NAADAC, ADDICTION TREATMENT IN MILITARY & VETERAN CULTURE PART ONE: SUPPORTING

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>> SAMSON TEKLEMARIAM: Hello everyone, and welcome to part 1 of 6 for the specialty training series of Addiction Treatment in Military & Veteran Culture Part One: today's topic is Substance Use and Comprehensive Mental Health for Military Affiliated Populations presented by Duane France.

It's great that you can join us today. My name is Samson Teklemariam and I am the Director of Training and Professional Development for NAADAC - the Association for Addiction Professionals. I'll be the organizer for this session.

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Now, let me tell you about today's very skilled presenter. Duane France is a retired army, noncommissioned officer, combat veteran and a master's level licensed professional counselor, practicing in Colorado Springs, Colorado.

He is the director of Veterans Services of the Family Care Center, a private, outpatient mental health clinic, specializing in supporting wellness in service members, veterans, and their families.

Duane is also the Executive Director of the Colorado Veterans Health and Wellness Agency a 501C3 nonprofit professionally affiliated with the family care center.

He's the member of public policy and legislation committee for the the American Counseling Association for military and government counseling association. He was also selected as a member of the inaugural class of the George W. Bush Institute Veteran Leadership Program.

And Duane is an active member in legislative and public advocacy for both the military population and the counseling profession. In addition to his clinical work, Duane also writes and speaks about veteran mental health on his blog and podcast. Head, head space, and timing, which can be found at w ww.veteranmentalhealth.com.

Honestly, I cannot think of anyone more ee equipped to provide addiction-related professional training on the clinical needs and culture al issues related to our honored service members, veterans and their family.

So Duane, if you're ready, I will hand this over to you.

>> DUANE FRANCE: Samson, thank you very much. I appreciate the opportunity to talk about service member veteran and military family culture. I appreciate everyone who is tuning in live. And I appreciate everyone who is watching this on demand.

So to get started, I really would like to be to have a discussion about what we're going to be talking about and what our learning objectives are. First, we're going to be describing the different aspects of the psychological impact of military service. There are very positive ones and negative ones.

We would like you to at least list three orientations or interventions addressing the different domains of veteran mental health. And then articulate how substance use disorders interact and influence these different domains.

So to begin with, I really would like to be able to provide an opportunity to start the discussions a little bit and have Samson give us an opportunity to answer some polling questions early.

This first polling question is, in addition to substance use disorders which NAADAC is obviously focusing on, the military affiliated population struggles most with, PTSD, TBI, emotional dysregulation, purpose and meaning or disrupted relationships.

Samson?

>> SAMSON TEKLEMARIAM: thank you, Duane. Yes, everyone, the poll is popping up on your screen now. And you will have a chance to interact with our presenter by answering this poll question. I'll give you about 20 to 30 seconds to answer. Again, there are five answer options. Just take a moment to answer these. Looks like already half of you have. And I'm give you about, let's say, 15 more seconds.

excellent. Thank you so much, everyone. We've got 82% and still a few more trickling in. As a reminder, in order to access the CE quiz, please view the entire webinar and listen for the password. This password is revealed in three separate sections throughout the webinar. Here I will share with you the first part of your password.

The firsts part is [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance). This is the first of your three-part password. And now, back to our present. I will close the poll and share those results where you all can see it. And Duane will speak to these results and continue with today's presentation.

>> DUANE FRANCE: Yes, thank you, Samson. So this is as I anticipated well over half of you said that the primary comorbid diagnosis with substance use disorders is posttraumatic stress disorder. Over 55% of you think that's the case.

The prevalence rate of PTSD in service members whether combat related or not combat related is really depending which research you're looking at, anywhere from 11 to 20%. Maybe in the clinical space it might be more because these are veterans who are seeking services and treatment.

But it's not all just about PTSD. And we'll talk about that here in a bit. The emotional dysregulation is another significant piece. And I really appreciate that 10% of you recognize that a lack of purpose and meaning is what veterans struggle with as well as disruptive relationships.

so we do have after PTSD a pretty even spread there. And we'll talk about these things as we move forward.

So whenever I talk about comprehensive veteran mental health, much like we did in that poll I asked, what is the first thing people think of. And usually it is posttraumatic stress disorder. If there is a pie of veteran mental health or service member mental health, PTSD is at least half of the pie if not the entire pie.

We'll talk a little bit in the webinar about what each of these mean as well as the interventions for them. Whenever I ask again what a second issue is, it's traumatic

brain injury. We know that instances of traumatic brain injury in the current population are more significant. They're higher numbers than we were in previous populations. Due to that increased equipment, better equipment, increased medical care. There's more survivability of wounds. And with more survivability of wounds, there's nor instance of physical injury and traumatic injury. Also a lot of the explosive injuries that happen with improvised explosive devices or rocket prop he willed grenades or situations, vehicle roll overs does cause traumatic brain injury.

And then we say what else? Now, of course addictions are an issue. The military is a drinking culture. We drink to celebrate. Drinking is recognized as part of the culture as when officers, they have their right arm nights and their commander's calls. There's drinking in the barracks and things like that. And so it is both a celebratory, drinking culture. But it is also a coping, drinking culture.

Also the opioid epidemic that is occurring in the service member veteran population starts when they're on active duty, addressing chop chronic pain issues, addressing things like physical injuries with prescription opiates and things like that.

So when a service member leaves the military, they have the need for these things. Next is emotional dysregulation. So posttraumatic stress disorder absolutely has an emotional component. We'll get into the diagnosis later. Theres a level of emotional dysregulation that service, veterans and their families deal with that is separate from PTSD. We'll does that later as well.

As many of you identified, 10% of you identified there is a lack of purpose and meaning in a service member's post military life. Whether I served for four years or 24 years, how do I find as much meaning in my life after the military as that very important job that I did when I was in the military?

Next there's moral injury. This is an emerging concept. Again whether it is a part of PTSD or whether this is intertwined with some other things, but in a lot of the veterans that I treat, moral injury is a significant part of what they're dealing with. We also have challenges and needs fulfillment. How do we meet our needs once we leave the milt tri. And we'll talk a little bit about that in the future.

And then finally our relationships. So our mental health impacts our relationships. And our relationships impact our mental health. Not necessarily are partnered or mirrored relationship but intergenerational as far as our parents, children, peer groups. So relationships is another significant aspect of post military life.

Now, there are a number of barriers that keep some veterans from seeking help when it comes to these issues.

So there are internal barriers, things like stigma against help seeking. The warrior ethos, the I must be strong and the warrior ethos carries on for many service members even after they leave the military. And then just the common across all of the different services, the suck it up and driver on. I'm just going to push through the pain because that's what I've been trained to do. That's what I'm used to doing. And I'm just going to suck it up and drive on, deal with what my discomfort is and push through it rather than actually seeking some support, some professional support to address these issues.

There are also a number of other external barriers that keep veterans from seeking treatment. So there are situational and systemic callings of behavior.

If we think back to the Stanford prison experiment, for example, doctor-- identified that if you put individuals in a particular situation, whether they weren't acting, behaving in a certain way before, they would take on some of that.

So there are situational systemic causes of behavior, but it's internalized for a lot of veterans. Of course, there's societal judgment. The idea of the crazy combat vet. There is the external stigma against help seeking. The idea of, it may be better for my Jeep to be seen sitting outside of a bar instead of sitting outside of a mental health clinic.

So there's either the perceived or the actual stigma against help seeking. There are stereotypes that some people consider when we talk about the veterans. Either that they're a villain. John Rambo, I'm going to come take over the town and shoot up the place.

Or they're a victim. They're this broken winged bird that needs to be cared for. Poor baby or this mythic hero striding across the battlefield, saving the university. None of those things are true. And perhaps in some ways all of these things are true. But some of these stereotypes that service members and veterans are faced with really make, I don't want to deal with that.

Then there is peer judgment, of course. I'm afraid of what my fellow service members, my buddies I served with might think. They might think I'm weak. I was their leader and go-to person in the military. And then they see the real me if I can't hack it.

And then finally there's barriers to care. If you're a rural veteran, if you don't have access to same kind of treatment in more urban populations, do, not having the same type of insurance or the correct type of insurance to access mental health care. We know there's an issue with parity between mental healthcare and physical healthcare. And there were things unique to the military.

That is veterans who are discharged with less than honorable discharges have less access to care. And research has shown that these veterans have a greater need but also have least resources.

So this is the medical model of mental health. This is not military exclusive. We know that a posttraumatic stress disorder can occur from physical assault, sexual assault, vehicle accidents, anything that threatens life.

Traumatic brain injury, Colorado does have a number of very good traumatic brain injury research centers, not because of the military here but because of skiing accidents. It's actually how it started. So traumatic brain injury from motorcycle accidents. We're seeing this conversation around CTE in the National Football League.

We also know that addiction doesn't just happen in the military. And it's not the only drinking culture. And we know that depression, anger and anxiety are very general throughout the population.

There are DSM diagnosis for all of these things. We can look it up and see that there actually is a diagnosis for this and all the different subsets and there are

medications for these conditions. Through all of them if not medication, the natural medication intervention speaking about TBI.

This aspect, however, is unique to military and also first responders. If we're looking at people who are engaging in a service oriented kind of profession. And so I may get PTSD and a traumatic brain injury from a vehicle accident but I don't necessarily get a sense of a lack of purpose and meaning and have damaged relationships or don't know how to meet my needs.

There may be some of that, but not as pervasive as widespread as it might be in the military population. There's no diagnosis currently for moral injury. There's no diagnosis for not having satisfaction with my life right now.

And the same thing with relationships. And there's though medication. There's no medication that we have that can help me figure out my needs, socially and safety needs. If we want to understand all of what we're going to be talking about for veterans and service members, we have to understand that it's not just the diagnoseable concerns but also the things on the top of the screen that really means that we need to take a look at the comprehensive aspect of veteran mental health. So at this point, we'd like to be able to provide another poll.

And then we'll move into another of a breakdown of each of these things. Now, if a veterans experiencing difficulty in one or more of these domains, they also likely have a substance use disorder. There's a Likert scale. So Samson, please take it away.

>> SAMSON TEKLEMARIAM: Thank you, Duane. All right. Everyone, this will launch on your screen in just a moment. There you go. You can interact with our presenter by participating in our live pole. And as it says, if a veteran is experiencing difficulty in one or more of these domains, they also likely have a substance use disorder. A, strongly agree; B, agree; C, either or disagree. D, disagree; E, strongly disagree. I'm give you 10 or 15 or seconds to respond.

Excellent. Wow, over 90% have responded. Thank you, everyone. And I will be closing this in just a moment. As a reminder, for those of you who missed the

instructions earlier. We will be revealing the password for the CE quiz in three separate questions. We have already revealed the first password. We will reveal the next two in a moment. Also if you have any questions for our webinar presenter, we will have two live, Q&A moments in this webinar.

One will be coming up soon, please send your questions, in the questions box in your GoToWebinar control panel. I am going to close the poll now and share the results, and I'll turn this back over to Duane.

>> DUANE FRANCE: Thank you very much, Samson. I really appreciate that. So well over 50%, nearly 70%, I think of you either agree or strongly agree that, if a veteran is experiencing challenges in one or more of these domains, and they do have a comorbid substance use disorder in my experience, and research shows that that is accurate. By all means, it's not a blanket. There were veterans who are struggling in some of these areas and have a handle on their addictions.

So it's something that, of course, it's an issue. But more likely than not, I would say, when we are addressing a substance use disorder in a service member, a veteran likely is addressing one of these domains. And we have to try to understand whether or not there is a substance use disorder as well.

So I'd like to go a little bit more in-depth on these domains. So we're going to go through these domains are.

So posttraumatic stress disorder. And this is directly out of the DSM5. It is a cognitive behavioral and neurological reaction to exposure to traumatic events. For an individual to be diagnosed with PTSD, the following criteria must be met.

They must be exposed to death, actual or threatened serious injury or violence. This is one of the things that many people assume because you're a combat vet, this criteria is in play. And it's not necessarily. I have five combat non-operational deployments. Only on two of those five were there significant threat to serious injury, actual or threaten violence.

And so it's not like I personally was exposed to trauma or anything like that. Many of our colleagues-- I had a colleague of mine, asked me how many deployments I had. I said I had five. She said, of course, you had PTSD. Well not necessarily.

So we reality have to understand that to actually diagnose someone with posttraumatic stress disorder, it must meet this criteria. It must have intrusive symptoms. There must be a measure of avoidance, negative alterations in thought and mood, arousal, and reactives, last longer than 1 month creates impairment, and not due to medications. It's not attributed to a side effect of medications we're taking.

So there different times, veterans can be experiencing some of these symptoms and not other symptoms. They could be experiencing these symptoms in a high degree or low degree.

The lasting longer than one month is a significant issue in that it, if it lasts less than one month, it is a traumatic stress reaction. It is an accurate reaction to an incident of trauma. So if immediately after a vehicle accident I start to have nightmares for a couple of weeks and I seek help and resolves on its own, it doesn't mean I have posttraumatic stress disorder. It's really when it becomes longer than one month that we start to see the neurological changes in the brain that are associated with posttraumatic stress disorder.

Next we talk about traumatic brain injury. Traumatic brain injury is a physical injury to the brain that's a result to a blow or jolted head or objects penetrating the brain or widespread injury across the brain.

This is a significant thing is that there are two different types of traumatic brain injury that we see in the veteran population. There's the focal brain injury. We have the concussion. I got my bell rung. I saw stars and headaches. It's usually a coup counter coup, a front or back or top and bottom or left and right. So these are focused injuries to the brain. And then there's the defused traumatic brain injuries. This is what we're starting to see. This is what a lot of people believe that CTE and NFL players. But blast waves. If you have a glass of water in front of you and you flick that glass of water and

you see the ripples going through the water, that's what happens to service members' brains whenever they have blast waves travel through their body and brain.

We start to see a number of diffused traumatic brain injury where there is shearing in the brain that actually impairs the the veteran.

We talk about different severities for traumatic brain injury. We talk about mild, moderate and severe. We can have a very, very debilitating mild brain injury. Really what these are doesn't mean what the impact is. It really is a measure of how long the individual lost consciousness. So there's different criteria about-- if it's 10 or 15 seconds if mild-- and then moving on if someone is in a comb for a long time. Then it's a severe traumatic brain injury.

Traumatic brain injury is really challenging because the symptoms can be cognitive, physical, and behavioral. If we all think back to -- the first traumatic brain injury sort of hero in history where his personality changed significantly after he had a railroad spike through the frontal lobe of his head.

So symptoms of traumatic brain injury can be a number of different things, or cognitive and physical and behavioral. PTS trauma and TBI trauma can be the same. When we talk about posttraumatic stress disorder, we're talking about a trauma that that we are experiencing or witnessing, and we think about traumatic brain injury. The word trauma there means a physical trauma. And so both of those things can be true. And this is what some of the challenges is understanding if I am, if I received a traumatic brain injury from a blast, from an improvised explosive device, it is a life threatening event. So I meet the criteria for PTSD. It closely mimics PTSD.

This is where a differential diagnosis and really the history of a veteran, have you ever been knocked out, gotten your bell rung? Have you been in a place where you were disoriented after a type of injury or blow. Because the symptoms of traumatic brain injury closely mimic the symptoms of PTSD as far as hyper arousal and changes in cognition and mood.

But PTSD does not-- PTSD provides the nightmares and the intrusiveness and the traumatic brain injury doesn't necessarily.

However, if you have a veteran who experienced a life threatening event and has all of these things, again, we really need to understand what the difference there is.

Moving onto addiction. This is something obviously that the audience is likely very familiar with. Up to 75% of veterans with a history of PTSD in their lifetime met criteria for substance abuse and dependence. So this goes back to the polling question is, how likely is it in one or more of these domains.

So this research showed that it is a rather significant prevalence. One of my mentors in the beginning quoted about 80%. So this is something again that I as a clinician, if someone is seeking mental health services from me, one of the first things is I figure out whether or not there is addiction in the past or is there currently substance use concerns.

as I mentioned before, there is a glorification and normalization of drinking culture in the military. Chronic pain resulting from constant physical stress and injuries. We know that this leads to pain alleviating seeking behavior. I've known a number of veterans. Again this is by all means not all of them. But once they leave the military, and they have gaps in their treatment and they're not able to access their pain killers, then they will turn to heroin which is unfortunately in many of our communities more readily available and honestly cheaper than some of the prescription medications.

So this is a challenge. Again, opioid dependence due to access to prescription pain relief while in the military. There is also the concept process addictions. This isn't just a substance use disorder. A likely mini veteran, in my experience, struggle with pornography addiction that we're addressing this. And we have a long time away from our family members and loved ones and partners. So we may engage in pornography use in order to satisfy that.

And we know that some of these process addictions will come into play. Probably won't touch on caffeine addiction. But the military runs as much on caffeine as anything else. But there is a significant aspect of addiction when we're looking to deal with service members veterans.

Next moving onto emotion dysregulation. Many veterans are resilient and adaptive. I don't want this to say that all veterans are broken down, PTSD riddled, nut cases. That it's not villains or victims or heroes. Many veterans are resilient and adaptive, but often the constant barrage of negative experiences can wear down even the most hardy of service members.

Most of the challenges that I see when it comes to emotional dysregulation is anger anxiety in depression. This can be part of posttraumatic stress disorder as a result of exposure to trauma but not necessarily.

One of the challenges that many service members may not adjust from protective behavior while deployed on in the military to al adaptive behavior whether in different environments.

For example, hypervigilance is a protective factor when somebody is deployed to a combat zone, experiencing fearing, aggression is appropriate in the combat environment in the military but not appropriate when we switch back to a non-nonmilitary environment when we're back home.

Similarly, the types of emotions or states back home like feeling comfortable or even care and concern, those are actually detrimental when we're in combat. I often say when I was leading a platoon in security escort in Afghanistan that I used to tell my troops I don't want pictures of wife and baby in your helmet. Leave that stuff back in base. I don't want that out here on patrol because I need your head in the game.

So it's one of these things that we have trouble adjusting our emotions from one environment to the other. And some of the challenges, of course, is in the current generation, the multiple deployments. My five provides deployments over a 22 year career is actually on the low side of average

Whereas a number of post 9/11 veterans are probably at six or eight or ten. And our highest performing, the special operations, the Navy seals, the green berets, marine force recon, we are looking at double digit deployments in probably a 10, 12 year time span.

A lack of ability to achieve desired goals through individual effort. This goes through disruptive needs. But if we look at toxic leadership and unavoidable adversive stimuli in the military, leads assumption of helplessness during the military.

When I first looked at Seligman's learn helplessness concept and understanding how this applies, and we know Seligman's research identified that developed into depression. That if we cannot avoid this aversive stimuli then we might as well give up and roll over. There is toxic leadership in the military. There's toxic leadership in civilian employment, of course.

But it's easy to quit, perhaps, maybe easy to say to quit a job. But for someone who is trapped under a toxic leader in or outside of a combat environment, there's really limited choices in being able to get out of that. So a lot of this leads to the anxiety, the frustration, the anger, and the depression.

And so again, these first four are really about the kind of medical model. These are diagnoses. And there are interventions which we'll get into in a bit.

A number of you in the beginning poll identified that purpose and meaning was a concern. Many veterans with PTSD live with profound doubts about a meaning of a life (Record read.)

Here we are, and again we'll talk about it in a bit. But here we are talking about the existential concerns. In the military it was part of a communal environment. We were part of something larger than ourselves. We were a very important COG. But we were also a very small COG in a very large machine with a very long history.

And so understanding how important I was before I left to how important I was after I left. I make a joke that when I retired in 2014 and I stayed here in Colorado Springs, the day after I retired, I drove to fort Carson and they had the audacity to raise and lower the flag. The army kept going without me.

Not to say that I was egotistical to expect that it ended with me. But it's shocked to say I am no longer a part of this. I am on the outside. There is a loss of camaraderie and mutual connection which can lead into disengagement which we'll go into needs fulfillment relationships.

But this loss of camaraderie is a significant aspect of some of the disillusion in most military life.

And then confusion and anger about the loss of purpose and meaning is not necessarily explained by PTSD and TBI. Again, PTSD is, I am exposed to trauma. And a traumatic event and I developed the PTSD symptoms.

I have known service members who have nerve been exposed to traumatic events but still struggle with purpose and meaning. I would even go as far as to say, is the number of clients not all the clients that I see as a clinician do have posttraumatic stress disorder. Nearly 100% of the clients I see struggle in some way with the lack of purpose and meaning.

I want to pause here. I want to make a note that I have a web page set up where you can learn more about some of these things. It's at veteran mental health.com/NAADAC1. And you can get more information. I've had a number of podcast, blog post, research, that goes into these things. And all of these references will be at the end of the webinar but also they are linked on the web page so you can see the source material that we're working off of

We also talked about more injury. This is a concept that has been emerging over the last 15 to 20 years. It was first identified by Jonathan Shay. But doctor-- and his colleagues are the ones who defined it the best in 2009. Moral injury is defined as perpetrating, failing to prevent, bearing witness to or learning about acts that transgress deeply held moral beliefs and expectations. It is related to betrayal. It's related to betrayal of one's own values by others individually-- so my platoon leader always wanted to put us in harm's danger because he was always looking for promotion and a medal. He wanted to be a hero or betrayal by others check relatively. My unit command or I hate the army or Marine Corps because they did this to me.

So moral injury can be both self-directed. I did things in combat that I'm not proud of. I made a decision, and someone didn't make it back. Or I saw people doing things, and I did nothing to stop it. We think about moral injury, we think things in Vietnam, the massacre or the current era the Abu Ghraib. The MPs at Abu Ghraib, they

didn't grow up to say, I'm going to torture these detainees and take pictures of them and pose with them.

We didn't grow up to think that. They were in an environment that was permissive. And their core values switched enough to say that this isn't something that I shouldn't do. Then there is again, as I mentioned other directed moral injury. Others did things that I'm not proud of or others did things to me that injured me in this way.

There are three types as identified as Litz and his colleagues. Of course, life threat trauma. That does meet the criteria for PTSD.

These aren't necessarily as separate and distinct as I make them here. They are really co-connected in many ways.

So life, threat, trauma actually does, I should not have-- I should have made a right instead of a left when I went down this patrol, this route. And a vehicle was blown off. And it's my fault that person died. So there is life threat trauma. There is traumatic loss. To be honest, I have lost service members in my later deployments. I was in a decision making capacity. There was a moment when I made a decision check relatively which led someone to be on a patrol. And subsequently that non-commission officer was killed by a rocket propelled grenade.

So I was not there at that incident of trauma. I was not there when it happened. But I experienced traumatic loss. And then moral injury is defined above the perpetrating failing to prevent or bearing witness to acts that lead to deeply held moral beliefs and expectations.

So there's this concept of big moral injury. The idea that the war crimes or the egregious nature of things that happened again going back to Abu Ghraib. But then there's small things that kind of twist. There's though stop signs in Afghanistan, no speed limits, no one way streets.

When a 19-year-old learns that they can point a weapon at someone and get them to tell them what they need to do, and now they come back to the United States where it's a lands of rules and laws, we have to adapt back to those lands of rules and laws. But we've learned in some way that there is another environment which maybe

that doesn't necessarily fit. And so really need to understand that, it can tweak our moral compass in large ways or small ways.

It's important to note that this does not mean that service members are immoral. This isn't an immorality issue. This is the things-- it's a personal core belief modification.

Now, before I move onto needs fulfillment, I would like to offer Samson an opportunity to give a quick note.

>> SAMSON TEKLEMARIAM: Thank you, Duane. Everyone, as a reminder, in order to access the CE quiz, please view the entire webinar and listen for the password.

The first password was revealed earlier in this webinar. If you missed it, no worries. Everyone who registered for this webinar will receive the link to review the recording. So you will get to rewind and view the recording to catch the first part of the password to access the CE quiz.

Now, I will shaver with you the second part of the password. The second part of your three-part password is [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).

We'll reveal the third part of your password later in this presentation. Now, turning this back over to Duane.

>> DUANE FRANCE: Thank you, Samson. So moving onto needs fulfillment. Once a veteran has developed a sense of achievement and mastery in the military, we then have to pivot to developing mastery an entirely different arena.

I had one tie. I learned how to tie it one way and one way only. When I left the military, I literally had to stand any men's warehouse, in a mirror in the back. I had just bought a different tie that wasn't black and figure out how to do a double Windsor knot. And it might seem trivial, but there's dozens and dozens of experiences that veterans need to learn how to meet old needs in new ways.

It's not necessarily changing the needs being met. When I was in Iraq and Afghanistan I didn't have to worry about who gave me food or water. There were people in the military that did that simultaneously there were never people that had to

worry about making sure the route was secure to deliver supplies because that was my job.

So in the military we are very much co-supportive. And then when I leave the military, I have to figure out how to meet those safety needs.

We're talking about Maslow's hierarchy of needs, our basic needs, our safety needs. When I was in the military they gave me lodging when we decided to move off post they gave me money for housing.

The interviews that I did in 22 years was my promotion board. So I was 40 years old, really the last interview I had done before was for little Caesar's pizza about 23 years before I applied for my first job afterwards. So it's one of these issues we need to learn how to meet these needs.

But there's also the higher needs as far as the social needs. In the military our social group is handed to us. Here is your platoon, your squad, your troop, your wing. These are the people you will associate with. These are the people that are going to be your partners for however long. Like them or love them, they're yours. And you were forced to learn to make those connections. It's hard for adults to make friends anyway.

And coming out from a situation where there is one way I was able to connect to individuals but yet now I have to do this a different way.

And then of course there's the concept of the shadow side of Maslow's hierarchy. This goes back to the idea of, I got my meets met an aggressive way. I'm not trying to perpetuate the stigma that all veterans are gun toting maniacs. But how do we meet needs in socially unacceptable ways using force and aggression to meet needs, taking what I need.

I have worked with a number of justice involved veterans. And some veterans who are justice involved, I see they have to figure out how to meet their needs and socially acceptable ways because they were survivors after the military. And they were meeting their needs in not socially acceptable ways.

And then finally, we talk about relationships. Military parents fulfill occupational duties during wartime. Children and families face multiple challenges-- compromised parenting, related-- subsequent mental health problems.

My wife was with me for four out of five deployment. My first was back in the last century in the mid 90s. And she experienced those deployments in a very different way than I did. And it was just as stressful on her as it was for me. There was not a calendar year between 2,006 and 2013 that I was not gone part or the entire year.

My children started out when I started to deploy again in the later half of my career. My children were in kindergarten and first grade. When I stopped they were approaching high school. These are formative years that had to do with relationships.

So there are disrupted relationships whether or not the family stays together and goes through challenges. Or the family relationships dissolve.

Cross generational combat operations. This is something that's significant, not well understood. So my father was a Vietnam veteran and three of his brothers served in Vietnam between 67 and 70 or so. So we have-- I grew up, I was born well after my father came out of Vietnam. But I grew up with the experiences of the combat operations. I grew up with understanding what the aftermath of combat was.

And then myself and my younger brother are both combat veterans having both served in Iraq and Afghanistan.

Multiple deployment compounding impact on the family. This is a nature in the current generation. When I say generation, it really is cross generational in the current conflicts.

The senior leaders in the military, when these conflicts began, and I'm talking about the generals in the Pentagon and master chiefs at the highest level, they were Vietnam veterans. Then you have my generation which is split between my pre and post 9/11 military career.

In this past year was the first time that an individual, not born on the incident that precipitated the combat is able to join the military. My son turned 18 this past August. He was born shortly before 9/11. He could enlist in the military and go fight in the same

battles that I could. That hasn't happened arguably with some of the exceptions of the border wars with Native American in two centuries ago. But really in declared war, this has never happened. This is crossing a three generational gap.

The oldest post 9/11 veteran is well approaching their 60s. The youngest post 9/11 veteran likely has not yet been born.-- not yet been born. Likely has not yet joined the military, I hope because I hate war. I hope the youngest of our population have seen the end of it.

Relationships does have the challenges with domestic violence. And so I would like to pause now, before we go onto this poll to answer a couple of questions.
SAMSON TEKLEMARIAM: Thanks, Duane. This is Samson. We have a few questions that have come in. The first question is, can you have PTSD from moral injury?

>> DUANE FRANCE: So yes. There is-- there is an aspect of moral injury. And again you can have one incident could cause all of these things.

The key is that the moral injury for it to also be someone has post-traumatic stress disorder must have experienced that criteria event of exposure to trauma. That's not to say that everyone who has PTSD has moral injury. That's not to say that everyone who has moral injury has PTSD.

And so the answer is maybe. But it is really -- it is possible. And it is also probably distinct from many as well.

>> SAMSON TEKLEMARIAM: Thank you, Duane. And everyone else, continue to send in your questions in the questions box. We have time for two more now. And then we'll do another live Q&A towards the end of the webinar.

Duane, the second question, nowadays more and more military members may experience combat without experiencing traditional combat. Should we consider anything unique when providing counseling support or recovery support for military involved in drone strikes?

>> DUANE FRANCE: This is something interesting. And there's not been a lot of research around it. I would recommend Dr. Dave Grossman's books on combat non-killing. And Dr. Grossman really talks about the very personal nature of killing. And

there are different levels of distress when someone has, say a face-to-face -- the most being hand to hand combat all the way back to the someone on a ship in the gulf that's shooting a tomahawk missile that doesn't have that.

The one exception that he did identify was snipers because you can have a very long distance kill. But also it is a very personal kill because it is very up close in a manner in which snipers do that.

I personally believe that drones are the same way. If we consider the fact, especially if some drone operators that were here in the United States. They stop at McDonald's on the way home. But they had just to execute a strike and witness that strike and see that. So there is some emerging concern and definitely-- just like anything else, not assume to say that we know what this person experienced. Oh, because you were in the Air Force base for your entire career, you weren't exposed to some of these stuff any more to expect that someone that was deployed to Afghanistan which you did.

>> SAMSON TEKLEMARIAM: Thank you so much. Third question, and everyone this will be the last one for this Q&A portion. But we'll do another one towards the end. As a reminder you can he your GoToWebinar control panel. Hit the questions box and send your questions in to our facilitator.

This last question Duane for this moment, does the military use EMDR. So do you think if EMDR is used early on that one's addictive behavior could be avoided to some degree because they are not needing to self-medicate as much since the replay of the PTSD isn't going as loudly in the frontal lobe?

>> DUANE FRANCE: That's a great question. Multiple great questions actually. Yes, EMDR is an evidence-based practice for PTSD. We'll talk about that. Thank you that was a great lead in for the next portion of the webinar.

Yes, EMDR is used in my experience, and I will caveat I am neither a DoD clinician nor Department of Veterans Affairs clinician. But I have colleagues in both.

But yes, EMDR is a widely used intervention that has been shown to address post-traumatic stress disorder. There are also individuals looking to adapt it for moral

injury. So anything that has an intrusive or painful memory where we need to consolidate that memory in such a way. Then EMDR is appropriate.

You know, is it necessarily, will EMDR address the purpose and meaning issue or the family issue? We're looking at what is the primary issue the person is dealing with and using the appropriate tool for that particular job.

Now, absolutely yes. I would say that getting any kind of intervention early on that keeps the service member or veteran from needing to address other types of coping than it would, could reduce some of these addictive behaviors. So great question. Thank you.

So moving onto the third polling question, an opportunity to be interactive.

The polling question is, there is a single intervention that is best at addressing all or most of the aspects of comprehensive SMVF mental health. Samson?

>> SAMSON TEKLEMARIAM: Thank you, twain. And we just launched this third poll. The poll is up on your screen now. You can interact with our presenter. You'll have 1, 2, 3, 4, 5 option. There's a single intervention that is best at addressing all or most of the aspects of comprehensive, SMVF mental health which is service members, veterans and their families. We'll give you just about 10 more seconds to answer this. More than happy if you already have. So we'll give you ten more seconds.

Awesome. Thank you so much, everyone. I'm going to close this poll and show the results and turn it back over to Duane.

>> DUANE FRANCE: And I really appreciate this. A number of you know one said strongly agree. This is perhaps some that are good at most. But disagree and strongly disagree again looking at it from this conceptualization, there is no one intervention that's going to address all of these different things. And we know that a lot of our clients don't necessarily react to different interventions within the same. And we'll talk a bit about a number of evidence-based intervention. I do personally agree with the disagree -- the majority of you chose. So thank you.

So now I would like to briefly go over interventions. This could be and probably could need to be a webinar in and of itself. But I'd like to go through a number of

evidence-based interventions or interventions that have seen and been researched working with some of these things.

So for posttraumatic stress disorder, again we're talking about literal DSM5, meets the criteria of posttraumatic stress disorder, cognitive processing therapy, prolonged exposure, cognitive behavioral therapy. The attendee who asked that question preprocess is one that's on here.

These absolutely have been shown to work if a veteran primarily or solely is experiencing posttraumatic stress disorder. I've seen this with a number of my clients whenever I start with a new client I go through all of these things. And had one particular veteran in mind, obviously not revealing specifics. But a gulf war veteran whose specific challenge was solely related to PTSD. None of the others were in play other than emotion dysregulation which is part of the PTSD and moral injury about the PTSD event.

So I had a colleague who does EMDR. And we transitioned him over to her because that was best for him. So yes, if we are dealing solely with posttraumatic stress disorder, there are absolutely excellent interventions that have had very, very high evidence-based to improve this condition.

we talk about traumatic brain injury. We need to consider treating comorbid filing Cal disorders with brain injury-- we're talking about chronic pain. We're talking about if a service member experienced an amputation or limited mobility from being wounded or injured, that that creates neurological changes in the brain.

There will need to be medical interventions for many. Traumatic brain injury has migraine components. There are physical interventions, balance as far as our inner ear and vestibular changes and physical rehabilitation. Traumatic brain injury in my experience is one of the things that really cuts across all of these. So if a service member experiences TBI, then likely some of the other challenges here are going to be different.

And then of course, cognitive restructuring, neuro feedback, biofeedback, speech language pathology has been shown to have good benefit for traumatic brain injury.

If we look at addiction interventions, I might be able to slide through this one pretty quick. Understanding the audience. But we do know that contingency management, motivational interviewing, cognitive behavioral therapy for addictions and relapse prevention, these absolutely do work. You know as addiction professionals work if addiction is the primary issue.

Now we may have a veteran who is engaging in substance abuse who has depression and anxiety and has disruptive relationships and PTSD. Really what is the primary thing? What is the thing that's disrupting the service member the most. If it's the addiction, we need to address the addiction and get to the bottom of all the other things.

If the other things are more primary, then we need to address the PTSD or the substance use disorders and the addictions will resolve themselves.

Emotional dysregulation interventions. We know what, woulds with depression and anxiety. Cognitive behavioral payment, I personally use dialectical behavioral therapy. I conduct a DBT skills group. Many service members recognize-- many of my clients say that it has worked better than the other anger management programs because dialectical therapy has the different aspects of first mindfulness which I think is key in all of these than the emotional regulation, the interpersonal relationships. You know, all of these things really address how do we, the distressed tolerance, how we tolerate it and the emotions, and how do we get back to getting some measure of control from our frontal lobe over that bottom part of our brain.

And finally just the concept of learned helplessness. And I really do often, if this is what I see in clients, to talk about Seligman's concept and how it applies to their experience.

Now moving to purpose and meaning.

When we're talking about evidence-based, we know that we're talking here about existentialism. Rollo May, Irvin Yalom, Viktor Frankl. I read Viktor Frankl's * Man's Search for Meaning before I deployed and after I deployed to combat. And I saw Man's Search for Meaning especially that first half. I saw it in a totally different way after I had

been in combat than I did when before I went to combat. So we're talking about purpose and meaning. We're talking about existentialism.

This is a quote from a qualitative research-- vet (Record read.) again this is not a one size fits all. Someone could be struggling with their purple and meaning while struggle with PTSD. But it is an aspect that we need to understand.

We talk about more injury interventions, this is an area that is starting to be researched. I personally do feel that future editions of the DSM should include aspects of moral injury.

But-- there is a book called Adaptive Disclosure which has shown prolonged exposure, a colleague said that he has worked with prolonged exposure with moral injury as well as PTSD because its intrusive and negative thoughts based on moral values versus the traumatic exposure.

And there's currently some research being done in some publications that are coming out in the next several years. They're looking at acceptance and commitment therapy. So act, looking and act as a way to address some of these moral injury components.

Wants and needs fulfillment. Again this is a challenge where it's not necessarily psychological. It may be systems based where professional counselors like myself will necessarily need to look at some of the things like our social worker colleagues will need to address the systems in which the veteran is in. But looking at Maslow's hierarchy of needs. And if this individual, veteran or client we're working with is addressing their needs through Maslow's hierarchy or whether-- how they're doing it.

but it may be community based intervention, homelessness, employment. A colleague of mine, he quotes it from someone else but I quote it from him. He says it's very hard to talk about your inner child where you don't know where you're sleeping tonight or where dinner is coming from.

So addressing these basic needs this might be the critical need we need to support veterans addressing before we get to their challenges with addiction. We know

addiction and homelessness-- but understanding how a lot of these things interact. Connectiveness is huge just like purpose and meaning. Just like normalizing events through moral injury.

And then again here acceptance and commitment therapy act. What decisions am I making to meet my needs? And are the decisions I need to make? And how can I look at those decisions in a critical way and decide to do something different.

And then finally, our interpersonal relationship interventions. Again our colleagues, really definitely understand this. As I mentioned before it is intergenerational as far as our spouses and our peers. It's intergenerational as far as our parents and children. Family systems theory. We definitely understand that this is critical.

I will-- and I have been vocal about it. My wife and I went to a marriage and family therapist after my Iraq deployment for 15 months and after my first Afghanistan deployment. We went to the same marriage and family therapist two separate times. And I personal believe and my wife has agreed that, had we not done that. This goes back to the question as far as EMDR to avoid addictions, but I do believe that that saved our marriage and saved our relationship and allowed us to get back to the communication that we need.

And then again dialectical behavior therapy especially the interpersonal relationships aspect of it.

Those of you who are DBT practitioners, there is adherent DBT, the significant three stage, the groups, the individuals, and the peer supervision and the review. But just basic DBT skills groups can also be beneficial as well.

So at this time, before we move onto how the addictions interact, I would like to provide the opportunity for a forth polling question, comorbid substance disorders-- (Record read.) Samson?

>> SAMSON TEKLEMARIAM: Thanks, Duane. All right. Everyone, this is will be our last poll. I'm going to launch that poll. Your opportunity to interact with our presenter. You will see five options, strongly agree, agree, neither agree or disagree,

disagree and strongly disagree. We will leave this up for you for about 15 more seconds. Looks like half of you have already responded. And then we will reveal the results and turn this back over to Duane. About ten more seconds. All right. Thank you, everyone. And thank you those who are sending in questions into the questions box.

We will be doing one more live Q&A. Please get your questions in. Any questions that don't get answered will be sent to Duane and will have posted on our website at a later date, probably in about two weeks. Thank you for interacting with this poll. We've got 85% responded. I'll share the results here and turn this back over to our presenter.

>> DUANE FRANCE: Again, in crowdfunding this, perhaps it's a softball question, but yes it adds fuel to the fire. If a service member is able to have their substance use under control and relationships are stable then some of the other things can really be worked on with ape lot-- without a lot of catastrophe. And so the majority of you agreeing that the substance use.-- and finally in in last part, and I want to be able to make sure that there is enough time for questions as we go through at the end. I'd like to talk a limb bit about how-- a little bit about how addiction and some of these comorbid psychological concerns are occurring. Here is another quote. (Record read.) so this is the coping technique. The unfortunate cases that alcohol use, opioid use, you know amphetamine use. Addiction is substance use specifically. It increases the avoidance of traumatic memory. It impacts -- -- and then the alterations are impacted by a substance abuse.

Looking at addiction and traumatic brain injury. Increased risk for self-inflicted death. TB and associated psychiatric substance use disorders are 20 times more likely to attempt suicide according to the reference there.

So the research is still being done on this. But the combination of addiction and TBI is shown to increase self-harm.

Looking at emotional dysregulation. Overall emotional dysregulation fully meditated-- (Record read.) if I don't have the emotional awareness that I should, partly due to association.

Lack of access to adaptive strategies-- lack of access to adaptive strategies and unwilling necessary to experience emotional distress.

So it's no longer comfortable for me to go to a Denver broncos game. But just out in crowds or out into things that I used to do I don't longer want to do. I no longer want to do to the mall or go to concerts, things I used to enjoy.

I'm unwilling to experience that distress. So I isolate.

A colleague of mine says that she really understood that there was a problem when she was drinking beer in the dark in the basement by herself. That that's not where she wanted to be or even necessarily needed to be.

Addictions and purpose and meaning. Addiction may become a purpose substitute, satisfying the need for purpose and meaning in an unsatisfied life. I'm going party. If we don't fill the space it's going to be filled for us with things like substance abuse, pathologic abuse-- addiction and moral injury. According to Carmona Pereira and her colleagues, substance use indicate defective decoding of moral emotions. There's reduced reactivity to emotional competent stimuli. And it leads to poor decision making especially in addressing our more needs or understanding what our values are. The rates of -- this is something I referenced before. We know about the rates of medical psychiatric and substance disorders among homelessness. The unemployed are more likely to consume excessive amounts of alcohol and use elicit prescription drugs. Difficulties in achieving positive lasting social relationships because of ongoing struggles. If we're going on Maslow's social needs and basic needs it can be impacted by substance use. And the struggle to find, different playmates in different playgrounds is exacerbated when the servicemen or veteran may not be familiar with how to do that.

And then finally in the relationships, high levels of PTSD severity combined with substance abuse-- there's this one study alcohol exacerbates PTSD symptoms not necessarily traumatic experiencing. But tolerating and regulating negative strong

emotions whenever we have a conflict in the home. Again either intergenerational, intergenerational and aggression is directly related to PTSD experiencing symptoms and alcohol misuse.

And so here is a quote that I would like for you to consider. And as we prepare for, I think we have some 15 minutes for questions. So hopefully I can get to some. But there's a myth that veterans are broken. Even with all of these. I gave you a lot of different things about how combat impacts or how military service impacts.

The fact that the war has somehow destroyed the mind-body and soul (Record read.) by many of us do it to ourselves. Many veterans it's a self-inflicted wound although we don't do it on purpose. Society has stigma about warriors that what we do somehow rips apart our humanity and damages us beyond repair. We respectfully disagree it is but a symptom.

The suicide epidemic is significant in the military and veteran community and families. But this is the first time I mentioned suicide during this webinar.

Suicide is not a problem to be solved but it is not a problem to be solved. It is a symptom, and lagging indicator of an underlying problem which is a a lack of regulation in these separate areas.

There is much more as well as its references on the web page that I prepared for this. Veteran men at that time health.com/NAADAC 1. There will be a separate page set up for these webinars. There is a short video that explains in much less length about the comprehensive veteran model for the reading and listening as well as the references.

And then ways to contact me on social media. I'm a big guy both in real life and online. I would like to turnover to Samson to maybe get an opportunity to answer? Questions.

>> SAMSON TEKLEMARIAM: Duane, thank you so much for this incredibly valuable learning experience. We have some great questions coming in. And I'm just going to place it right here so that we can all connect with you and start some of these questions.

I'm start with Lisa from Dallas. Lisa from Dallas asks, isn't it dangerous to be pushing EMDR when TE is clearly the frontline treatment for PTSD?

>> DUANE FRANCE: You know, this is some of the challenges. There's some research now showing that not all service members and veterans react in the same way. Their prolonged exposure has a dropout rates. And so it's one of those things, it's about meeting what the veteran needs and pushing prolonged exposure or pushing any treatment before the service member or veteran is ready is dangerous. Obviously and could perhaps do more harm than good.

I personally do work with preparation, the expose you're therapies. And I have colleagues that do EMDR.

But in my experience, there is evidence for all of them. And it's simply other tools to be used.

>> SAMSON TEKLEMARIAM: Thanks, Duane. And from libby, she asks, is ECT ever utilized?

>> DUANE FRANCE: So this is when we're looking at medication resistant depression. ECT is still a significant intervention in those extreme cases. It does have like many of the interventions and challenges.

There is also an alternative to ECT. Trans cranial magnetic stimulation, less invasive than ECT. We're starting to see, my clinic here in Colorado springs as well as different clinics across the VA have started to see the trans cranial magnetic stimulation works well for depression. And it's FDA A approved-- if the service's primary challenge is trans cranial magnetic estimate-- ECT would be appropriate.

>> SAMSON TEKLEMARIAM: And the next question, you mentioned Martin Seligman. Is that the positive psychology guy? Sorry I'm reading this verbatim. Can you say more about this affiliation and work with military and veteran culture?

>> DUANE FRANCE: I have to say that Dr. Seligman is not saying this is my own observation. Although his-- dear sir Dr. Seligman and the positive psychology center out of the University of Pennsylvania.

The United States army has developed a master resiliency training course. They have developed a master resilience training course to teach individuals how to develop resiliency skills. This is very CBT based but it's looking at strength.

Before I retired, I am a master resilience training certified instructor. I as a professional counselor, I approach this from a wellness based. Veterans are not sick or ill or broken that need to be fixed. We can get well in those areas.

Looking at it from a wellness base, one of my personal thee relate Cal orientation is looking from a positive psychology stand point. I find that Dr. See rig man's three fierce especially with negative cognitions and how others see themselves have seen that beneficial as well.

>> SAMSON TEKLEMARIAM: All right. And our next one, can a family member of a vet experience PTSD from hearing about their loved one's story? And if so, how can we help them and that creates a traumatized experience or reaction?

>> DUANE FRANCE: So we as clinicians understand there's vicarious trauma. We experience vicarious trauma not necessarily working with veterans but working with clients in general. Vicarious trauma is a thing.

So yes, it can be that the family member, if they are experiencing post-traumatic stress disorder are experiencing this from being exposed to their loved ones' stories or experiences.

But also in my experience, not all veterans really explaining some of these. As I mentioned of about, my father is a Vietnam veteran. One of the pieces of advice he gave to me before my first combat deployment to Iraq, make sure you talk to your wife about these things. The one of the reasons he and my mother didn't work out is he kept a lot of these things inside.

One of the keys I try to tell my clients, you need to have somebody in your life that you can tell anything to, you can trust them enough to be nonjudgmental. But you don't have to tell them everything. There's a measure you're ever personal safety and safety for others. And really it's a matter of really exploring how that spouse and child of

the service member is experiencing their service member or veteran's post combat or post military reactions.

>> SAMSON TEKLEMARIAM: Okay. I think we have time for two more. In your experience what are the most prevalent and dangerous substance used by military members who also have PTSD

>> DUANE FRANCE: I think the first three things that come to mind is alcohol, open Yates and methamphetamine. . We know in our nation and many of our communities, and opiates abuse both prescription and nonprescription elicit and then alcohol are the three that impact the most and are the most prevalent.

>> SAMSON TEKLEMARIAM: Thanks Duane. I know we had a lot of other questions come in. Remember any questions you send in, they will get written in a Q&A document along with the questions we've been asked. It will be sent to Duane post those online. Then you have a Q&A captured everything collected in this webinar.

>> The last one for today, Duane, have you written any books on today's topic where we can learn more about military and veteran culture?

>> DUANE FRANCE: It's like an infomercial. Wait, there's more. So I do have. I have written two books not on this topic specifically. There were two books. If you go to my website, I have two books that are collections of blogs. There's a great story about the first one about how some justice involved veteran incarcerated in our county jail were looking to learn how, learn more about some of these things in mental health.

So I do address some of these things throughout either of these two books or on the website. But to be honest, this is the next largest project and have been in discussion with a couple of academic publishers to get this through.

So the answer is both yes and not yet. but there will be.

>> SAMSON TEKLEMARIAM: Thank you, Duane for this valuable and necessary information.

Also Duane and all of our other veteran out there listening, please know that NAADAC genuinely appreciates your service. As a reminder, in order to access this CE quiz, please view the entire webinar and listen for the password. The password is one word, all loafer case, but it is revealed in three separate sections throughout the webinar. If you missed it no worries. After the webinar, you're going to get a copy of the recording and view that webinar recording and rewind and fast forward. You can find the first two parts of the password.

Now I will share the third part [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance). There are three parts of our password, this is the final part. It goes altogether as one word. If you have questions you can email CE@NAADAC.org. I would say, congratulations, you have completed part 1 of the training series on addiction treatment in the military and veteran culture. You are that much closer for certificate of achievement-- this certificate is an excellent resource to end to your career portfolio and resumé that will validate your interest-- in providing treatment to this honored population.

Make sure you register for part due, Supporting Those Who Served: Addiction Treatment in Military & Veteran Culture Part One: live-- live Saturday. From 12 noon to 1:30. Registration is only $25 per web which including eligibility for certificate of achievement and access to the CE quiz and certificate upon successful completion of that quiz.

Again, Duane, thank you so much. If you see here his contact information, feel free to save that. It will be on the webinar slides that you can access any time on our website.

Those who missed our earlier instruction. This webinar is approve for 1.5 continuing education hours and contains the full list of accepting boards and organizations. To obtain your CE certificate follow the steps on the slide. Watch the online webinar. Make sure to keep records of your invoice and receipt of payment and CE certificates. Email CE@NAADAC.org if you have questions or difficulty.

Thank you to all of our NAADAC members for your continued partnership. And those who are not yet members, please visit w□ww.NAADAC organ/join and think of the benefits of joining us. If you join NAADAC you will have access to 145 free CEs each year.

You'll receive our quarterly advances in addiction and recovery manage where each -- NAADAC offers in between seminars.

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If you have any questions about becoming a nature a NAADAC member, please email NAADAC at NAADAC.org. Duane thank you for your valuable expertise. I encourage you to browse our website and learn how NAADAC helps others. Stay connected with us on LinkedIn, Facebook, and Twitter. I'll see you all next Saturday. Have a great day, everyone.