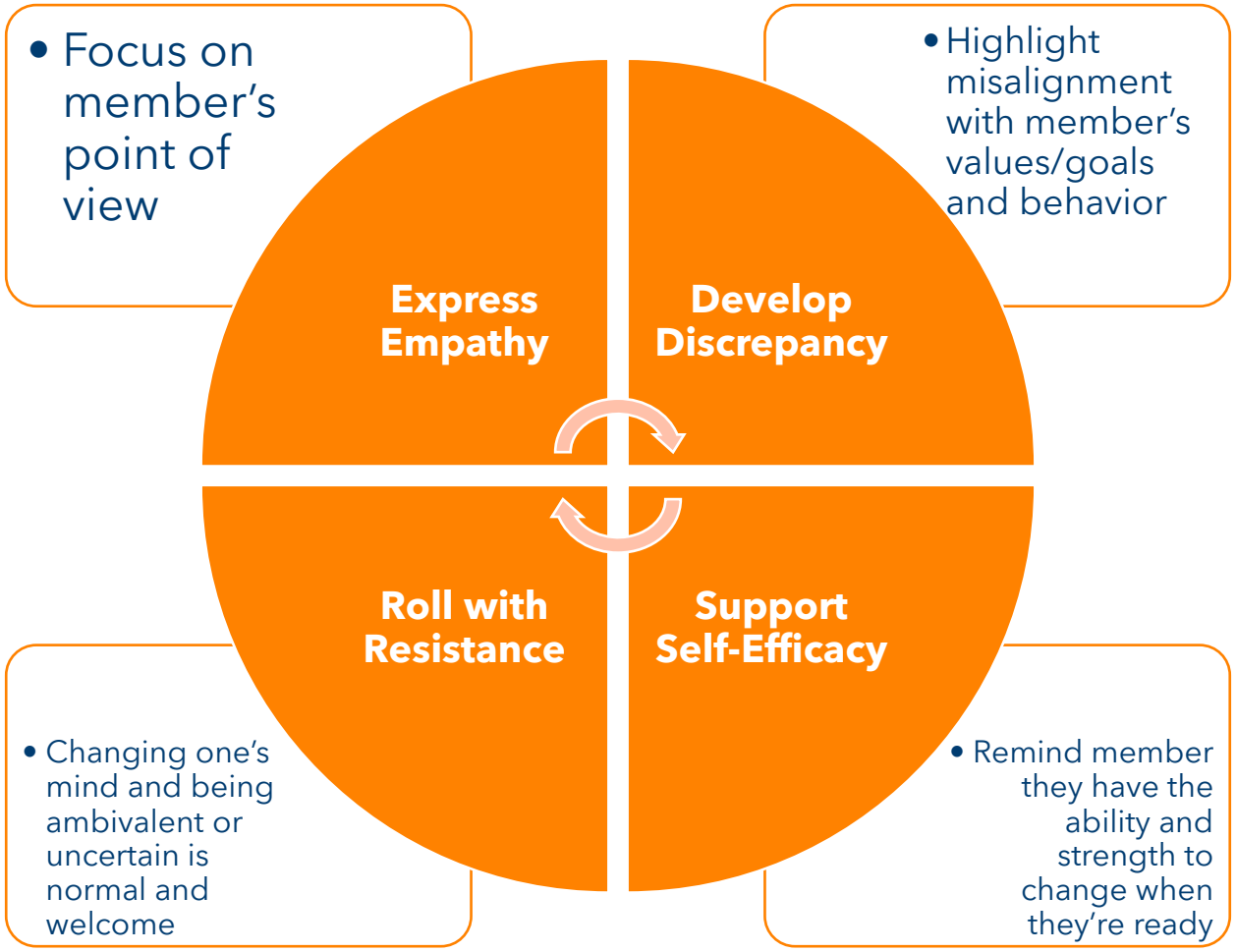
Applying Motivational Interviewing



(Hartney, 2025)

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Motivational Interviewing in Action

- Express empathy
  - "It sounds like you've been having a really hard time trying to reach your goals."
- Develop discrepancy
  - "What I hear you saying is that you would really like to work and that drinking has made it difficult to find and keep a job you enjoy."
- Roll with resistance
  - "It sounds like you aren't quite sure if you want to cut down your drinking yet. That makes sense! Are you open to talking about ways of staying safer while drinking?"
- Support self-efficacy
  - "It sounds like you have a good idea of what has worked and what hasn't. You have resources available to you when you are ready."

(Hartney, 2025)

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Harm Reduction and Safer Drinking Practices

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Is There a Recommended or "Safe" Amount of Alcohol?

- According to a 2023 World Health Organization analysis… **no!**

- "Currently available evidence cannot indicate the existence of a threshold at which the carcinogenic effects of alcohol 'switch on' and start to manifest in the human body."

(WHO, 2023)

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Safer Ways to Drink

- NA options
- Don’t mix with other substances (including medications!)
- Lower ABV drinks
- Keep keys away
- Don’t drink alone (neverusealone.com or 1-800-484-3731)
- Drink water and consume food

(Martens et al., 2005)

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Safer Ways to Drink

- Not to exceed #
- Buddy system
- Leave/stop drinking by certain time
- Extra water
- Extra ice
- Avoid drinking games and “shots”
- Sip, don’t chug
- Designated driver
- Monitor drink

(Martens et al., 2005)

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In Summary

- Alcohol is used for many reasons, and sometimes, a person's use can turn into a substance use disorder
- Alcohol use disorder is a treatable medical condition, and many treatment and support options exist
- Language is important! It can empower and create connection
- There are ways to mitigate risk while drinking

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Boulder

Telehealth addiction treatment grounded in kindness, respect and unconditional support.

The Boulder Approach to AUD | November 2025

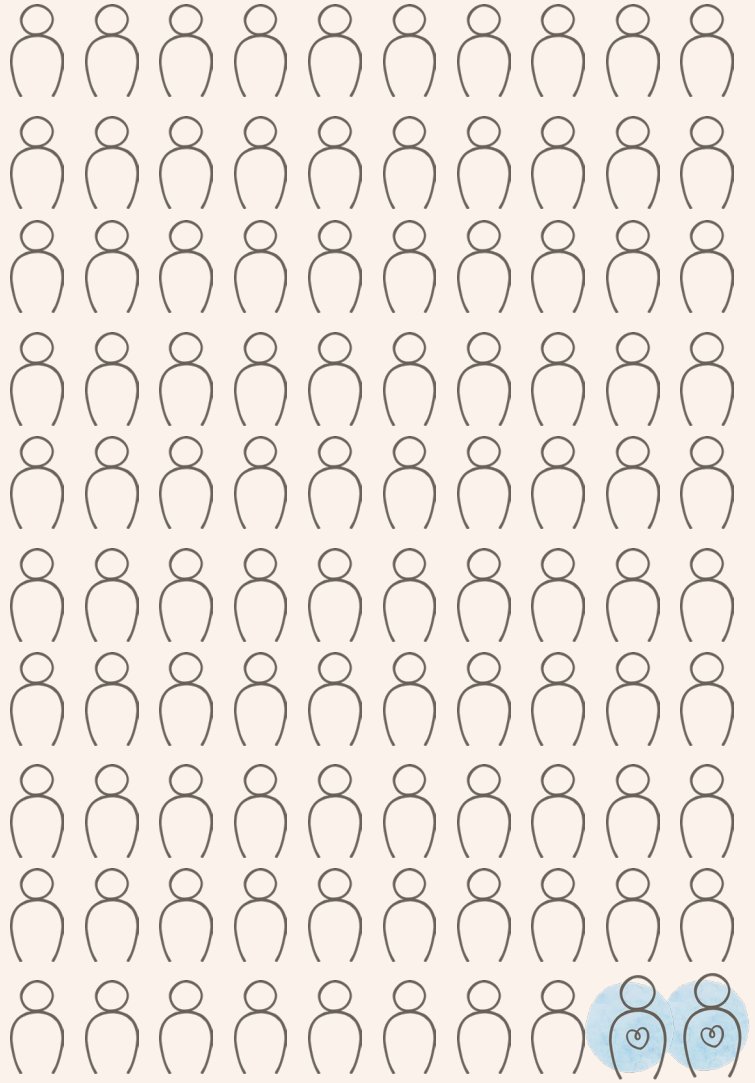
Alcohol Use Disorder (AUD) affects millions

27.1 million

Adults age 18 and over had AUD in 2024 compared to 9.4 million with OUD

2 in 100

AUD patients age 18 and older receive medication as part of their treatment



Source: SAMHSA, National Institute on Alcoholism and Alcohol Abuse

AUD and OUD often occur together

38% of people seeking OUD care have comorbid AUD

Case

Julia is a 45yo female with a history of anxiety and depression who presents for evaluation of AUD. She reports drinking **~8-10 white claws daily** for the past couple years. Started drinking ~16yo and has always been a regular consumer of alcohol but use escalated after divorce ~3 years ago.

No history of complicated withdrawal or hospitalizations.

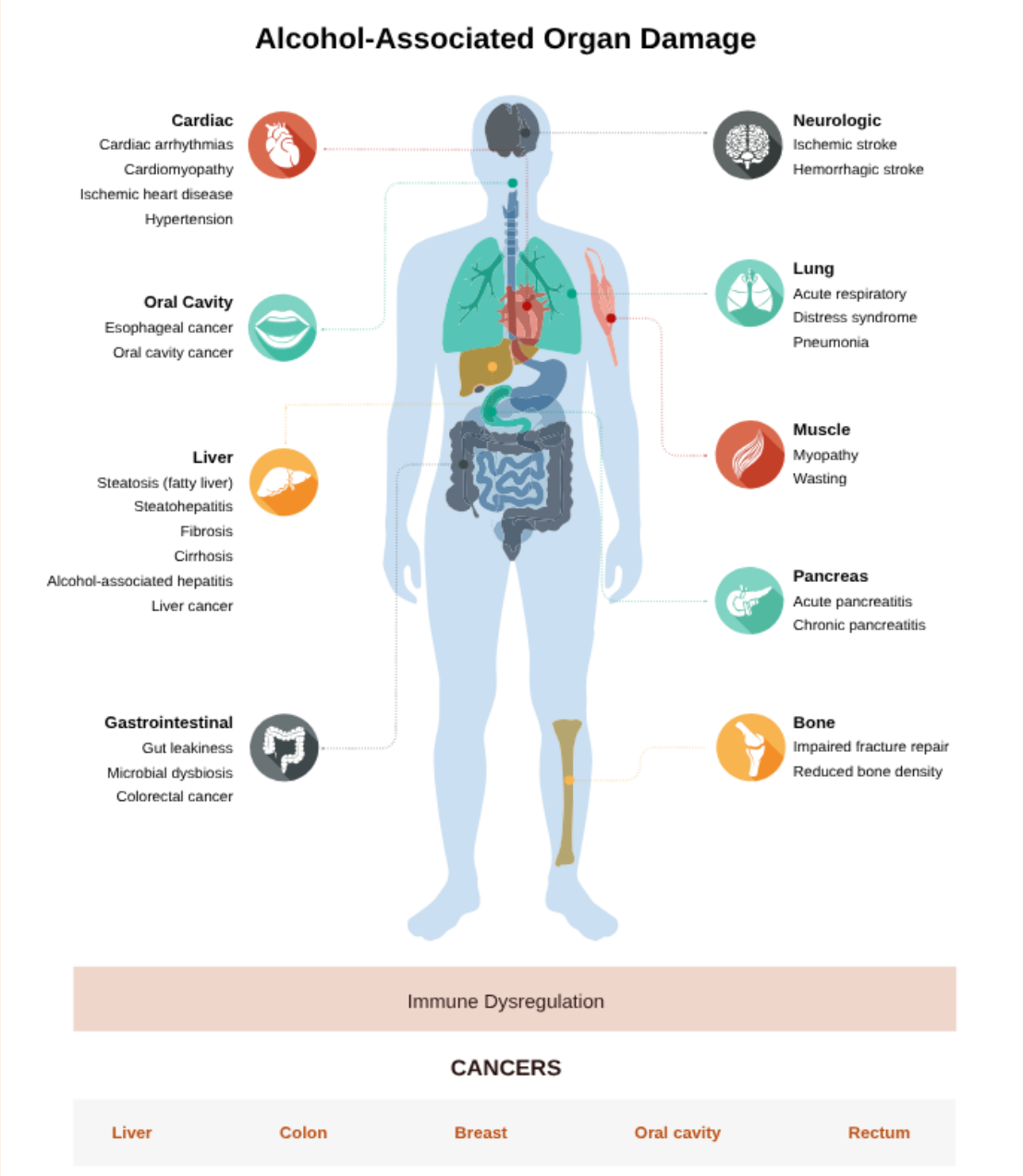
Has tried a couple times to quit on her own but feels incredibly anxious and overwhelmed when she reduces use.

She shares custody of her 13 and 15yo sons and works as a social worker supporting people with severe mental health diagnoses. She has noticed that he drinking has negatively affected her time at home and her ability to focus at work.

Inpatient does not feel like an option due to work and family obligations.

Poll Questions:

1. How comfortable are you offering medications to support someone through ambulatory alcohol withdrawal?
    a. uncomfortable - I often feel like these folks need a higher level of care
    b. It really depends on the patient
    c. Pretty comfortable - I've done this quite a bit in other settings
2. What are the biggest barriers to offering medications to someone interested in changing their alcohol use in our telehealth environment?
    a. Time - I just don't have enough time to assess risk
    b. Safety - I don't feel like we have the tools to assess and keep someone safe
    c. Other



Alcohol affects nearly every body system from our teeth and bones to our gut and heart.

2.5 - 5x higher relative risk of death compared to the general population

Source: National Institute on Alcohol Abuse and Alcoholism

Up to 70% of patients with AUD have comorbid anxiety disorders compared to ~18% in general population. 2-3x higher likelihood of co-occurring depressive disorder

Source: The Curbsiders Addiction Medicine episode #16

Timeline for withdrawal symptoms

- 6-36 hours – Minor symptoms including nausea, agitation, tremors, autonomic hyperactivity
- 6-48 hours – seizures
- 12-48 hours – hallucinosis (e.g. visual, auditory, or tactile hallucinations with intact orientation)
- 48-96 hours – delirium tremens (e.g. agitation, hypertension, fever, diaphoresis, delirium)

Alcohol withdrawal seizure = grand mal or generalized tonic-clonic seizures characterized by rhythmic, yet jerking movement, especially of the limbs, loss of consciousness, typically self-limiting

Alcohol hallucinosis = typically ego-dystonic, patient know they are not real

DTs = severe confusion, disorientation and/or hallucinations accompanied by severe autonomic dysregulation.

Source: The Curbsiders Addiction Medicine episode #16

Why medical care for AUD?

Nothing else is working

For many people with AUD, attempting to stop or manage their drinking simply doesn't work — nor do other non-medical options.

Regaining control

Unlike illicit substances, alcohol is interwoven into American culture. It's part of everyday life. Abstinence isn't for everyone.

Avoiding social consequences

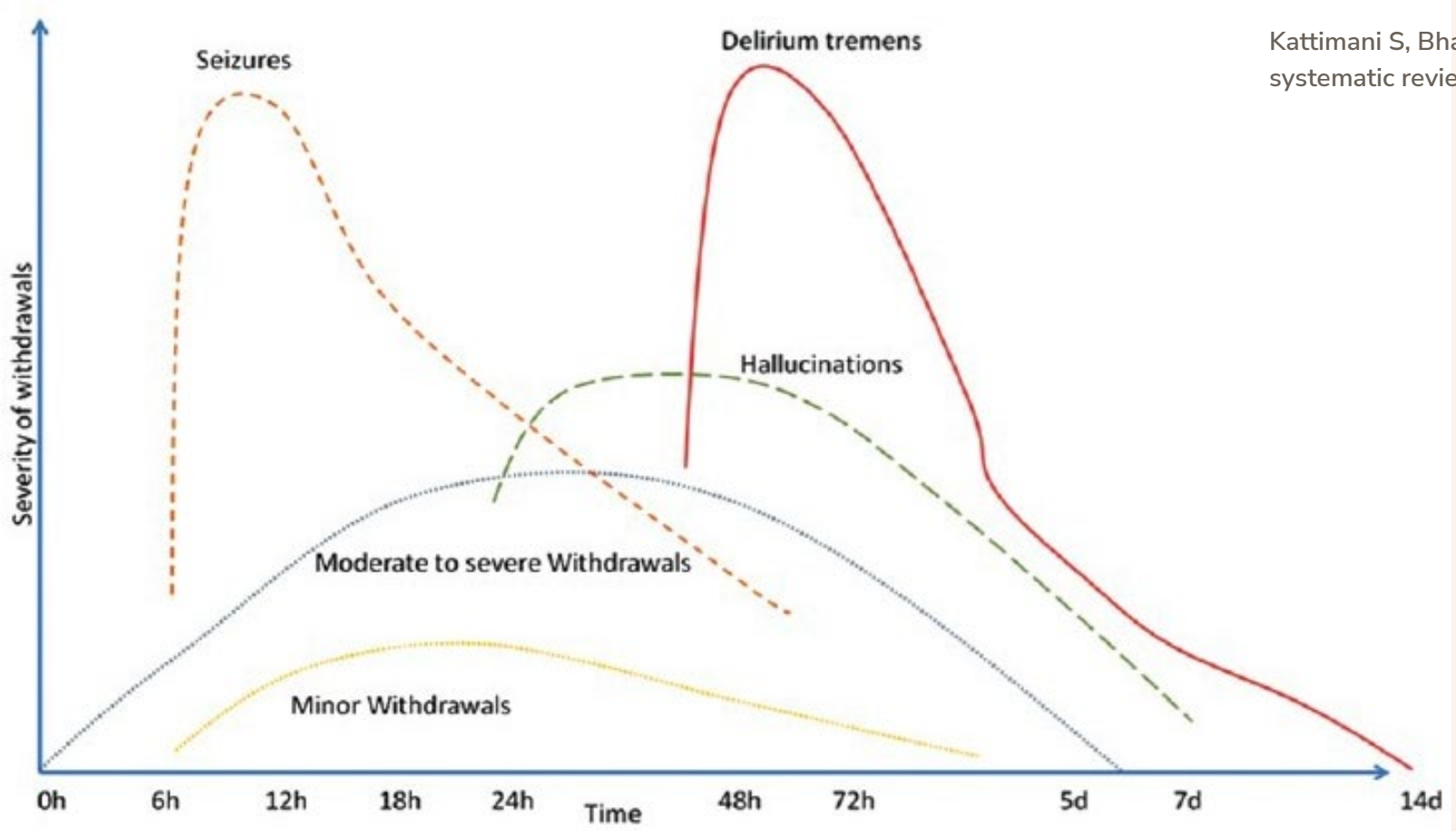
Unwanted drinking can put employment, family, and other relationships at risk. It's hard to manage without medical care.

Improving health

Prolonged use has detrimental effects on physical and mental health. Rebuilding health starts with managing alcohol use.

Legal involvement

Court- or jail-ordered mandate to seek treatment due to DUI or other alcohol-involved issues.



Kattimani S, Bharadwaj B. Clinical management of alcohol withdrawal: a systematic review. Ind Psychiatry J. 2013 Jul;22(2) :100-8

Several risk factors and warning signs can help identify who is at risk

- Up to 50% of folks with long term alcohol history will develop some degree of withdrawal symptoms within 24 hours of cessation
- 4-10% of people with severe alcohol withdrawal experience seizures
- If left untreated, one third of patients having withdrawal seizures are at risk to progress to delirium tremens
- Delirium tremens occurs in 3-5% of people hospitalized for alcohol withdrawal
- Mortality rate of delirium tremens is between 1-5% with treatment

Boulder Risk Stratification: supportive detox

Absolute contraindications

- ❑ History of -or- presenting with acute confusion or hallucinations from alcohol withdrawal (alcohol withdrawal delirium)
- ❑ History of -or- current seizures from alcohol withdrawal, or any recurrent seizure history
- ❑ Pregnancy

Relative Risks

- ❑ SAWS score >12
- ❑ >10 standard drinks daily

- ❑ >65yo
- ❑ **Comorbidities**: 4Cs (CHF, decompensated cirrhosis, CKD stage 3, COPD on O2), h/o traumatic brain injury (TBI), unstable psychiatric disease
- ❑ **Psychosocial**: availability of supports, transportation to higher level care

- **NOT eligible** for withdrawal medication support through Boulder
- **Advise AGAINST abrupt cessation**. Discuss comfort medications to support a gradual taper.
- Shared decision making. Discuss medication supports for abrupt cessation or gradual taper in line with patient's goals

Case follow-up

Julia was not ready to stop abruptly and opted for a supported gradual taper*. She is now taking gabapentin 300mg TID.

She also started taking lexapro, now 20mg/day to address chronic underlying generalized anxiety.

You have been meeting together for 6 weeks and she has cut down from 8-10 to 5-6 (12 oz) white claws a day and feels like she just wants to stop all together.

**safe gradual taper guidelines; 50% reduction every 4-7 days*

Withdrawal support for patients risk stratified as appropriate for outpatient management

Primary supportive medication:

- gabapentin 300-600mg TID
  - for patients appropriate for abrupt cessation a taper of gabapentin is also an appropriate option *(see table)*
- If gabapentin is contraindicated, and patient is working on gradual taper. Not supported as monotherapy if patient is planning abrupt cessation:
  - methocarbamol 750 - 1000mg QID
  - baclofen 5-10mg TID

Additional supportive medications:

- clonidine 0.1 - 0.2mg TID
- ondansetron 4-8mg BID prn

**discontinue comfort/support medications (including gabapentin) when no longer experiencing acute withdrawal (1-2 weeks after most recent alcohol use)*

Abrupt cessation taper	
	Gabapentin
Day 1	300mg QID
Day 2	300mg TID
Day 3	300mg BID
Day 4	300mg once
Additional PRNs	300mg x5
*600mg QID on Day 1 for higher risk patient	

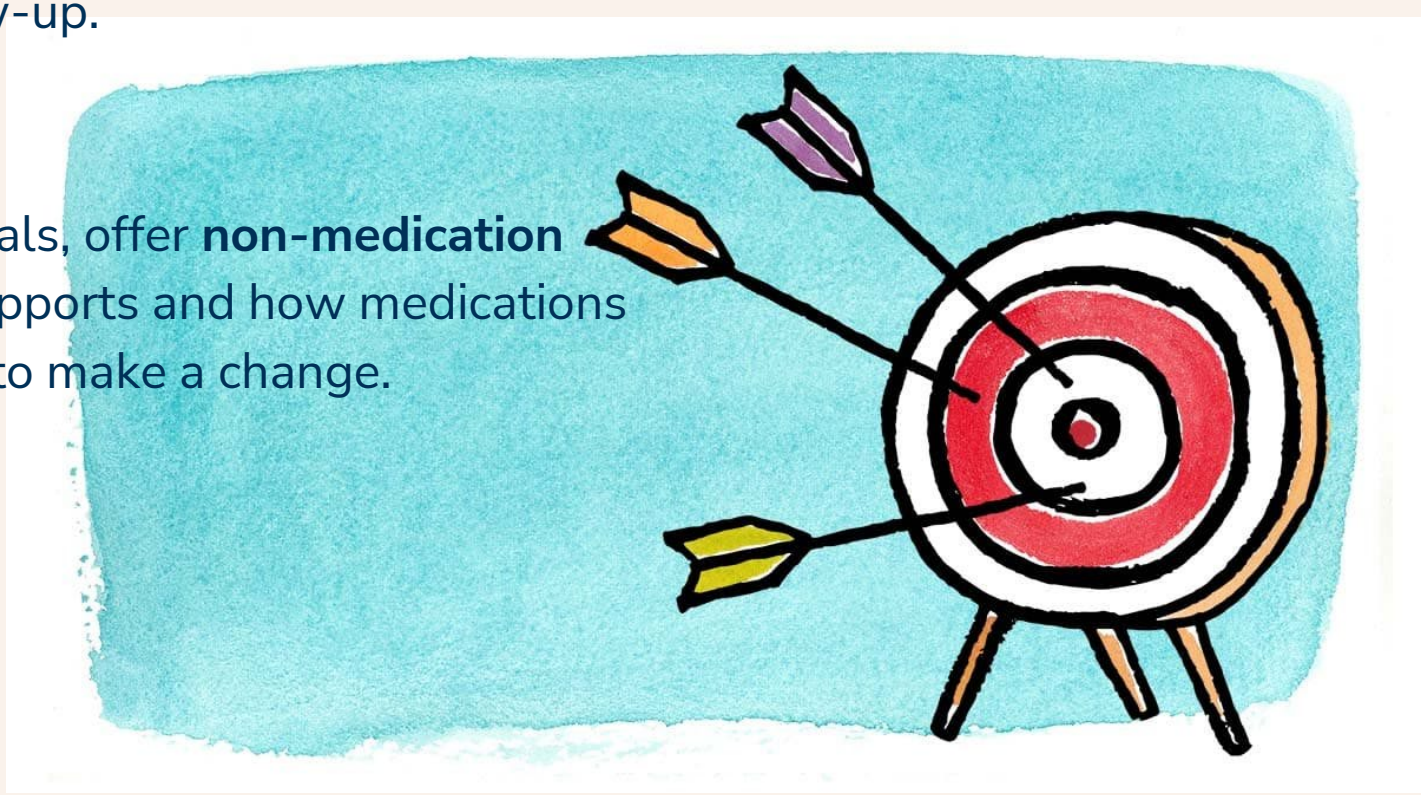
Warm hand off to Peer team encouraged!

Schedule follow-up with clinician every ~2-3 days during acute withdrawal phase

Additional medication tips

- Withdrawal and Maintenance medications should be initiated in conjunction with **clear outlined patient goals** that are SMART (specific, measurable, achievable, relevant, time-bound).
- Re-evaluate these goals at each follow-up.

- If a patient is **not** ready to set these goals, offer **non-medication support and education** on recovery supports and how medications might be helpful when they are ready to make a change.



Additional medication tips

- Consider **starting maintenance medications early**:
  - Acamprosate and naltrexone could be started simultaneously with either abrupt cessation or gradual taper. Disulfiram cannot be started until at least 12 hours after last alcohol intake, recommendation is 24 hours after. Talk about the plan for these early!
  - Absence of lab values, liver function and renal function should not be an impediment to initiation of treatment
  - Note that patients may experience nausea with acamprosate and especially naltrexone which may they may also be experiencing secondary to withdrawal. Offer temporary comfort medications to address this.

- if patient needing additional support after trial/discussion of first line medications, consider adding or **switching to second line** (gabapentin, topiramate). *Anyone receiving monotherapy of a second-line maintenance medication should have documentation stating why the first-line option failed*

Case follow-up

Julia was successful discontinuing alcohol use with a gabapentin taper and supportive medications.

She is now taking naltrexone 50mg/day, lexapro 20mg and buspirone 15mg TID and feels her anxiety has been manageable. She has been meeting with a Boulder peer for support every 2-4 weeks and started attending some SMART recovery meetings and a weekly gentle yoga class that she really looks forward to.

We can support people

With good risk stratification, ambulatory alcohol detox can be

- Safe and effective
- Shorter than an inpatient stay
- Much less expensive than an inpatient stay
- Build trust and autonomy

Questions?

Medication for AUD is safe and effective

~5% reduction in drinking days

Compared to placebo, injectable naltrexone was associated with 4.99 fewer drinking days over a 3-day treatment period.[1]

Increased days of abstinence

Acamprosate and oral naltrexone help prevent return to any drinking with 11 and 18 numbers needed to treat, respectively.[1]

MAT to support psychosocial treatment strategies

Studies show that when MAT is used in combination with psychosocial treatment strategies, outcomes improve. For example, when acamprosate is used with these strategies the number needed to treat is 9.[2]

Number Needed to Treat (NNT): the average number of patients who need to receive a specific treatment to prevent one additional bad outcome or achieve one additional positive outcome

Sources:

1. McPheeters M, O'Connor EA, Riley S, et al. Pharmacotherapy for Alcohol Use Disorder: A Systematic Review and Meta-Analysis. JAMA. 2023;330(17):1653–1665. doi:10.1001/jama.2023.19761
2. Rösner S, Hackl-Herrwerth A, Leucht S, Lehert P, Vecchi S, Soyka M. Acamprosate for alcohol dependence. Cochrane Database of Systematic Reviews 2010, Issue 9. Art. No.: CD004332. DOI: 10.1002/14651858.CD004332.pub2

Medication summary for AUD maintenance medications

TOP TIER MEDICATIONS

Acamprosate

For patients whose goal is to **reduce drinking** and are **using opioids** (including buprenorphine).

Naltrexone

For patients whose goal is to **reduce or stop drinking** altogether and are **not using opioids**.

SECOND LINE & ALTERNATIVE MEDICATIONS

Disulfiram

For patients whose goal is **total alcohol cessation** and drinking is not an option.

Topiramate & Gabapentin

Effective, off-label medications. Note: These have **not been FDA-approved** for treating AUD.

Naltrexone and Acamprosate

The best first-line therapy for AUD in most cases

	Naltrexone	Acamprosate
How it works	blocks opioid receptors that are involved in the rewarding effects of drinking & cravings for alcohol	reduces symptoms of protracted abstinence by promoting a balance between excitatory and inhibitory neurotransmitters
Dose	50-100mg oral, once daily *(consider starting at 25mg for a few days)*	333-666mg oral, three times a day
Side effects	nausea, vomiting, hepatic toxicity, precipitated opioid withdrawal	diarrhea, headache, insomnia, anxiety, muscle weakness, dizziness, suicidal ideation (rare)
Contraindications	Patients taking opioids or buprenorphine. Acute hepatitis or liver failure, LFTs 5x upper limit normal	severe renal impairment, CrCl <30mL/min
Monitoring	check liver function every 3-6 months	check renal function every 3-6 months

Disulfiram and Topiramate

Can be prescribed together, providing both a deterrent against initial drinking and help with managing cravings

	Disulfiram	Topiramate
How it works	a deterrent that works by blocking the breakdown of alcohol in the body, causing people to feel very sick	anti-seizure medication, not yet approved by the FDA for this indication
Dose	250mg oral, once daily	25mg daily for one week; then slowly titrate up to a maximum dose of 300mg per day
Side effects	will cause a significant physical reaction including nausea/vomiting, flushing, and heart palpitations if used with alcohol	cognitive impairment (eg, word-finding difficulties), paresthesias, weight loss, headache, fatigue, dizziness, and depression.
Contraindications	coronary artery disease, suicidality, transaminitis	pregnancy, renal impairment
Monitoring	check liver function every 3-6 months	none

Gabapentin

An option for when a first-line approach failed

	Gabapentin
How it works	Gabapentin helps by stabilizing neural activity, reducing the risk and intensity of withdrawal symptoms such as anxiety, restlessness, and the potential for seizures, and reducing the desire for Alcohol
Dose	300 mg once daily; increase dose based on response and tolerability in increments of 300 mg every 1 to 2 days up to a target dose of 600 mg 3 times daily
Side effects	drowsiness, fatigue, potential for dependency
Contraindications	Hypersensitivity to gabapentin, high risk for CNS depression (comorbidities and/or other meds)
Monitoring	none

Resources for AUD

Community Supports

Reddit: r/quitdrinking

Facebook “Be Sober — Quit Drinking & Enjoy Life

In the Rooms

Soberistas

Ben’s Friends (Hospitality Specific)

SMART Recovery

Recovery Dharma

Moderation Management

Books

“The Easy Way to Quit Drinking”
— *Alan Carr*

“This Naked Mind”
— *Annie Grace*

“We are the Luckiest”
— *Laura McKowen*

“Quit Like a Woman”
— *Holly Whitaker*

“The Unexpected Joy of Being Sober”
— *Catherine Grey*

Podcasts and Apps

Sober Powered: The Neuroscience of Being Sober

The Happy Sober Podcast

Sober Awkward

Hold My Drink

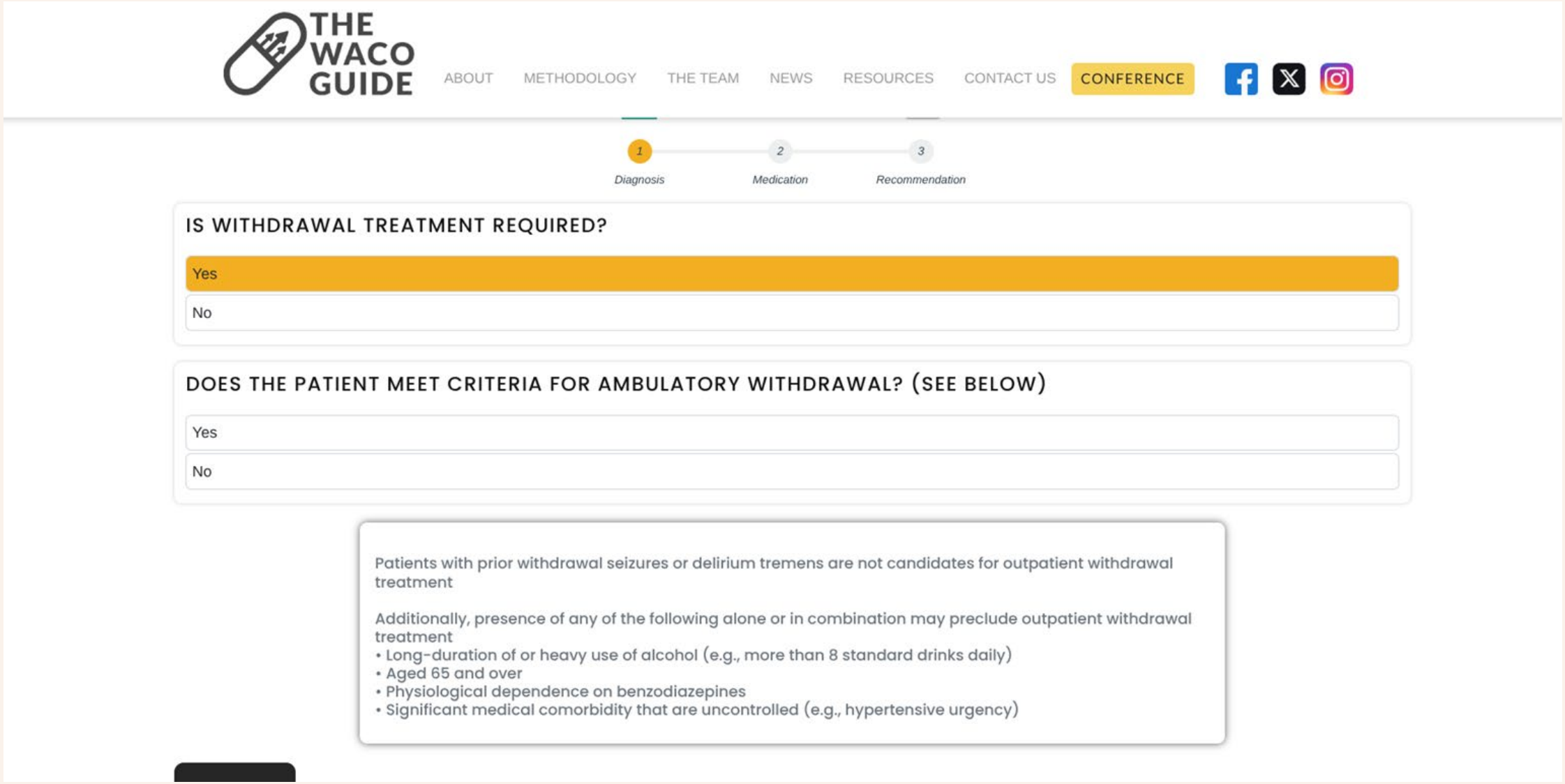
The Sinclair Method Podcast

The Way Out

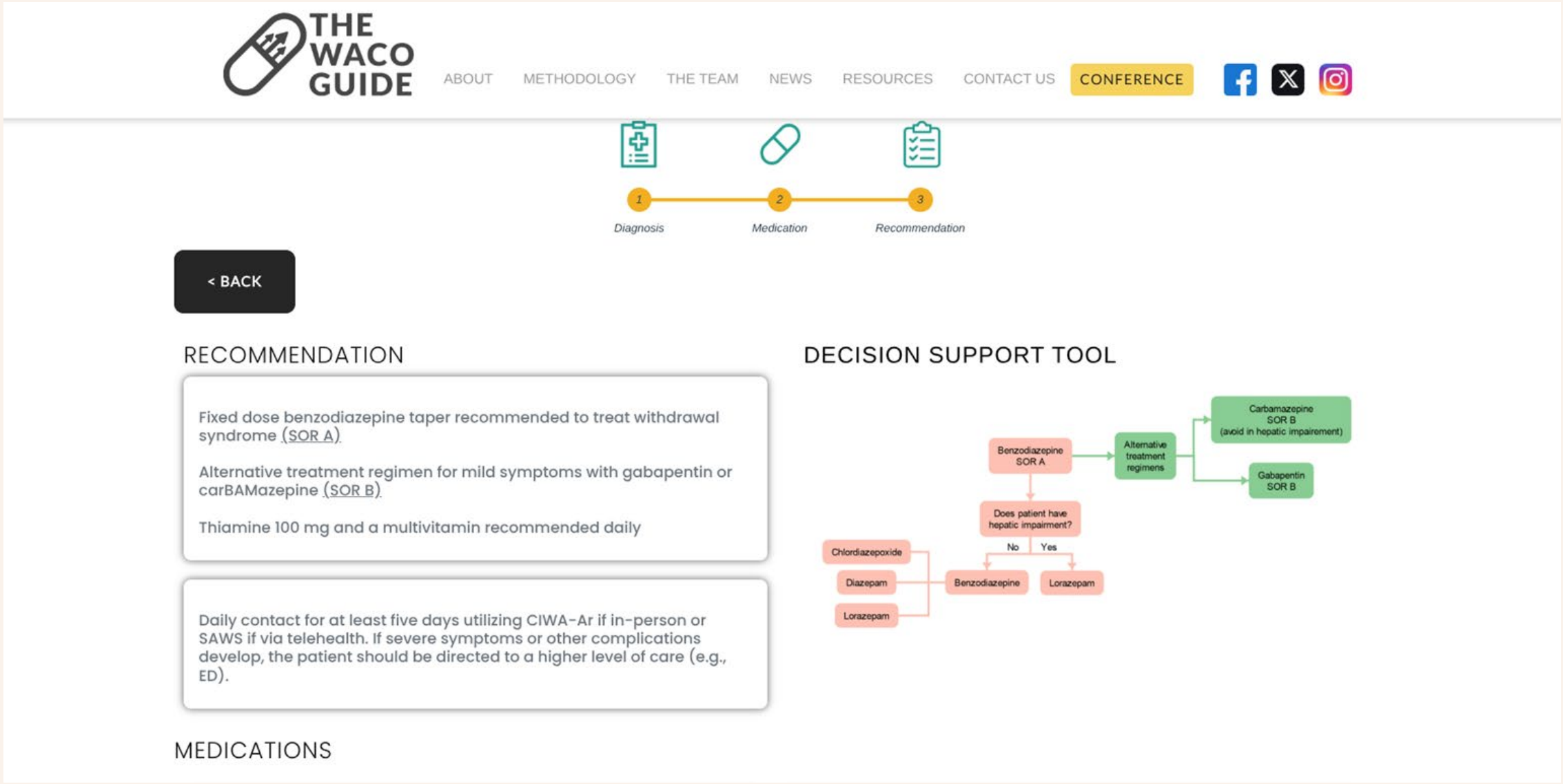
Recovery Hour

Seltzer Squad

The Waco Guide



The Waco Guide



chlordiazePOXIDE *Benzodiazepines*

Class: Benzodiazepines

Brands: Librium

Fixed-Dose Regimen:
Day 1- 50 mg every 6-12 hours
Day 2- 25 mg every 8 hours
Day 3- 25 mg every 12 hours
Day 4 -25 mg nightly
Day 5 -25 mg nightly
Do not use if comorbid hepatic impairment is present

Side effects (common):
Somnolence, ataxia

Side effects (rare/serious):
Anterograde amnesia, paradoxical reaction, increased fall risk, respiratory depression

Monitor:
No specific recommendation.

Additional Info:
FDA has issued a Drug Safety Communication requiring an update to the Benzodiazepine Box Warning to include the risks of abuse, misuse, addiction, physical dependence, and withdrawal reactions in order to help improve their safe use.

FDA box warning- Risks from concomitant use with opioids.

https://medlineplus.gov/druginfo/meds/a682078.html

LORazepam *Benzodiazepines*

Class: Benzodiazepines

Brands: Ativan

Fixed-Dose Regimen:
Day 1- 2 mg every 8 hours
Day 2- 2 mg every 8 hours
Day 3- 1 mg every 8 hours
Day 4 -1 mg every 12 hours
Day 5 -1 mg at nighttime

Side effects (common):
Somnolence, ataxia

Side effects (rare/serious):
Anterograde amnesia, paradoxical reaction, increased fall risk, respiratory depression

Monitor:
No specific recommendation.

Additional Info:
FDA has issued a Drug Safety Communication requiring an update to the Benzodiazepine Box Warning to include the risks of abuse, misuse, addiction, physical dependence, and withdrawal reactions in order to help improve their safe use.

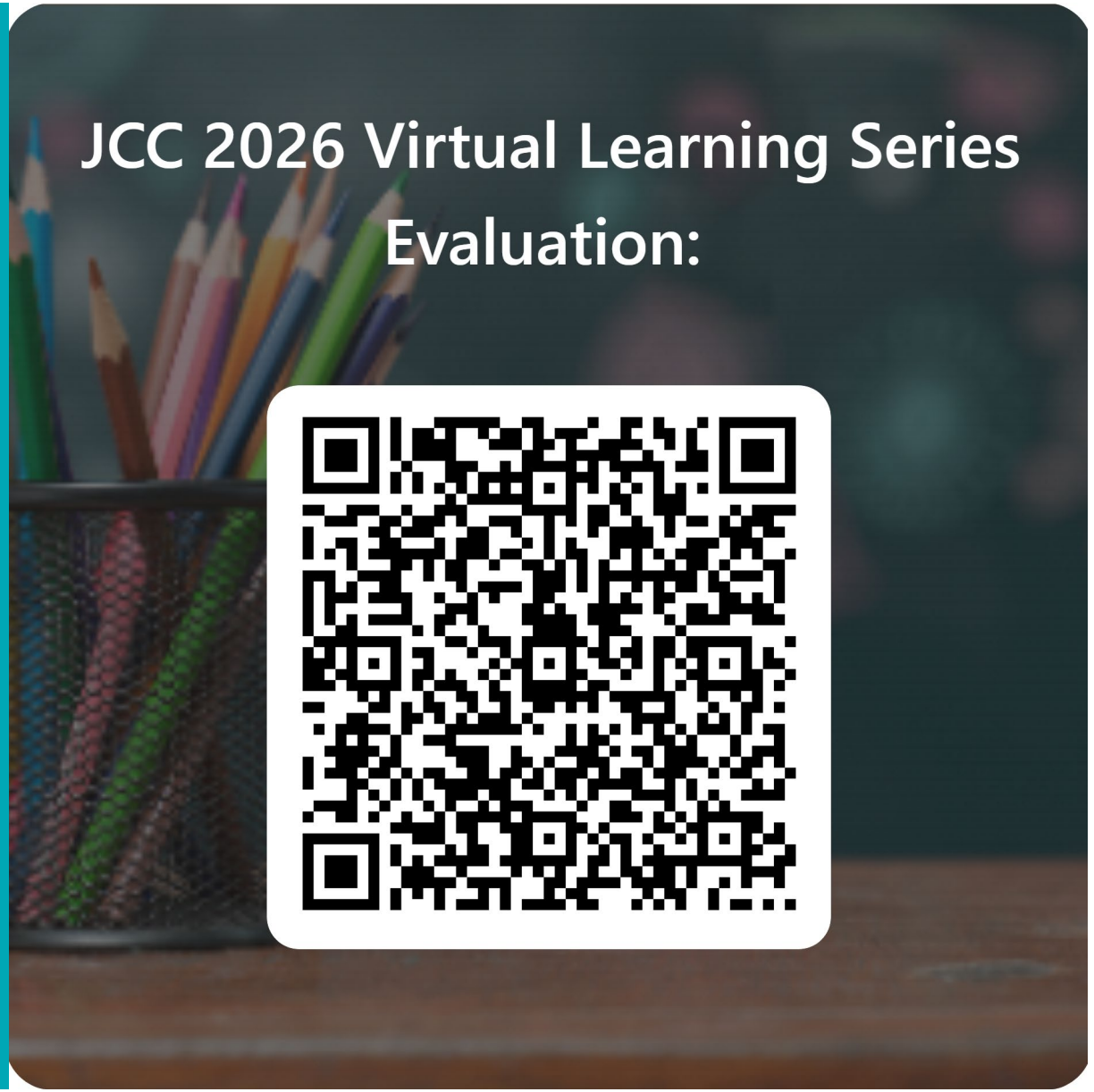
FDA box warning- Risks from concomitant use with opioids.

https://medlineplus.gov/druginfo/meds/a682047.html

Learning Series Evaluation

Your feedback is requested:

Help us improve and ensure we are offering meaningful learning sessions.



Jackson Care Connect™

JCC 2026 Learning Series Resources

Interested in future sessions?

- Check the JCC Learning Series webpage for announcements and registration links

[JCC Learning Series]

https://jacksoncareconnect.org/providers/jcc-learning-series

Questions?

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Health Equity, Diversity and Inclusion Manager

Jackson Care Connect

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