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Translating Research into Practice on Alcohol and Polysubstance Use Disorders
by Educating the Interprofessional Primary Care Team

Welcome to Weitzman Science to Practice: Alcohol Use Disorder!

We will begin the session shortly.

*Please keep your microphones on **mute** for now to avoid background noise.*

You are muted if there is a line across your microphone icon.

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Translating Research into Practice on Alcohol and Polysubstance Use Disorders by Educating the Interprofessional Primary Care Team

Welcome to Weitzman Science to Practice: Alcohol Use Disorder Summer 2026!

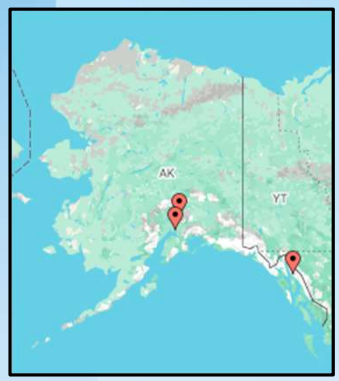
Session #2:

Navigating Research Evidence and the Emerging Role of GLP-1s in Alcohol Use Disorder Treatment

June 25, 2026

Our Learning Community

255 participants across 41 States, and 3 Countries



Technology: Your Zoom window

Sound

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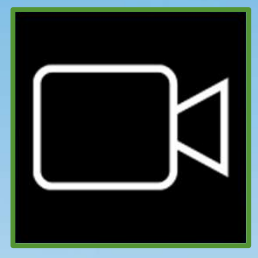

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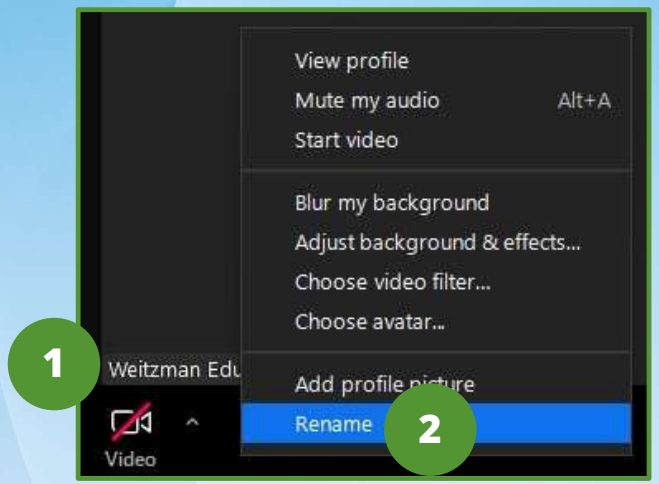
Technology: Your Zoom window, continued



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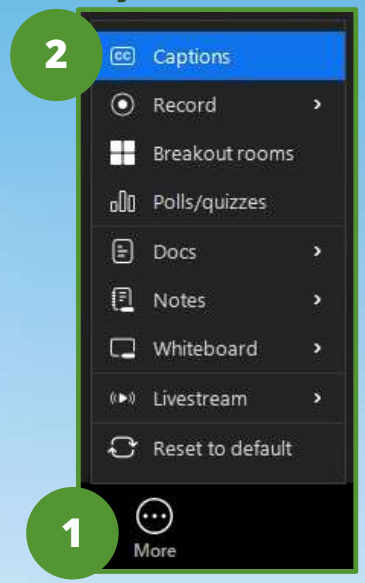

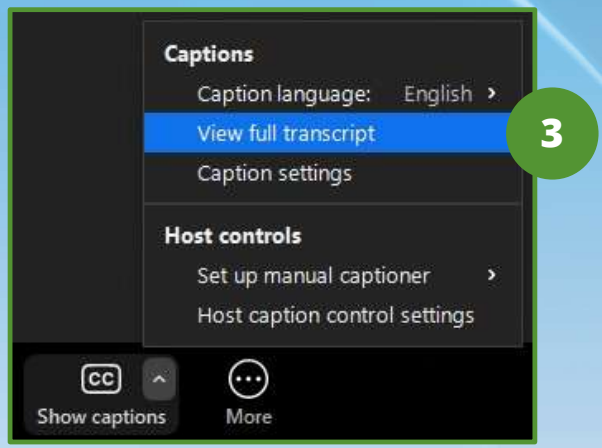

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2. Select “Captions”.
3. Select the carrot and then select “View full transcript”.

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In support of improving patient care, Moses Weitzman Health System is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

This series is intended for primary care providers (MDs, DOs, NPs, PAs) and behavioral health providers (psychiatrists, psychologists, social workers, therapists).

Please complete the post session survey and claim your post-session certificate on the WeP after today's session. **Please note: Pharmacists must claim credits within two weeks following today's session or we will not be able to award ACPE credits.**

You will be able to claim a comprehensive certificate on the WeP at the end of the series, July 9, 2026.

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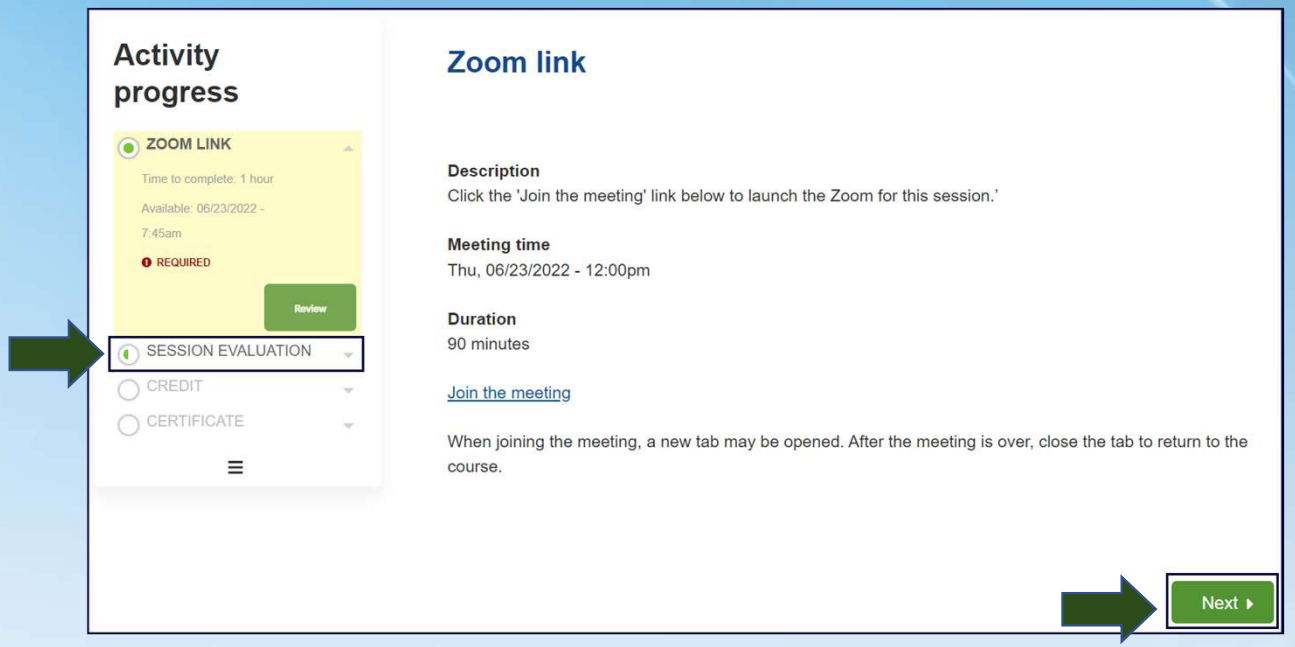
Program logistics post-session

Completing the session evaluation and claiming your CME/CE credit

After the live session has ended, **select the Next button or Session Evaluation** in the left-hand navigation bar.



Program logistics post-session

Completing the session evaluation and claiming your CME/CE credit

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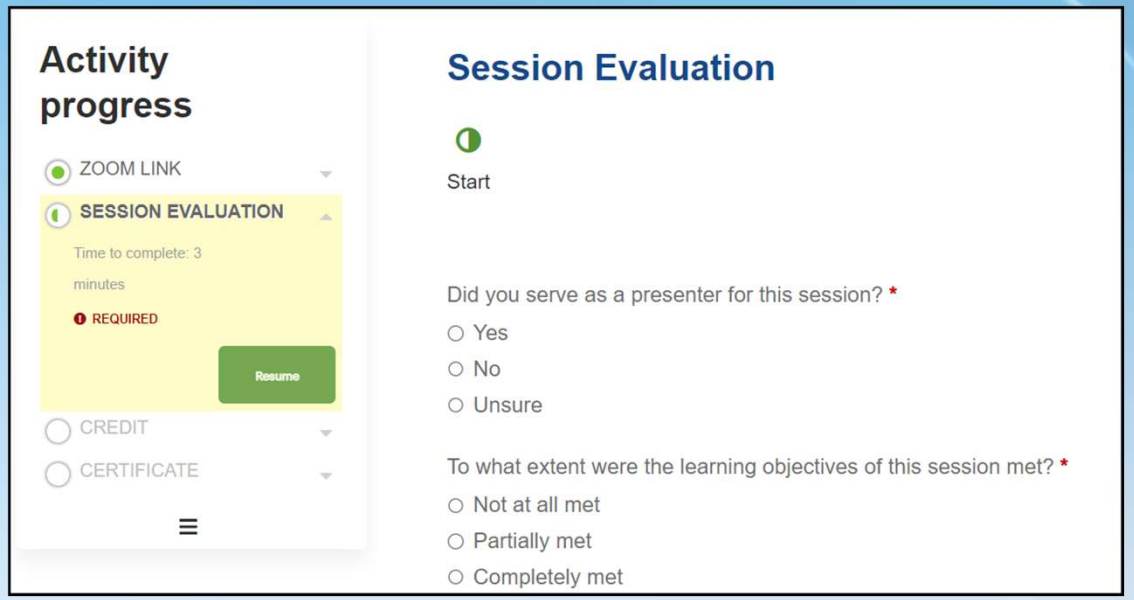

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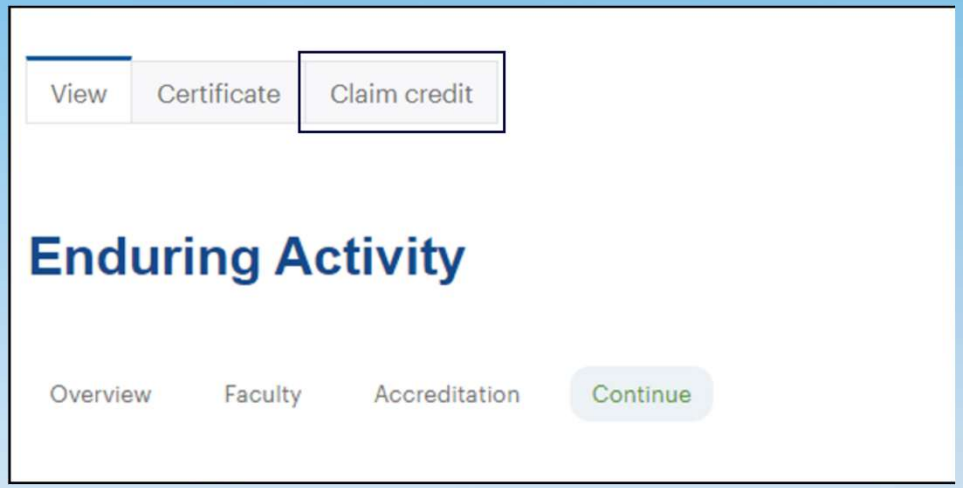

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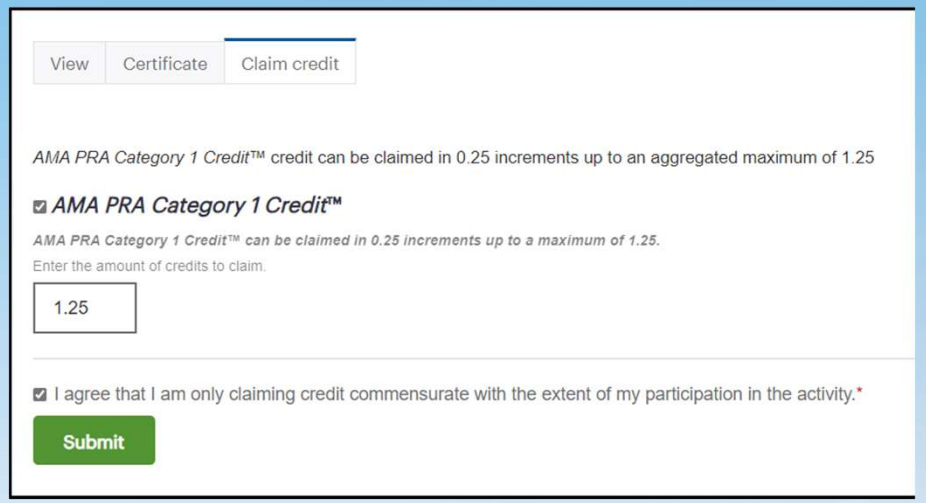
3. Enter the number of credit(s) commensurate with your attendance for the activity.
4. You may only claim credit(s) **once**, so be sure you have completed all session activities **before** completing this step.
5. Then, select **Submit**. You will then be able to download your certificate.



Weitzman Education Platform: End of Series Credit Claiming

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- **For additional instructions**, please read:
  - How do I claim credit at the end of an activity?
  - How do I view and download my certificates?
- **Still have questions?**
  - Submit a Help Desk Ticket and someone from the WeP team will respond and an assist!

Accessing session recordings and materials

1. Return to the **Overview tab** of the live activity, *Weitzman Science to Practice: Alcohol Use Disorder – Modern Screening and Evolving Treatment Strategies (May 28, 2026)*
2. Scroll down to the **Required Readings, Presentation Slides, and Session Recording** headers

You will then be able to click on **Required Readings, Session Recording, and Presentation Slides** listed below the headers to access the resources.

This Weitzman Science to Practice session has been made available by:

NIH R25 Alcohol and Other Substance Use Research Education Programs for Health Professionals

This project is supported by the National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health under Award Number R25AA031951 to translate research into practice on preventing, screening for, and treating alcohol use disorders in primary care. The content is solely the responsibility of the Weitzman Institute and does not necessarily represent the official views of the National Institutes of Health.

Disclosures

- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the faculty listed above or other activity planners and any ineligible company in the past 24 months which would be considered a relevant financial relationship.
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All Are Welcome

Learning Objectives

By the end of this session participants will be able to:

1. Use a clinical question to guide literature searches
2. Evaluate strengths and limitations of observational research
3. Describe why GLP-1 receptor agonists are biologically plausible treatments for addictive behaviors
4. Critically appraise the BMJ 2026 GLP/SUD Study
5. Apply findings appropriately to clinical practice

Case Discussion – Meet Bill

WM is a 61-year-old male:

- Severe alcohol use disorder
- Lived in the area for his entire life
- One of 12 children, his father left when he was very young
- Worked doing manual labor all his life
- History of difficult maintaining housing
- Multiple alcohol related Emergency Department visits
- Falls and Bar fights
- Progressive medical complications

Bill Today

Current situation:

- Fatty liver disease
- Mild hypertension
- Sleep apnea
- Prior upper GI bleed
- Severe alcohol cravings
- Multiple relapses
- Family concerned
- Siblings increasingly involved

Previous interventions:

- Declined rehab
- Declined detox
- Not interested in AA
- Naltrexone ineffective
- Declined acamprosate
- Declined disulfiram

Why is Bill So Difficult?

Not because:

- He lacks intelligence
- He lacks insight
- He lacks support

In fact:

- He understands alcohol is harming him
- He likes his physician
- He has family support
- He wants fewer consequences (He wants a TKR)
- Yet he continues to drink.

Why?

Poll

Why do patients like Bill continue to drink despite severe consequences? (Select your "top" choice)

- Lack of motivation
- Trauma history
- Physiologic dependence
- Craving
- Social environment
- Something else

Salience

Salience = what the brain decides is important

Examples:

- Fire alarm
- Spider/Snake
- Baby crying
- Someone shouting your name
- Text saying “Call me immediately”

The brain automatically prioritizes these signals.

Addiction as Disordered Salience

Most people walking down the street notice:

- Restaurants
- Stores
- Traffic
- Other people

Bill notices:

- Every bar
- Every beer sign
- Every drinking cue

Alcohol occupies disproportionate mental space.

The problem may not be insight.

The problem may be salience.

From Pleasure to Salience

Early addiction: "I drink because I enjoy it."

Established addiction: "I think about drinking all the time."

Advanced addiction: "I drink even when I don't want to. I drink to feel normal"

Addiction is increasingly about salience, craving, and compulsion rather than pleasure.

What If Craving Is a Biologic Target?

Traditional treatments often focus on:

- Withdrawal
- Consequences
- Behavior change

But what if we could reduce:

- Craving
- Cue reactivity
- Compulsive reward seeking

Why Are We Talking About GLP-1s?

Initially:

- Diabetes treatment

Then:

- Weight loss treatment

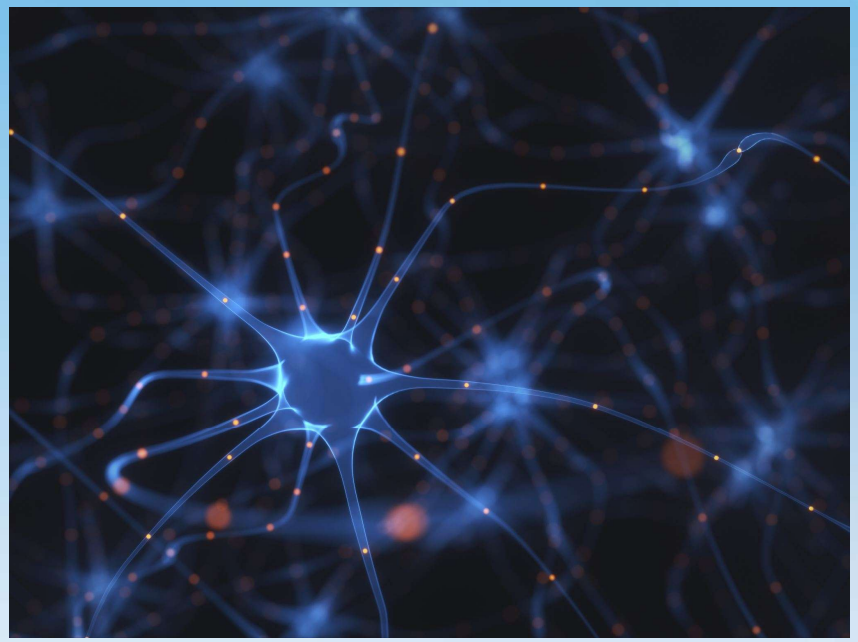
Now:

- Potential effects on reward circuitry
- Potential effects on craving
- Potential effects on addictive behaviors

Before changing practice, how do we evaluate the evidence?

Simple Reward Circuitry

PFC	Judgement Impulse Control Executive Function Decision making
NAc	Reward and Pleasure Reinforcement Craving Goal Directed behavior Compulsive Seeking
VTA	Dopamine Signaling The Engine Room
Hip	Memory Contextual Clues



Why GLP-1 Biology Is Plausible

GLP-1 receptors are found in areas involved in:

- Reward
- Motivation
- Learning
- Cue response
- Reinforcement

Animal studies suggest effects on:

- Drug seeking
- Alcohol consumption
- Reward responses

We have a question… now what?

- Turn clinical uncertainty into a searchable question
- Separate signal from hype
- Practice journal-club reasoning with one current article
- Leave with a usable framework that fits in busy clinical practice

GLP-1 RAs are biologically plausible — but biologically plausible is not the same as clinically ready.

Turn the case into an answerable question

P **Patient / problem**

Adult in primary care with T2D/obesity and alcohol, opioid, nicotine or other SUD concern

I **Intervention**

GLP-1 receptor agonist initiation or continuation

C **Comparator**

Other diabetes/weight-loss medications, usual care, placebo

O **Outcome**

Craving, use, remission, overdose, ED visits, hospitalizations, mortality

Searchable version

In adults with diabetes/obesity and SUD risk or existing SUD, are GLP-1 receptor agonists associated with lower substance-related diagnosis or harm compared with active comparators?

Poll: where do you get your "first pass" answer?

A patient asks whether Ozempic might help with alcohol cravings. Where would you look first?

- Colleague / curbside
- Google / media
- UpToDate / Dynamed
- PubMed / Google Scholar
- Guideline / society statement
- OpenEvidence or other AI tool

A free-source search that takes five minutes

1	**Start broad**	OpenEvidence, Google Scholar, PubMed: GLP-1 receptor agonist substance use disorder
2	**Narrow**	Add substance, setting, trial/cohort, comparator, outcomes
3	**Filter**	Recent, humans, clinical trial, systematic review, guideline
4	**Trace**	Follow editorials, citing articles, references, study registry

Pearl: read the abstract last. First identify the question, design, comparator, outcome, and denominator.

What kind of evidence would change practice?

Guidelines / implementation evidence	What should systems do?
Randomized trials	Does starting this lead to benefit?
Target trial emulation / well-designed cohorts	What happens in real-world treated patients?
Case reports / mechanistic studies	Is there a plausible signal?
Headlines / social media	What should we verify?

For GLP-1 RAs and SUD: a strong cohort can justify "pay attention" — not "prescribe off-label as addiction treatment."

Observational studies and randomized trials answer different questions

Well-designed observational cohort

- Large real-world populations
- Can study rare or serious harms
- Faster, cheaper, pragmatic
- Vulnerable to confounding, misclassification, selection

Randomized controlled trial

- Best design for causal effect
- Pre-specifies intervention and outcomes
- Can measure craving/use directly
- Often small, selective, expensive, short follow-up

Translation : “associated with” is not just hedging — it is the correct verb.

OpenEvidence

Share | New Conversation

In adults with diabetes/obesity and SUD risk or existing SUD, are GLP-1 receptor agonists associated with lower substance-related diagnosis or harm compared with active comparators?

Analyzed query, searched for evidence

Harm Reduction in Pre-Existing SUD

Among 81,617 veterans with pre-existing SUD, GLP-1RA initiation (vs. SGLT-2 inhibitors) was associated with markedly reduced adverse outcomes: BMJ

- **SUD-related ED visits**: HR 0.69 (0.61–0.78)
- **SUD-related hospitalizations**: HR 0.74 (0.65–0.85)
- **SUD-related mortality**: HR 0.50 (0.32–0.79)
- **Drug overdose**: HR 0.61 (0.42–0.88)
- **Suicidal ideation or attempt**: HR 0.75 (0.67–0.83)

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Glucagon-like peptide-1 receptor agonists and risk of substance use disorders among US veterans with type 2 diabetes: cohort study

Cai et al

BMJ

March 2026

BMJ. 2026 Mar 4:392:e086886. doi: 10.1136/bmj-2025-086886.

Glucagon-like peptide-1 receptor agonists and risk of substance use disorders among US veterans with type 2 diabetes: cohort study

Miao Cai [1 2], Taeyoung Choi [1 2 3], Yan Xie [1 2 3 4], Ziyad Al-Aly [1 2 5 6 7]

FULL TEXT LINKS

BMJ Open Access Full Text

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ACTIONS

Cite

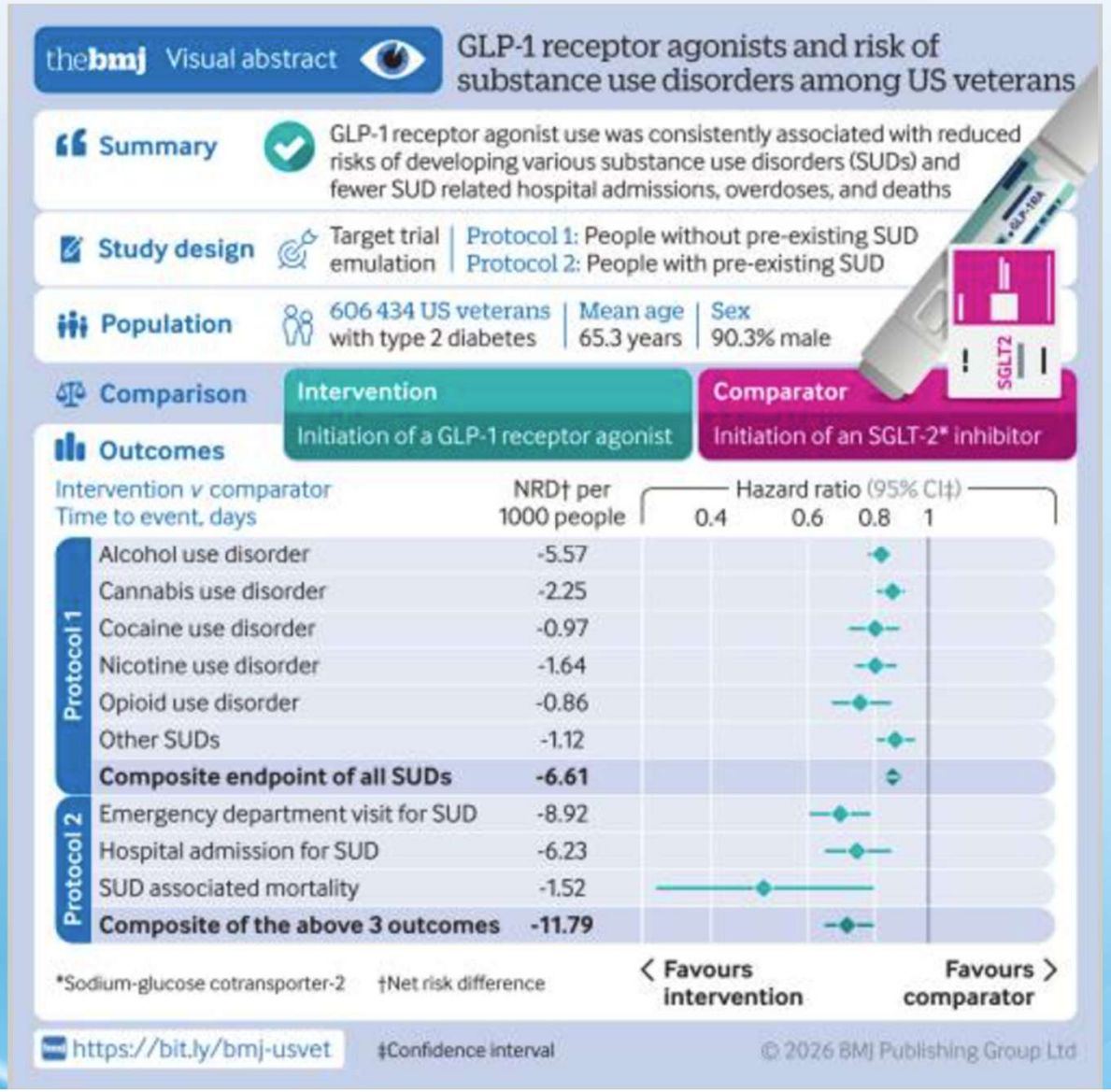
606,434
US veterans with type 2 diabetes in the base population

8
parallel new-user active-comparator target trials emulated

3 yrs
maximum follow-up after treatment initiation

- Population: people receiving care in the US Department of Veterans Affairs
- Intervention: initiation of a GLP-1 receptor agonist
- Comparator: initiation of an SGLT-2 inhibitor
- Outcomes: incident SUD among people without prior SUD; adverse clinical outcomes among people with pre-existing SUD

Source: Cai et al., BMJ 2026;392:e086886; BMJ.


thebmj Visual abstract
GLP-1 receptor agonists and risk of substance use disorders among US veterans
Summary
GLP-1 receptor agonist use was consistently associated with reduced risks of developing various substance use disorders (SUDs) and fewer SUD related hospital admissions, overdoses, and deaths
Study design
Target trial emulation
Protocol 1: People without pre-existing SUD
Protocol 2: People with pre-existing SUD
Population
606 434 US veterans with type 2 diabetes
Mean age 65.3 years
Sex 90.3% male
Comparison
Intervention
Initiation of a GLP-1 receptor agonist
Comparator
Initiation of an SGLT-2* inhibitor
Outcomes
Intervention v comparator
Time to event, days
NRD† per 1000 people
Hazard ratio (95% CI‡)
0.4
0.6
0.8
1
Protocol 1
Alcohol use disorder -5.57
Cannabis use disorder -2.25
Cocaine use disorder -0.97
Nicotine use disorder -1.64
Opioid use disorder -0.86
Other SUDs -1.12
Composite endpoint of all SUDs -6.61
Protocol 2
Emergency department visit for SUD -8.92
Hospital admission for SUD -6.23
SUD associated mortality -1.52
Composite of the above 3 outcomes -11.79
*Sodium-glucose cotransporter-2
†Net risk difference
‡Confidence interval
Favours intervention
Favours comparator
https://bit.ly/bmj-usvet
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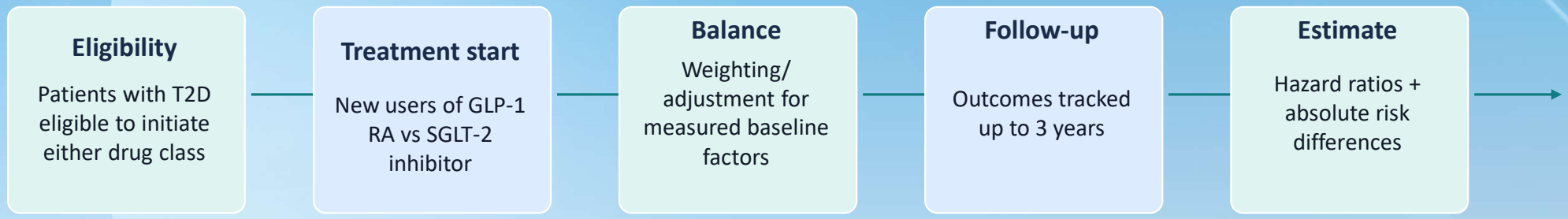
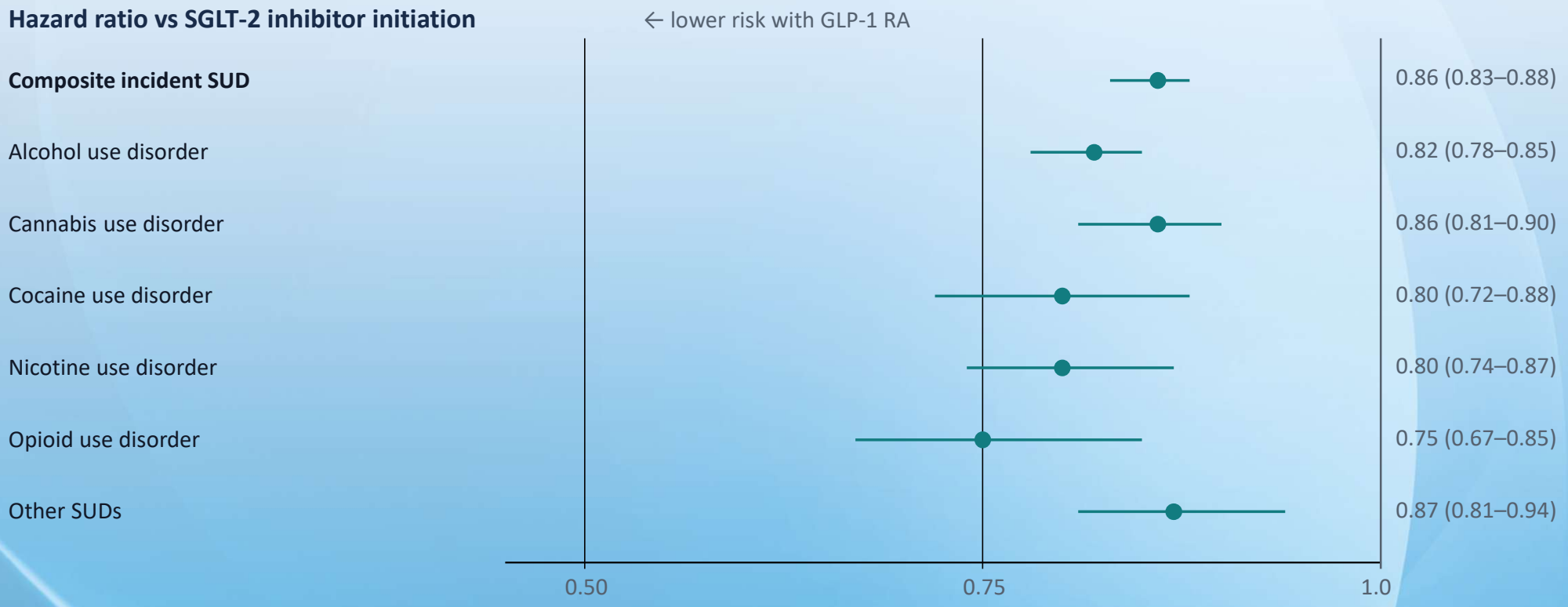
Methods & Limitations



Why it matters: "active comparator + new user" is stronger than comparing people already on GLP-1s to everyone else.

- Active comparator helps reduce confounding by indication and healthcare access
- Still limited by unmeasured confounding and quality of coded outcomes

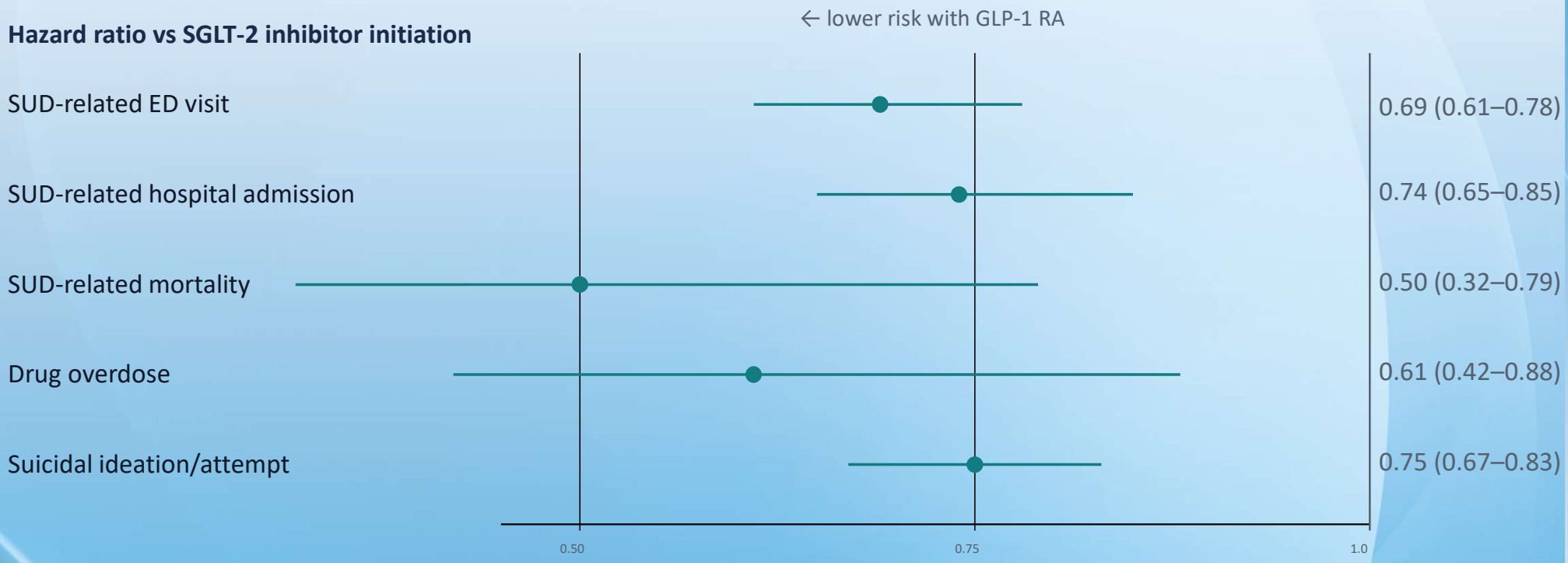
Key findings from Protocol 1: incident SUD diagnoses were lower



Translation: the relative signal is consistent; the absolute risk differences were modest over 3 years.

Source: Cai et al., BMJ 2026;392:e086886. Hazard ratios from article.

Key findings Protocol 2: serious SUD-related outcomes were lower



These outcomes matter to primary care and FQHC teams — but coding-based outcomes do not directly measure craving, drinking days, or recovery goals.

Source: Cai et al., BMJ 2026;392:e086886. Hazard ratios from article.

Strengths: why this paper is worth discussing

- Large national VA dataset with substantial power
- Active-comparator, new-user design rather than simple exposed/unexposed comparison
- Target trial emulation makes the causal question explicit
- Consistent direction across multiple substances and outcomes
- Absolute and relative effect estimates reported

Limitations: what conclusions cannot be drawn

Causality	Observational design cannot eliminate unmeasured confounding
Measurement	EHR codes miss substance use, craving, treatment engagement, and patient-centered change
Population	VA patients with T2D; mostly older, male, medically engaged
Medication context	Exposure is GLP-1 RA initiation for diabetes/obesity care, not randomized SUD treatment
Equity / access	Results do not solve cost, supply, coverage, or monitoring issues in FQHC practice

Conclusion language: “promising and hypothesis-supporting” — not “GLP-1s treat addiction.”

Science-to-practice: what do we do Monday?

- Do not start GLP-1 RAs solely to treat SUD outside evidence-based indications and shared decision-making
- Do ask about substance use and cravings when prescribing GLP-1 RAs for diabetes/obesity
- Do continue first-line SUD care: medications for OUD/AUD/TUD, harm reduction, behavioral supports
- Do consider research referral or registry participation when available
- Do document uncertainty: potential benefit, known risks, alternatives, cost/access barriers

Possible Conversation 2:

"Because you have type 2 diabetes, a GLP-1 may be appropriate for blood sugar and weight.
Some early evidence suggests these medications may reduce alcohol craving or alcohol-related harms, but they are not yet proven AUD treatment. So we can monitor whether it helps your cravings while also offering established AUD treatments and supports.."

Back to Bill!

Interview Discussion

- Would Bill have been included in this study?
- Would insurance cover a GLP-1?
- What concerns you the most about Bill?
- What would success look like?
- How would you discuss GLP-1's with Bill?

Take-Home Points

1. Patients like Bill drive interest in new therapies.
2. Salience and craving may be central drivers of addiction.
3. GLP-1 biology provides a plausible mechanism.
4. Cai et al. provides important observational evidence.
5. The findings are promising but not definitive.
6. Good clinicians balance curiosity with rigor.
7. Explore Free-source searches such as OpenEvidence, Google Scholar, PubMed