Today's Webinar is:

# PTSD 101: Education for the Civilian Health Care Provider Treating Service Members

Aug. 23, 2012

1-2:30 p.m. (EDT)

# PTSD 101: Education for the Civilian Health Care Provider Treating Service Members

DCoE Monthly Webinar, Aug. 23, 2012

**Terence Keane, Ph.D.**
Associate Chief of Staff for Research and Development, VA Boston Healthcare System
Director, Behavioral Science Division, National Center for Posttraumatic Stress Disorder

**Maj. Jeff Hall**
Operations Training Officer, First Army Headquarters, Rock Island, Ill.

# Webinar Details

- The following continuing education (CE) and continuing medical education (CME) credit is approved for this activity:
  - 1.5 AMA PRA Category 1 Credits™
  - 1.75 CE Contact Hours Physical Therapy and Occupational Therapy
  - 1.5 Nursing Contact Hours
  - 1.5 Social Work CE Hours
  - 1.5 Psychologist Credit
- For complete accreditation statements, visit the DCoE website to review CE and CME credit
- Webinar pre-registration **required** to receive CE or CME credit
  - Registration is open for the next 15 minutes; register at dcoe.adobeconnect.com/dcoeaugustwebinar/event/registration.html
  - Some network securities limit access to Adobe Connect

# Additional Webinar Details (continued)

- Webinar audio is **not** provided through Adobe Connect or Defense Connect Online
  - Dial: **888-455-4265**
  - Use participant pass code: **9415208#**
- Webinar information
  - Visit dcoe.health.mil/webinars
- Question-and-answer session
  - Submit questions via the Adobe Connect or Defense Connect Online question box

# Agenda

- Welcome and Introduction
- PTSD 101: Education for the Civilian Health Care Provider Treating Service Members
  - Terence Keane, Ph.D.
    - Associate Chief of Staff for Research and Development, VA Boston Healthcare System
    - Director, Behavioral Science Division, National Center for Posttraumatic Stress Disorder
  - Maj. Jeff Hall
    - Operations Training Officer, First Army Headquarters, Rock Island, Ill.
- Highlight of latest Military Medicine Supplement: Psychological Health and Traumatic Brain Injury
  - Ms. Rabia Mir
    - Education Directorate, DCoE
- Question-and-answer session/discussion

# Webinar Overview

## PTSD 101: Education for the Civilian Health Care Provider Treating Service Members

- Published studies suggest that 10-17 percent of service members self-report significant PTSD symptoms following deployment. The prevalence of clinically diagnosed PTSD in returning OEF/OIF service members is 2.4 percent, according to the Armed Forces Health Surveillance Center. However, 2.4 percent is likely an underestimate, given the stigma associated with receiving a diagnosis of PTSD and seeking mental health care.
- PTSD is associated with many comorbid conditions, including heart disease, susceptibility to infections and chronic pain. Patients with PTSD are likely to use health care services at higher rates than non-PTSD patients. Health care providers have a unique opportunity to identify, treat, monitor and refer patients with PTSD, increasing the chance that patients receive help.
- The goal of this webinar is to enhance civilian health care providers' knowledge of trauma and its treatment for service members and veterans.

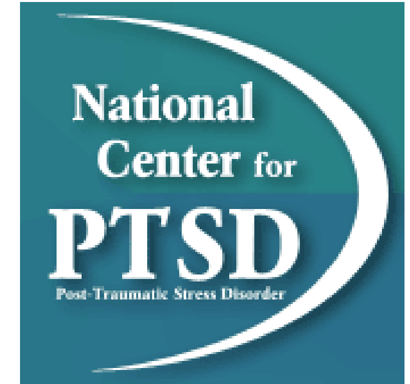
# Terence Keane, Ph.D.

Associate Chief of Staff for Research and Development, VA Boston Healthcare System
Director, Behavioral Science Division, National Center for Posttraumatic Stress Disorder

# Required Disclosure

I have no relevant financial relationships and do not intend to discuss the off-label/investigative (unapproved) use of commercial products/devices.

# Recent Advances in the Psychological Treatment of PTSD




TERENCE M. KEANE, PH.D.

National Center for PTSD
VA Boston Healthcare System &
Professor & Vice Chairman of Psychiatry
Assistant Dean for Research
Boston University School of Medicine

# Purposes of this Lecture:

- Describe conceptual model of PTSD
- Describe evidence-based treatments for PTSD
- Provide solutions for barriers and improve access
- Present findings from recent Internet trial
- Present future directions

*Note: Posttraumatic Stress Disorder (PTSD)*

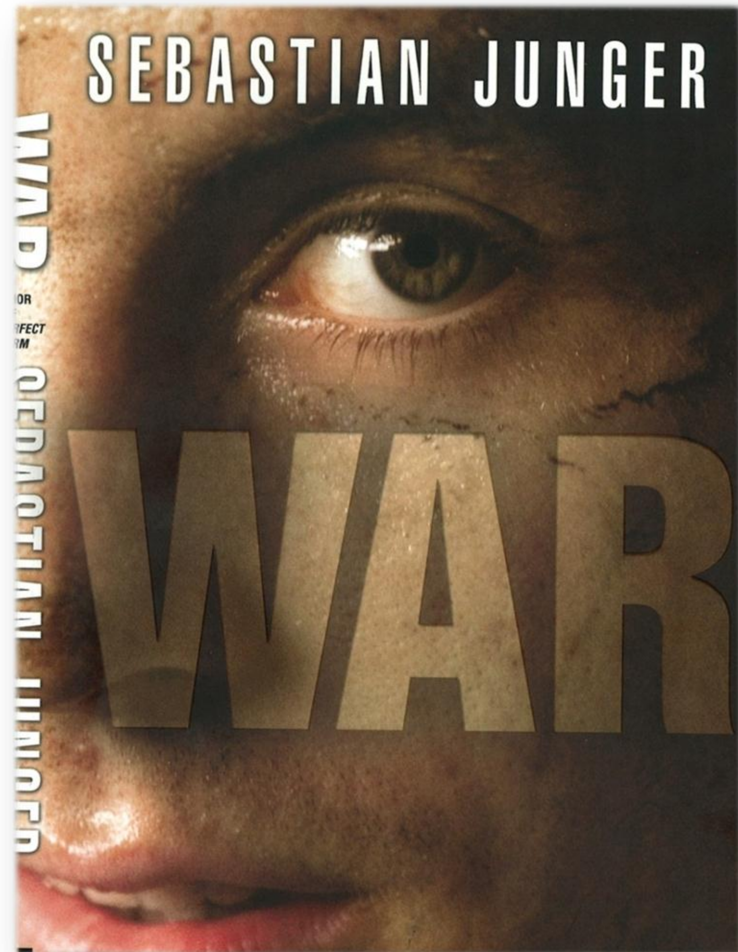
# Military Combat

*Photo by Senior Airman Bradley A. LailIraq, USAF*

# Sebastian Junger's "War"

*"The unit  was in over 400 firefights during their deployment — and they came home deeply traumatized by their experience.*

*...the most upsetting thing was the loss of their friends. They felt responsible for their deaths, convinced there was something they could have done to prevent them, and a sense of guilt that they should have been killed instead."*



# Signature Wounds of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF)

# OEF/OIF: Pain, TBI and PTSD

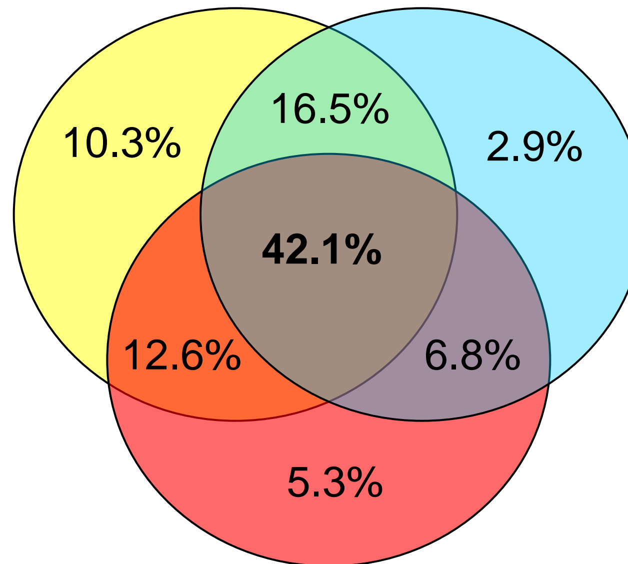
*Photo by Airman 1st Class Nathan Doza, USAF*

*Notes: Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF); Traumatic Brain Injury (TBI); Posttraumatic Stress Disorder (PTSD)*

# Prevalence of Chronic Pain, PTSD and TBI in a Sample of 340 OEF/OIF Veterans

**Chronic Pain**
N=277
81.5%

**PTSD**
N=232
68.2%




**TBI**
N=227
66.8%

# Can Therapy Help Chronic PTSD?

# Single Subject Designs…

*References: Keane & Kaloupek (1982); Fairbank & Keane (1982)*

# Brief Reports:

- Imaginal Flooding in the Treatment of a Posttraumatic Stress Disorder

Journal of Consulting and Clinical Psychology
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## Brief Reports

### Imaginal Flooding in the Treatment of a Posttraumatic Stress Disorder

Terence M. Keane
Veterans Administration Medical Center and
University of Mississippi Medical Center

Danny G. Kaloupek
Concordia University

A 36-year-old Vietnam veteran was treated for the anxiety-related symptoms of a posttraumatic stress disorder. Therapy consisted of 19 sessions over a 22-day inpatient hospitalization. Primary treatment was the exposure technique of imaginal flooding using the intrusive thoughts (nightmares, flashbacks) associated with the traumatic events. Self-monitored data, psychological test instruments, and physiological responding (heart rate) during scene presentation provided empirical, objective evidence for treatment efficacy. A 12-month follow-up assessment indicated improved adjustment as supported by employment status, residential stability, emotional involvement, and self-report of anxiety, nightmares, and flashbacks.

For some individuals the psychological sequelae of combat are acute and chronic states of anxiety, depression, constricted affect, and recurrent, intrusive memories of specific events either in an awake (flashback) or a sleeping (nightmare) state (cf. Posttraumatic stress disorder, *Diagnostic and Statistical Manual of Mental Disorders-III*, American Psychiatric Association, 1980). While there is a great deal written conceptualizing the etiology of combat disorders and describing potential treatment approaches (cf., Fairbank, Langley, Jarvie, & Keane, 1981; Figley & Leventman, 1980; Horowitz, 1976), very little work has been conducted in the objective evaluation of any one therapeutic intervention. The purpose of our study was to empirically evaluate the efficacy of treating a combat-related disorder by imaginally presenting the aversive events surrounding the individual's trauma. We hypothesized that, consistent with the implosive therapy model of psychopathology (Levis & Hare, 1977), prolonged and repeated imaginal exposure to these events would result in the extinction of anxiety.

#### Case

The patient was a 36-year-old, divorced black male whose presenting problem was alcohol abuse (1 quart of gin per day for nearly 5 years) for which he was treated in a 4-week inpatient alcohol program. He returned intoxicated to two consecutive follow-up appointments, where it was learned that he was experiencing the following: (a) chronic anxiety with acute panic attacks that occurred about 2–3 times per week, (b) catastrophic nightmares that relived traumatic events (2 per week), (c) insomnia, (d) flashbacks, (e) depression, (f) social anxiety, and (g) vocational problems (seven jobs in 3 previous years and unemployed immediately prior to treatment).

#### Traumatic Events

Three events from Vietnam that frequently recurred in the form of nightmares, flashbacks, and intrusive thoughts were isolated. Scene 1 involved the sudden death of a buddy in the mess hall when a rifle was inadvertently fired while it was being cleaned. Scene 2 involved the death of a buddy by an ambush attack 2 weeks before the buddy's scheduled departure. Scene 3 consisted of feelings of helplessness and anxiety while standing watch during the night with instructions to observe only and not fire until fired upon.

#### Measurement

Measures included daily self-monitoring, a standard psychological test, and psychophysiological recordings of anxiety. Upon admission, the patient recorded the following: (a) anxiety ratings (0-10) five times per day at specified intervals, (b) hours of sleep the previous night, (c) frequency of nightmares, and (d) frequency of flashbacks.

This research was supported by a Veterans Administration Merit Review Award to the first author.
The authors would like to thank John A. Fairbank for his commentary.
Requests for reprints and for an extended report should be directed to Terence M. Keane, Psychology Service (116B), Veterans Administration Medical Center, Jackson, Mississippi 39216.

# Eleanor Roosevelt's View

US Library of Congress image

*"You gain strength, courage, and confidence by every experience in which you really stop to look fear in the face. You must do the thing you think you cannot do"*

# First Randomized Clinical Trials for War Veterans with Chronic PTSD

# Cognitive Behavioral Therapy Treatment of PTSD

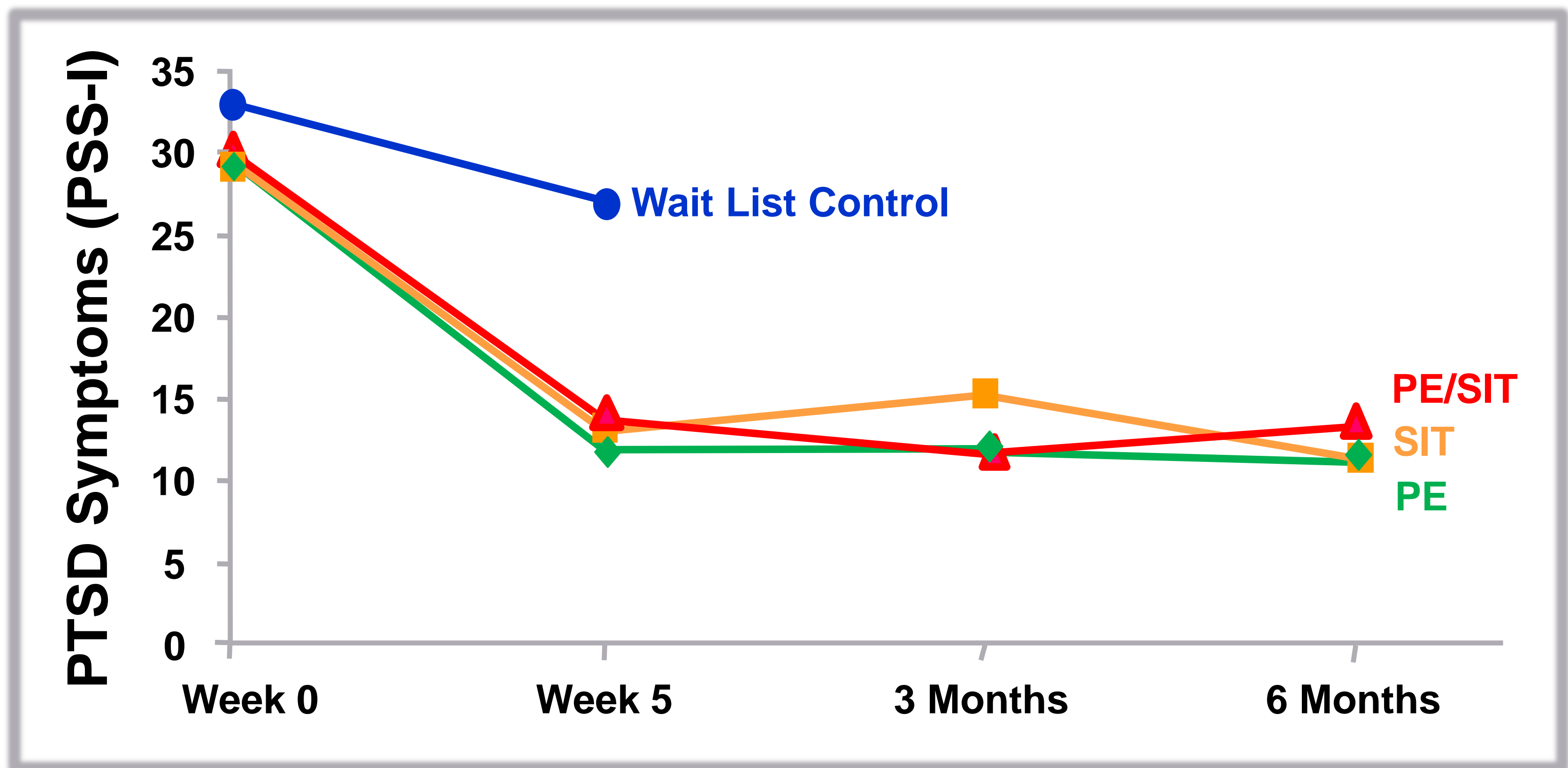
- Vietnam veterans with PTSD
- Prolonged Exposure (PE) versus Anxiety Management (AM) versus Wait List Control (WLC)
- Six-month follow-up

*Reference: Keane, Fairbank, Caddell, & Zimering (1989)*

# PTSD Symptom Checklist Scores in Combat Veterans

# Series of Randomized Clinical Trials of Non-veterans with PTSD…

# PE, Stress Inoculation Therapy (SIT) and Their Combination for Female Assault Victims with PTSD



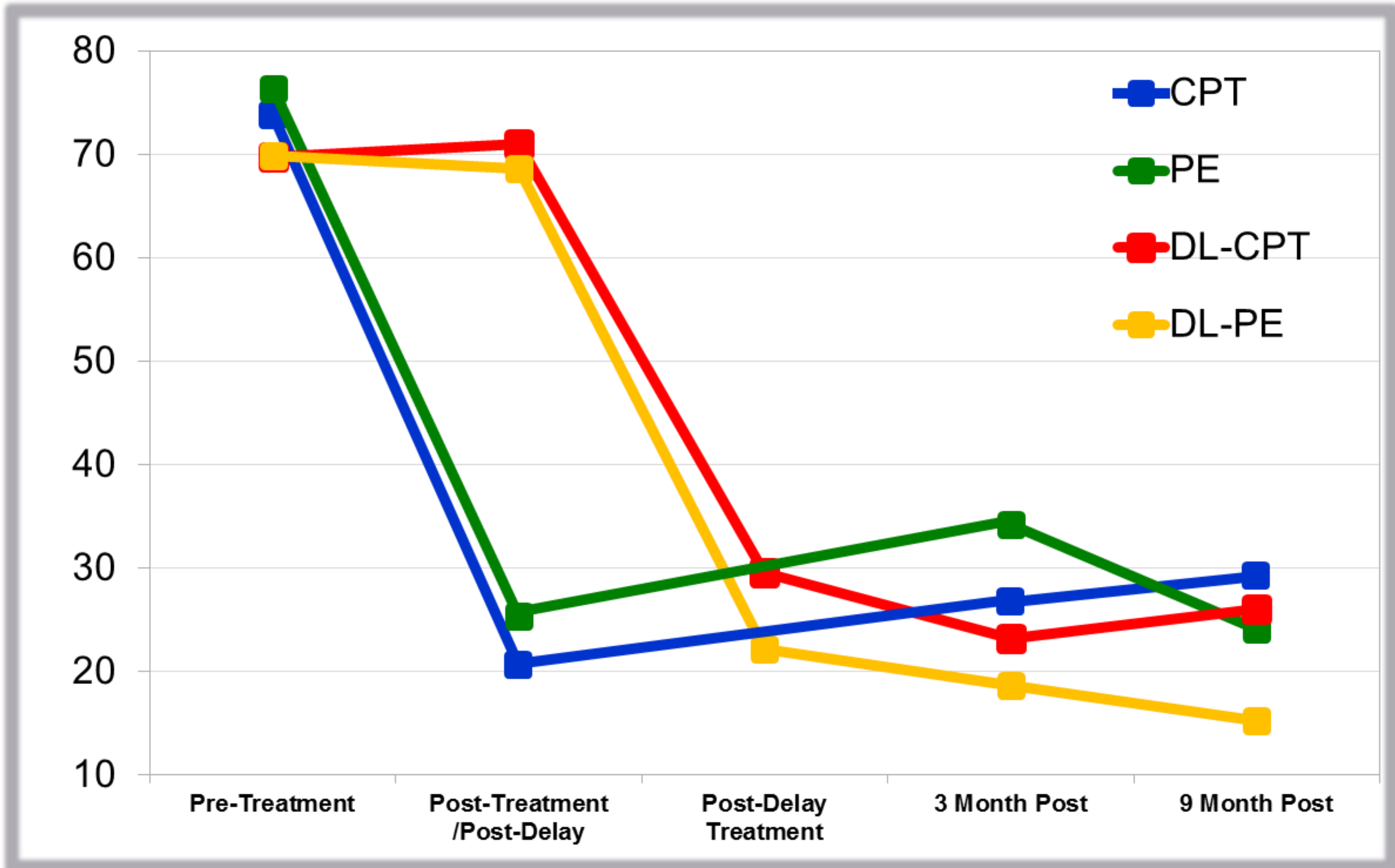

*Reference: Foa et al. (1999b)*
*Note: PTSD Symptom Scale -- Interview (PSS-I)*

# Cognitive Processing Therapy versus Exposure versus Delay

- 171 participants with rape-related PTSD
- 121 completers at post-treatment

*Reference: Resick et al., JCCP (2002)*

# CAPS with Completers



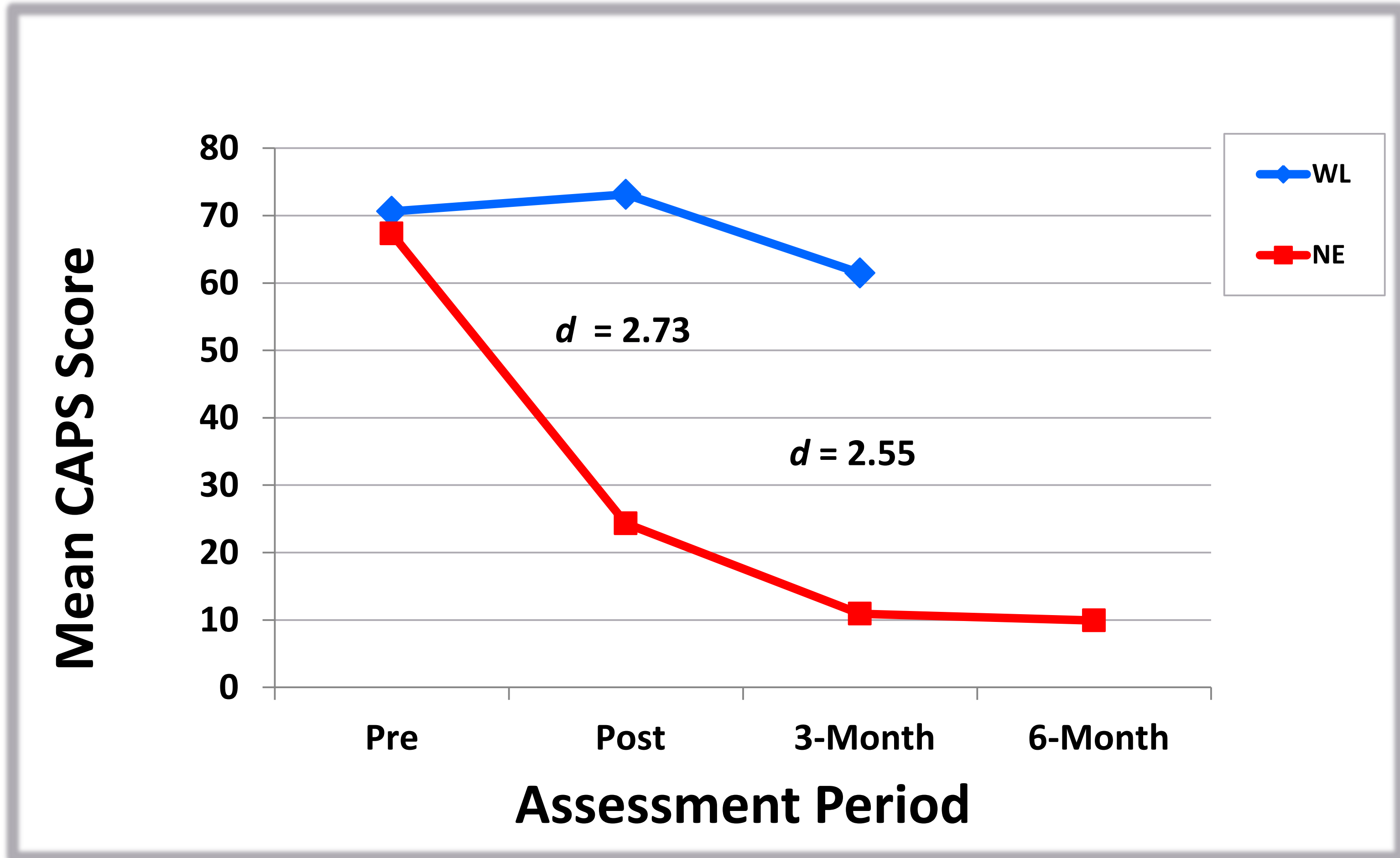

*Notes: Clinician-Administered PTSD Scale (CAPS); Cognitive Processing Therapy (CPT); Prolonged Exposure (PE); Delayed Cognitive Processing Therapy (DL-CPT); Delayed Prolonged Exposure (DL-PE)*

# Narrative Exposure Therapy

- Moving vehicle accident survivors
- PTSD by CAPS
- 48 randomly assigned to condition
- Narrative Exposure versus Wait List Control
- Followed for three to six months

*Reference: Sloan, Healy, Mills, & Marx (2011)*
*Note: Clinician-Administered PTSD Scale (CAPS)*

# CAPS Total Score



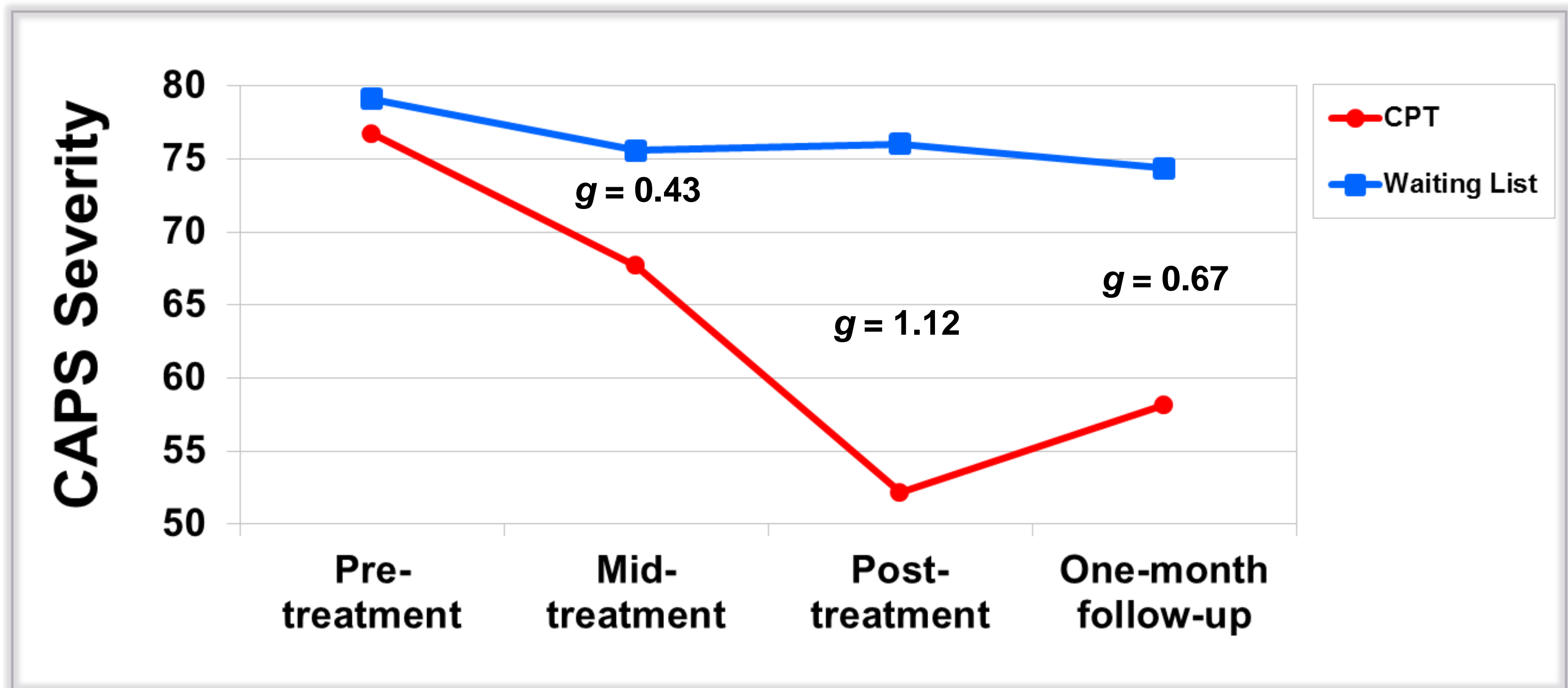

*Notes: Clinician-Administered PTSD Scale (CAPS); Wait List (WL); Narrative Exposure (NE)*

# Veterans Affairs Cognitive Processing Therapy Versus Wait List Study

- The purpose of this study was to compare CPT with a wait list (or treatment as usual)
- Intent-to-treat sample with 30 veterans randomly assigned to CPT or wait list

*Reference: Monson et al., JCCP (2006)*

# Intention-to-Treat Clinician-rated PTSD Severity




Drop-out from CPT = 20%        Drop-out from wait list = 13%

*Notes: Clinician-Administered PTSD Scale (CAPS); Cognitive Processing Therapy (CPT)*

# Are there effective treatments for PTSD?

# PTSD Treatment Options

## Psychosocial

- Exposure therapy
- Cognitive therapy
- Anxiety management
- Cognitive processing therapy
- Eye movement desensitization and reprocessing (EMDR)

## Pharmacological

- Tricyclic antidepressants (TCAs)
- Monoamine oxidase inhibitors (MAOIs)
- **Selective serotonin reuptake inhibitors (SSRIs)**
- Mood stabilizers
- Anti-anxiety agents

*Reference: Foa, Keane, Friedman & Cohen (2008)*

# Common Elements of PTSD Treatment?

- Disclosure of the elements of the experience
- Direct therapeutic exposure to events
  - Countering avoidance strategies
- Education about trauma and PTSD
- Cognitive restructuring on key distortions
- Skills for anxiety management

*Reference: Keane (2008; 2010)*

*There are many roads to Rome…….*

# George Albee, Ph.D. (1921-2007)

*Photo is personal collection of Dr. Terence Keane. Used with permission.*

# Advantages of World Wide Web

- Increased confidentiality
- Easy to use within schedule
- Low costs per capita involvement
- Addresses public health nature of trauma
- Military would utilize evidence-based treatments for adaptation, coping and recovery

# Web-based Intervention for Returning Veterans with Risky Alcohol Use and Posttraumatic Stress Symptoms

U.S. Army photo by Brittany Carlson

U.S. Army photo by Sgt. Mike MacLeod

**Support from National Institute on Alcohol Abuse and Alcoholism (NIAAA) and VA National Center for PTSD**

# Design

- RCT with a wait list control group
- 2:1 ratio to IIG or a DIG
- Based on EBPs, so likely to be of benefit
- Anonymous web-based treatment
- Amazon.com gift codes for assessments

*Notes: Initial Intervention Group (IIG); Delayed Intervention Group (DIG); Evidence-based Practices (EBPs)*

# Inclusion/Exclusion Criteria

- OEF/OIF veterans
- 18-65 years old
- Audit: 8-25 for men and 5-25 for women
- Drank at-risk amounts in the past 30 days
- Valid email address

Home page - Mozilla Firefox

Home page

# VetChange.org

Helping veterans help themselves

Local Resources

PARTICIPANT LOGIN LOGIN

## Welcome to VetChange

This is a website for OIF and OEF veterans who are concerned about their drinking.

If you're a returning veteran who is having problems related to drinking, you're not alone. Many returning veterans have increased their drinking since returning from deployment and are wondering if it's time to make some changes.

If you'd like to cut down or stop drinking by using a self-management, confidential program on the Web, we may have a solution for you.

We're conducting a research study to figure out whether our web program, **VetChange**, will help returning veterans change their drinking on their own. If you participate in the program, you will be compensated with an online gift card each time you complete one of several evaluation surveys in the program.

## Let's Get Started

If you're interested, let's start by having you answer a few questions about your age, service, and drinking and then we'll give you some information about whether you're eligible to be a part of the study and use the website.

Are you between the ages of the 18 and 65?

Did you serve in Operation Iraqi Freedom or Operation Enduring Freedom?

Are you Male or Female?

Male

Continue

### Privacy

**Private and Confidential**

Your participation and all your responses will be kept confidential. Nothing you tell us will be shared with your healthcare providers, including VA providers, or with the military. We only ask for your email address. More information about this is in the Web program.

About the Program | About Us | Study Payment | Eligibility

Research studies over the past 30 years show that people can often reduce risky drinking on their own, and sometimes with help from written materials that describe some ways of doing this. VetChange is a self-management program on the Web that can help you decide if you want to change your drinking (to cut down or stop) and assist you in making these changes if you're ready to do so. It may also help you reduce combat-related stress which may be affecting your drinking. This research is designed to find out how well VetChange helps people meet these goals.

# Recruitment

# The Facebook Campaign

- Concerns about security led to Facebook
- Facebook allowed us to track if people came from correct link and, combined with IP address, they were likely to be legitimate participants
- Cost equals $30 per randomized participant

# Costs of Advertising: Facebook versus Newspapers*

| Source of Recruitment | Cost Per Person Recruited |
|---|---|
| Worcester Telegram and Gazette | $240 |
| Burlington Free Press | $275 |
| Concord Monitor | $315 |
| Metro | $725 |
| Facebook | $30 |

*Reference: * Used an Interactive Voice Response-based intervention for problem drinkers*

# The Facebook Campaign

- Facebook allowed us to show ads to people meeting our criteria:
    - 18 to 65 years old
    - U.S. or a country with a U.S. military presence
    - Listed one of about 20 "interests" on their Facebook page (e.g., OIF Veteran Community, OEF/OIF veterans Massachusetts, etc.)
- Men and women in proportions similar to OEF/OIF
- Two exceptions:
    - African-Americans were under-represented
    - Almost two-thirds had treatment in last three months

# Sample Facebook Ads

**Veterans and Alcohol**
vetchange.org

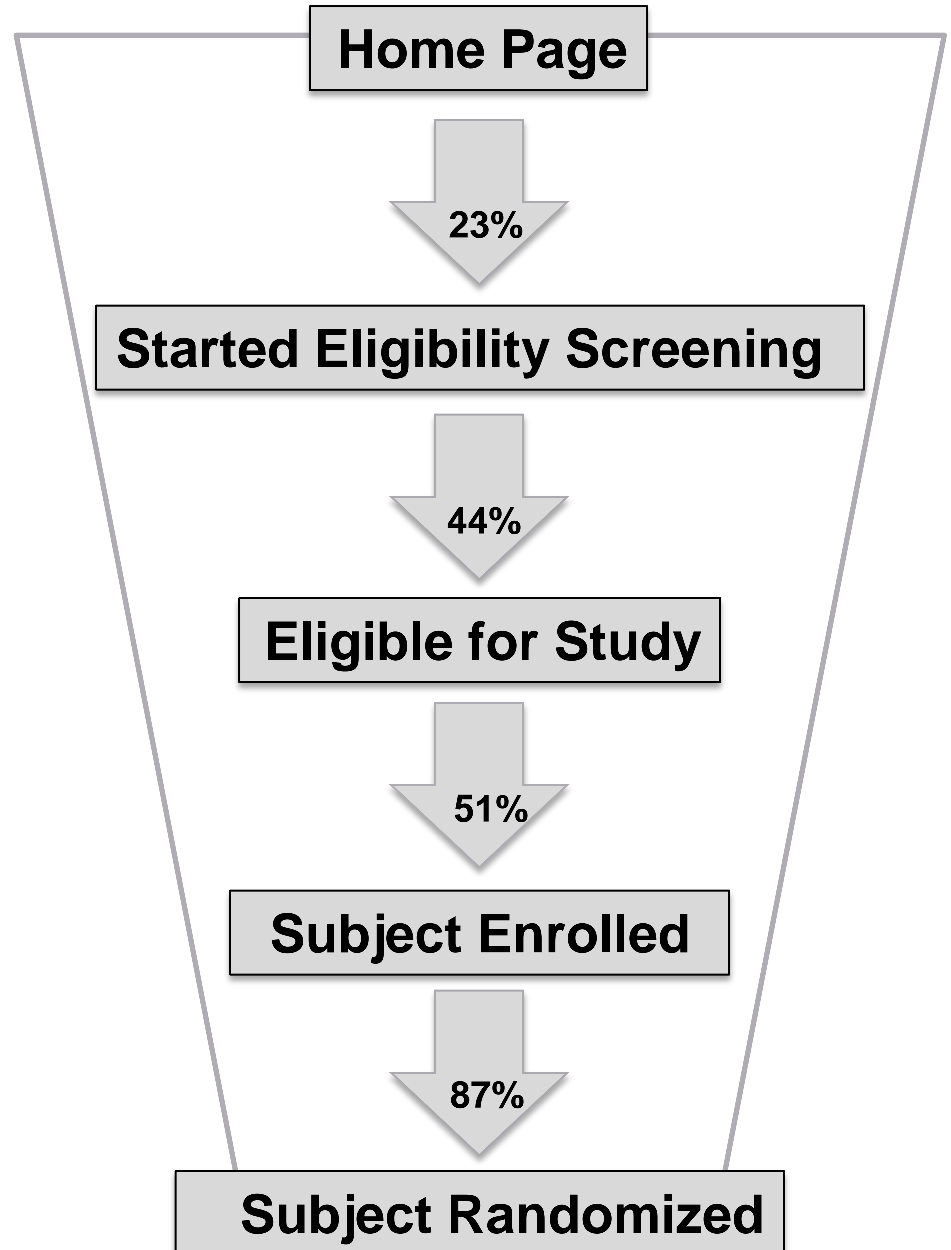
OIF/OEF veteran? Sign up for a paid online research study and learn skills to manage your drinking.

**OIF/OEF Veterans**
vetchange.org

Want to cut back on alcohol? Sign up for a paid online research study and learn skills to manage your drinking.

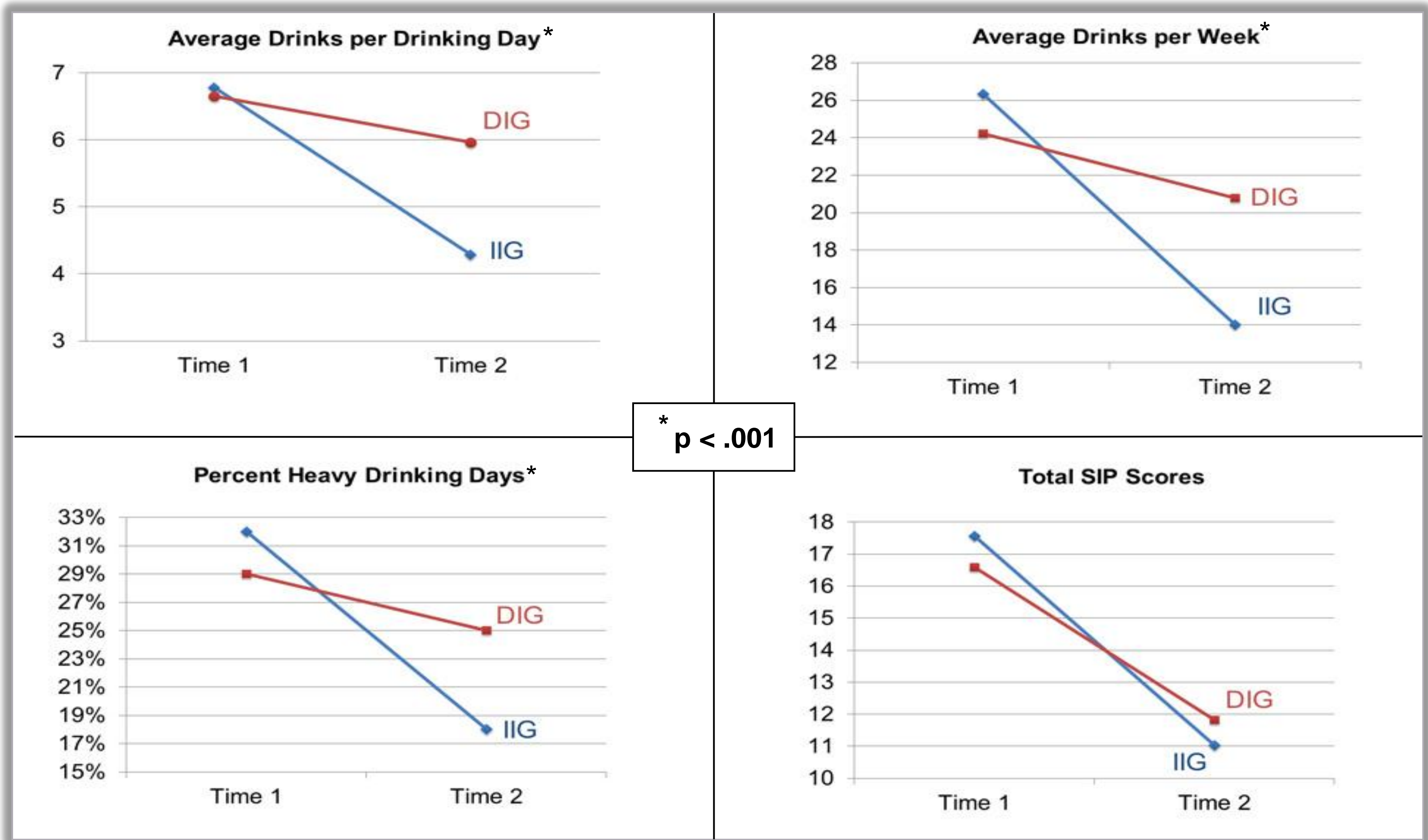
- Seen by at least 317,000 users likely to be returning veterans, over 43 recruiting days.
- $30 per subject ($1.27 per click, $17,964 total)

# Recruitment



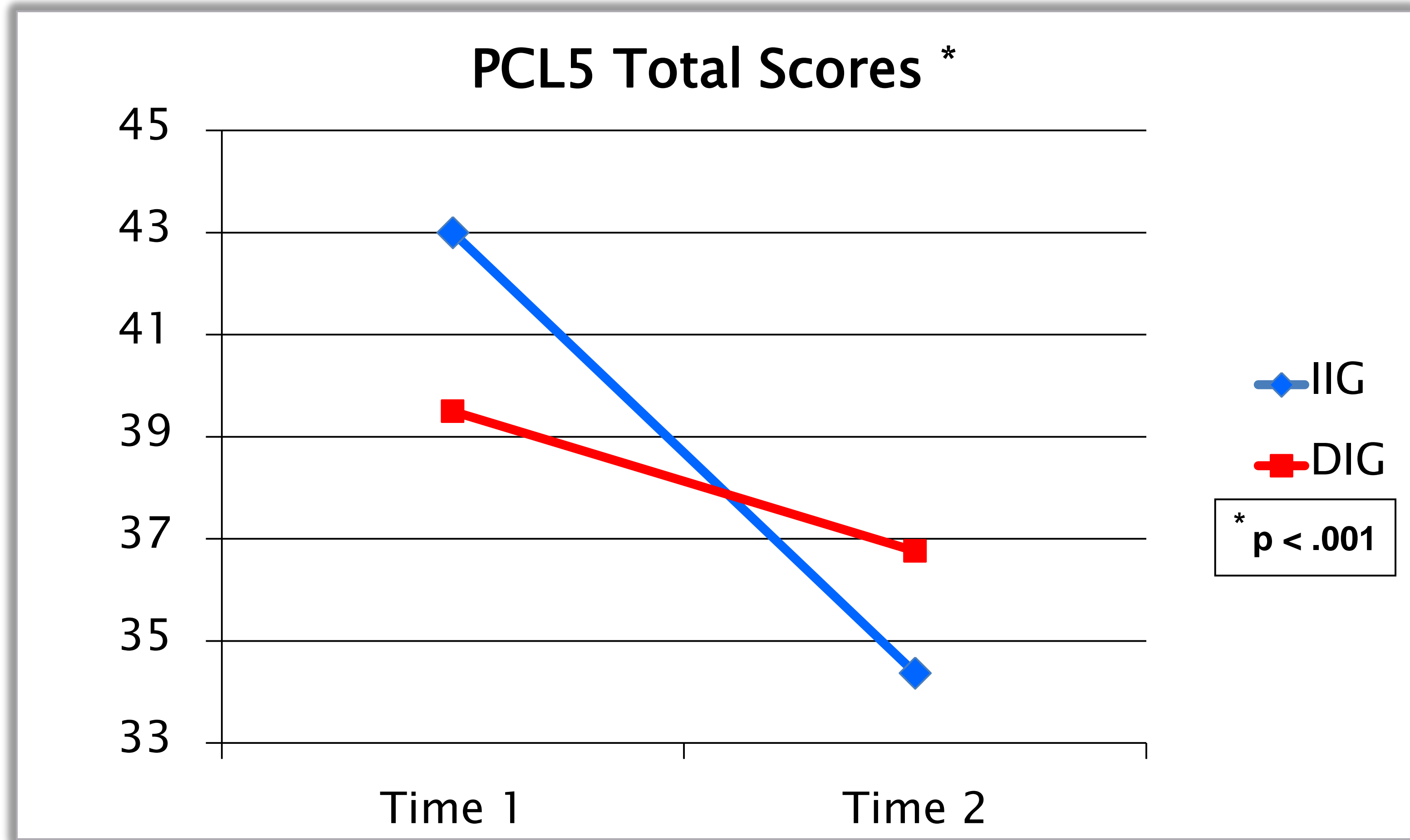

**Of those ineligible due to AUDIT score:**
76% too high
24% too low

# Drinking and Alcohol-related Outcomes



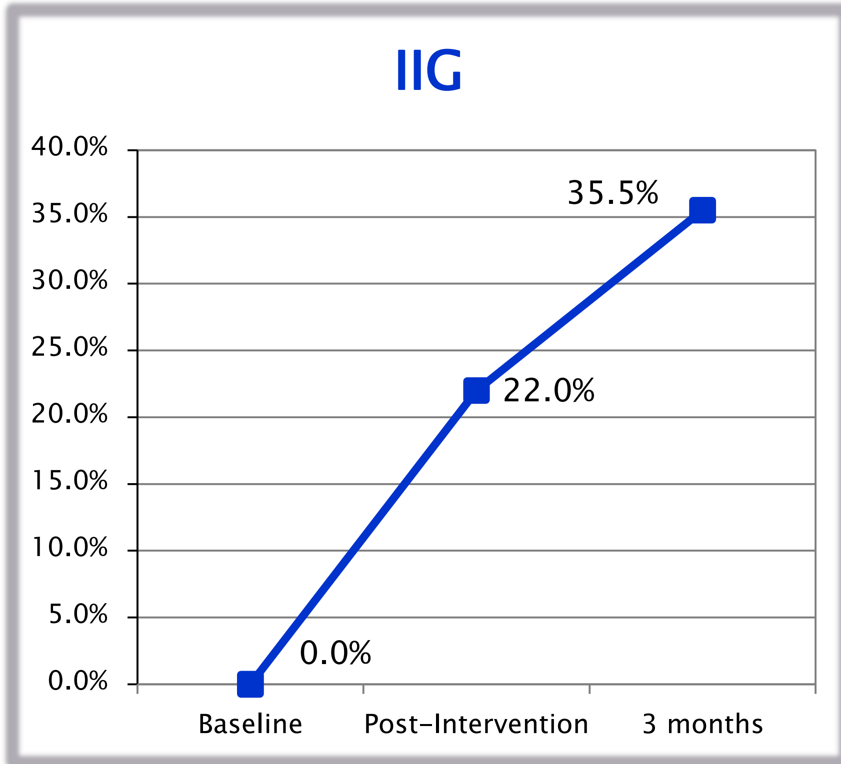

*Notes: Initial Intervention Group (IIG); Delayed Intervention Group (DIG); Structured Interview for PTSD (SIP)*

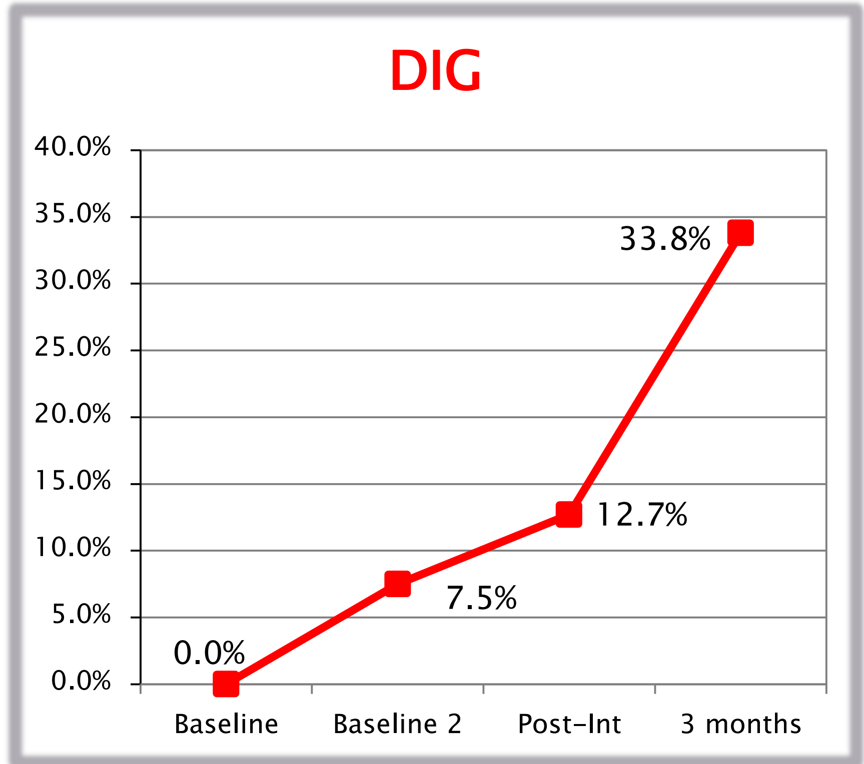
# PTSD Symptom Changes




*Notes: PTSD Checklist (PCL); Initial Intervention Group (IIG); Delayed Intervention Group (DIG)*

# Percent Drinking Within Guidelines




*Notes: Initial Intervention Group (IIG); Delayed Intervention Group (DIG)*

# Percentage of Participants Recently in Treatment

| Treatment in Past Three Months | % (n) |
|---|---|
| None | 37.4 (221) |
| Drug/Alcohol | 4.1 (24) |
| Mental Health | 37.7 (223) |
| Mental Health plus Drug/Alcohol | 20.8 (124) |

*Note: 49.2% (292) of participants also endorsed the above treatments as PTSD-related*

# Lessons Learned

- Facebook is an extremely effective marketing tool
  - Reach a huge audience
  - Can target ads to your audience
  - Can employ social marketing strategies
  - Reach those who want self-directed treatment
  - Web-based security steps needed to be enacted

# Lessons Learned

- Large number in treatment.
- Ads attracted people for whom alcohol use is most salient.

# What are the remaining key issues?

# We know little about the impact of TBI and chronic pain in treatment for PTSD, etc.

# How can we develop new integrated treatments for PTSD, depression, addictions and TBI?

# Summary Points:

- PTSD is a treatable condition.
- Psychological and pharmacological treatments are available.
- Creative delivery of treatments is needed.
- Develop integrative treatments for multiple injured patients.
- Will these treatments work for women, rural, and minority veterans and patients?

# Questions?

# Thank You

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# Maj. Jeff Hall

Operation Iraqi Freedom 1 and 3 Veteran
Training Officer, G3, First Army Headquarters

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# Major Jeff Hall

## Operation Iraqi Freedom 1 and 3 Veteran

- Observer Controller, Joint Readiness Training Center
- Fire Support Officer, First Infantry Division
- Training Officer, G3, First Army Headquarters

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# How do we know when we need help?

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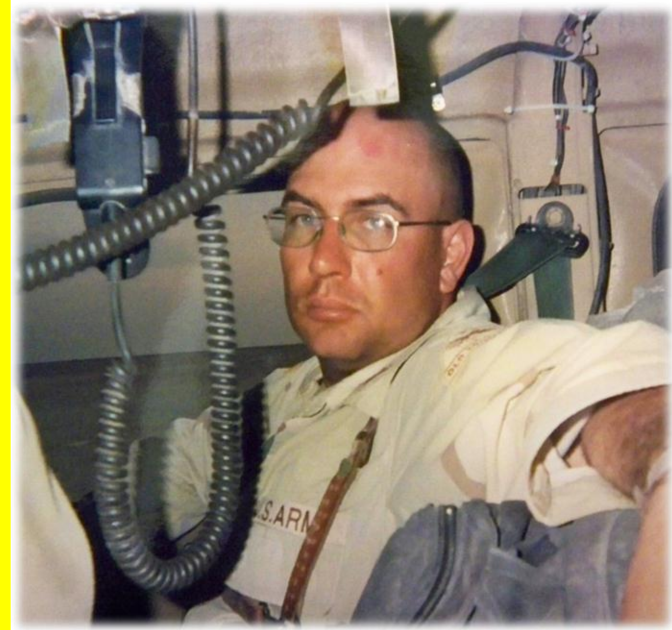
# Common Questions

- Who do I turn to?
- What do I say?
- Where will I go?
- When is enough, enough?
- How is this going to affect me?



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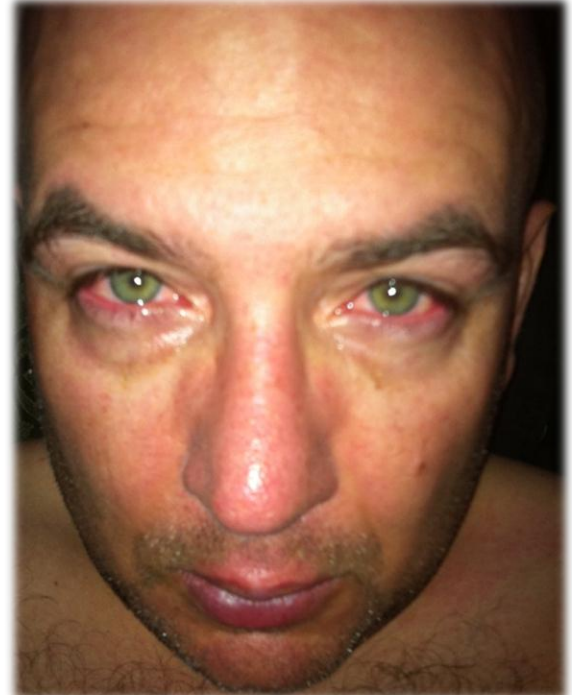
# Other Discussion Points

- Trouble with seeking help
- Why civilians with little military experience were not the right fit for me
- What civilian providers need to understand from a combat-experienced service member
- Why over diagnosing is so harmful to the service member
- Follow-up and service members helping service members

# Who do I turn to?

- Behavioral self-aid is a new concept to professional soldiers.
- Fear of being weak in the eyes of the command, service members you lead or the ones who depend on you.
- Is the command just giving you lip service or do they really care?
- Bug in a jar -- Do I just keep grunting it out?
- Should I be in charge when I feel this way?
- I was lucky, but I know examples of horror stories when the command was turned to for support.



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# What do I say?

- Do I say what is really on my mind?
- Do I just say enough to get them to know I am ok, but need a break?
- Once the cat's out of the bag it does not go back in.
- Spiritual wounding – "Jesus doesn't talk to me anymore."

*Photo is personal collection of Maj. Jeffery Hall. Used with permission.*

# Where will I go?

- Who can I talk to?
- Psychiatrist just wanted to medicate.
- Army OneSource sent me to a civilian who was used for couple counseling. (A bad fit for me.)
- My commander got involved and made the behavioral health clinic understand me.

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# When is enough, enough?

- Anger is out of control
- Making stupid harmful decisions
- Running away from responsibility
- At the point when your body will not move
- Fits of rage followed by sorrow
- Lost in thought; prefer to stay lost in thought over living

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# How is this going to affect me?

- Is my career over?
- Will I be allowed to do the things I love to do?
- How will I ever be able to live again?
- I am screaming and no one can hear me!
- Life certainly changed.

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# Trouble with seeking help

- Availability of one-on-one care
- Hard to explain why I feel this way
- Don’t trust civilians
- Don’t trust the command
- Too damn tired to keep explaining what's wrong to different providers
- I am an artilleryman not a doctor!!!!!

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# Why civilians with little military experience were not the right fit for me

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- Patronizing me.
- Had to constantly keep bringing them up to speed on my language.
- Stopped talking about my issue to educate them about basic military jargon.
- Lifestyle changes they recommend to ease the situation does not fit military life.
- Almost 100 percent of the civilian providers told me to leave the service to help me with my condition.
- Quick with PTSD diagnosis with a recommendation to medicate.
- Most service members are not sheep. Most are sheep dogs or wolves. To put us in a box with medication is to kill our spirit.

# What civilian providers need to understand about combat-experienced service members

- Not all service members see combat.
- Not all service members who have seen combat are bothered by the blood and carnage.
- Most of the service members I talk to have a bigger problem with not accomplishing anything, and being told we have.  This is a hard thing to stomach.
- Failure on the battlefield by lack of direction is tough to swallow, when in our subordinate lives we are not allowed to fail.
- Spiritual wounding can be fatal. Beliefs are broken by the reality of our experience.

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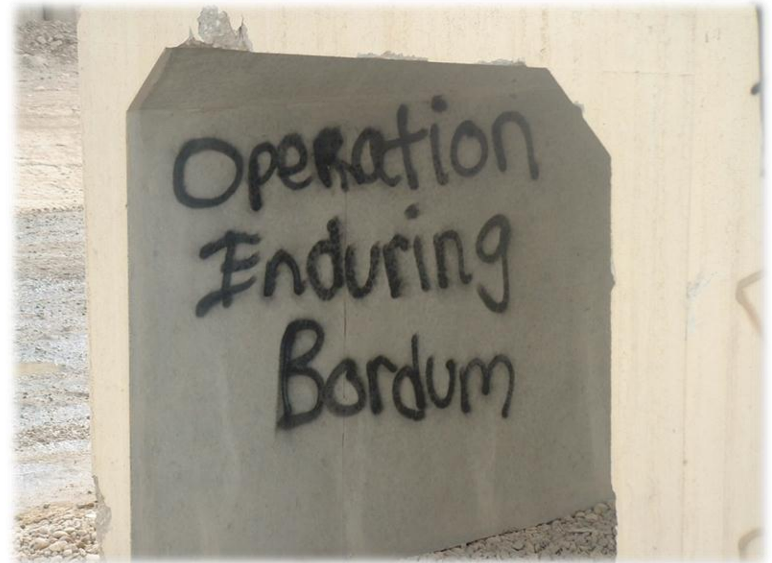
- Do NOT feel sorry for us.  Give us a way to fix ourselves.  Don't just talk for months.  Make us take action and be active!
- We often feel like our experience seems unbelievable – understand that some of it is!

# Why over diagnosing is so harmful to the service member

- No matter the order from higher leadership, **stigma** is still part of the problem.
- Recently a person talking about his new PTSD diagnosis sent the notification message, “Hey have you all got your disability yet” on Facebook.
- Commands have a mission to do. Many times it involves life or death. Playing the “crazy card” is a method that is used in our ranks. This goes without saying – it is very harmful to those who need help and deserve the best care.

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# Follow-up and service members helping service members

- Once a service member has had treatment it is imperative that the service member has follow-up, help or support.
- I cannot stress enough – **Leadership** is the key.
- Groups are the best for follow-up support. “Service members helping service members is the least expensive and most effective way to help each other.
- Service members have to learn to be survivors – **NOT victims!**

*Photo is personal collection of Maj. Jeffery Hall. Used with permission.*

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# Association of Military Surgeons of the United States: Military Medicine Supplement Special Edition

**Rabia Mir, M.P.H.**
Education Directorate,
Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE)

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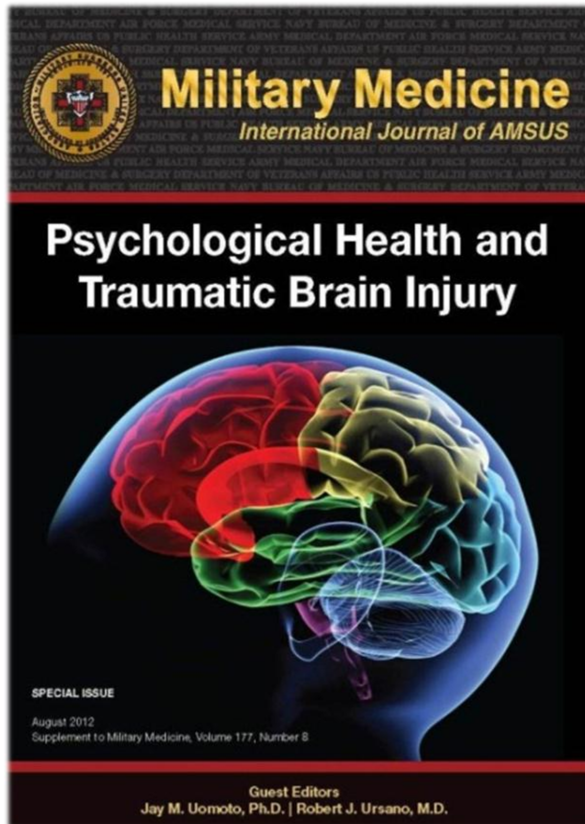
I have no relevant financial relationships and do not intend to discuss the off-label/investigative (unapproved) use of commercial products/devices.

# Background




**Psychological Health and Traumatic Brain Injury**

***Supplement to Military Medicine***
***Volume 177, No. 8***

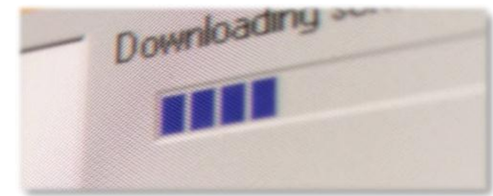
**August 2012**

- Audience: Federal medicine, health care disciplines, active and reserve components
- Highlights recent progress made in epidemiology, prevention, screening, diagnosis, treatment and research of posttraumatic stress disorder, depression, substance use disorder and traumatic brain injury
- Developed through the collaborative efforts of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, Center for Deployment Psychology, Department of Veterans Affairs, academia, U.S. Navy, U.S. Army and Uniformed Services University of the Health Sciences

# Manuscripts

- Post Traumatic Stress
  - Epidemiology and Prevention (Friedman, Hermann, Shiner)
  - Screening, Diagnosis and Treatment (Keane, Wisco)
  - Next Steps, Research or Resources Needed and Priority Focus Areas (Riggs, Sermanian)
- Substance Use Disorder
  - Epidemiology and Prevention (Ozanian)
  - Screening, Diagnosis and Treatment (Kivlahan, Hawkins)
  - Next Steps, Research or Resources Needed and Priority Focus Areas (Saxon, Tollison)
- Depression
  - Epidemiology and Prevention (Kessler, Garcia)
  - Screening, Diagnosis and Treatment (Robinson, Greenberg)
- Traumatic Brain Injury
  - Screening, Diagnosis and Treatment (Marshall, Martin)
  - Screening, Diagnosis and Treatment (Riechers)
  - Next Steps, Research or Resources Needed and Priority Focus Areas (Helmick, Goldman)

# Access




**e-Download:**

1. Visit the AMSUS website at www.amsus.org
2. Select Online Journal from below the Journal pull-down menu.
3. A pop-up window for Military Medicine's IngentaConnect page will appear
4. Click on Military Medicine
5. Select Supplement 1, August 2012 under Volume 177
6. Select and download the full text in pdf format

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2. Click on the AMSUS Store graphic
3. Select the Military Medicine menu
4. Scroll down to Supplemental Issues
5. Select the 2012 August – Psychological Health and Traumatic Brain Injury, Volume 177, No. 8S
6. Proceed to Check Out

# Next Step

## Military Medicine Supplement Podcasts

# Thank You

- Throughout the webinar, you are welcome to submit questions via the Adobe Connect or Defense Connect Online question box located on the screen.
- The question box is monitored during the webinar, and questions will be forwarded to our presenters for response during the question-and-answer session during the last half hour of the webinar.
- Our presenters will respond to as many questions as time permits.

# Question-and-Answer Session

- Submit questions via the Adobe Connect or Defense Connect Online question box located on the screen.
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- Our presenters will respond to as many questions as time permits.

# Webinar Evaluation/Feedback

## We want your feedback!

- Please take the Interactive Customer Evaluation found on the Monthly Webinar section of the DCoE website

- Or send comments to DCoE.MonthlyWebinar@tma.osd.mil

# CE and CME Credit

If you pre-registered for this webinar and want to obtain a continuing education certificate, you must complete the online CE/CME evaluation.

- Did you pre-register on or before Monday, **Aug. 20**, 2012?
  - If yes, please visit conf.swankhealth.com/dcoe to complete the online CE/CME evaluation and download your continuing education certificate.

- Did you pre-register between Tuesday, **Aug. 21**, 2012, and now?
  - If yes, your online CE/CME evaluation and continuing education certificate will not be available until Monday, **Aug. 27**, 2012.

- The Swank Health website will be open until **Sept. 24**, 2012.
  - If you did not pre-register, you will not be able to receive CE/CME credit for this event.

# Save the Date

DCoE Monthly Webinar:

***Managing Suicide Behaviors***

Sept. 27, 2012
1-2:30 p.m. (EDT)

| SEPTEMBER | | | | | | |
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| 30 | | | | | | |

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