Week 10 (edited) - History and Mutual Help

Thu, Oct 05, 2023 1:05PM 57:07

SUMMARY KEYWORDS

aa, alcoholics anonymous, alcohol use disorder, people, level, patient, dimension, question, treatment, substance use disorder, narcotics anonymous, asam, abstinence, physician, meetings, recovery, alcohol, contingency management, important, step

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00:02

All right. So now officially I'll say it again. Good morning and welcome, everyone. In a lot of cases, welcome back. Thanks for joining us. Again, if you're willing to and able please feel free to turn on your cameras. As you already know the format of this is we'll go through some of the practice questions and through the rationales. And if you have any additional questions as we go, please feel free to type them into the chat or you can unmute yourselves and chime in. Today, we're going to be focusing on history and mutual help. I know on the schedule, we had talked a little bit about prevention, but that will be covering next week. And then today, we are featuring Dr. Paul Earley. So at this time, I'll turn it over to him to introduce himself and get us started.

00:45

All right, morning, everyone. This, I'm trying to do this as directed, which means we go through the slides and answer some questions. If there's more, if there are more questions, well hopefully we'll have some time for that. And anyone that knows me knows that I'm going to have some parenthetical comments that go along with the discussion. So let's just dive in with questions today. Okay. And I think, Giulia, we what we do is I read the questions, and then people sometimes want to vote in the chat box? Is that how they do that?

01:26

Yes, so they can just type their answers into the chat and we'll be able to see them.

01:30

Okay. So the first question, the first question is, which of the following best describes the state of knowledge of effective substance use treatment, A- decades of clinical practice have yielded definitive evidence on the most effective approaches to provide substance use treatment? B- there is abundant evidence that short term abstinence is predictive of long term outcomes. C- treatment for substance use disorders can be effective as treatment for other chronic conditions, or D- manualized therapies guarantee the success of various conceptualized models of treatment.

02:10

All right, let's move on to the answer quickly. And that's C, basically, A is not correct, because we have... the definitive evidence is lacking. And that's mostly because of two separate items. One was, I'll harp on this throughout this time, one is that this is a terribly underfunded field, as we know, and so we don't have good clinical practice. The second issue is, is that clinical practice has evolved organically versus scientifically. And despite the fact that many people are helped tremendously by different types of treatment. There's no way of comparing apples to oranges. So those are the two biggest issues.

02:58

Short term absence is not predictive of long term outcomes. Many people can stop using substances over short term, but the long term outcomes are more complex. And so that looking at short term outcomes, or effectiveness, and trying to extrapolate to long term outcomes is a fool's game.

03:19

Manualized therapies, although they're helpful, we'll talk about those a little bit later on, they're not- they don't have any, you can see guarantee the success. That's if you're taking the test, you can see that's, that stands out in your head that says, I don't think so. And you can kind of say, then you go ahead and look at this: C Item treatment for substance use disorders can be effective as other chronic medical conditions. And that's something that is basically important when you work in this field, because there's a general concept in the public at large, that treatment is not effective, which is inaccurate, especially when comparing it with other common conditions such as diabetes, hypertension, or obesity.

04:07

Next is this question. Which of the following are part of Marlatt and Gordon's 1985 model of relapse prevention utilizing cognitive behavioral therapy adapted for the treatment of substance use disorder? And the question here, obviously is not about other things, other types of treatment, but specifically about Alan Marlatt and his amazing work with a team at University of Washington that really defined the field of relapse prevention training. Item A is eliciting change talk. Item B is earning vouchers for negative urine drug screens. Item C is targeting cognitive, affective and situational triggers for substance use. And item D is conducting a moral inventory.

04:59

I see lots of Cs He's already in the chat.

05:02

Okay, great. I need to open up my chat so I can see the answer. The answer is C. Let me open up my

chat here real quickly. Yeah, it looks like most people got that. That's great. And so change talk is part of, you know, of working with the patient on developing motivational interviewing, responding motivational interviewing. Vouchers is part of a, we're going to talk about that in a little bit a different type of care model. And conducting a moral inventory is one of the aspects of, of 12 Step recovery programming.

05:49

So these cognitive, these cognitive issues. If we have a chance we can talk more about this. I'm a big believer in Alan Marlatt's work.

05:58

Okay, so this one is a little tricky, so spend some time thinking about it. The Minnesota Model was based upon these precepts: A- abstinence is the only goal of treatment. B- initial motivation or lack thereof is a major predictor of outcome. C- alcoholism is an involuntary primary chronic progressive biopsychosocial, spiritual disease. D- motivation is the sole responsibility of the patient.

06:34

Trying to get my chatbox bigger so I can see what's going on.

06:38

I'm also happy to let you know what's coming through so far, we have some Cs.

06:42

Yep. It's people "C" the right answer, no pun intended. So the trick here is that the Minnesota Model talks about more than just abstinence, it's really about the belief that rearranging one's concepts about the world and one's behaviors in the world and one's beliefs about what the what you know, human beings are all about, is a larger part of treatment goals. B is a little tricky, but the Minnesota model really is based on the precept that, that is important in many types of treatment today, that many people arrive in treatment lacking motivation to get better, and that the motivation is actually produced by the milieu in which the people are interacting. So that's an important part of that.

07:37

And and actually, in my own personal work over, over decades, you know, watching other people's motivation increase, sometimes people with terrible lack of motivation, just by being in in an environment where people are working together is helpful. And then that last one- motivation is the sole responsibility patient, you get that and obviously C is that kind of definition. That was part of the

ASAM definition of addiction for a while and it's, in my mind, probably needs to return into the definition because it is a primary gret- chronic progressive, certainly biopsychosocial and most people think spiritual illness.

08:20

Okay, Alcoholics Anonymous as well as other 12 Step programs are best described as A- peer directed group therapy. B- a fellowship of persons on equal terms. C- a tax exempt religious organization. D- a charitable organization that supports treatment for addictions.

08:43

So, the key words on this one are this in A is that it's talks about group therapy. Now, importantly, there is a psychotherapeutic component of AA which is all delivered, in my mind, unconsciously. Essentially, how the how the group of people works together, creates some energy within the group, which tends to direct it but that's not done in a psychotherapeutic environment. There's no group leader, there's no psychotherapist involved. It is a tax exempt organization, by the way, but it is not a religious organization. There are religious precepts that are part, an optional part of that process, but not the whole thing. And and D is incorrect because the statement that it supports treatment for addiction. It is part of many people's recovery process, but it is does not it doesn't support external treatment.

09:47

To attend AA meetings, it is expected that a person will A- have been referred by the courts or a professional. B- have a desire to not drink alcohol. C- be completely abstinent from alcohol. D- agree that his or her sponsor can contact family members for further information. Now, this one, I mean, if you're if you're a test taker, you can see this that there's, you know, that if you look at C, and then you'll look at well, it can't be that, that's kind of the most strong negative there. The only desire to attend an AA meet, the only requirement to att- attend an AA meeting is a desire to not drink alcohol. That doesn't mean that you need to say you have an alcohol use disorder. It doesn't need to say... those individuals don't need to say, believe they're alcoholic in a particular way. People with drug dependence issues that have no alcohol misuse history are, in general, welcome at AA meetings, as long as they confine their statements to alcohol. And depending on where you are with different meetings, some meetings will even allow people to mention other substances as well. So there's a... again, and the reason that's difficult is this is a this is a social movement. It's- there's no control by any sort of oversight, oversight agency. So that's the way it is and working within that is helpful when we work in addiction medicine.

11:23

Okay, so here's an interesting practice question. In your practice, you have diagnosed a 46 year old nurse as having an alcohol use disorder and a benzodiazepine use disorder. He has been absent for six weeks and is attending Alcoholics Anonymous and Narcotics Anonymous. He reports to you that several Alcoholics Anonymous members have told him he's not a real alcoholic, and should only attend Narcotics Anonymous.

11:49

Your best response is: A- keep going; ignore the comments, they indicate prejudice. B- that's good advice, Narcotics Anonymous is as good as Alcoholics Anonymous. C- keep going; just don't talk about anything other than your drinking experience, or D- keep going; the only requirement for membership is a desire to stop drinking.

12:09

And the answer is D. The, the people in AA just like people in the world in general have prejudice. And you might find that people in AA might either talk negatively about people that have concomitant drug use, or even only drug use histories. But you can't use- you have to work with your patients to get them to deal with the reality that AA is a, an organism which is beyond your control. And Narcotics Anonymous is, depending on who you look at, Narcotics Anonymous tends to be a little, have a little less depth of sobriety in it. But most people who have narcotics issues without alcohol issues often go to a mix of Narcotics Anonymous or Alcoholics, Alcoholics Anonymous, and some even switch over to AA. But both are good organizations and people- it's a personal choice. Don't talk about anything other than your drinking experience is kind of right. But it's- you just have to be careful. And you also have to select your meetings properly. Okay.

13:31

Your patient complains that although he was raised in a Roman Cath- Catholic Church, Alcoholics Anonymous and Narcotics Anonymous are too religious for him; he assures you that he can make it on his own. Your most effective clinical response would be: A- Alcoholics Anonymous and Narcotics Anonymous were designed for agnostics and atheists; keep going. B- validate his spiritual perspective and suggest that he find AA and NA meetings with less emphasis on religion per se. C- keep going but see a priest who can explain the differences. D- Alcoholics Anonymous and Narcotics Anonymous have approve- been approved by the Catholic Church; keep going.

14:14

Just as a quick reminder, if anybody has any follow up questions or additional questions as we go, feel free to type them into the chat and I'm monitoring or unmute yourselves and chime in.

14:24

Yep. And Giulia will if you can make sure you remind me because I have this tendency to keep going, speaking of keeping going. So the answer here is B. A is is is difficult. People that are have agnostics or atheists, remember it's only you have to... there's a great saying in AA that "You don't have to believe in God. You just have to believe you're not him or her." And that's a nice saying that, that we use. Everyone finds a an external power, if you will. A lot of people will find the power of that group. Because it seems to be holding lots of people in remission. That power is really endearing and draws many people who are agnostics and atheists to AA. C is not correct. Although many priests by the

way do and many pastors know a lot about AA, some from their personal experience and some from their parishioners, that's really not the way to go about it. And there's no approval of Narcotics Anonymous by the Catholic Church. I mean, they're both...they're they're they're speaking of agnostic, they're agnostic about each other.

15:39

Okay, before a physician recommends 12 Step meetings for a patient should A- discontinue any psychotropic medications. B- contact a local meeting in order to facilitate the referral. C- offer an explanation of the evidence of the benefits of Alcoholics Anonymous, and how she has seen it help others. D- explain to the patient that his treatment with her cannot continue unless they attend AA.

16:10

Okay. Sorry. Yeah, so the answer is C. Let's talk about the other ones. Because there's a lot of issues that pop up with these questions. Some people in AA are, have difficulties with being on psychotropic medications. It's important for you to know that the official stance of AA, they actually even have a pamphlet about it, is the use of other medications. And basically, they, the official position of AA is we have no stance on whether other medications should be used in people with alcohol problems. And they also acknowledge that people have depression illnesses, anxiety illnesses, sometimes thought disorders, mood disorders, all sorts of other things in that pamphlet.

17:01

B doesn't work because there's no one to talk to to facilitate the referral. However, what's important and if you work with people in recovery, I can't stress this enough. Finding some, developing a relationship with people in various meetings in your area is super helpful. So for instance, I had a person that come, came to me who was an attorney who wanted to get into remission from his alcohol use disorder, and he said, I can't go to AA. I mean, I might see one of my clients there, that would be terrible. And I just happen to have had treated another physician, another physician, another attorney who was in long term remission, and he has said to me, this patient of mine, if other people come along, why don't you just send them to me, I'll talk to them. So having a network of your own that, of people that you know, and recovery or under- and understanding what goes on in various meetings in your area is super, is a superpower for getting people well connected to recovery.

18:05

Okay, we're moving along. What are the four core concepts of 12 Step facilitation? This is one of those you got to pick from the list questions. I hate these, but we'll do it anyway. A- is abstinence, spirituality, consistency, restraint. B- is abstinence, attachment, pragmatism and spirituality. C- is moderation, expression, restraint, acceptance. And D- is abstinence, acceptance, spirituality, pragmatism. Now, each of these are, have some elements of the correct thing. So it's important to figure out which is which? And the correct correct answer is the last.

18:49

Abstinence is a concept of 12 Step facilitation. Abstinence is the goal that people are trying to reach. It doesn't mean one needs to be abstinent, when beginning AA meetings, and one of the things you hear, if you go to an AA meeting is they say, is anyone here for their first meeting, and they the group says that you are the most important person here. And they say, you know, and oftentimes people talk about their struggles with obtaining abstinence, and that it takes some time and during that time, they go to AA meetings. Accepting the fact that they have an illness. One of the problems with addiction disorders in general, is that people have difficulties accepting them as a problem. And this varies from place to place. And by the way, it is not correlated with intelligence. I've had the joy in my career of taking care of physicians for almost my entire career in addiction medicine as patients and various forms, running physician treatment programs. And very bright physicians have just as many difficulties accepting the illness as people with less intelligence, in some ways it's worse. Spirituality is a pursuit, and pragmatism is part of that process.

20:03

This which of the sty- following statements is true about the spiritual aspects of recovery from alcohol use disorder: A- the term spiritual and religious are used interchangeably by Alcoholics Anonymous. B- belonging to an organized faith fills the Alcoholics Anonymous concept of spirituality. C- Alcoholics Anonymous requires a Judeo-Christian base as important to recovery. D- spirituality is expressed through Alcoholic, through Alcoholics Anonymous, as expressed through Alcoholics Anonymous reflects the acceptance of a power greater than oneself. And it looks like everyone's getting that one, that's great.

20:44

There, there, you'll hear people in AA talking about religion occasionally and other members will gently correct that, that we're not here to tell people what to believe in. The concept is that recovery becomes a spiritual goal as well as a physical and a health goal. And that actually bolsters the long term recovery according to AA tradition. There's no requirement for an organized faith, we've already been over that. And although Alcoholics Anonymous- we have to remember when it began, it began in the 1930s, the middle of the Depression, and both the first members of AA and many of the first members, the first 100 members of AA, were Judeo-Christians but there were several agnostics and atheists in that first 100 people. That's why the AA big book has a whole thing about we the agnostics talking about what happens if you if you don't believe in any particular organized higher power.

21:48

As a practitioner in primary care setting which of the following best describes how and under what circumstances to discuss Alcoholics Anonymous with an individual with a moderate or severe alcohol use disorder: A- patients with severe social anxiety should be required to attend 10 AA meetings in person as a condition of further treatment. B- refer only those patients who best fit the profile of successful affiliates with Alcoholics Anonymous. C- refer patients with stable but severe co-occurring psychiatric conditions to psychiatric care, and alcoholism counseling but not alcoholics anonymous. D-give direct advice to patients who have gone to Alcoholics Anonymous, and use a motivational approach with Alcoholics Anonymous-naive patients to encourage AA participation.

22:45

And this one's a little tricky as well. It is D, although it brings up several issues to consider. Many of the reasons why people have difficulties with AA is social anxiety. Social anxiety is over-represented in alcohol, especially in alcohol use disorders, especially type type one alcohol use disorders. And so social anxiety needs to be considered. And in my practice, what I do is, is I actually walk through with my patients, what it's going to be like going to an AA meeting and in treatment settings, they actually do mock AA meetings so people social anxiety can understand how they can attain safety and deal with their social anxiety. So it's important to assess for social anxiety because those people always have a difficulty with AA at first, but AA is very respectful and doesn't pressure people to contribute if they don't need to

23:49

B doesn't work because I've seen lots of patients who have not met the profile of success, who have taken to Alcoholics Anonymous or Narcotics Anonymous or Cocaine Anonymous or Methamphetamine Anonymous like a duck to water. Refer patients with severe co-occurring psychiatric conditions of psychiatric care... many patients with severe psychiatric conditions can adapt to AA and actually do quite well because it tends to stabilize, create kind of very pragmatic approaches to living and it tends to be helpful if they can again deal with some of the anxiety surrounding it.

24:31

Okay, next one is Alcoholics Anonymous was founded in 1935 by two A- individuals with an alcohol use disorder. B- clergyman. C- wives of men with an alcohol use disorder. D- social workers.

24:47

Okay, so it's A- Alcoholics Anonymous was formed by two men, Dr. Bob Smith and Bill Wilson. Bill Wilson was actually in Akron, Ohio. He was trying to do a deal in the middle of the post-Depression era, the deal fell through, he wanted to drink. He actually found Bob Smith, who was a hopeless alcoholic colorectal surgeon. And in their meeting, the dynamics of forming Alcoholics Anonymous began. Wives of men with an alcohol use disorder, again, it was mostly men in the 1930s with alcohol use disorders, although the first 100 people that were in AA had many, had multiple women with alcohol use disorder, the first five or 10 people were all men. And that means, that would be true if the question stem had AlAnon in there, correct because it was started by Bob- primarily by Bob Smith's wife.

25:58

Which of the following is a recognized risk factor promoting the development of a substance use disorder, A- initiating drug use at an older age. B- genetic predisposition based on family history. C- weak or immoral personality structure. D- intolerance to the drug's adverse effects.

26:21

People come through with that quite quickly. The most important thing to know is- when I teach medical students about alcohol use disorder, I tell them, if you want to know if you... whether you need to worry about your patient having an alcohol use disorder, you ask a family history, about alcohol or other substance use disorder, that is the best single predictor of whether the person in front of you is has the possibility of developing an alcohol use disorder. It's not always genetically determined. I want to be clear with that; the genetics don't quite support that. But a strong genetic predisposition is really highly predictive of developing an alcohol use disorder or drug use disorder. And we also say to medical students, usually you can't ask that directly, because in many families, there's out there's there are occult alcohol, drug use disorder problems.

27:16

Obviously, weak or immoral personality structure... Although I will tell you that when I started out in this field, in 1984, the, one of the current thinkings was that people that had antisocial personality disorder had the highest probability of developing substance use disorder. And it turns out that that's simply not true.

27:42

All right, here's switching topics a little bit, contingency management. Another topic I love- contingency management is comprised of which of the following and this is one of those listings so read the steps carefully: Rewards are consistently administered at regular intervals once per week. B- rewards occur as close as possible to the desired behavior and are matched to a patient's needs. C- the reward must be of the same value each time and be paired with a desired behavior for best response. D- behavioral response and mindfulness-based approaches.

28:24

Okay, so contingency management is really based on game theory and a lot of other things that have happened. The answer is, B- that rewards occur as close as possible to desired behavior pairing the behavior that you want, shaping the behavior that you want, by a reward. Now, what are the behaviors you might use: a negative drug screen, attending a support group meeting, showing up in therapy, showing up to your doctor's appointment, calling your counselor on time, calling your...remaining in contact with your peers in in a particular addiction treatment, all those types of things can be rewarding. Contingency management really benefits from a computerized system, because it has a lot of stuff in the background that needs to occur in a regular fashion, but is highly effective in both shaping substance use before remission occurs and helping to sustain remission.

29:32

The reward must be the same value each time- actually there's some interesting data that varying the results because it is just as effective, that having a high reward occasionally creates an anticipational edge, more behavior shaping. And then the last thing I'd like to say is that people always worry about gambling dependence, the research shows that contingency management does not increase gambling dependence. Some pretty well designed studies show that as well.

30:08

Wow, I've zoomed through them in 32 minutes. So now we have the fun thing. What do you want to talk about?

30:16

Well, one thing, and I'll turn it over to participants to ask additional questions, for sure. But one of the questions that we got throughout the week was about the criteria actually, which I know you've covered during your session at review course, and just tips on what you should know for the exam. So what the basics are, if you don't mind going through that?

30:35

Yep, I'd be happy to do that. I could probably even pull up a couple of slides. But the, so the most important thing to, to know, the ASAM criteria is, is complicated. And, you know, we've worked for, it's another one of my projects, as Giulia knows, for most of my career, and the the there's a fourth edition coming out, you don't need to know anything in the fourth edition. So you know, if you've heard "Oh, there's another edition coming out," don't worry about that.

31:09

The, what I would certainly want to know is you need to have nailed down what the dimensions are, you need to be able to kind of pull them out of your hat as soon as you, a question about the ASAM dimensions, because I would be willing to bet there's going- I don't know, I've not seen exam questions, I'd be willing to bet there are a few exam questions that says, you know, the following are...the following are dimensions, one, two, and six. And then they list them out in some sort of order. And you need to know what the dimensions are. And then the second part, and again, if you visualize it, the right way of visualizing it is the dimensional criterion, you can put in a grid across the top, I might even be able to show that. Let me see if I can pull that up real quick,

31:56

I'm actually pulling up your slides from the review course, if that's helpful. And so...

32:00

Why don't you go ahead and show the, remember the grid, we'll just pull up the slides about the ASAM criteria. And if the ASAM criteria seem abstruse, and kind of hard to get your, wrap your arms around, you're in the right place, because they are not completely intuitive. So here's, here's one way of thinking about the ASAM criteria is that the levels of care go across the top and then the dimensional cares go, dimensional items go along the side.

32:36

Next slide, Giulia. See, is there another one that has... can you go...? Well, okay, so here are the dimensional, here are the dimensions. Dimension one is acute intoxication or withdrawal potential. And that's detox basically. It's a little more complicated, because sometimes there's people have protracted withdrawal. Biomedical conditions, those are the things which are the kind of the center of traditional medicine, if you will. And they often are, you know, something as simple, a dimension two issue as something simple as diabetes. You know, if you have someone with diabetes, then you need to attend to that in treatment, it's kind of a no brainer. But there also are biomedical conditions which arise out of substance use disorder, such as, you know, liver problem, liver failure, those sorts of things.

33:28

Dimension three is emotional, behavioral, or cognitive conditions. Think about that, as the psychiatric kind of conditions. Cognitive- they may slip something in there, by the way about an individual that has, say cognitive issues from alcohol use disorder, or is an individual that has a delayed emotional growth because of a biogenetic condition. That would make it a dimensional three problem. People with severe dimensional three problems. need attention in both areas.

34:08

Dimension four is readiness to change and the real, the way to think about that is just the stages of change, the DiClemente and Prochaska scale. If you know that scale, you ought to know that scale, before you go into the ...

34:25

Those guys came out with the stages of change and everyone said, "Oh, where have you been all along?" It was like everyone, it was a way of codifying a notion that all of us held in our in our kind of way of thinking about patients, that patients are different stages of change and how you approach them is different.

34:46

Dimension five is relapse, continued use or continued problem potential and that's basically you know, if an individual has multiple relapses, or they have had difficulties with continued use, or they have problems resulting from use, that will go in dimension five.

35:04

And finally, dimension six is the recovery and living environment, whether that's a home that's infested with alcohol or drug use or that's the fact that they're homeless. Or there's the fact that they don't have a... they have a home which is psychologically not stable.

35:21

Why don't you show some other slides, see what else we have. Okay, great. And then the treatment axis. Oh, and you can actually, once you click forward to the first...to click, there we go. Okay, you did all of them. That's great. So now you know you're taking away- you drive me crazy, is it Giulia's, you guys don't know this but this is Giulia's full time job. She drives me crazy. I can say that, because we're good friends.

35:49

So. So the way of thinking about these is in the blue lines there. So the prevention services are level 0.5. And that's going to be talking to an at risk population. You have a family, where the father has an alcohol use disorder, and they have three teenage children, you might do level 0.5 intervention to talk, when you talk with those children about about the fact that their father's addiction, if he's biologically related, or even if he's not, frankly, places them at risk. That would be an early intervention example.

36:35

Outpatient treatment is less than three times per week. It's commonly individualized services at level one. So level one is individualized services and they become group-based services when you move on level two and higher. So group, level 2.1, and 2.5 are group-based treatment at a center which does that, usually 2.1 traditionally has been an evening intensive outpatient program. 2.5 tends to be a day long program where people stop working and attending a process for a period of time.

37:10

Next slide. Sorry, Guilia. I kind of made fun of our relationship. And I hope that's okay. Yeah. Okay, she's waving her hand. Okay, and then level 3.1 services are all of the residential level of services. A 3.1 program has a low intensity residential services, which is primarily recovery housing, plus some additional psychotherapeutic elements that go along with that. 3.3 is a medium intensive residential services. It's important for you to know about this because this is actually, we're getting rid of this in the next edition. It is usually referred for people with developmental disabilities or other neurocognitive problems. And really, it's it's a very rare very rarely are programs level 3.3. Unfortunately, we don't have enough of those in the country. Level 3.5 is a high residential- high intensity residential treatment. That means that the services are provided in an area that are primarily clinical with less physician involvement, they tend to use a mileau to help shape the patient's behaviors and address their concerns about their illness. Level 3.7 involves physicians and is medically monitored intensive inpatient treatment, physicians and nurses. And the primary diff- primary difference between 3.5 and 3.7 are the more intensive medical involvement . For instance, if there's a question that says, you know, John Smith needs nursing care that cannot be done, performed by a visiting nurse and needs maybe IVs twice a day for antibiosis- then that would be a level 3.7 program. And finally, level four programs are really in a medical hospital, that would be a a, a medical hospital that has a detox wing that deals with medical complications, such as renal failure, liver failure, and that would be, usually that's a stabilization. Any questions about those?

39:24

I want to be clear, with everyone on here, I get tired of hearing me speak so I'd love to hear someone else speak. Okay. All right. So that's that those are the most, probably the most important things to kind of know in your head is what are the differentiating points between the different levels that I explained to you- what they generally are, when they set when you say level one, it's a clinician's office. And it's oftentimes it's, sometimes it's a medical physician's office, more often it's a psychotherapy office. If they say two, level two, then it's a program where someone attends but sometimes it's either working, but it's part of the day and they go along with their lives. And when you get to residential services, that usually means people have unstable housing or unsafe housing, or their illness is so severe that they need to be stabilized in an environment which can help that occur. And the higher the level, in 3.7, the more medical involvement is involved. So 3.7 medical, 3.5 has very little medical involvement at all, although there is a 3.5 that has, unfortunately, a bio version of it just to complicate things, but I don't think you have questions about that.

40:42

We did get a question on the chat from Dan Jackson. And I see you're here, if you want to unmute and chime in? Or would you rather me read it?

40:51

I can unmute. So, in terms of applying those, the dimensions and those axes. So if I'm looking at somebody's readiness to change, and then on the x-axis, and on the y-axis, you're looking at levels of care, it's not super clear to me how I would use each of those dimensions to correlate to a specific level of care, and then how each of those would be weighted and integrated into a specific treatment plan. Yes. So readiness to change? And do you know, does the patient need intensive outpatient or to come to my office? Is it clear, like, are they going to go into DTs? So?

41:32

So application of some of the dimensions to the levels of care, I guess, is my question.

41:38

Yeah, great question. And I want to be clear that if you're confused, you're understanding it properly. That sounds crazy. But there's no, there's no way of, of... there's some types of cases. And I bet the questions on the exam, Dan, are going to be very clear cut. But there's no "If you have this, you go here" kind of a thing with the exception of big drivers. So for instance, if I wish I could click on this and put an X in there. But so for instance, if an individual in dimension one, as you point out, Dan, has an acute withdrawal need that is life threatening from either opioid use disorder or alcohol use disorder or benzodiazepine use disorder, then you're going to need to have the medical care necessity available for that. So let's say someone's having pending DTs, that really pretty much buys them at 3.7. Because they need the medical care.

42:44

And I...or if a question says an individual is has a psychotic an individual on methamphetamines has had a psychotic break. And they are, you know, they're they are hyper, they're hyper verbal, they are, that reality testing has slipped, it's unclear whether they are have a thought disorder, or whether this is just an effect of the, of the methamphetamine, that too would be a very high level. And I would bet that the questions they're going to give you are kind of clear in all of those areas, they're not going to give you a case, like an individual has a next door neighbor who is alcohol dependent, who keeps on wanting to drink, but the wife is supportive of him not drinking, and he has a history of being able to abstain on the outside on his own. What level do they need? That... I don't think they're going to ask a question that's that nuanced.

43:44

And the reason they're not is because the rules are literally, we wrote the computer program for the first model of what's called the level of care determination. And it was 1200 lines of Boolean algebra. So it's, it's not clear. And the questions you're going to have are probably going to be pretty clear. And so if you have a question, the most important thing is to zone in on what dimensions they're focusing on in the question. And I bet they're going to zone in on either dimensions, one, two, or three, meaning withdrawal to medical, see psychiatric, or maybe dimension six, which is housing-related stuff, you know, where does he live? He lives in a crack house. Well, okay, so that that gives you a residential level of care automatically. I don't think they're going to give you a nuanced thing.

44:41

And then the last thing, Dan to say about dimension four and stages of change in motivation, is they're almost the there are, they're almost never predictive by, by themselves I can maybe I can even say they are never predictive by themselves with proper level of care. So there, they might throw in something about the patient is ambivalent about recovery. And what you can do with that in your head is probably say this...it doesn't, isn't determinant of level of care. It's something we learned in the fourth edition. And actually dimension four moved all the way down to dimension six, because it's, it's so lo- so rarely determinant of any particular level of care. Did I answer your question?

45:30

Yes, thank you. Okay.

45:32

If I may, I have a slide from our fundamentals of Addiction Medicine workshop that kind of goes through it, and I think it might be helpful, so I'm going to do something unorthodox and share that screen as well. Here, so it kind of pairs the axis with the actual factors, and I think it helps with the visualization.

45:53

This is a great one, this is a slide from, I think this is actually from the text. So if you want to know, so outpatient would be, you know, for instance, you see along the dimensions, if we go to a level of care of level one, there has to be no risk of acute intoxication, no risk of biomedical complications, and no risk, current risk, of emotional, behavioral, cognitive conditions. That means that a patient can have a depressive disorder, but they're stable on it.

46:26

The readiness to change can be, it can be anything...it has to be, they're motivated enough to show up for the appointments basically. And then the return to use on level one is that their abstinence, and so you get that idea. And then when you move to intensive outpatient, they're, depending on the type of issues they're really still minimal or mild on dimension one, two, or three. So someone can be in acute alcohol withdrawal, stabilized on a benzodiazepine taper, and going to an intensive outpatient program. But that intensive outpatient program rarely, if ever has a physician on staff that's administering that. They usually utilize that ex- exterior point.

47:13

And then as you move towards the right, you begin to see that the conditions are more severe. So for instance, on a monitored, a level three program, unable to stop using is a big driver, he can't stop using, you have to do something to get in there to intervene. And what that what most commonly used is some type of, of 24-hour oversight or housing.

47:41

So taking a look at this, I think that Giulia, great, thank you very much for this, Giulia, this is exactly the kind of thing you need to be familiar with for the exam, because this is, if you understand this, you're going to answer, be able to answer the questions. I'm pretty much completely sure. There are subtle nuances and complicated cases, but they're not going to throw you a complicated case. Because you know, there's, there's just too many rules that go into it for that.

48:15

And I know I did this for the epidemiology session. But if it's helpful to put those graphics together, I know we talked about the readiness to change sort of scales, and this graphic, I'm happy to put that into a handout and share with you all as well.

48:31

And then just want to plug one more thing in from the BEST. One of the sample questions that you would have on the criteria is much more general, which is like, how would you describe like, what is the criteria? So the actual stem is, Which of the following is the best description of the ASAM criteria?

And in that case, the answer is the ASAM criteria is a way of matching patient's needs for a type of service with the appropriate level of care that can be provided. So it could be just that general in a test as well.

49:01

And the keywords there are "matching." So matching needs with with the right type of treatment, that's really the heart of the ASAM criteria. And just for your information, there's lots of interesting research that was done by David Gastfriend, when he was at Massachusetts General Hospital, Addiction Psychiatry program, about mismatch. When you mismatch people to the wrong level of care, either too high or too low, the outcome is not as good as when you properly match them to the correct level of care. That research is really the research which validates the criteria and that sort of thing.

49:47

We still have about nine minutes if anybody has additional questions

49:52

I actually, yeah, and I actually have one more thing I wonder maybe I can share this This is one of my I'm gonna sound like my pet peeve. So let me make sure I...alright...

50:12

So this is not going to be, not, I don't think this is going to be part of the exam, but it's important to know. There might be a general question on it. Let me share my screen, share my screen, share my screen. Let me put this...one more time...

50:36

So there are questions about, about the efficacy of AA in helping people remain abstinent. And I don't know whether there's going to be a question about this. But there's a general misperception of people that Alcoholics Anonymous is not effective, or it's- it doesn't have any science behind it. And the truth is, it evolved organically. Okay, it was an organically evolved outfit. But this is from the 2020 Cochrane review, the definitive thing which defines, defines evidence based medicine. And it was written by John Kelly, Keith Humphries, and Joan Ferri. And they, basically they looked at 27 studies with almost one- 10,500 participants. And they compared cognitive behavioral therapy, motivational enhancement therapy, and what's called 12 Step facilitation, which is a manualized way of teaching people how to use Alcoholics Anonymous. And the conclusion was that AA and 12 Steps through 12 Step facilitation produced higher rates of continuous abstinence than the other established treatments. So it's more effective than MET and CBT in terms of continuous abstinence, and maybe superior to other treatments for increasing the percentage of days abstinent, particularly in long term.

52:13

So if people say, oh, AA doesn't do anything, well, the research says it does. And the other piece is it performs just as well as the other treatments for reducing intensity of alcohol consumption. And four of the five economic studies found a substantial cost-saving benefits for AA and 12 step facilitations. And so in this, you know this led John Kelly, who just... "The closest thing in public health, we have to a free lunch." So it's just important for you to know about that. I don't know if they're going to ask about it. They might ask a question about is there evidence that AA works and these these are very definitive evidence.

52:55

There's also several studies. Here's one large meta analysis done by Mark Galanter looking at what's called recovery oriented systems of care and opioid use disorder, and basically using the urine negative, urine drug screens negative for opioids at the time of second buprenorphine prescription. So these were usage of buprenorphine plus, plus referral to recovery oriented, getting people to understand the 12 Steps, go to 12 step meetings, Narcotics Anonymous, Narcotics Anonymous. Show that you see the, the remission rates at this at the time of the second buprenorphine prescription with 34% for medication management alone, 56% for limited psychosocial and 62% for recovery-oriented systems of care, which has a p value of 0.001. So it also works in opioid use disorder. Now, is it harder to get people to go to these things? Yeah. But learning something about it is good medicine.

54:07

There was a question in the chat just asking for the study that you mentioned about the mismatching levels of care and outcomes. Do you by chance have that?

54:16

if you hang with me for one second... Well, I can see...

54:24

While you look for that, we got a question about transcripts. So if you're looking for the transcripts for the office hours, they can be found in the eLearning Center under so if you go to review course there's several products within it and one of them is the office hours. And then if you're looking for a transcript for the lectures that will all be contained with the videos for each of the sessions as well.

54:54

I couldn't pull it up. I'm sorry I had the book over...the easiest way to do that would be look to go into scholar.google.com I can actually I can do that maybe...

55:05

It, also, Dr. Earley, you don't have to rush. If you can find it afterwards, I'm happy to send it over email to folks.

55:20

So, the work I'll find, I'll find it primarily was from David Gastfriend's office G, A, S, T, F, R, I, E, N, D and... let's see. I'll be able to pull it up, there is actually a book, a compendium of all those articles that was published by Hayworth Press. And I, I'm sorry, I can't remember the name of it right now. It's part of getting old.

55:54

Well, thank you very much for your attention today. Welcome to the field. If you're new, if you've been here for a while, thanks for taking I assume most of you are taking the exam. Relax, enjoy it. If you, if you're participating in all these things, you're going to do just fine. I will tell you that this is a complicated illness. I learned something new every day. And and and it's important that you keep learning because there's no illness that affects more parts of a human's life than than addiction. And you kind of need to know a little bit about it just about everything which is can be daunting and exciting at the same time.

56:37

Just want to say one more time. Thank you so much, Doctor Earley for taking time to be here with us today. Also, thank you for contributing to our question bank. I know you were part of the original team that developed that. So we have you to thank for a lot of our practice questions. If you all come up with any other questions, you know how to find me it's gdemello@asam.org. Feel free to shoot them and then if we find those studies specifically, I can also share with everyone. Thanks, everyone, and we'll see you again next week.

57:04

Have a good day.