**Season 3 Episode 6 Brian Noonan**

**Voice over –** Season three of the Options Save Lives podcast is brought to you with the support of our presenting sponsor R Street Institute and is hosted by Executive Director, Jenny Williamson.

**Jenny Williamson** – Today we have Brian Noonan with us from sinclairmethod.org by Ballard Psychiatry. Welcome back to the show, Brian.

**Brian Noonan** – Hi and thank you very much. It's great to see you and talk to you again.

**Jenny Williamson** – So let's take a moment, introduce yourself to the audience and just share a little bit about your background helping people on the Sinclair Method.

**Brian Noonan** – Well, I am a psychiatric nurse practitioner. I've been that for almost 15 years now. And I'm licensed, I sort of lost count but I'm gonna say 13 states plus the District of Columbia and I, actually my career and actually even my training, my education at Vanderbilt began in addiction at the Vanderbilt Institute for treatment of addiction. So I've really been doing one type of addiction treatment or another for quite a while. And I believe it was in 2016 plus or minus that I was first introduced to the Sinclair Method. I had been quite familiar with naltrexone, just as a kind of the traditional kind of conventional use of naltrexone. But this was the first time that I had heard of drinking in combination with the naltrexone, and it was brought to my attention by a patient who had been doing quite well on it and he explained to me the whole protocol. And it was, I still remember it like we remember all kinds of events certain meaningful events in our lives, and I remember very specifically the first time I heard about this, because it really was the first time that I had heard any kind of treatment that just made perfect sense to me on the face of it, it just, that made total sense. And I remember giving him a refill and just trying to find every amount of research or any type of information about it like a lot of people do the first time they hear about it. And it wasn't long before that, before it was kind of treatment a specialty that I had just because I had seen so much success with it right out of the gate, to the things that people were saying to me about it, the responses, And then it didn't take long for people, this was in Seattle, for people to contact me from other parts of the state, other surrounding states, and that's where the idea for having TSM provided through telehealth came about.

**Jenny Williamson** – So you heard about this life changing, and for you somewhat career changing, treatment for addiction from a patient. Talk a little bit about how different that is from everything else that you have learned in your addiction studies and profession. Have you ever been in a situation where a treatment that you then researched and embraced was brought to you by a patient as opposed to the medical addiction and educational system?

**Brian Noonan** – I can't think of a better, I mean this is definitely the most striking example of that. I will say that, you know, it's kind of thought any kind of professional training is really just thought of this as kind of the launching pad for your career. Because you're always going to want to, there are continuing education requirements or new kind of breakthroughs come in or that are developed and new medications and treatments, so you're always kind of learning. I think what was different about this is that it was not, it was not new, it wasn't something that was, you know, kind of a new medication that was being marketed or we, you know, someone developed a new type of treatment for trauma, you know. EMDR for example, that kind of had this breakthrough, that, you know, there was some point where it was not known and then it became widely known. So I think what was interesting about this is that naltrexone had been FDA approved in 1994. It was something that I had prescribed. It was something that we had used in various facilities or centers that I had worked at. I think that was what was new about it, that it was just kind of something that was the kind of the basic materials for the Sinclair Method were there. And yet this kind of the way of using all these materials was what was novel about it. So but that but yeah, it was not something that certainly was not taught in schools or I didn't learn it from any other professionals. And as I mentioned, I was in, this was addiction, it was not that I was an outsider, you know, I had worked in addiction for quite a

long time, different types of approaches, inpatient, outpatient, you know, and so it was just not on the radar at all. So it is surprising that it kind of took so long for all of these ingredients which we knew to assemble them kind of in this particular way.

**Jenny Williamson** – And you mentioned that upon seeing not just the success rates in patients but also the distances people were willing to travel to access this treatment, so far is even out of state, that all of that kind of went into your thought process about building an entire telemedicine practice around the Sinclair Method. Can you talk about how the process itself of going through and building a telemedicine service in multiple states, especially pre COVID, some of the difficulties that you encountered in trying to grow the practice beyond the state of Washington.

**Brian Noonan** – Right, you know, of course, pre COVID this was something a very small percentage of people were familiar with. Even professionals, a very small percentage of professionals had ever practiced any type of telehealth, video appointments, things like that. So it was completely brand new, and actually, it's sort of just interesting now just to think about how much time was spent explaining exactly what the idea of it was, and you know, the benefits and all these types of things. So some of the just kind of the practical things in terms of were just related to educating patients about it. You know, there were many pages on the website and emails sent out just explaining exactly what this is and that it is safe and that there's limited research on it at the time, but all the research, you know, kind of supports this practice and of course, you don't have to drive from Portland to Seattle or Boise wherever they were coming from to do this. In terms of the kind of professional issues and this is still kind of, I think people are really so surprised by this, is that it requires you the provider to have a license in each of the states that you're going to practice in, and the determination of what state is the relevant state is where the patient is, not where the provider is. So in this particular case, although I was in Seattle, if I was seeing a patient who was in Portland, then at the time of the appointment, then that required me to have an Oregon license. If they were in Boise I needed an Idaho license. So the restrictions were that, despite that there was seemingly no difference really, and people were often kind of perplexed by this, it does still continues to require a license wherever the state, whatever state the person is in at the time. So if I had someone who wanted to see me and they were in Utah, then I would not be able to see them even though of course, you know, we could just as easily do it as not, but I wouldn't, that would be considered practicing without a license. So there were these types of state license issues that really did not consider telehealth at all until pre COVID, or this was pre COVID. And then of course now we're having all kinds of conversations about what are the requirements what, you know, how do we handle this? When you think that at the time it was all of the laws and regulations were just based on seeing someone in an office so that was kind of everyone slowed things down, because otherwise I could have seen anyone, anywhere, no matter where they are. So it took some time to acquire these licenses, which also take, people are surprised, it can take six to eight months to get a new license in a given state.

**Jenny Williamson** – The other thing that many people don't understand is the differences between licensing requirements from one state to another. So talk about how that was also a challenge.

**Brian Noonan** – That's right. It's really amazing how, of course there's some baseline similarities, you know, they all want some type of transcript or they, or some type of background check or there are, you know, some basics that they all require, but some of them require fingerprints. Some of them require various things from your employer or some verification of, you know, a signed document from your program director verifying that you had specific pharmacology credits. So they all have these little wrinkles in them, you know, you would have this basic kind of requirements, but then they each seem to have this very, kind of just very esoteric demand of you. And even the fact that you had say 12 licenses in other states, and in theory it would be simple to verify those licenses and perhaps speed up the process, that in fact did not speed up the process. You know, each state that you went to was a brand new endeavor, and it was often quite time consuming to do it, and in fact, a lot of times I'm still, for example, I have been trying to get a California license for over a year now. And it requires some cooperation with former directors that I've worked under. It requires a

specific things from Vanderbilt that I went to 15 years ago. So it's very, it's not as easy as it would seem to just have these. Some of them are on or are completely by paper so you have to print these things out. Some of them are electronic now, more and more are electronic, but so there are all kinds of hurdles to go through, and each state has its own peculiar way of doing it.

**Jenny Williamson** – So hopefully people who hear that will recognize that even among TSM providers, it's not always easy to just run out there and just go and do it and treat and just help everybody that you can, because you have these challenges in front of you as well.

**Brian Noonan** – That's right and I hope that, I think there should be if there aren't already, studies about the cost of all of these hurdles. Of course, there is a public safety element. Of course we want to screen potential medical and therapeutic providers. At the same time if it takes six months to do that there is some cost there as well in terms of people who were not able to be cared for during that time. So it's not as easy as just kind of we're making this safer by having 100 requirements, perhaps you're making it less safe to the extent that the process takes so long.

**Jenny Williamson** – You are set up and you said you think you are personally licensed in 13 states but you have other providers that work for you. So sinclairmethod.org is available in roughly how many states right now?

**Brian Noonan** – I should know this exactly, but it's around 30 states plus the District of Columbia. And I guess and what's interesting about that is too, it's 30 states, but it really is about, it's over 80% of the population of the United States. You know, the places that we don't have licenses tend to be places like North Dakota and, you know we, of course we would love to tell people in North Dakota, but it's in terms of kind of weighing, you know, how many people we can help versus the, you know, the amount of time it's going to take to do that. So the states that we are not licensed in tend to be small states like North Dakota, Vermont is one, South Dakota even. So, in terms of just the percentage of people we can help in the United States, it's quite the vast majority of people we're able to help, even though the states, there are about 20 states we'll say that we're not licensed, and because it's just so complicated to do that, given that there might only be a very small population there.

**Jenny Williamson** – Well, thankfully, we do have other telemedicine providers in those states. So all of North America, thanks to telemedicine is covered both in the US and Canada, so that's great at least. So let's talk about some of the pros and cons from the patient side of using telemedicine to treat addiction in general and using the Sinclair Method specifically.

**Brian Noonan** – The obvious ones are convenience I think for most people. Now of course with any type of approach, whether it be office or telehealth, there are going to be some people who simply do not have the access to it for one reason or another, you know, even in an office appointment. Perhaps the person doesn't have transportation. Perhaps the person doesn't have these other types of means to get to the appointment. So for telehealth there are going to be some percentage of people who do not have the computer or they do not have the internet or they do not have those types of equipment needed for to make the appointment, so that's going to be true regardless of what platform you use. There are going to be some people unfortunately, who simply just do not have those, what is needed to access the appointment. But for most people, telehealth is overwhelmingly more convenient than going into an office appointment. I think that's what people found out during the pandemic. Especially if you are in a big city, if you consider traffic, how long it took to get to an appointment, to get, you know, anything anytime it required to get dressed, to get prepared to go to a 30 minute appointment. It might be a two and a half hour, three hour chunk of your day that's taken out for a 30 minute appointment. Whereas with telehealth a 30 minute appointment, maybe it takes 45 minutes if it takes you a little bit to sign on and maybe the provider is running a little bit behind or something like that. So the amount of time that you spend kind of around the appointment certainly is decreased quite a bit. And then of course, if there's no provider there to treat you, it doesn't matter how convenient it is. So that's the other thing to what we just talked about. Just the sheer opportunity to see people who might be, if you live in Miami,

there's someone maybe there's a TSM provider in Jacksonville that you could see. So just the sheer number of people, number of providers that you're going to have the opportunity to see in the first place for even beyond convenience. So I think people just really like the idea that they're not spending too much time taking time off from work, taking time off from their day, simply to get to the appointment. Of course the advantage too is if there are any physical disabilities, you can stay in your home and also just still concerns related to the pandemic and to the viruses, things like that. So people definitely prefer or find that to be a huge advantage. Just the convenience of it.

**Jenny Williamson** – You have, you've treated people in an office setting for many years before you did this. Can you talk a little bit about how the shame and stigma can be reduced by using telemedicine as opposed to maybe walking into an office and sitting there in a waiting room with other people and we've heard you know, the internalized judgment that can happen when they walk into that kind of setting. Can you talk about how that is affected through the privacy of being able to use telemedicine

**Brian Noonan** – Right, that's really just an amazing benefit to telehealth, especially as it relates to mental health generally and of course, you know, addiction is even kind of even further stigmatized within that sub specialty. The telehealth is one on one. You know, when I see someone, the patient completely controls who is kind of aware of this encounter. Of course oftentimes they will have partners or whoever else they want sitting alongside of them, but if they want it can be a completely confidential encounter, just me and the patient. Whereas, kind of like you're saying, if you go to, the very least there's going to be a waiting room there. There's going to be front desk help, there's going to be possibly even a sign on the door that indicates why you're there. Hopefully there would be some sort of discretion with that. But it's very possible that from the parking lot into the office, you know, any number of people would know or have a vague idea of what type of care you're doing and how often you're going there, so it really increases privacy substantially. But and especially for addiction treatment, it just, it's really is stigmatizing to be seen, you know, if you were to be seen going into something you know for, you know, just called addiction treatment or something like that, you know, even just, people kind of piece piece a story together, or, again the front office desk or just sitting in the waiting room and therefore the people and everyone knows why they're there.



**Jenny Williamson** – And so who is the ideal person, the ideal patient who would be best suited to telemedicine especially with TSM?

**Brian Noonan** – Yeah, I think you know, TSM is nice because it really kind of the basics of it are very, there's a practicality to it that I think that's its strength, so I think that it really lends itself well to telehealth. You know, there's not a lot of, you know, the very core of the Sinclair Method, there's not a lot of, or any really kind of psycho-dynamic processing. There's not necessarily, certainly not any type of transference or any of these types of dynamics that we think of in kind of traditional psychotherapy. So that lends itself well to a platform which I think most people will agree, there is a certain element missing from it, that beyond verbal communication and even the visual, the limited kind of visual window we see, we do have something very important called body language and these other types of nonverbal cues that we see when we meet people. You know, if I wanted to have the kind of the deepest connection possible with another person, I certainly would choose an in person visit of any kind versus any kind of video encounter and that would be true, whether it's telemedicine or just meeting someone, you know, just 100% social engagement. You know, I think most people will find it more meaningful in person because of these other elements of human interaction that the video appointments don't capture. That being said, I think while that is important, it is not kind of an essential feature of the real core basics of the Sinclair Method. So I think that's why we have so much success with telemedicine because while we do miss out on some things, the benefits that we've been discussing, those are so, so tremendous, that they really do offset some of that loss. But I think, you know, one of the things that we encourage with the Sinclair

Method in terms of coaching and these other types of things, is to find those meaningful relationships out there and community and those types of things. That oftentimes those in person relationships are damaged, or simply don't exist in the course of the addiction, so that's one thing we do work on, is that piece of the puzzle we do address. But I think the Sinclair Method is wonderful. It's really perfectly suited for telehealth because it is very practical. It's instructional. It's educational. And one of the things, some of the early studies that have come out since kind of the pandemic has been with us, is that almost all the studies show at least equivalent outcomes with various types of addiction, not just alcohol. But one of the, kind of the nice things that we see about telehealth, telemedicine, is that retention rates are much higher or are higher, statistically significantly higher, so that people just once they start them, they are more likely to remain in the treatment. And that's really the key with the Sinclair Method because it is a long term process. So people are dropping out and not taking, the longer they are taking the medicine of course the likelihood of extinction increases.

**Jenny Williamson** – What kind of patient or issues a patient might be facing may mean that they would be better off in a face to face setting?

**Brian Noonan** – Well, it would kind of, there would be situations where if for example, they were close to the office or these other kinds of convenience issues were not there. In other words, if it was not a barrier, if it was not inconvenient for them to get to the office, that would be a good candidate. We know that whether it be the length of distance to the office decreases retention. We know even for example, if a person has to take a medication once a day versus twice a day versus three times a day for example, the compliance gets worse, you know, every additional time during the day they have to take the medicine, so just generally speaking, medicine outcomes are going to be improved when all these barriers are limited. So in terms of thinking, well who would be good for the office, it'd be the kind of person who doesn't necessarily capture all these benefits telehealth offers. So if it is very convenient to get to the office, and they are not concerned about privacy, or as concerned, you know, I think most people would have some just kind of basic need for privacy, but if that is not the kind of deal breaker or if hopefully the providers have taken some sort of measures to increase privacy. So if it's convenient, if it's private, and also if they just like it. You know some people really find that element that is missing from the telehealth appointments people really do find that beneficial, so if that's the case, all things considered, you might do well in office appointment. I think too, some people find that the office appointments do offer some sort of, if you're thinking of kind of behavioral activation, if you're thinking of behavioral therapy, people who might have some depressive symptoms or other kind of co-occurring issues, the kind of the prompt and the kind of the requirement that they do get up and get dressed and take a shower and go to this appointment, you know, that lends itself to them engaging with other activities during the day. So if there are co occurring issues, that would be I would say that would be a consideration for an office appointments.

**Jenny Williamson** – So let's talk a little bit about some common challenges that you see. One of the things that we were speaking about before we started taping was extinction bursts. People lowering their drinking and then having either a one night or a weekend or a week where their drinking goes up and that first thought is to panic. Can you talk about first of all how common this is?

**Brian Noonan** – So, an extinction burst is a type of burst I can say, I should say that, you know, I'll talk about this in just a minute, but we do see sort of a, broadly speaking we see variants. So one thing to keep in mind is that while you're doing the Sinclair Method it's - although the overall trend we expect, you know, we expect the overall trend to be a reduction in drinking that from one month to the next or some interval to the next, you should see a reduction over time, on any given day, there can be increases and that's just kind of true broadly speaking, that there is going to be some variance, especially at the beginning. You get more variance at the beginning, and then as time goes on those variances tend to even out towards complete extinction. So we do see increases in any kind of, just generally speaking, so if you, if a person were to have an increase in their drinking, despite taking the medication as prescribed and all these things, there was just an increase for whatever reason, that certainly is not a reason to panic. It certainly is not a reason to think that the Sinclair Method is not

working. All of those things are just kind of part of the process and I spend a lot of time the first appointment or just when people are beginning, really explaining all these expectations. These are the range of things you might expect. You are, it's very likely you're kind of, the frequency of your drinking won't decrease all that much at the beginning. And also, there might be a slight burst here and there, an increase in your drinking.

Now the extinction burst is a particular type of increase that by definition is post extinction. And extinction being that you know, this association between the behavior and the reward has essentially been erased. And yet you see, you know, a spike or an increase or a burst of this, of in this case the behavior of drinking. Usually this occurs, kind of if it does occur, and I don't really know the exact percentage of of extinction bursts, other than to say that I'm not surprised when it happens. If someone reports it I say okay, that is something most people don't have it but it is something that does occur, but it usually occurs pretty close after extinction occurs. So if someone has reached the extinction point, and then somewhere in the vicinity of that you can see kind of a sharp increase in the drinking and a person might kind of overdo it or even kind of drink in some way that's familiar to them pre TSM, but it's really a predictable kind of thing when it happens. And I just encourage people to not, it definitely doesn't mean that it's not working. In fact, it's really a phenomenon, it's a component of the extinction process. So if anything, it kind of really reiterates or kind of reinforces that this is really working. But I think that's kind of an easier kind of idea to kind of appreciate if the person has told in advance that this is going to happen, you know, that this is a possibility and then when it happens, you know kind of prepare people for it. I mean, I think after the fact, a person is doing very well and then all of a sudden they have this burst, that can be a pretty offsetting or kind of really off putting or really kind of shake their confidence in it. So I think it's really important that people understand that should they have this, it's not, it's a kind of, it's part of the phenomenon of extinction and nothing to be really concerned about. And this occurs not just for drinking, but, you know, of course, the Sinclair Method is just based on operant conditioning, so we see this with all type of learned behaviors, and then when those behaviors are unlearned, we see these extinction bursts. So it's a very common phenomenon, not just as it relates to the Sinclair Method, but in any type of unlearning process, very common.

**Jenny Williamson** – And speaking of things that people are wary about, or uncertain about. Let's talk about side effects and side effect frequency a little bit. So far as the official documentation submitted by Revia, only about 10% of people get side effects and of those that do most get rid of them in seven to 10 days. Does that match with what you have seen in your practice? Because it's at least a once or twice a week occurrence across the various peer support groups, where we will have that tentative person who will say, I've got my medication, and I've had it for a week, and I'm terrified of the side effects and I haven't taken it yet. So can you talk about that frequency and the severity and a little bit about how to minimize that.

**Brian Noonan** – Yeah, I would say 10% would be low. If you consider all the side effects, you know, does someone have a side effect? I would say it would be higher than 10%. What it would be I don't know, but I would think higher than that. One third will have some minor side effect in the sense of, did you have a stomachache? Oh yes, I did for a day or two. Okay, well, then you, that will qualify as you having a side effect. So now in terms of it being mild, it's usually mild, but I would say 1/3 of people have some mild side effect, transient that goes away after a day or two. So in that case even still, you're most likely not, any given person is most likely not going to have a side effect. But if they do, it's overwhelmingly likely to be mild and then it's also overwhelmingly likely to go away. Sometimes with a second dose, you know, a lot of times with the initial reaction of the body to the first exposure, for second exposure that's when you're going to have your kind of largest response to it and then it rapidly goes away. So but I would say 10% is fairly optimistic and a lot of times we see this in studies where there's this very small population of people. And a lot of times too of course, to even participate in a given study, these are kind of ideal kind of patients, are very say uncomplicated. They're not taking any other medications. They don't have any other health problems. They don't have any other types of issues. So we often see that when these drugs are then used across a large population it is not uncommon to see that Oh well actually, this is more kind of typical of what we would expect.

A lot of times people are taking SSRIs for example, for depression like an antidepressant when they take naltrexone, and those have some gastrointestinal effects that may be sub threshold, but then when you combine it with the naltrexone, now you really have two kinds of medications that are affecting these receptors and so that can sometimes be the issue as well. Whereas in the study, they were not taking, they excluded people who were taking antidepressants, for example. So I would say 10% would be very optimistic. What I tell people is sort of what I just said, is that most likely you're not going to have these. These are potential side effects. A lot of times people say speak of side effects with a certain conviction that this is going to happen, you know, that these are the side effects when really it's a potential side effect. This may happen. But of course the other side of that is that these are potential benefits as well. You know, in both cases, these are probabilities, you know, these we expect this to happen with some frequency and this to happen with some frequency as well. So it's a potential side effect, but by far and the one that's most famous are the gastrointestinal side effects, nausea, vomiting, diarrhea. Most of our opioid receptors, which is what the medication blocks, are actually in our gastrointestinal tract, not our brain, which is kind of what we're thinking we're targeting. And that's also true for antidepressants for example. Most of our serotonin dopamine, norepinephrine, these kind of what we think of as brain chemicals, they're really mostly gastrointestinal in terms of their origin and in terms of where these receptors are located. So it's a very kind of predictable side effect from naltrexone. We would expect that gastrointestinal side effects would be the most common. So that's really the main one I kind of warn people about, you know, you might have nausea, vomiting, diarrhea. But really the best way to to prevent that is to at the beginning, first couple times, to prevent any side effect, just take a half a tablet. But then also, you really want to take that with a meal. And I really emphasize a meal versus food, you know, just generally speaking, you really want to take a half a tablet, full meal and that's going to be the best way to reduce any side effect, but especially the gastrointestinal ones And I will tell people as well, especially if they are anxious like this person you mentioned here, that's very common to be anxious about taking a new medicine. Take a quarter of a tablet if you know that you have a sensitive stomach, irritable bowel syndrome or just you're just anxious about it, just take a quarter of a tablet. You know this is really such an amazing treatment that there's no reason to kind of take a risk by having an unpleasant side effect, and there's also no rush to long term treatment as well. So if there's any concern, just take a quarter of a tablet the first time, full meal and see what you think. And then you can go to half tablet, full meal, just see what you think. So just be very, very slow and very, very cautious when you start out. But again, I will say even if people ignore all of my advice and recommendations, they're still most likely not going to have a side effect. But you just never know who you're going to be. But people can have, some people it makes them a little tired. Some people feel like it makes them a little kind of wired, even a little bit. You can have generic kind of side effects like dizziness or dry mouth or headache or something like that. But really the gastrointestinal nausea, vomiting, diarrhea, those are going to be the ones that are most likely to happen.

**Jenny Williamson** – And can you just talk briefly about what it does to the process if someone is drinking on an insufficient dose for them? So some of the blockade is there, and they're still achieving some of the alcohol rewards when they drink.

**Brian Noonan** – Yeah, well, I mean part of it is that it's just not likely to work very well. And in terms of reaching extinction, I mean, there could be because the reward we could say is less, the strength of that reward has been diminished somewhat, you might see some kind of reductions in sort of short term, but because the person is still getting the reward, and the kind of the more meaningful unlearning would not take place because you would still just associate the behavior with a smaller reward. So the underlying interest in drinking and the underlying interest the brain has in this reward, that would never really be extinguished because they were still getting the reward. And I would say even the short term benefits would be, I'm just speculating there, that might not even be something that would occur. So essentially, if you're not getting adequate blockade, you could very well expect zero benefit from it. But certainly long term you would, the person would not really reach extinction as long as they were getting any type of reward for the behavior.

**Jenny Williamson** – For anyone who hasn't seen our previous episode together where you appeared on our channel, can you talk a little bit about you know, the number of people that you've helped through the Sinclair Method and what your success rates are like that you've seen in your patients?

**Brian Noonan** –Well, it's certainly in the 1000s by ow me personally. I've been doing this since the very least kind of full throttle since 2017, and I've just seen in the 1000s by now personally, and then, of course, our team here, when we combine them, it's 5000 plus maybe, I don't know, combined, but something pretty substantial. So we have seen, I feel like I've seen quite a bit to kind of at least kind of know what the basic kind of range of responses is, what's kind of normal, the kind of the issues that might occur in terms of the success rate. You know, it really is hard to say because sometimes, you know, one of the nice things about the Sinclair Method is that if we were to successfully treat someone, and also their goal was complete abstinence, we will never see them again, you know. And it would be hard to sort of distinguish between someone who had reached extinction with abstinence - of course, a lot, many people, most people continue to drink at some extent, so we would likely see them again for refills at some point or something like that – but if they were, if their goal was abstinence, and we never saw them again, that would be a great success, but it'd be hard to distinguish between that and someone who, you know, was given bad advice and stopped because they were still drinking per month or something like that, so that would be hard to say. But I can tell you that 78% is usually the number that is quoted, and that really is about right. I mean, you know, that would be about four out of five, or you could say with confidence that about four out of five people are going to reach extinction. And I think, again, if you just include people who take it as prescribed, it would be higher. But I think four out of five, 80%, that's, that really is about what we would see, you know. I fully expect when I talk to someone, I never make promises this is 100% gonna work for you, but I really expect that when I see them for a follow up, and then a couple of months after that, you know, I truly expect that everyone I see, I really have high confidence that they're gonna get this monkey off their back. And even if they're drinking more the next, or they're still drinking more than they would like the next time they see me, they're gonna have some evidence, some kind of loosening of this grip that it has on them, that when they come back, most just about everyone feels positive. They feel like they're on the right track and they can sort of, for the first time, kind of see something that was really unimaginable, which is that this kind of, this addiction that was kind of occupying so much of their mind, they can almost imagine it not quite being there all the time. So the 78% I would say that's about right.

**Jenny Williamson** – Well thank you so much for your time today, Brian, I really appreciate having you on the show and sharing your expertise with myself and with our audience.

**Brian Noonan** – Oh yeah, you're very welcome and of course, we appreciate everything that C Three Foundation is doing and just I feel like, you know, the momentum is growing and pretty soon, you know, this will be I hope, just kind of considered mainstream treatment, you know, this will be *the* treatment for alcohol use disorders.

**TSM Tip Voice over –** This TSM quick tip is brought to you by the C Three Foundation with support from our sponsor, Alcure.

**Claudia Christian** – Sarah, so many people come to me and say I was on Facebook and I heard a girl had reached extinction in three weeks.

**Sara Michael Novia** – I get his all the time. Comparison is nasty. Do not compare your journey to anyone else's. We are all going through completely different things under completely different circumstances.

**Claudia Christian** – We all drink for different reasons and our journeys are not linear. I do not see drink logs that are completely linear or the same. You?

**Sara Michael Novia –** No never.

**Claudia Christian** – So please don't compare yourself to anybody online. Just remember this is your journey,  your accountability, your mindfulness.

**Sara Michael Novia –** Your health

**Claudia Christian  -** Yes your health, mental and physical.