Hi everyone. Well congratulations, you've made it to the end of the 2021 Review Course. We're really happy to have you here with us. This is our final Q&A panel of the course. So we will be doing the Q&A around the lectures for today. We Will have a little time at the end to also address some points that have come up and talk tips and tricks for the exam itself.

So we'll start you off with Leslie Hayes.

Hi, Very nice to see all of you again. I first wanted to start off by sayingThe second best part of speaking for ASAM is being able to interact with you folks and speak about something I am passionate. The best part is that actually gave me socks this year with ASAM and I'm so excited about it. If you are not a member I encourage you to join, I answered most of these questions in the chat. But it came up so many times but I just wanted to mention the different medicines with pride -- Pregnancy. There are still enough organization including a cog that recommended the mono product. Women have miscarriages and women have stillbirths, and I definitely had it blamed on various things that maybe were not --I think the science is pretty much there, and I'm hoping within the next couple of years, all of the national organizations will go to providing -- Are recommending that we provide the and just the mono product because as someone mentioned it's very hard to switch somebody back to the combination product many people are quite resistant, and complain of nausea and other problems presently also has two bed micro dosing, and that's probably the way we will be heading. I don't think there is great date on micro dosing which is disappointing to me. Because I think it's really a much better way to start. I have not found any data on micro dosing during pregnancy that being said I had it at work on other people fairly well. There was a question about how to talk to somebody who's using cocaine about a potential referral to Child protective services actually start talking about child protective services especially during pregnancy. At the very first visit when I'm talking about confidentiality. And these are sort of the myth of confidentiality. And these are --One of them is child protective services and here's the circumstances in which I might refer. I think you want to be very honest with the patient print this is one of the circumstances where I will, and one thing I tell people is, when we first started back in the third year of med school, and whenever you started discussing D and RD and I, or death with patients, that was so incredibly hard. But you've done it enough times now, that most of us probably feel reasonably comfortable doing this. And it's the same thing with child protective services. When you first start talking with people about it, it's a very very hard, but it's a very important conversation to have and to be able to do well, and so I think it's really vital that we start discussing this with people. So, things I talk about my I was let them know what are the circumstances of a child protective services will be called, and let them know that this is state law this is what I need to do to follow state law. I also talk to them about the importance of being honest for many of these women being honest for someone with child protective services is just not something they think about. If they lie in child protective services catch them they will be far less likely to be treated well. Talk to them

about having a plan on how they are going to get drug-free or any major issues that are going on. Many of them they've just been kind of sailing along. Talking to them about this is you know, you really want to be thinking about counseling so you can show them how hard you are working on this. And then --I also talked to them about safety monitors, I don't think every state has a speed bump in the next --New Mexico has someone who can be a safety monitor, and they make sure that the child is okay. So identifying people and their personal life who might be able to be a safety monitor. There was a question about treating hepatitis C during pregnancy. Currently that is not being done except in experimental settings. What they recommend is treating hepatitis C before the person gets pregnant and since the treatment was three months of someone is planning in advanced I think it's really beneficial. As I said, it's only an experimental settings that they are treating frequently the medications can be used when someone is breast-feeding. If you are taking care of the child you want to make sure that the child gets tested about the age of 18 months. Then, people were asking about their so much difference between the speakers, and a lot of this genetic separate and a lot of that is not many of the --Genetic polymorphisms and such are not really used in practice so it's all individual papers that have shown different things. And I recommended the chapter in the ASAM book and I realized that was not actually available. When I put something in the chat I am hoping that this will go out to everyone. But I just put in a couple of resources I consider useful for looking up -- Information on genetics. Then, the last and no one actually asked question about this in my session but the question the session on tobacco there a lot of questions about tobacco and pregnancy and what was best for tobacco sensation. There is surprisingly little data on this considering what a huge problem and how adverse effects have during pregnancy, so they do recommend behavioral first, and they just about contingency management. That actually has the best data in pregnancy but is contingency management. I went to a really great conference this week, and one of the doctors there who was speaking said she talks a lot about harm reduction she said it very hard for her patients completely, but they talk about 15 cigarettes today to about two a day. And that makes a big difference. Chantix just does not have good data during pregnancy either for effectiveness or for safety. We tended to avoid that. And then, bupropion has fairly good data overall, and it's believed that it will likely be helpful, during pregnancy again, there is not great data with pregnancy. There was a question about nicotine replacement for there are some concerns whether or not nicotine replacement could cause problems. In general it's believed that it's safer than smoking during pregnancy. And so, if someone needs it, I don't hesitate to prescribe it. I have no data on this. What I do kind of feel like a nicotine patch is going to be taken in things like nicotine gum, or the nicotine inhalers just because you get a more steady level of nicotine. So you're not going to get the increased blood pressure and increased pulse that can be damaging to the placenta. Like is that I halved no data on it just seems like that would make sense. And that is all I have, and I am going to hand it over to Dr. Ed.

Okay, thank you very much Leslie. I am going to see you and raise you on the socks. I don't have the flexibility to show them on my feet. But here they are. I agree with you, it's one of the best things about working

with ASAM. And, I'm doing a show and tell here. I have my ASAM sunglasses here as well. The sunny day in New York City. Thank you very much Leslie. A couple of things just to begin. I have the correct --I have to correct one of my multiple-choice questions I think it was Dr. Lake who said -- Who sent me a reference that the marital status does indeed have an impact on whether someone has a misuse problem with prescription opioids, and unmarried people have more of a problem than married people, in a very good study that was published in internal medicine. I want to echo what Leslie said, on the genetics as well, I think it's really interesting stuff, and some of it I think is ready for prime time. For example the SNL and the dehydrogenase of sis and maybe the cytochrome 2-D six for the conversion of codeine and morphine. There were a number of questions, so somebody asked me a question of the receptor. And the issue about a snip in that gene resulting in an amino acid substitution, and the receptor. And Mal tracks on. This I know a little bit about print in 2003 a study came out said that if you had that variation, it would work better. And in the same group a number of years later published another study and said that the results were incorrect, that there was no impact of the genetic polymorphism on the efficacy. So, people asking whatever comes up on the exam, you'll have to figure out if they know that the subsequent study was a negative study. So on my talk on pain and addiction, I think I elected to speak a little bit about what about pain management and people on meth and on the maintenance, and I prefer North Enid maintenance could there were some similarities. And of course we have a lot more experience with methanol, we've been using it for much longer time than view print morphine. Both of them in both cases, the analgesic effect of both of them are approximately 6 hours. Similar to a drug like morphine, or as the anti-craving an anti-withdrawal affect can last for 24 hours allowing once a day dosing. But if somebody is on meth and on, and there is a pain issue occurring it's very logical and reasonable to divide the dose this is relatively simple to do. But harder to do with a liquid preparation from a methadone clinic. But that would make sense in terms of getting more benefit from either one of those long-acting opioids. In terms of pain, we had to talk a little bit about dividing this up. If somebody is on meth and on, on the pupil North Enid and they develop an acute pain problem like a dental problem or renal stone, the paradigm is to use, to keep them on the methanol and and the view print morphine, maybe we split it, and use IR opioids to treat acute pain. May be a more potent opioids like hydromorphone, rather than a drug like oxycodone. So that would be acute pain. A lot of conversation comes up around perioperative issues. So this is where you have expected acute pain have time to prepare for it. The older paradigm is a recommendation to start tapering it prior to surgery. Because there was concern that had such a high affinity and slow dissociation from the receptor, that if you didn't do that, how would the patient get pain relief if they were going to use opioids for pain perioperative Lee. And so the paradigm was to taper people down either to a low dose like two or four milligrams or 20. The day of, the day before surgery. Use the usual opioid analgesics 6 Perry off vertically. And PCA, and form any other route of administration. Then, when the acute pain had resolved to do a re-induction onto the buprenorphine. So, subsequent studies and involving area I have shown, that it is more effective and better to maintain people on their toes may be divided up but cannot taper them off. Have the surgery, use again immediate release opioids, and it turns out that

if you keep them on you wind up using less of the opioids, then if you take them off and put them on. And when I'm done with my little speech here, I will mention a reference, because over that, and there are a number of good references now. With methanol and, we've always just maintained the methanol and dose, and used opioids, on top of it. In the perioperative. Heard the other thing is you can temporarily increase the dose if somebody were having acute pain, or maybe chronic pain to me could increase the dose that would be harder to do in terms of people getting it dispensed from a clinic. So, one of the problems is even though there is no good evidence for maintaining it many surgeons and anesthesiologists still in set cyst on tapering them off Prince of this is the discussion you have to have with the other providers involved in the patient's care, and sometimes you can convince them you can send the miracles. But if they insist on the older paradigm, you can kind of compromise let's say somebody is on 16 milligrams, maybe they could compromise to get them down before the surgery rather than completely taper them off. Because tapering it off as a kind of uncomfortable and can lead to inadvertent problems. Now, I want to go back to the formulations and the indications. So, we all know the films, the tablets combo, and opioid use disorder. However, they have and can be used off label. Treated both pain and addiction as long as you have the waiver to treat the addiction for it. The problem is that sometimes it is hard to get approval, insurance approval if all you are treating is pain, with the products that are approved for opioid use disorder. When you are only treating pain, no waiver is required, and there are no patient caps, you can have as many patients as you want if you are treating pain. Then there are products, with formulations approved only for the treatment of chronic pain. And there is reasonable evidence of effect of NIST and safety of using it as an alternative opioid, for the treatment of chronic pain. As you know it has a at safety profile. It doesn't have the QT problem that methanol has. Maybe less testosterone, decrease than full opioid agonist. And we have three formulations approved for pain, but not for use disorder for the first one is the form that's been around a very long time for postoperative pain, not used very much for the second one is the seven-day transdermal patch. And this is an effective treatment. Particularly for people who have any problems with adherence or compliance, they come in a number of different strengths, they stay on for seven days and they provide a steady level. In the third one is the buccal mucosal patch, it comes in a number of different formulations. These formulations are only approved for chronic pain and cannot be used off label for the treatment of pain because they are not proved under data 2000. So, that would be illegal. I was asked the question you know, can you use it the opioid --The opioid use progress --Products for pain and addiction, and you need a waiver. It depends on how your notes are written. If the primary disease you are treating is opioid use disorder, then you always need a waiver. If you are only treating chronic pain, then you can use off label but then, my recommendation or question would be, why not use the on label products. Where I think there would be less of a problem with prior authorization. So, I think that's what I wanted to say about them, I still have a couple of minutes Abigail?

Yes that would be fine, go right ahead please.

I was asked a question about the gabapentin and opioids, I only mentioned gabapentin briefly because it become a big topic, there are increasing rates of misuse particularly among people with opioid use disorder, and particularly those on meth and on maintenance. They have the highest rates of misuse at super therapeutic doses. And the reason that there is a problem with gabapentin and opioids. There are two mechanisms were gabapentin increases overdose risk in that situation. One is that gabapentin itself can cause respiratory depression. So there have been a number of case reports where people were given gabapentin as a preoperative analgesic to see if they could reduce it postoperatively, and in some of these case reports they develop decreasing PCO2, and it had to be discontinued. So somehow rather the gabapentin itself can cause respiratory depression, and the other interesting fact, which is very interesting is when an opioid is taken, then gabapentin is taken next, the opioid delays the peristalsis in the small intestine, and that's where gabapentin is absorbed. And so the combination of the gabapentin and an opioid has a higher level of the gabapentin, and a higher blood level of the gabapentin. There have been two good studies from Canada, one with gabapentin, one with pregabalin. Both showing that when people are on the combination the risk of overdose death is higher than when they are just on the opioids alone. The me see what else I have here, let me know Abigail when I am up I haven't kept track of the time. Please comment on D prescribing strategies, for patients resistant to taper, that's a difficult problem of someone has been on chronic opioids, and they don't see the benefit of either decreasing the dose, or tapering off education, education. We recommend people are not fired, or discontinued abrupt sleep. Those are the people that are going have to return to the illicit drug department because they are physically dependent, they have to figure out something to treat the root the draw. So I would say with so much else that we do in addiction medicine, a lot of education both for the patients, and for their significant others the other thing is to think about switching from a full agonist to be a print or theme. If the patient is having problems let's say with sedation, or some other issue where it might be advantageous. How effective is buprenorphine in treating chronic pain, it's very effective, we just take the few minutes I have left, and if you want, those people out there, here's a good review article on view printer working for chronic pain and general drugs. The year is 2018 volume 78, the first author is Davis and here's a good one for the perioperative pain management for the clinical Journal of pain the first author is Lea 2020 volume 36, I suppose I could somehow put this into the chat and we can send it to the audience, the participants. I think I'm going to stop there Abigail.

Sounds good yes we can distribute that out to the participants for trumpet

I will send to Julia.

Yes. Thank you so much Ed. We will see you back in a few minutes and we look over to Carla now. >> Welcome and thanks to everyone. I always learn a lot so I do appreciate that. So, there were a couple of questions at the end of my session that I think I responded to the chat but I didn't know if people had a chance to actually see the responses because I'm trying to get through to the end. So thank you for the person who

pointed out, A.C.T. the court process around cognitive D fusion as in diffuse, so my apologies I said that incorrectly. The idea behind that is that you defuse the thought and feeling. And so you are sort of another analogy they say is detangling her thoughts and feelings from one another so that they are not so highly linked together. So you are diffusing that feeling, that emotional intensity, from the thoughts you can kind of work more on the thought for there is another question a physician with a background in family medicine how does one build for motivational interviewing or something only a concerned psychologist good notes and counseling codes could as a psychiatrist I rarely build counseling codes. Usually I build a code plus a psychotherapy add-on. And I don't think there is any reason family medicine can't bill for this you can bill them onto your EM and codes, anytime you do any psychotherapy, if you motivational interviewing as a therapeutic modality, then you can do that. The requirements for that is you fill your normal ELN as you would, it can no longer be time-based so if you have a psychotherapy add-on you can't do it and you have to do it as medical decision-making based for that level. And then the psychotherapy add-on is time-based it's hope for a 30 minute session he had to have a minimum of half. So 16 minutes of the therapeutic modality. And that would be the 980833 as an add-on to whatever your code was printed in order to bill Ft. Greeley to indicate what your therapeutic modality is and you have to provide a few sentences about what was discussed in the patient's response. It is not that intensive so I have some phrases for internal viewing, that basically say we did it, and we targeted you not alcohol or whatever we were targeting we elicited some change talk where the patient said the reasons for changing or X, Y, and Z, and they need some commitment. Statements such as I will make the phone call, I will go ahead and start the medicine or whatever so I have some smart phrases with some lingo that basically I can just fill in based on what we do with her patients so I recommend building that stuff out, I think it's really handy and it makes it quick to add the codes that you get use for the time. Programs that the patient is willing to go to 12 step meetings this is considered antiquated because patients reduce use with medication alone. So, I hate using pejorative terms. There is a lot of data on medication for us and the importance of getting patients on meds. Even as a fellow a decade ago, I remember participating in a study where we were looking at CBT in addition to methadone. And because the meds have such a big effects, it's really hard to show any additional benefit from therapy. I was kind of a negative study and it doesn't mean that there is not benefit from therapy. In fact I think it is, I think many patients benefit from meds, and all of these other potential interventions, and therapies you know mutual help groups in the community etc. But I think that mandating that, for a patient where it may not be clinically indicated, was probably too much of a one size fits all when we have the data on how robust and effective medication has. That being said if you have patients that are struggling in various areas, and groups or other things like that will be clinically indicated to address their specific problems, I think that's when you want to have the conversations that recommending that kind of therapy. I practice in a harm reduction model. And you know there is a lot of evidence for harm reduction. I think anything you're going to say if you don't do X then you are not going to get this life-saving medication would be against the evidence at this point. So anything really safe you don't do what I want you to do, I'm going to take away

your medication is probably maybe a bit antiquated despite the term. Let's see, is it possible to --Decriminalization will also remove --So we are talking about some of the therapies, and the idea that we want a person to have conversations with therapeutic modality and how family can take a role where they are not enabling the person with these natural consequences. Substance use alone has a lot of natural consequences destroys relationships, there are certainly health consequences. You know, risky behaviors, can worsen mental health. No anxiety and depression etc. So, there's a lot of natural consequences. The problem with legal consequences is that they are often fairly far removed from the actual act itself. So talked little bit and can agency management. Her consequences with the rear talking about rewards, or other types of punishments or negative consequences depending on what you are looking at the closer they are. To the behavior the more effective they are at impacting behavior. Three years later that doesn't have a huge ability to motivate it five years ago. In making that decision to carry a small amount of drugs. The other challenge with legal consequences as they are inconsistent the applied, and there's all kinds of historical legacy on how and why certain substances are smart, the other big thing is there racial and ethnic minorities, and other groups where they are differentially applied, and so, there is you know huge ethical issue around that in terms of whether or not they are appropriate consequences or not. Going back to the question with decriminalization removing some of the natural consequences theoretically but I'm not sure based on the reasons I've just said that legal consequences are the best construct. So, I think that was most of the ones that I didn't respond to although I think I did try to respond to some of those there. Let's see what the other questions are. Let's seek him so I've dealt with family and friends I found it very challenging to be supportive and not enabling processing family members be so not enabling that the person feels completely unloved. Any good resources on how to balance these?

I mentioned my talk, and I put the link back in there, and I don't know it's an old book probably there is better resources. But I really like getting your loved one sober, how to avoid what is it nodding pleading and begging and all of those things, I think it's a good resource because it just really captures that idea of what role I can play, and how I can be thoughtful about the behaviors that I am doing that may help or hurt our goals around helping this person who I love. Family member friends, whatever it who is really struggling with substance abuse. Yes you know, if you are so not enabling that you are cuddled -- Putting the person off that can sometimes have consequences. And in fact, as a prognostic factor, people who have family members involved in their substance use treatment, have that are outcomes. So family members do play an important role on the outcomes. Can you recommend a good course, I recommend the one that we run every year and then we actually doing one again this October. We've added on respond to that question for one hour sessions. Four weeks apart to help reinforce some of the skills and answer questions as people practice things. Because well know just one-time training is the most effective way to change behavior there is a fee. Through the American psychiatric Association we have some grant funding and did some free motivational interviewing I think there was one that was eight sessions, and wonders 12, not sure you can go back into those those were some free ones that have the component but I would go back to

motivational interviewing.org there's lots of supports and things like that there could and then the other thing I put in for building skills is using some of the rating scales D --MITI is the abbreviation that is a scale. You can go in and record yourself doing a session getting patient permission you can record yourself doing the session and you can go back through and inconsistent things that I say or do, that's a good way to go back and reflect on what you did, but the significant and then from there target one or two things. So you might target annual I want to more reflections and questions insured --Should for that ratio. So I think that that is a really good way to start improving your skills on your own. If you have access to somebody else who's learning. Somebody who is fairly pre-proficient. Who can listen for you and with you and kind of do some supervision around that's also a great opportunity if you have that. Good evening --Even somebody who's learning, reviewing each other sessions. And score them and you can kind of identify various practice areas and things like that that you want to do. And there's a question about you two. Google and YouTube there is a lot of good practice videos on there. So the last one that we use although I still think that there is some room for improvement in the scope of the effective physician the pediatrician talking to mom about wanting to quit smoking in front of her kid. And you can really see the difference in the go with the style in terms of effectiveness there was roughly the same length of time and you really see the difference in the nonresponsiveness and openness when you have a more medical approach. With that I think I'm going to end and turn it over to I believe the next person is Abigail. So thank you all.

Thank you so much Carla we're going to hand it over to Paul. >>> Thank you Abigail. Great session and it was great to hear the questions as well. Have a bunch of questions in front of me. I think I will start with a couple of simple things. But I didn't have time to complete that print the definition of conflict, and --That's a concept a conflict between a person's behaviors and their beliefs. So in the relapse prevention world, they were doing well and avoiding the relapse, and yet they are in the midst of the early parts of the substance use, for the education that serves to further the relapse process along. And the other one is the concept of self attribution. And the other one is an individual's tendencies to attribute to their success their successes to one thing and their failures to other. So they may say with the success have been able to stay in remission for a long time because I've been working hard but I had this relapse because you know, my parents yelled at me. Or I had a difficult day at work. So that is the self attribution, which is in truth, we just have to figure out how to take responsibility for each, the goods in the beds in each thing we do, and self attribution is when those are polarized. There were a ton of questions about referral to AA, and the use of referring people to AA, where currently on medications for their OU D. So I wanted to eat for a minute about about what you can do to learn more about how to use this tool. The biggest reason why --I have had people come to me, they go to AA, and then they say would you do to get there and I tell them to look it up and go to a meeting. And that the data is very clear, that the hotter the handoff is, and the more follow-up you have, the more likelihood that individual is going to become engaged with self-help point remember, very few people walk into a Narcotics Anonymous and Alcoholics Anonymous meeting and say this is great I love it, people have difficulties with that, they been in a world

where --Altruism doesn't exist so they misinterpret what is going on there. The fact that people do not address each other directly is actually as designed. It creates a sense, it feels odd sometimes for people. And some people have difficulties with the spiritual or religious aspects, that becomes a fused into an alcoholic's anonymous or Narcotics Anonymous meeting, it's always an ongoing process. What you can do is you can go to meetings. You can look up your local AA or NA online in your city, or your town, and you go to what's called an open meeting, and an open meeting all are welcome. And that a closed meeting they prefer that people are there who have a desire to stop drinking or using substances. So, that is the first thing one can do, you can kind of learn how the process works, get a cup of coffee, sit down in the corner, kind of listen to it see what strikes you is helpful and what doesn't. The second thing you can do and I've had the pleasure of doing this in my career, as over a long haul. Have had people that I have treated and then stayed in psychotherapy with me for decades. And so --My reality is maybe not the same as yours. Some of those folks that are with me for longer-term, if they are in solid recovery, at some point I was at some point down the road, would you be willing, usually when people are beginning to terminate with me in the therapeutic relationship would you be willing to meet one of my newer patients, go to a meeting with them, help them ask questions and kind of help and mentor them in if you will. So having a couple of those people in your pocket, or in your drawer, in your guest, that you can have someone call to meet at an Alcoholics Anonymous meeting. Then, when your patients go to a meeting it's really important to ask questions like how did it go, what did you like, I usually start with by the way, saying what didn't you like, so people can kind of get off their chest but they like. With the open way, and I reiterate the concept that this is free. So --And it's hard to argue against that cost factor. And as I showed earlier the date is very clear. And have multiple questions about medication assistant treatment, or treatment of addiction, this is a bit tricky. If you know the meetings around that are accepting of people who are on medications, then I tend to refer to those meetings, I live in Atlanta, so there are lots of those meetings, both for alcohol use disorder, and opioid use disorder, and medications and AA has a position they have no issues on matters including medications. They say don't lead with that information, hold onto your hat until you have the sense about how, about how that will go forward for them. And don't offer it right away people. Because people who go to AA, they are going of their own free will. And each of them have opinions about medications vary from no way to it's not a problem. And so you don't know who you are talking to, so you hold under your hat first. And not talk about any kind of medications you are on. You will also find that meetings that tend to be in cities where there is a more vibrant recovery community, and more treatment, tend to have more people on medications and be more accepting then as you move out into more rural areas especially for me and in rural Georgia. And that is an issue as well. The other question I had a really interesting question that I didn't respond to because I didn't have time to respond to it. Is it possible this up on his representation of the Mayza limbic reward system and its addiction. That is absolutely dead on. I think. But the reality is that people who become powerless over their substance use, it has so much dyscontrol, there is not normal control, that Mayza limbic reward circuit has become altered by long-term substance use. Standard rewards that occurred in our daily lives such as

a good meal, good conversation with the Fred, a hug from a friend, or your lover. Those things, just pale in comparison to the overwhelming surgeon that occurs with substances, and -- They become turned down. Powerlessness in this piece, that people experience, is a long-term process for people with substance use disorder. I have the joy of following people for 30 and 40 years in the recovery, and they sometimes have relapses. And the universal experience, and my patient population is neither starts to get out of control, very rapidly or gets out of control, in a short period of time. I would like to comment about also issues around Alcoholics Anonymous and powerlessness. When you have disenfranchised populations, when you have individuals who have been the subject of systemic or institutional racism, or prejudice, this concept of powerlessness is a little more dicey, and requires a conversation with your patients who have been subject to discrimination in their lives. And I mentioned that earlier talking about in a couple situation. So, the powerlessness is limited to the substances, and that is the way to start with it. You have power to deal with other things in your life, and I will help, but until we learn how to sustain your recovery, you will tend to fall into a one down position over and over again. You will feel worse and worse. And --Be the subject of more difficult discriminations. And the other question I had was to people, patients attend multiple types of meetings, like Alcoholics Anonymous and celebrate recovery? I encourage people to go and people have a strong Christian faith, they celebrate recovery, there are also groups with Judaism and Muslim face that are about recovery as well. We talked with patients about their faith, and how that inter plays with this, and encourage them to think through what exactly they would like to do. And I think that's just about it. I had one more set of questions. And, if you are someone who uses the criteria the concept here when you're using behavioral therapy, it's usually for people that have a concomitant problem with affect dysregulation. I would not necessarily send 100% of my patients to dialectical behavioral therapy, and is much as they would love affect regulation to help them not have continual relapses which are driven by regulation. So that would be an excellent person to send to DBT. It's not under any circumstances that show DB he alone is good for all people who have substance use disorder. So again it's an individual that has a co-occurring condition. As well. Just wanted to let you can clarify that question. And I that is really it. Maybe I can turn this and thank you for your time Abigail.
>>> Thank you so much Paul, love the way you characterize that about affect regulation. I think I have found a lot of --I am a psychiatrist I found a lot of success using elements with patients, who certainly don't have borderline personality disorder. But, that is a really nice frame for it. I think that is really great way to think about a print so you know, thank you to everyone, we have just a couple of minutes left. So I am going to give Dr. Hayes the opportunity to answer a few more questions. We also wanted to bring everyone back to just talk a little bit about some tips and tricks for the exam, for those of you that are taking it. I want to thank everybody for your level of involvement, and the questions and comments that you have data really showed how engaged you are. I do want to remind you for those of you taking the exam, that it is you know, a broad overview, and it looks at all aspects of addiction medicine. While I appreciate you done a lot of things for the exam you want to know some about a lot of rather than everything about somethings. And I think that's actually something that you want to keep

in mind, you are having trouble with a certain area. Feel like you need to spend hours and hours of your life and get one small concept, and focus on the bigger pitcher and getting breath of different things practicing questions, and I would particularly encourage you to look outside for your everyday practice. I am a psychiatrist, I don't spend a lot of time I took the exam myself this fall, so I didn't and the behavioral therapies or psychosocial treatments because I do that in my day to day practice. For me I want to to look more of the medical management. And vice versa. If you are an inpatient attending any spend a lot of time taking care of patients acutely with alcohol use disorder probably don't need to spend a lot of time on that but you probably do need to focus more on looking at psychiatric conditions in all of those things like that. Whatever your specialty is good we will bring back the panel, and everyone else can offer some suggestions I have for the exam, comment anything else that they wanted to comment on, will try not to step on each other, also I will give Leslie come I know she really thoughtfully answered questions during her talk in the chat but if there was anything else that you really wanted to get to know as an opportunity to answer another question or two as well. Speak of the big one I wanted to answer, or it wasn't even asked but I'm going to answer it anyways. If you are a non-opiate provider that has a patient come in and they turn up pigment, really all you need to do is just make sure you continue the Meadow View print morphine. I put a link to the a study I learned about this week, on the number of patients who are pregnant and calling to a clinic. It is like only two thirds of them can get an appointment versus people who are not pregnant. These are the people we want most of all to be getting pregnant. So really it's not that scary, the only difficult part is it's a little more challenging is starting them, and I still do it in a monitored setting, there is a move towards not doing it. And, I still change them to the mono product, but it's even reasonable if you want and continue them on the combination product, if they are Arianna buprenorphine, just keep doing it, if you're totally not comfortable doing it, make sure you refer them to somebody them enough medication to go by without print because you are not going to harm them by continuing to buprenorphine.

You will harm them by not continuing it.

If you get one take away from us all about buprenorphine it's please keep patients on the working while you are figuring out what else to do while you're calling experts, calling for consult, whatever else please try to keep them. Everyone else, what would you like to say about the exam, but anything else, about how wonderful it is to be an addiction doctor.

Definitely wonderful to be an addiction doctor.

It is. >> Amen Pitsburg I want to echo what you said Abigail, the test is fair they are not looking to trip you up with a high-level of academic science research. The exam was made before the time. Speak of the things I found on the exam a lot more than not --The company useful. As the acts that have been passed sort of knowing roughly when they will be passed, and when they were covered, that was a lot more on the exam than I had anticipated, the criteria which I don't really use diligently. I mean I kind of have some idea with them. I think the other criteria was really

helpful, and there was a lot of stuff on ethics, and do something with the autonomy, and that I think was definitely something going back to the stuff that you don't use on a regular basis. I don't really ever use those concepts, explicitly. So, look -- I think was really helpful.

Let me just hang off what you said, because I was asked to cover that area but didn't have much time to do it. For sure you need to understand what the dimensions are, the six dimensions are, and for sure you need to have the levels of care, and probably understanding the mechanics of what the criteria is in terms of it's a placement tool, and every assessment tool, to kind of understand the process. You don't need the criteria book, I did know that, but kind of having a general understanding of that. And I think you probably will have some questions in that area I would guess.

I agree, I had I have been addiction psychiatry certified for over a decade now. And I just took the addiction medicine exam this past fall. And, I found a very reasonable, I was actually pleasantly surprised with the topics, I was feeling a bit nervous about you know, hepatitis C management or things like that that I don't really do, and so I spent a lot of time studying that which I didn't find to be on the exam much. I agree, I noticed that there were a number of questions about ethical considerations, and that was an area I probably could've reviewed a little bit more, and having to pull back the medical school knowledge, there are a lot of questions on at-risk drinking criteria. So, I was happy that I had it memorized, I get that speech to patients, day in and day out. Overall, I found the exam to be pretty straightforward. And reasonable. I think there are one or two things like you said Ed, or something may have been fairly well accepted, and then all the sudden there was a study that shows maybe that wasn't the case, and I was trying to question when was this question written, was it before or after our practices change, you know for example all the stuff with micro dosing now. That's all really new and important for us to know about, but it's not --

Certainly didn't make the 2020 exam right?

Yes. So there is I think things like that. Also because I do the cannabis lecture, inevitably I always get 1 million questions about all of the public policy, and when we think about legalization and not and those are great questions for you to be prepared to answer as a representative of our field, and have some sense of how to answer those questions but but I thought about going to be on the exam and so just some things to think about in terms of the goal of this course, and that your role and it general into an addiction medicine provider, so those are some of my thoughts point

I would highly recommend reviewing Jeff DeVito's epidemiology talk, and slides, and, also the ethics and the law lectures from here, depending on what you do, some of you may be in public health, research heavy backgrounds, and that stuff might be second nature to you. But both of those are sections where I find it you can't reason your way through it, you can't logic her way out of those questions. You kind of either know what the odds ratio is or you don't, and you know what it is or you

don't. And so those I think are definite bang for your buck. If you understand the concepts that are in those lectures, you will have down the type of questions, and the debtor on the exam. I think those are very worth going back and reviewing. And I will make another plug before just doing as many questions as you can get your hands on. So communal, using the other questions that you have, you learn a lot from the questions, and from going to the wrong answers as well. So I think those are definitely, strong tactics, I also just took this past fall. So it is fresh in my mind to. >> I also like I'm probably going to steal Ed's Thunder on this it and if you're not a member of ASAM please consider joining, it really is a great organization. There is a lot of illegality, a lot of meeting people that have an expertise that you know, is orthogonal to yours. And you learn a ton, and we are all pioneers in this emergent field. And it's great to be a part of the field I'm going to do it myself but quoting Rodney Dangerfield, for a few years we didn't get no respect. Another field has some respect, and people are beginning to say boy we really need to do something about it, and it's a tragedy that not only was helping with the opioid deaths, let's put this into the public zeitgeist. But we should take the time to make sure our patients get the care that they need. And when we can do that is become a member of ASAM and become active politically, become active in the organization and we love to have you. >> I will certainly echo that as well, I am sorry that we didn't get the experience of being together in person, and in Dallas and Chicago or were ever this was going to have been. These are absolutely lovely conferences and end up feeling like a community with people that live across the country, for all around, I've been doing a review course since I was a fellow. Carl and I have had three babies between us while being faculty on this course, we've gone through people that have really been around for a long time. People staying active. With so much of for such a long part of their careers, because it really was a great organization. Ed you wanted to say something you are of course Dr. ASAM. What would you like to say to close us out ?

That was a great way to end the session point

Think it everyone can look to those of you taking the exam, we look forward to meeting you in person at an upcoming event someday soon. And don't hesitate to reach out if you have any questions after the course is over. Thank you to everybody. >> Bye-bye.

By. [Event Concluded]