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NAADAC

USING WHAT WORKS: A REVIEW OF EVIDENCE-BASED TREATMENTS FOR MILITARY POPULATIONS

DECEMBER 7, 2019

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>> SAMSON TEKLEMARIAM: Hello, everyone. And welcome to Part 6 of 6 for the Specialty Training Series on addiction treatment and Veteran culture. Today's topic is Using What Works: A Review of Evidence-Based Treatments for Military Populations presented by Duane K.L. France. And it's great you can join us for this Specialty Training Series. My name is Samson Teklemariam and I'm the Director of Training and Professional Development, Association for Addiction Professionals. I'll be the organizer for this session.

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This training is approved for 1.5 Continuing Education hours. And our website contains a full list of accepting boards and organizations. As you know, you have already paid the registration fee of $25 and this includes your access to the CE quiz, receiving the CE Certificate upon successful completion of that quiz, and eligibility to apply for the certificate of achievement for addiction treatment and military and Veteran culture which will be posted on our website when week from today. Please remember to follow these steps. Watch this entire training. Two, pass the online quiz which is posted at the website you see on this slide. Www.NAADAC.org/using-what-works-webinar.

Maintain records of your invoice, receipt of payment for registration and any CE you have received from this series. It's very important these records will be required to apply for the certificate of achievement. Then email CE@NAADAC.org if you experience any difficulty with this process. Please note you will have to listen closely to the entire webinar to capture the password for access to the CE quiz. The password will be one full word, all lowercase, but will be revealed in 3 separate moments throughout the webinar.

If you happen to miss one part of the password, no worries. You will have access to this recording and be able to capture it by viewing the archived recording. We're using GoToWebinar for today's live event. Here's some important instructions. You've entered into what's called "listen-only" mode. That means your mic is automatically muted to prevent any disruptive background noise. If you have trouble hearing the presenter for any reason, I recommend switching to a telephone line as some Internet connections are for the strong enough. If you have any questions for the presenter, type into it questions box and it looks like the one you see on my slide here. We'll gather the question and I'll pose the questions to the presenter during two designated places during live Q&A. Any questions we do not get to, we will pose the questions on our site. Now, let me tell you about this presenter. Duane K.L. France is a retired Army non-commissioned officer, a combat Veteran, and clinical mental health counselor practicing in Colorado Springs, Colorado.

He’s the Director of Veteran services of family care service, a private outpatient mental health clinic specializing in supporting wellness and Service members, Veterans and their families. He is also the Executive Director of the Colorado Veterans Health and Wellness Agency, a 501 (c)(3) non-profit affiliated with the Family Care Center. Duane is a member of the public policy and legislation committee for the American Counseling Association and the Military and Government Counseling Association. He is a member of the inaugural class of the George W. Bush Institute Veteran Leadership Program and is active in legislative and public advocacy for both the military population and the counseling profession.

In addition to his clinical work, he also writes and speaks about Veteran mental health on his blog and podcast, Headspace and Timing. Which you can find at www.veteranmentalhealth.com. NAADAC is delighted to continue this series presented by this accomplished trainer. So, Duane, if you're ready, I will hand this over to you.

>> DUANE K. L. FRANCE: Thank you, Samson. And I appreciate everyone attending the webinar live and those who are watching this on-demand. I appreciate the opportunity to bring this critical information to you. Today, we're going to be looking at the evidence-based practices for some of the conditions that Service members, Veterans, and their families will face. You'll see the learning objectives. We'll learn the components of SMVF mental health and core clinical competencies treating the military-affiliated populations. And identify core aspects of the treatment.

So to begin with, as these last several webinars, we have done, I'd like to provide a review of the comprehensive Veteran health model. You can see further discussion on that in earlier webinars. I recommend if you haven't seen those to go back and start at webinar 1 moving forward. Additionally, there's more information located at the web address on the o bottom of each of these slides. Veteranmentalhealth.com/NAADAC6. There's a webpage for each of the webinars. On that page, you'll see a short video describing more about the comprehensive Veteran mental health model. And you will see the core clinical competencies that we're going to discuss. And then you'll also see the references. We will get the references with links to the actual references so you can do further research.

But to begin with, I'd like to provide just a quick overview and reminder of what we look at when we're looking at Veteran mental health or Veteran in the military-affiliated population. Post-traumatic distress disorder is an aspect of Veteran mental health. Many people are aware of this, although some people might think it's greater in the population than it actually is. Also, currently, in the, especially in the current conflicts, traumatic brain injury is definitely a factor, both physical and psychological health. The audience with NAADAC will be most familiar, I think with the aspect of addiction and impact on military Service members and families. And, finally, emotional dysregulation, that's anger, anxiety and depression for Veterans, controlling the

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emotional state, how some of them may be separate from PTSD, exacerbated by TBI, attempted to alleviate through addiction. In addition to that, many Veterans are struggling with purpose and meaning in their post-military life and find meaning in the military than they did when they were in the military. Moral injury is a construct of last 20 years or so, but really identified in the end of the 2000s, probably 2009 as a similar but separate construct from PTSD. And worthy of review in its own right.

Needs fulfillment. When we were in the military, all of our needs were taken care of. If you think of Maslow's hierarchy of needs, how do we meet the needs and how one met the need in the military than when they're out of the military and they need to learn to meet old ones in new ways which can be challenging. And relationships, our relationships impact our mental health, and mental health impacts our relationships. So if we're working with military clients, it's important for us to understand where the client is functioning in each of these domains.

In addition to this, and these are the last four webinars that we've done have been focusing on proposed core clinical competencies for treating Service members, Veterans, and their families. So my colleague Elizabeth Prosek and her colleagues published these that identified a number of domains, and then subcategories, and each of those domains that will help mental health professionals understand how to address these domains with military clients.

We have discussed military culture. We discussed the assessment of presenting concerns. And today we're going to discuss the treatment domains. But as you can see, those are 3 out of the number of different domains. Again, on that website on the bottom, all of these domains are identified along with their subcategories.

So, before we get into that, I wanted to hand it over to Samson to do Polling Question 1.

>> SAMSON TEKLEMARIAM: Thanks, Duane. Yes, everyone will see the first polling question on the screen. The treatment of comorbid PTSD and TBI include treatment for components of each and treatment for condition specific symptoms. Analyses are A through E there. 5 options. Quarter of you have answered. And we'll

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give you about 20 more seconds. But, as a reminder, in order to access this CE quiz, please make sure to view the entire training and listen for the password. This password is revealed in 3 separate sections, and here, I'll share with you the first part of your password. The first part [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).

Again, [redacted] If you have any questions for the presenter, please send them into the questions box and we'll answer them in the order which they are received during our live Q&A. So about 80% of you have responded to the poll. I'm going to close the poll and share the results and turn this back over to Duane.

>> DUANE K. L. FRANCE: Thank you, Samson. So the majority of or the entirety of you agree it is important to both consider the components of each. So how do we treat PTSD separate from TBI? But also how closely they're linked. We have to consider the intervention for both. And we'll talk about this as we talk about the PTSD and TBI coming up here shortly. But there are things we have to consider about them separately. And then there's things we have to consider together or the influence that each has on the other.

So to begin with, I'd like to go through the treatment competencies. These are the subcategories of treatment competencies listed in Dr. Prosek and colleagues articles. The general information about the unique issues that may arise in the treatment of military affiliated clients and approaches support bide research for military populations. So this is what they recommend all mental health professionals understand and know when it comes to military population. We need to be aware of the evidence-based treatment utilized by the Department of Defense and Department of Veterans Affairs. We have to understand what those evidence-based treatments are, because the Department of Defense and Department of Veterans Affairs are the primary caregivers for that population. So they've done the research, and community providers absolutely must and absolutely should be aware of the evidence-based treatment and train in them.

We need to recognize the treatment needs may include range of presenting concerns. This is what we're going to talk about today. This range of the

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Comprehensive Veteran Mental Health Model. Since impairment, decreased memory concentration, headaches, sleep disturbance. A lot of this is talking about the comprehensive Veteran mental health, there's comorbid physical concerns we need to be aware of as well.

We need to be aware of the adjunctive interdisciplinary services that are available within the Department of Defense and Department of Veterans Affairs. I work closely with my colleagues in the Department of Veterans Affairs. And I understand and very specifically do recommend to some of my clients, go to your primary care. And I know this program is offered in our local area or you can go do, you know, different offering through the Department of Veteran Affairs specifically. But it is necessary for community mental health providers if you're not in the DOD or VA to be familiar with the services that are provided by them.

We as clinicians need to supported coping skills and encourage their development for effective functioning. Not just in psychological, it's the mental health concerns don't happen in a vacuum. Our career, recreation, justice involvement, financial solvency and, so, it's not just about PTSD and TBI. It's our role to provide development of coping skills within these other areas. And then of course we need to considerate inclusion of the military member's family and social supports and treatment. The research does show there's better treatment attendance and better treatment outcomes if the Service members or Veteran has a connection to a strong support system. The lack of that strong support system conversely shows a lack of engagement and treatment or treatment effectiveness.

Another competency we must understand the effects of pharmacotherapy and support of appropriate client medication management services as needed. Again, it's not all medications or it's not no medications. There are some conditions, as we all know, that definitely require medications throughout the client's life or it may be just something they need for right now. But we, as non-pharmacotherapy clinicians, need to understand the benefits and support clients if they want to use medications to manage their symptoms or if they don't want to.

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We need to continually assess for the nature of frequency and severity of trauma exposure as well as ongoing stressor and protective factors, such as social support substance and risk seeking behaviors and this is something we're going to see it everywhere, so we can't assume every client who comes into our office experience some earth-shattering trauma, but we can't also stop asking about that trauma. So it's critical for us to continually assess about the nature of the trauma. Or even the severity of it. I've had long-term clients, and we call it obviously in the field the doorknob confession of maybe we may be thinking we're going to wrap-up our clinical work and then the client says, by the way, or even in the clinical how, we go through whatever protocol we're doing and something gets dropped at the last-minute. I have had clients who I had seen for many months that didn't disclose the severity of their trauma. They really dismissed it. Or they hadn't revealed it at all. So it's important to continually assess for trauma and consider how trauma exposure has impacted the client.

And we need to be aware of holistic mindfulness-based treatment that are supported by research for military population. This is something that again has been emerging in the last 20 to 25 years. The effectiveness of mindfulness treatment, research shows that mindfulness meditation, the neuroplasticity and neurological benefits of neuropsychology, so we have to be aware that there are these mindfulness-based treatments that are effective. But also we have to make sure that these approaches are backed by evidence and not just something that maybe somebody thinks like it felt good so it must work.

This is concerning increasing help seeking. So we need to seek tragedies to improve our client's access and engagement in mental health services. Sometimes that may take the role of being an advocate in your community or providing support outside of the clinical space to organizations that are serving Veteran's other needs. We need to recognize that operational tempo impacts scheduling for mental health services. And that's, for example, Active Duty or drilling guards and reservist. Or the working adult. Or we have to be aware of the fact that, you know, we can go to a doctor every once in a while between the hours of 9 to 5, but if we're having a client coming to sessions weekly, it might be challenging for them to be able to get off work. I have seen

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employment as being a barrier of choice of going to my therapist or going to the job to get a paycheck. They will choose the job. Lose the job. Get into therapy. Get another job and go back and forth. So we have to understand what's going on in the client's life that impacts those accessing those services.

So, again, looking at the Veteran mental health model, we'll look through each of these both in overview and then some of the treatments that have shown to be effective or can be supportive in the population. So, start out with post-traumatic distress disorder. It is, you know, a common thing. It's something to rule out very quickly. Whether the client is or is not experiencing post-traumatic distress disorder.

Trauma focus psychotherapies are very effective. These is Lee and his colleagues k conducted a meta-analysis. And trauma focus psychotherapy out performed medications in treating post-traumatic distress disorder.

Outcomes from evidence-based therapies persisted longer for psychotherapy, but continued medication use was necessary for long-term benefits. So this is an issue of the psychotherapy lasted longer, but sometimes continued medication is necessary to ensure that the symptoms don't persist.

One of the challenges that medications do blunt the symptoms of PTSD. So it gives the Service member or Veteran the idea that this is taken care of. But psychotherapy addresses the underlying neurobiological mechanism of PTSD.

Trauma focus psychotherapy also outperform non-trauma focused psychotherapy some of if we're looking at individuals who have -- who have been proven to have post-traumatic distress disorder, just like we wouldn't provide marriage counseling for someone who has PTSD. The trauma focus psyche therapies are definitely the gold standard when it comes to treatment of PTSD.

And then we need to be educated on the priority and method of trauma focused therapy in order to provide the clients most benefits. So this is where we need to, if we're working with the military and Veteran population, not just the Service members themselves, but the secondary trauma, or the vicarious trauma experienced by their

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families, we have to be ready to address PTSD because it's going to come up fairly often.

And, so, these next three treatments according to the VA DOD clinical practice guideline for treating PTSD, the trauma focused psychotherapy is defined therapy that uses cognitive or emotional behavioral techniques to facilitate processing a traumatic experience in which the trauma focus is a central component of the therapeutic process. So, if the client is experiencing specifically post-traumatic distress disorder, these are the interventions that work for them.

Manualized trauma focused psyche therapies that have a primary component or exposure or cognitive restructuring. So prolonged exposure. CBT that teaches individuals to gradually approach trauma-related memories, feelings and situations. Cognitive processing therapy. That helps clients learn how to modify and collage unhelpful beliefs related to trauma. And Eye Movement Desensitization and Reprocessing which helps the information processing is enhanced. I work with my clients, and I am not trained in EMDR. I work in a clinic where there are number of us who focus on different aspects of this. I have a client who his main concern was a traumatic event that occurred when he was in the Navy in the Persian Gulf. And everything else, all these other things, the emotion dysregulation was tied to the PTSD. Previous substance use was tied to the PTSD. So I referred him to a colleague who does EMDR and address that very specifically. And we got to a very good point. And we had good rapport. But best for the client, we have somebody that does EMDR or prolonged exposure cognitive processing therapy.

So I think it's very important that anyone working with military colleague or military population either are familiar with these interventions or are closely connected to someone who is so that the Service member can be referred to that. Moving on to traumatic brain injury, the presence of the mild traumatic brain injury can be complicated. And neural cognitive rehabilitation can be ineffective because of psychological concerns. And each of these areas are cracks and foundation, the traumatic brain injury runs the other cracks and makes them worse. Neural cognitive rehabilitation can be ineffective because of psychological concerns, interaction between

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the psychology and the neurobiology of the client. Attention deficits can undermine therapeutic process the client is unable to focus during the therapy sessions.

This is an issue I often run into. Memory problems can cause the client to fail to retain session details, reducing their ability to apply what has been learned some of I'll see a client after a week and how have things been? Did you apply what we talked about? And they're like, I don't remember what we talked about. So it's taking different steps of, that particular client brings in a notebook and writes down this was his own choosing, but he rights down specific notes he wants to apply and then receive the support of a spouse to reply in the time between our sessions.

PTSD and TBI often overlap. Nearly 45% of Service members who sustained a mild traumatic brain injury meet full diagnostic criteria for PTSD. This is where things can be challenging. It's not only is it a comorbid condition, but they can present very similar conditions or symptoms for each of the conditions. But I often describe it as we have the word trauma in each of these, but the meaning of the word is different. So traumatic brain injury means a physical trauma. I bruise my elbow or bruise my brain sort of speak. Whereas, PTSD post-traumatic distress disorder is a psychological trauma some of being traumatized as opposed to experiencing a trauma. So, really, it's a matter of, as we discussed in the polling question, separating the two but combining the two and addressing what each needs to be considered.

Again, the V.A./DOD clinical practice guidelines for treating concussion mild traumatic brain injury, best practices include offering a primary care symptom driven approach in the treatment of a clients with history of mild TBI. So you or the careful are coordinating their psychological wellness along with the physical wellness. Treatment strategy should remain the same regardless of method of injury. So whether it's a focal traumatic brain injury or coup counter coupe, or the blast over pressure which blast waves are traveling through the gray matter. Treatment is the same regardless of whether it is a focal or diffused brain injury. This is something I talk with my clients. Help them understand what the difference is, but then when we identify the difference, well, it doesn't matter, because this is -- the treatment is always the same.

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We need to -- we don't treat physical symptoms, but we need to ensure client is treating the physical symptoms. Headache, vestibular therapeutic exercises and dizziness and things like that. Treatment of sleep disturbances related to mild TBI. And then clients with a history of mild TBI who presents symptoms related to memory, attention, and executive function and other symptoms for them it does not revolve within 30 to 90 days and not responsive to symptom management, should be referred to cognitive rehabilitation specialist for treatment. This goes back to the idea of competencies, knowing what the client has available in their local Department of Veterans Affairs. Or even in the Veteran Affairs symptoms.

So perhaps you're in a rural location and you're working with a client who has these experience. Well, that rural location likely has a community-based outreach clinic it may not be large but it may be within an hour or two of your location. And they're attached to a hospital and region and so on. so having that individual connect with their provider through the Department of Veteran Affairs if they're eligible, then getting them to the neurologist or to that. But there are also programs throughout the country, the warrior care network through the wounded warrior project has some excellent opportunities.

And here in Colorado, the Marcus institute for brain health is very specifically focused on helping traumatic brain injury and Service members.

So it's looking for if you know, if it's the TBI, it's not just hey, we have to live with it. It's we have to figure out how do we provide the right treatment for it if it's not treatment through us?

I will now turn it over to Samson for Polling Question 2.

>> SAMSON TEKLEMARIAM: You will see Polling Question 2. The question asks treatment for emotional dysregulation, anger, anxiety, depression is similar in the military and non-military population. You will see answer options from strongly agree to strongly disagree. Sorry about that, first one should say strongly agree. Miss print. You have about 20 more seconds to respond to the poll. As you're doing that, another reminder. In order to access the CE quiz, please review the entire training and listen for

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the password. This password is revealed in 3 separate sections. I'm going share the second part. When you enter the online CE quiz, the password will be all one word, lowercase. I gave you the first part earlier. The second part of your password is: [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).

[redacted]

Now, if you happen to miss the first part of your password, no worries. GoToWebinar will give you an automated thank you for attending email with a watch recording link at the bottom of the email. Now I'm going to turn this back over to Duane so he can speak to the results of this poll.

>> DUANE K. L. FRANCE: So there's almost an even split here in the treatment of emotional dysregulation in the military and non-military population and those that think it is similar. Sort of the answer is, you're both right, because what works, it doesn't matter whether I blow my knee out jumping out of the helicopter or having a ski accident. A knee is a knee. So depression is depression. Anxiety is anxiety. And anger issues are the same. And one sense, treatment for these in the military population is very similar to the non-military population.

With that said, there are underlying issues that cause anger, anxiety, and depression in military Service members that is different than those causes in the non-military population. So, I would say maybe it was a trick question, because the answer is both. But half of you got or all of you got the right answer.

But it is complicated, because in the very sense, and we'll talk about the treatment in a minute. And in one sense, the treatment that works for depression works for depression whether they were in the military or not. But the underlying issues that were complicated by some other factors also have to be addressed.

So moving on to addiction treatment. This is squarely in the realm of NAADAC and the professionals that are viewing this or taking this webinar. Substance use disorders are a significant problem in military population, despite numerous attempts to reduce substance use. SUD are closely associated with negative outcomes, such as

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medical problems and psychiatric disorders such as depression and anxiety. So, again, this is one of the things that probably within the second or third session after the initial session I have with the new client is we go through what the addiction issues they're experienced in the past or are experiencing. I ask them about how long they've been drinking or using their substance of choice. Which is very telling, right? If they started drinking at the age of 11 or 12, they have a long history before the military of substance use.

What is the home life around that? And, so, there's, or conversely, if they never touched a drop and they got in the military and thing got out of control, what does that look like? So addiction is a core component of the clients I talk to. One study indicates that approximately 30% of completed suicide were preceded by alcohol or substance use. 20% of high-risk behavior deaths were attribute to do alcohol and drug over doze. Treatment of SUDs can be included both behavioral and pharmacological treatments. Treatment options range from preventative screening residential treatment programs and in include IOP, PHP and EOP. But the lowest level is not always what is needed depending on what the Service member or Veteran or family members level of condition is.

So, with the V.A./DOD, clinical practice guideline for substance use, best practice for treatment is to engage in shared decision-making with clients in order to make the most appropriate decision regarding what care they choose to engage in with guidance and information from clinicians. And, so, giving a level of self agency to the client, say we have this protocol, this protocol, that one, which one do you feel comfortable in? Because that buy-in will lead to the effectiveness of the treatment. Listed in the best practice clinical guideline. These are some of the approaches for different types of addiction uses. Behavioral couples therapy, CBT, motivational enhancement therapy and 12-step facilitation. Opioid use disorder. No sufficient evidence to recommended a specific therapeutic intervention and this is specifically for the, you know, opioid issue. Pharmacotherapy is recommended, but therapy can't support life change. So therapeutic intervention to help the client to decide they need to

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get different playmates on different playgrounds and make changes in their life, a while coupled with pharmacotherapy to reduce the body's reliance on the opioids.

Cannabis use disorder. It's always ironic. Guy from Colorado talking about Cannabis abuse disorder. Because we're in Colorado. But a lot of this is whether or not the use is disturbing or impacting the client in a negative way. So number of my colleagues at the local substance abuse treatment program, they do support Cannabis use disorder when the client does not -- they recognize themselves that their use is problematic in their lives.

Using CBT, again, motivational enhancement therapy. If then a combined version of CBT and motivational enhance meant therapy. And stimulant use disorder. Recovery focused behavioral therapy, and contingency management.

Looking at emotional dysregulation. Emotional dysregulation is associated with many psychological disorders, including PTSD and substance use disorder. Traumatic exposure leads to anger, depression, and anxiety. With comprehensive Veteran mental health, it's not to say there's discreet buckets they fit in. Often, I've got a big whiteboard in my office, and as I go through this, as I'm talking to the client at the end of the session, it looks like a spider web. With all the addiction, traumatic brain injury, prefrontal lobe and it's not doing what it's supposed to do to manage the emotions. This is not to say it's not a discreet thing but what is primary. Veterans experiencing anger control issues. This is my problem. Nobody else should have to deal with my problem. Or I don't want anybody else to help me deal with my problem, which leads to treatment avoidance.

42%, one study with the Thomas and their colleagues, 42% of Guard and Reserve components soldiers screened positive for further evaluation and treatment for depression. They weren't diagnosed with treatment of depression, but almost half of them showed positive screening symptoms and only 42% went on to seek treatment and only 32% of that half actually completed a full course of the treatment. And one of the issue is when there is a or potential to be a diagnose clinical mental health condition, the Service member and the Veteran, and often the family, for number of different reasons don't follow-up with that treatment.

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Cognitive-Behavioral Therapy interventions have been long known to be effective in reducing emotional dysregulation. DBT skills. Dialectical Behavior Therapy skills training has been proven to reduce anxiety and depression severity in adults. I personally endorse this. I use a 13 session, excuse me, a 21 session DBT skill some of this isn't adherent DBT. But this is a DBT skills training which I found to be very effective to anger management. Right? Because it talks about in dialectical behavioral therapy, talks about how to tolerate that distress. And talks about interpersonal relationship. Talks about emotional dysregulation and other component independents the mindfulness piece. So I personally have seen a lot of benefit with DBT skills training in the Veteran court, the justice involved Veterans I've worked with. Many Veterans who have been in therapy for years have said, you know, that's the one thing that helped me understand what I needed.

Along with the DBT, other effective interventions suggested by the VA/DOD clinical practice guidelines. Acceptance and Commitment Therapy. Emphasizes acceptance of emotional distress and engagement of goal directed behaviors. Interpersonal psychotherapy. Focuses on improving interpersonal functioning and exploring relationship based thistles. Problem-solving therapy. Focuses on learning to keep specific problems areas and client and clinicians work collaborated actively to identify the problems. We see a lot of overlap. We'll talk about acceptance and collaborative therapy coming up here in the webinar. The problem-solving therapies and these can be applied to the addiction. It's the same tool, but the target behavior or the underlying cause for the behavior really needs to be understood to be most effective.

And for now, I will hand it over to Samson for our mid-Webinar Q&A.

>> SAMSON TEKLEMARIAM: Thanks, Duane. Yes, everyone, we do have couple of questions that are in. If you have any more questions, please feel free to send them into the Q & A Box. Duane, the first question is asking are there specific manualized treatments or treatment manuals that you would recommend?

>> DUANE K. L. FRANCE: I definitely recommend, depending on what condition you're looking at, there are number of organizations around the country that are trying to

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provide community providers with the same training that VA and DOD providers are. I would suggest that would you look into the STRONG STAR training initiative. This is a program out of Texas. And, so, STRONG STAR has couple of different programs. But one of them is to train clinicians specifically in these exposure based PTSD focused manualized trainings.

Again, so we know that there are the CPT and prolonged exposure manuals out there.

>> SAMSON TEKLEMARIAM: Thank you, Duane. And, so, she asked a follow-up. This is from Diana from Carson City, Nevada. And the follow-up question is 21 week DBT skills training, can you provide the reference for this manual? Or where we can purchase it? And Duane, also, if you don't have it there, we can add it to our Q&A document so people have access to that as well.

>> DUANE K. L. FRANCE: Yes. So what I use is the DBT skills training manual. So this is the Marsha Linenhan's book. This gives a number of different types of protocols. So there's the 13 week. 21 week. There's the 52 week. So they actually have listed in there the number of week protocols, and then what they recommend or what she recommends which of the modules. And I really like DBT, because you can get as in-depth as possible. It can be very surface. But, again, I would say I have a number of colleagues in my clinic who do specifically inherent dialectical behavioral therapy some of all four phases of groups, the skills training groups, the individual treatment, the phone consult. All of that.

And, so, that is very specific. Adherent DBT is based on that book. But there's also let's get an introduction to the basic skills. So I have found that's very effective. Again, that's Marsha Linehan training manual 2nd edition. And she has the worksheets and the handouts. So each of these, when I provide my DBT skills training groups, it's not a group per se as far as a processing group. It's a psychoeducation group in which some processing may be done if we're looking at examples throughout the time and the session. But it is still very heavily focused on learning new skills. Again, how to tolerate this distress.

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>> SAMSON TEKLEMARIAM: Thanks, Duane. First treatment competency is to stay aware of DOD, EBT's. How do we do that? Is there a quarterly report or manage or page that we can stay current?

>> DUANE K. L. FRANCE: Periodically, and this is all of the information is out there, and sometimes too much information is out there. But the best way to do that is to periodically make sure there's not a new version of the DOD clinical practice guidelines. As I've mentioned, if you see at the bottom of the slide there, on Veteranmentalhealth.com/NAADAC6, I believe I have the current clinical practice guidelines for PTSD, TBI, addiction and emotional dysregulation. I think they're all linked on that page. They're not yet, but by the time someone views this, it will be.

But paying attention or being up to, you know, just like we're doing now, hey, there's a new clinical practice guideline. And that's typically where the DOD and the VA present what they know to be their best evidence-based practices.

>> SAMSON TEKLEMARIAM: We'll do one more and you can continue with the presentation. How do you convince a Vet to get their family involved when they don't want to?

>> DUANE K. L. FRANCE: I assume the question is when the Veteran doesn't want to get their family involved. And, really, I do a lot of motivational interviewing. How is that working for you?

I think that in my experience and this is anecdotal, but it's usually the other way around. The family wants to be very involved and the Veteran doesn't. But I have had those experiences where I don't want my wife or husband to know about this. About it's just a matter of where is that Veteran in their stages of change and addressing, you know, if they're in pre-contemplation stage about getting their family involved, then that's where they're at. And we have to help them move along the stages of change.

The Department of Veterans Affairs has a very, very effective program called coaching into care. And I'll make sure that in the final Q&A, I will have a link to that. And I may put a link to that on the page as well. Coaching into care, they have a

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coaching into care line where family members can call in and talk to about how do I talk to my Service member about getting into treatment or so on.

But also, it's effective for that coaching into care, they've teamed with PsychArmor to provide a short video based webinar series on coaching into care. But that would be a good place to look at as a clinician, we don't like to use the word "Resistance" because the client or Veteran is where they are, but to help that individual move into a certain stage. Coaching into care is probably a good resource.

Okay. So, that being the last question, we'll go ahead and move on to Polling Question 3.

>> SAMSON TEKLEMARIAM: Excellent, thanks, Duane. Everyone, you will see Polling Question 3 pop up in just a moment. The question asks: Addressing existential concerns in the military-affiliated population has been extensively studied and produced evidence-based practices similar to treating PTSD and SUD. Substance use disorder. You should see 5 answer option there. And this is one of many opportunities to interact with your live presenter. We will show you the results and close the poll in about 10 more seconds.

Perfect. Thanks so much, everyone. It looks like about three-quarter of you, almost 75% responded to the live poll here. I'm going to close the poll. There you go. That's almost everyone. I'm going to close the poll, share the results, and turn this back over to Duane.

>> DUANE K. L. FRANCE: So, again, we're not in consensus, but I do believe this one has a clear-cut answer. Existential psychology. I once attended a talk about Irvin la bon and existential should be basis for all therapies. But it is difficult to where we measure purpose and meaning. We have thinks life satisfaction survey and so on. But the existential concern, this purpose and meaning has not been as extensively studied. And there are for the a lot of evidence-based practices. There's no manualized treatment to making somebody find purpose and meaning in their life. And in lack of purpose and meaning is not a diagnosis in the DSM.

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You know, Veteran can't get service-connected disability. Existential concerns, it's real for Veterans, this is where we get into the non-medical aspect of life satisfaction. This is where if we're talking about treatment of this, we really have to be very focused and look at, you know, what we're doing and make sure it has at least some measure of efficacy and effectiveness. Meaning and purpose in most military life is significant. While not as wided studied as clinically diagnosed disorders in PTSD or SUD or emotional dysregulation, it is still an important area to explore with military clients. Veterans may experience grief like symptoms related to real or perceived loss of their military identity. Not to a loss of a friend, but to their identity. I've mentioned I have a friend of mine in Green Beret, he struggled in military life, because he couldn't be him anymore. His whole idea was wrapped up being an operation soldier and being best of the best and then losing that identity. So that is something that is very critical.

Quality of life for Service members, includes life satisfaction, functional level, and social material conditions.

A loss of personal meaning and purpose may manifest itself as an exist sensation or spiritual struggle in Veterans. And then a strong sense of purpose is associated with greater meaning in life along with greater happiness and self-esteem.

So understanding, again, and I think I mentioned this before, but many of us have read man search for meaning and find it valuable. I often recommend it to my clients. The first half. The second half is for us. I read man search for meaning before I we want to be combat. And I read it again after I went to combat, it had a totally different meaning because I had a lived understanding of helplessness that comes with being trapped or just the same thing day in and day out and how we protect our friends to the expense of maybe others.

And, so, understanding, you know, I can't help but recommend that individuals who are working with Veterans at least read some of Viktor Frankl and Yolan. Can exist sensation intervention could prevent Service members Veterans and their families and addressing meaning oriented existential concerns. They focus on positive direct education and meaning of life. And, so, here are some, again, these haven't been researched to show the level of gold standard to say the way prolonged exposure or

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EMDR have. Meaning oriented therapy, which involves discussing explaining and supporting clients to act directly and positively to find meaning in their life.

Supportive compressive group therapies, creating a supportive environment which clients are encouraged to share experiences, explore self-worth and decrease isolation. Experiential existential group therapy. Include sharing experiences receiving group support and focusing on the present. I talked about Marcus group for brain health and they include along with their cognitive-behavioral and neurological interventions, they have the Veterans go to a sweat watch, which is a experiential experiential group experience. So there are these kinds of things, sweat lodges, or, you know, even the hunting trips, or the fishing trips, or things like that. We as clinicians need to be involved in that, because sometimes there's non-clinical people providing that. But that really is, it can be brought into a clinical focus.

And then cognitive existential therapy, and cognitive and existential is planed and discussed. Moral Mormon. Moral injuries describe Veterans who are expose to do acts that transgress deeply held moral beliefs. A large portion of Service members have reported participation in or exposure to transgressive acts in the every conflict since Vietnam. It emerged in the '80s and then in Jonathan Shea, Achilles in Vietnam, it was based in his experience with Vietnam Veterans which shows this concept of moral injury has gone all the way back to, well, Achilles's days.

Exposure to combat and length of deployment are significant risk factors for exposure to transgressive events. Not every morally event needs to be in combat, but exposure to combat can be, can put someone at-risk for exposure to transgressive events.

Strong leadership and training in battlefield ethics may lower the risk of some transgressive acts. Transgressive acts are associated with greater PTSD risk. So, again, if we start looking at the interconnections between each of these areas, there is a link. And even some believe that moral injury is a subset or a type of PTSD. But it's connected to these different things. But experiencing these transgressive acts is associated with great risk to develop PTSD symptoms.

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And there's strong support for the relation between transgressive acts and substance abuse, potentially as a form of punishment. So the individual punishing themselves for engaging in or witnessing transgressive acts or to be used as an escape from the emotional burden of such acts. And, so, feeling the guilt and the shame, guilt and shame are not necessarily post-traumatic distress disorder. This is a much more moral, I describe and others have describe moral injury as injury of the soul rather than TBI as a physical injury.

Moral injury is relatively new construct, as I've mentioned, with some aspects of the condition shared with PTSD and some that are separate and distinct. Number of interventions are being developed or existing interventions are being adapted. Adaptive disclosure which is a 6 session CBT Gestalt intervention that promotes role playing. Which there is a identification of compassionate other and promotes self-compassion. Dr. Breck Litz conducted this study. And the link will be on Veteranmentalhealth.com/NAADAC6.

Building spiritual strength is another program. It's an 78 session group therapy used in faith-based settings. Again, Acceptance and Commitment Therapy for moral injury, a trans diagnostic approach that applies 6 core processes of act to moral injury. So this is where I have colleagues in Colorado doing some very good work on that. And I understand there's actually going to be books coming out based on using act to specifically address conditions of moral injury and Service members.

And then Dr. Shira Mageun. So the way Dr. Mageun has been doing it, she will go through a protocol of prolonged exposure and cognitive processing therapy and then provide this very specific intervention after that to address the impact of the moral transgressive act of killing.

Next up we're going to go to Polling Question 4.

>> SAMSON TEKLEMARIAM: Thank you, Duane. Yes, everyone you'll see this pop up on the screen. Question is addressing a Service member's challenges in meeting their needs and post-military life requires both psychological and systemic intervention. It should be active in just a moment. There it goes. You'll see 5 answer

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option there. We'll give you 20 seconds. So 10 seconds more. Three quarter of you are complete.

Great. Wow, that's almost 100% of you have answered. I'm going to go ahead and close the poll and share the results. And I'll turn this back over to Duane. Sorry as a reminder, if you have questions, please send them into the questions box. Thank you to those who have already sent them in.

>> DUANE K. L. FRANCE: Yes, thank you, Samson. So, again, majority of you either agree or strongly agree that these challenges in our lives, it's not just psychological, right? The mental health does not happen in a vacuum. We have to look at the individual's systems around them and how they're interacting with those symptoms, as well as how they feel about or think about those systems. So this idea of, you know, we're just going to talk about the psychological interventions. I have a colleague who mentions, sometimes psychotherapy is a little bit like cleaning the mud off the pig if then throwing the pig back into the pigsty. Not to indicate that Service members are pigs, but that analogy, we get some things straight, but if they go back to the same situation and environment, then we're just going to be continuing to do the same thing in trying to help that Service member or Veteran or the family member through the conditions they're experiencing.

Moving on to needs fulfillment treatment. So social and behavioral determinant of health are combination of behavioral, social, economic, environmental, and occupational factors. They impact morbidity, mortality, and well-being but not addressed in the clinical setting. So if we're here to talk about your trauma or PTSD, but you're also homeless or you're unemployed, and you wish to be employed, or you have financial instability, these are other facts that well prolonged exposure is not addressing homelessness, it's addressing that trauma piece. So this is another factor in which we need to understand and often address in the clinical space.

The underlying factors of health and wellness must be addressed at the community level as well as within groups of high-risk individuals. So addressing homelessness in your community, and while addressing homelessness in the subgroup of that community,, for example, Veterans or military families.

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Understanding the client's individual social and behavioral risk factors, as well as the social environmental impact of their community on the behavior is critical to understanding their level of wellness. Again, this is a concept of when I was in the military, when I got here to forth Carson in 2006, the Army handed a key to my house. We had a place to live within 24 hours of get to go Fort Carson. They gave me a key to a place where I was going to sleep at night. So it was easy to rely on that here's your automatic safety needs that are taken care of. Well, now that I'm out of the military, how do I pay the mortgage without the military giving me that extra money every year? Or negotiating rental contracts, and these are just basic skills that individuals in the military hadn't needed to attempt to access.

Another example is my last interview before joining the Army was for little Caesar's pizza place. And 23 years later when I was trying to get my next job after the military, so interviewing techniques. I had one tie when I was in the military. So that was my Class A tie. So learning how to meet the different needs is critical for Veterans.

And then the Veterans Health Administration has a statutory commitment to address both medical and non-medical needs of their patients. Not just the Veterans Health Administration but the Veterans administration overall. For those who may not be familiar with the Department of Veteran Affairs, when people talk about the VA, it's almost like talking about the Department of Defense. Underneath the Department of Defense, you have the Department of Navy, and Department of Army, and Department of Air Force and they don't always talk well with each other. You have the Veteran health administration and benefits administration and those are two different things. So you may have a Veteran who's experienced and accessing their physical care through the Veterans Health Administration, but they're trying to untangle their problems with their school, for example, their G.I. Bill, which is through the Veteran benefits administration. And, so, the Veterans administration more specifically has a statutory commitment to address medical and non-medical needs of their patients.

If we look although the treatment for needs fulfillment, again, this concept of Maslow's hierarchy in needs. We need to understand how clients meet their needs in 3 areas. So basic needs, both the physiological and safety needs. Psychological needs,

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belonging and esteem. I've had reconnaissance marine so, this is the recount of a marine is the Special Forces branch of the Marine Corps comparable to a Green Beret or Navy SEAL and I had one recount of a marine, I achieved really high mastery in one area. I briefed 3-star general. I'm absolutely competent in doing that piece. But I get out of the military, and I can't negotiate a rental contract. So it's high-level in one area and low mastery in a simple area. That's the hit to the esteem. Belongingness is the same way. When I was in the military, here's your friends and peer group. Like them or don't like them. These are the people you're connected with.

Making friends as adults is hard. And doing so when you're in a different culture, leaving the military culture into post-military life can be even more difficult. And then, finally, the self-fulfillment needs of self-application. And solution focused brief therapy. This helped clients to focus on present and future circumstances rather than past experiences. It is goal oriented rather than symptom oriented. So it's not something we're looking at PTSD. We're looking at how can you figure out how to meet your needs in these different stratospheres of Maslow's hierarchy. So acceptance commitment therapy. Research is starting to show that acceptance and commitment therapy helps adapt to one's life and what is important. So this is a recommendation if you're working with military and Veterans act addresses a number of different areas. So, ACT for emotional dysregulation or needs for fulfillment, the underlying technique we use is the same just like the CBT for emotional dysregulation and CBT for PTSD is the same underlying technique. But how we apply it and what we apply it to in the client's life is very different.

And then, finally, peer support. This is huge. It's huge in a lot of different areas. Of course with addiction and PTSD and relationships and all these other things, but very specifically, peer support is congruent with the Veteran common experience of military culture with a high value on camaraderie and cohesion.

Finally, personal relationship treatment. Post 9/11 Veterans faced challenges in multiple domains, including community involvement after deployment. Some problems that the military-affiliated populations faces, such as social functioning, anger control, spiritual functioning, all outside of traditional scope of clinical practice. We may not be

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thinking about their social functioning outside the realm of how their addiction and substance use impacts that.

Several facts impact the family unit during deployment. Increased domestic responsibilities for those not deployed. Loss of physical and emotional intimacy and communication problems. As a matter of fact, my friend Samson and I was discussing this before we started the webinar of how increased children, you know, more children in the memo provide increased burden on the spouse, which increases burden on the Service member themselves. And, so, there's all of these factors when it comes to deployment and military service.

Emotional numbing is associated with actual or perceived relationships with the children of combat Veterans some of if you're working with the children of military clients, emotional numbing is very significant. And then social support is associated with psychological well-being, and social support from significant other family and military peers can acting as a resilience trait that reduce the impact of stress in the Veteran's life.

Marriage and family therapy and other interpersonal relationship interventions is language based, client directed and focused on the relational process rather than step-by-step techniques, which leads to difficulty in manualization and replication by independent investigators. Again, the idea of a gold standard evidence-based practice such as prolonged exposure for CBT or EMDR for PTSD, you know, the interpersonal relationship aspect makes it difficult to provide this manualized step-by-step technique. But we do know the family therapy is not a single treatment method but a generic term for number of approaches based on broad principles.

A couple of different types of interventions. Social constructionism. And fair active family therapy. Changing the dominant stories a family tell themselves. Systematic family, helping families understand each other better. Change negative behavior and resolve conflicts. Again, if we look at that bottom half of the comprehensive Veteran mental health, that is the medical model. So we have diagnosis for each of these that are on the bottom part of the circle. But that top part of the circle, going back to the earlier webinar on transition, this is the emerging concept of

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transition stress, because there's not a diagnosis for an in ability to meet their needs. But clinician does have role to play in each of those top half of the model.

Next up, we will start to wrap this up and provide some answers to questions. This was a respondent, military spouse responding in the military in contrary time. Working with a mental health professional who understood my struggles within the context of military life instead of trying to force my unique experience into a box within a broader world view made all the difference for me. While she struggles with anxiety and probably always will, she learned life-changing practical coping techniques specific to my role as a military spouse. This really identifies the need to say it's not just this one thing. If the military spouse has developed a substance use disorder, there's underlying reasons for that and how do we understand how these interact with each other.

As I've mentioned, we have the references on the website, Veteranmentalhealth.com -- NAADAC 6. These will be accessible through a link. And we'll go ahead and pause for the questions.

>> SAMSON TEKLEMARIAM: Are there standout or obvious treatment models to avoid? Maybe treatment approaches that are common those with substance use disorder but shouldn't be used with a Vet?

>> DUANE K. L. FRANCE: I'm not certain. I would definitely have to defer. I may have to do a little bit of research on that. Not being an addiction professional myself, not as familiar with certain types of interventions with substance use professionals. Maybe the first thing that comes to mind is, you know, something that is very restrictive or almost, you know, ordered. They will resist against that type of thing. But I'm not certain at this point of anything specifically to avoid.

>> SAMSON TEKLEMARIAM: Thanks. And what does a taper off plan look like for a Veteran who is on medication assistive treatment? And what are some ways we can help them taper so it may not necessarily be towards are the later phases of treatment?

>> This falls into the area of know your scope of practice. So the owner of my clinic, Dr. Charles Weber and his wife, they do assistive medical treatment. I'm not sure

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what the protocol is on that. We do have in our clinic, and this is somewhat challenging whenever someone is, for example, part of a small group practice or you're in the community, this is challenging if you're not in a practice which provides both medication management and therapy.

We have that both among several locations in our community. Which we find that's very effective in that you know, we communicate with the medication providers and the medication providers communicate with us. And we talk about how it's working and how the things are.

And also, I have had typically when I have the Veteran, when I interact with the VA prescriber, and I'm a community prescriber, I usually have a discussion with the Veteran or how to advocate for themselves, that, hey, this particular medication is not working. How do you describe that to your provider and let them know? So it's developing how to self-advocate rather than me going directly to that provider. We do have that ability, and some of that is building the rapport, or building the connection between the providers.

But I think it's a lot easier if you have like us, both therapy and medication management in the same place. And some, you know, larger systems, if somebody is working in a hospital system, obviously, having that level of communication and approval through the client. We have a mutual client, can we discuss what I'm hearing versus what you're saying? That kind of thing.

>> SAMSON TEKLEMARIAM: Excellent. And another question. Where does art and recreation therapy fit into a treatment plan?

>> DUANE K. L. FRANCE: So I think art and recreation therapy very firmly fits into those existential experiential type of interventions. So it provides a level of purpose and meaning. But also the research is starting to show these are neurological benefits. So it can be applied to number of different types of situations.

For example, songwriting therapy is simply, or songwriting experience is simply a different type of exposure therapy. I often, when I talk to my colleagues doing these things, especially those that are not clinicians, I often highly, highly encourage them to

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be able to say get involved with clinicians. Have clinicians involved with your program to make sure that you're doing do no harm as opposed to doing good when possible. So there very much is a role. And that goes into sort of adjunctive and associative therapy. There's a program based out of Los Angeles, and it's in a number of different cities, off the top of my head, New York, Atlanta, and Las Vegas. But it's called merging Vets and players. This is a program that brings Veterans and professional athletes together, because there's a large overlap between this loss of purpose and meaning for a Veteran, and then a loss and purpose and meaning for professional athletes.

I think the one that comes to mind is, you know, Olympic athletes who, you know, were at the top of their game. Famously Michael Phelps came out and described housekeep suicidal he was after the real Olympics. Now, what? He specifically and clearly publically says that I was in my room, and if it weren't for my family, I wouldn't be here today. They intervened and got me into therapy so, merging Vets and player is a program for former athletes and Service members together to provide fitness therapy. And they actually have a group. One, it helps reduce the -- it's very hard to get emotional when you're bone tired after a hard work out. But in having conversations that I've had conversations with Executive Director, everything that they're doing is clinically based. They actually have a team of clinicians who go through and wrote their protocol, and monitored their protocol, so it's clinically based, but it is provided in such a way that it can be adjunctive to therapy. But it's not therapy itself. So, hopefully, that gives an example of incorporating this into what you're doing.

>> SAMSON TEKLEMARIAM: Excellent. Thanks so much, Duane. We have two more. One is asking when we talk about finding purpose and meaning, for some of our Vets, I feel like they just need to find the right career counselor or career counseling model. Is there recommended or best practice for career counseling military affiliated population?

>> DUANE K. L. FRANCE: There are probably a lot more military focused employment support than there is therapy. I would say that it would necessary, just like with clinicians, we need to make sure individuals are culturally-competent. The clear

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advisors understand the military. It doesn't mean they have to be military. But they have to be familiar with it.

But that is a very, very good point. I, like many others, I got out and I started working with homeless Veterans. It wasn't a clinical role necessarily, but I was there for about 18 months, and I realized that wasn't a fit for what I wanted to do. It was much more like social work than clinical mental health counseling.

And, so, even I, in my transition and like many other Veterans is rocky as it might be able to be. But even I thought that I was going to land in what I saw to be a dream job. Basically, the job description was looking for a first sergeant that knew how to run the barrack and I got that job and it wasn't satisfying to me. In the meaning and purpose aspect, I don't want to say one of the easiest to solve, but if that's the primary issue for Veterans, it's really just working with them to understand that you don't have to get it all in the same place. I often describe this. And it's amusingly, as we're talking about existentialism, and my colleague was writing a book and we're talking about psychological aspect of transition, and when I brought up the term existential psychology, she was like let's not go there. But the fact is, there's a difference between purpose, a thing to do, a task to be accomplished. So this is an external construct that we need to or want to accomplish. Versus something that's meaningful that is satisfying to us.

I often use Martin Seligman and Ma? And how do we find something and we don't have to find them both. Because in the military, purpose was what we were doing. It was the task to be established. But it was meaningful, even if we were just picking up cigarette butt, we knew we were part of a mission and part of of a larger thing. Where I have a Veteran came out of a job out of a saw mill, here's a dustpan and broom and pick up saw dust. And this was a marine in charge of million dollar worth of equipment. So they need to find meaning. And I also see Veterans that have a lot of Veterans and they call it playing call of duty or watching Netflix. There's actually not a purpose. So helping Veterans find that and that's a long answer I guess to say, yes, I agree.

Finding a good career counselor who understands the need for that balance to match the Veterans' inclination to what a potential career is. But there are literally

dozen, I think, that USO has a program. I believe it's called their pathfinder program that does career placement. Hire hero USA. U.S. Chamber of Commerce has a program. Bunker lab has some colleagues there. They help Veterans become entrepreneurs where they may not want to work for someone else. So I think there are many, many military culturally-competent employment programs out there.

>> SAMSON TEKLEMARIAM: Great. And we have just enough time for one more. In your experience, has basic financial management skill been a useful part of military or Veteran treatment plan?

>> SAMSON TEKLEMARIAM: Absolutely. I think that, and I make a joke. For 22 years, I was paid on the 1st and the 15th. And that's not how the majority of people were paid. My wife and I struggled for about a month and a half trying to figure out and how to pay the bills being paid every two weeks, which isn't always on the 1st and the 15th. And, so, that's maybe a trivial example. But financial literacy. A good colleague of mine, Chuck Sabola is with Prudential. But PsychArmor has teamed with Prudential to provide a very, very good financial management class. Also there's likely the same thing offered in workforce centers throughout the the country. So, yes, I think financial management, and just basic understanding of financial principles, investments, all of those things are very, very beneficial when it comes to needs fulfillment.

>> SAMSON TEKLEMARIAM: Thank you so much, Duane. Everyone, thank you for your participation. As we close out, please make sure to take one moment to complete the brief post webinar survey. Once we close the webinar, it will pop up on your screen. If do you for the see it, no worries. About one hour after the live webinar is completed, you will receive thank you for attending automated email from GoToWebinar. And within this email is a "Thank You" letter directly from Duane, but also there's a link to the post webinar survey. As we continue to build out our annual special training series and NAADAC series, we're going use your feedback to design a targeted learning experience foreign the addiction professional. And you can go Duane's website to continue your learning on this topic. You'll see books like Combat Vet Don't Mean Crazy: Veteran Mental Health in Post-Military Life and Head Space Timing: Veteran Mental Health from a Combat Veteran Perspective. Also coming soon

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is Duane's third book titled military in the rear-view mirror. Which is looking forward to that one touching on the Veteran concepts touching on what occurred in the rear-view mirror versus potential of what's ahead of them. And the transition to post-military life. As a reminder, in order to access this CE quiz, please view the entire training and listen for the password. This password has been and is going to now be revealed in 3 separate sections. Here, I'm going to share with you the third and final part of your password. Remember, when you enter the online CE quiz, the password you use will be all one word, lowercase. The third and final part of your password is the [redacted] [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).

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And if you missed our earlier instructions, these are the instructions. You can visit the webpage that you see on the screen. Or you can go to our website, www.NAADAC.org/education. And first you see will be specialty online training. You'll see all the instructions there. Of course if you run into any issues or need assistance accessing one of these trainings, you can email us any time at CE@NAADAC.org.org. That's C as in cat, E as in echo. @NAADAC.org. You have access to over 145 CEs of free educational webinars. And you will also receive quarterly advances in addiction recovery magazine. And the series will be available next week. If you haven't joined NAADAC yet, and I think it's probably time, here's an additional incentive. The Certificate of Achievement application is free to NAADAC members. Along with discounts on conferences and opportunities to present in front of a live audience, each of our certificate programs include member benefits.

Visit www.NAADAC.org/join to learn more. And you can also learn more about our 2020 annual conference, which has been visually announced at the Washington, D.C. at the Gaylord National Resort & Convention Center. Duane France your presenter today will be the live train he were in a live featured trainer in the conference and, so, you'll get to meet him in person. Thank you for participating in this webinar. And Duane, thank you for your expertise. I encourage you to browse our website and learn how NAADAC help others. Stay connected with us on LinkedIn, Facebook, and Twitter.