Defense Health Agency

Psychological Health Webinar Series

"The 2017 VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder - A Revised Framework to Assess and Treat Patients"

December 14, 2017 1-2:30 p.m. (ET)

Dr. O'Reilly: Good day, and thank you for joining us today for the Psychological Health December Webinar presented by Dr. David Riggs, Dr. Paula Schnurr, and Mrs. Corrine Devlin, "2017 VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder - A Revised Framework to Assess and Treat Patients."

My name is Dr. Holly O'Reilly. I'm a senior clinical psychologist in the evidence-based practice division at the Psychological Health Center of Excellence in Silver Spring, Maryland. I will be your moderator for today's webinar. Today's presentation will be available for download on the files pod and will be available next week on the education and training section of the webinar's page.

Before we begin, let's review some webinar details. If you've experienced technical difficulties, please visit dcoe.mil/webinars to access troubleshooting tips. Please feel free to identify yourself to other attendees via the chat box but please refrain from marketing your organization or product. All who wish to obtain continuing education credit or certificate of attendance and who meet eligibility requirements, must complete the online CE evaluation. After the webinar, please visit dcoe.cds.pesgce.com to complete the online CE evaluation and download or print your CE certificate or certificate of attendance. The evaluation will be open through Thursday, December 28, 2017.

Throughout the webinar, you are welcome to submit technical or content-related questions via the Q&A pod located on the left hand side of the screen. All questions will be anonymous. Please do not submit technical or content-related questions via the chat pod.

I will now move on to today's webinar, 2017 VA DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder, a Revised Framework to Assess and Treat Patients. Since the 2010 release of the Department of Veteran Affairs and Department of Defense Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder, a growing body of research has expanded the general knowledge and understanding of PTSD and other stress-related disorders. Improved recognition of the complexities of acute stress reaction, acute stress disorder, and PTSD has led to the adoption of new and/or refined strategies to manage and treat patients with these conditions.

A revised VA DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder was released in June 2017 to provide healthcare providers with a framework to evaluate, treat, and manage the needs and preferences of patients with PTSD and ASD. The new guideline incorporates current diagnostics as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition as well as evidence-informed recommendations from the VA DOD Management of PTSD work group.

This presentation will briefly review the purpose of the clinical practice guideline and discuss its key recommendations. In addition, the presentation will focus on the importance of patient-centered treatment planning, shared decision making, the provision of trauma informed psychotherapy, and over arching pharmacologic pharmacology treatment recommendations. The presentation will conclude by identifying new clinical support tools available for providers, patients, and family members to help attendees implement these evidence-informed recommendations in their practice. At the conclusion of today's session, the participant will be able to one, explain who participates in the development of a VA DOD Clinical Practice Guideline, determine key recommendations from the VA DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder. Three, identify first line PTSD treatment recommendations and four, examine clinical support tools that align with the clinical practice guidelines that are available for providers, patients, and family members.

Mrs. Devlin, a retired lieutenant colonel from the Army Nurse Corps is the chief of Evidence-Based Practice at the US Army Medical Command in Fort Sam, Houston Texas. She is a board-certified family nurse practitioner and a primary care provider for the DOD. She received her bachelor's and master's of science and nursing degrees from Georgia Southern University and is a member of various prestigious organizations. Mrs. Devlin was commissioned with the rank of second lieutenant in 1988. Deployed with the Second Mobile Army Surgical Hospital in support of Operation Desert Storm and Desert Shield and to Tikrit, Iraq Contingency Operating Base Spiker as the Chief of Clinical Services with the 21st Combat Support Hospital in support of Operation Iraqi Freedom from January to July 2010.

Dr. David Riggs is a clinical and research psychologist. He is a professor and chair of the Department of Medical and Clinical Psychology in the Herbert School of Medicine at the Uniform Services University of Health Sciences in Bethesda, Maryland. He is a training lead for active duty psychologist and civilian clinical psychologist to ensure delivery of outstanding patient care. Dr. Riggs also serves as executive director of the Center for Deployment Psychology where he oversees the development and delivery of training seminars for behavioral health professionals to prepare them to provide for the needs of warriors and their families. Dr. Riggs earned his doctorate degree at the State University of New York at Stonybrook and completed a clinical psychology internship at the Medical University of South Carolina.

Dr. Schnurr is the executive director of the National Center for Posttraumatic Stress Disorder and previously served as deputy executive director of the center in 1989. She is a research professor of psychiatry in the Geisel School of Medicine at Dartmouth and editor of the Clinician's Trauma Update online. She has investigated risk and resilience factors associated with the long-term physical and mental health outcomes of exposure to traumatic events. She is an expert on psychotherapy research and has conducted several clinical trials of PTSD treatment. Dr. Schnurr received her doctorate in experimental psychology at Dartmouth College and completed her postdoctoral fellowship in the department of psychiatry at the Geisel School of Medicine at Dartmouth.

Please join me in welcoming our speakers today.

Ms. Devlin: Good afternoon. This is Corrine Devlin. Myself, Dr. Schnurr, and Dr. Riggs have no relevant financial relationships to disclose relating to the content of this activity. Furthermore, the views expressed in our presentation are those of the authors and do not necessarily reflect the official policy or position of the Department of Defense nor the United States government. This continuing education activity is managed and accredited by Professional Education Services Group in collaboration with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. PESG, DCoE, as well as all accrediting organizations do not support or endorse any product or service mentioned in this activity. PESG, DCoE staff, activity planners and reviewers have no relevant financial or non-financial interest to disclose. Commercial support was not received for this activity. Support for the work described in presentation has been provided by [inaudible 00:09:06] at the US Army Medical Research and Material Command Award and the Center for Neuroscience and Regenerative Medicine. Selected technology described in this presentation is included in US Patent Application #14773987, European Patent Application and the International Patent Application.

We have a polling question for our attendees during this afternoon's webinar. If I could give you all just a few seconds to fill in some of the comments, I will be happy to see who our audience is. I'm going to give you a few more seconds and then we'll go ahead and proceed. Okay. It appears as if many of our participants are social workers. We have some psychologists and some pharmacists as well as a few case managers and counselors as well.

Okay, our next slide we're going to discuss the agenda, which will be the scope of the problem. We're going to provide an update of complex clinical practice guidelines, the guideline working group and project team, the goals of our guideline, the scope of our guideline, our evidence-based clinical practice guideline development process, grading recommendations using the GRADE process, updating and categorizing recommendations, our evidence-based clinical practice recommendations, our algorithm, and then to conclude our discussion.

Our scope of the problem, for the US general population, the wave of three national epidemiologic surveys on alcohol and related conditions studied found a lifetime PTSD prevalence of 6.1% and current prevalence of 4.7% in accordance with Goldstein, et al. For our military personnel, a meta analysis of studies of Operations Enduring Freedom, OIF, Operation Iraqi Freedom reported current PTSD prevalence of 5.5% overall and a 13.2% among operational infantry units. During FY 2015, 2.2% of active duty population were estimated to meet the criteria for PTSD based on administrative medical data of DOD, Direct Care System.

For our veterans, in a recent survey of a nationally representative sample of US veterans, lifetime PTSD prevalence was 8% and current PTSD prevalence was 5%. According to the VA Administrative office, 10.6% of VA healthcare users in FY 16 had PTSD. Among OIS and OES users in 2015, 26.7% had PTSD.

When we talk about the update of our Complex Clinical Practice Guideline, the 2010 CPG was outdated. It included nearly 213 recommendations mainly based on expert opinion only. We updated the Guideline with evidence published from January 2009 to March 2016. The Guideline was updated to evaluate the new evidence and establish evidence-based recommendations in the following key areas: Psychotherapy, pharmacology, and biological treatment for PTSD, efficacy of combined or augmented treatment approaches, complimentary and integrative treatments, group and peer treatment approaches, treatments for acute stress disorder, and technological-based care modalities.

The following several slides will share our Guideline work group members with you. I just would like to give you a few minutes to review the work group members and then we'll move on to ... I guess since this is recorded, I should read this to you. Let me read these to you. For our Department of Veterans Affairs, we have Nancy Bernardy with PhD champion, Dr. Matt Friedman, of course one of our speakers Paula Schnurr, Kathleen Chard, Lori Davis, Bradford Felker, Jessica Hamblen, Matthew Jeffreys, Sonya Norman, MaryJo Pugh, Sheila Rauch, Todd Semla.

For our Department of Defense our co-champions were Dr. Charles Hoge and our speaker today, Dr. David S. Riggs. We also had Megan Ehret, Major Joel T. Foster, Colonel Sean Kane, Kate McGraw, Commander Jeffrey Millegan, Ms. Elaine P. Stuffel, Colonel Lisa A. Teegarden, Commander Meena Vythilingam, Colonel Wendi M. Waits, and Dr. Jonathan Wolf.

Our project team for the VA was led by Dr. Eric Rodgers, Dr. James Sall, and Ms. Renee Sutton. Our Lewin Group, which was the facilitators for the Guideline was led by Dr. Clifford Goodman, Christine Jones, Erin Gardner, and Anjali Jain, complemented by Sigma Health Consulting, Dr. Fran Murphy. For Office of Evidence-Based Practice for the Department of Defense, Headquarters United States Army Medical Command, myself, Corrine Devlin, Elaine Stuffel, and from the ECRI Institute we had Dr. James Reston, Amy Tsou, Rebecca Rishar, Jeff

Oristaglio, Savvas Pavlides. For Duty First Consulting, Anita Ramanathan and Megan McGovern.

Ms. Devlin: The goals of our Guideline were to enhance the assessment of the patient's condition and determine the best treatment method in collaboration with the patient and, when possible and desired, the patient's family and caregivers. We want to optimize the patient's health outcome and improve quality of life, minimize preventable complications and morbidity, and emphasize the use of patient-centered care.

The scope of our Guideline in terms of population included men and women aged 18 years and older with posttraumatic stress disorder and related conditions such as acute stress disorder. We excluded children and adolescents. Our interventions were based on pharmacotherapy, trauma focused and non-trauma focused psychotherapy, non-pharmacologic biologic treatments, complimentary and integrative treatments, group psychotherapy, collaborative or integrative care, technology-based modalities, and peer support.

Our Guideline development process adhered to a strict approach to conflicts of interest, multi-disciplinary development teams, identification of key questions, evidence review for key questions, groups reviewing the evidence and applying the grading system, development of the recommendations and treatment algorithms, review from trained external and internal subject matter experts. Then our final CPG review were approved by the VA, DOD, Evidence-Based Practice Working Group.

The Guideline development process consisted of 24 subject matter experts from the VA and the DOD. We selected our topic, developed our key questions, reviewed the evidence, had in-person workshop. We drafted the products, had a second person workshop, and we had our final product. Of note, the draft product was reviewed on three separate occasions. We also note that our draft process was an iterative process and also included a peer review.

Our VA DOD Clinical Practice Guidelines are routinely updated every three to five years. We have immediate updates. We include any recommendations identified as harmful. We have pharmaceutical recall black boxes and a device recall. I will be followed by Dr. Paula Schnurr.

Dr. Schnurr: Thank you, Corinne. I'd like to thank everybody on the phone for making the time today to hear about the new Guideline. We're very excited about it because it represents, in my view, a significant improvement reflective of the profits for both of our agencies. VA and DOD now have switched along with many of the guideline producing groups around the world to ensuring that practice guidelines are based on evidence. The prior Guideline 2010 had a lot of additional clinical wisdom based on consensus and in this process, we have reduced the number of recommendations from over 200 to 40. I think most of the guidelines have seen a similar reduction. We've included content to address issues of clinical judgment, I'll be mentioning that throughout.

But I think one of the important things to understand about this guideline and other guidelines for VA and DOD that have been produced since this change is that they are strictly evidence based. We are using what virtually all other guideline developers are using as a system for evaluating the evidence and making recommendations, it's called GRADE. Essentially, there are three components to the GRADE methodology, assigning strength of the recommendations, strong or weak, direction for or against, and then the use of some decision domains, there are four them to temper comments about strength and direction and I'll say more about that in a bit.

The strength of a recommendation is on a continuum of strong for to strong against. If the recommendation is strong for, we use language we recommendation and if it's weak for, we suggest. Weak against, we suggest not. Strong against, recommend against. It's important to understand that the use of recommendation and suggest are not just ways to mix up our verbs but rather to clarify how strong the evidence is for or against something.

Recommendations may be conditional based on patient value and preferences, resources available, or the setting in which the intervention will be implemented. We spent a lot of time discussing the relative differences between VA and DOD. I would euphemistically say those discussions at times were lively because we do have some big cultural differences even though I think we're united in a common mission. We have tried and I think we have succeeded in trying to write a guideline that reflects the evidence while also taking into account the unique needs, culture, and resources of our organization.

Also, recommendations may be at the discretion of the patient and clinician. I have to emphasize that a guideline is a guideline, it is not a mandate and clinical judgment and patient preference have to be present in all aspects of the implementation of this or any guideline. Recommendations also may be qualified with an explanation about the issues that would lead decisions to vary and you'll be seeing that in some of the recommendations.

The decision domains, I mentioned there were four of them. Number one is the balance of desirable and undesirable outcomes. Confidence in the quality of the evidence, values and preferences, and then other implications such as subgroup considerations, acceptability, feasibility. These are some of the factors that came into play when we were thinking about VA and DOD, equity and then resource use. Let me just go back there and say, this is standardized. This is not unique to VA and DOD. This is GRADE, it's not unique to PTSD or mental health guidelines. These are criteria used across all guidelines.

I can't emphasize enough how much we discussed the issue of patient preference. We tried to reflect this along with issues about safety and education in the guideline, the background, the recommendations, and the tendencies. Patient-centered care and shared decision making are described in the background and referenced throughout the documents to emphasize their use.

They are the foundation on which this guideline fits. Then the recommendations were made taking into consideration all four of the GRADE domain.

There are five basic components of the guideline. General clinical management, diagnosis and assessment of PTSD, prevention of PTSD, treatment of PTSD, and treatment of PTSD with co-occurring conditions. This presentation is focusing on treatment of PTSD by itself and then with co-occurring conditions. We will reference as needed the issues of clinical management, assessment, and prevention. We also can take questions about any of those topics later on in the Q&A period. Now I'm going to turn things over to Dave Riggs to present the first section on general clinical management.

Dr. Riggs: Thank you, Paula, I will just add my appreciation to those who are in attendance. Along with Paula, I think this version of the guidelines provides a significant move forward for us with the emphasis on an evidence basis for the decisions that were made. As Dr. Schnurr said, the issue of patient involvement in decision making about their treatment was very much front and center of the discussions that we were having and that is reflective in the guidelines recommendations about general clinical management.

The very first recommendation that's made is that patients be engaged in the decision making process, which includes educating the patients about effective treatment options that would be available. Just to point out some of what Paula was describing in terms of the language of the recommendation, in the second column, you see that is a strong for recommendation. The language, the wording of the recommendation itself says, we recommendation engaging. That is just in contrast to the next recommendation, which is a weak for recommendation and you'll see the language reflects that. That is for patients with PTSD who are treated in primary care, we suggest collaborative care interventions that facilitate the engagement of those patients with evidence-based treatments. The recommendation is there to encourage clinicians in that direction but the strength of evidence or other considerations was such that it weakened the recommendation from a strong recommendation to a weak one but still in favor of it.

The next set of recommendations relate to the diagnosis and assessment of PTSD. It's suggested that there's periodic screening for PTSD using validated measures such as the PTSD screen or the PTSD checklist. For those with suspected PTSD, we recommend that is we strongly suggest or strongly indicate the use of appropriate diagnostic evaluation tools including assessment for risk to oneself or to others, functional status, medical history, family history, treatment history, and so on. This recommendation reflects the recognition that PTSD is often a piece of the puzzle confronting these patients often accompanied by additional problems, some of which may be diagnosable and some of which may not be about a diagnosis but may be about functional impairment.

Number five, for patients with a diagnosis of PTSD, we suggest using a quantitative self-report measure of PTSD such as the PTSD checklist. In both the initial treatment planning with the patient and the monitored treatment progress on an ongoing basis.

The next set of recommendations relate to early intervention or prevention efforts with folks who have been exposed to trauma. Though for the selective prevention of PTSD, that is in terms of an intervention that might be offered to everyone who is exposed to a traumatic event, there's insufficient evidence to recommend the use of either trauma-focused therapy or pharmacotherapy in the immediate post trauma period. That is, looking at the group of individuals who are exposed to trauma. There are not sufficient data to support the use of broadly-based intervention to try and prevent PTSD.

In contrast, recommendation seven focuses on preventative or treatment efforts that can be targeted towards those people who have been through a trauma and developed acute stress disorder. For the indicated prevention of PTSD for those patients who do have acute stress disorder, we recommendation an individual trauma-focused psychotherapy that includes a primary component of exposure and/or cognitive restructuring. If you have patients who are diagnosed with acute stress disorder, in order to reduce the likelihood that they convert to chronic PTSD, we recommend intervention but not for everybody who has been exposed to trauma.

For the indicated prevention of PTSD in patients with acute stress disorder, there is insufficient evidence to date to recommend the use of pharmacotherapy. There are not sufficient data to support the use of pharmacological interventions for people who have acute stress disorder in order to prevent transition to PTSD.

In terms of treating chronic PTSD, recommendation nine actually relates to the relative order in which treatments are recommended. Beyond that, I'll be talking about psychotherapy interventions and then hand it back to Dr. Schnurr to talk about specific pharmacotherapy interventions. With regard to treating individuals who have been diagnosed with PTSD, it's recommended that individual manualized trauma-focused therapies, which will be detailed later, be used over pharmacologic or other non-pharmacologic interventions for the primary treatment of PTSD. That is, if you have someone who is diagnosed with PTSD, the recommendation is as a first line of treatment if possible to use individual manualized trauma-focused psychotherapies.

Recognizing that that won't be available to everybody in every setting, recommendation 10 deals with what happens when that's not possible. When individual trauma-focused psychotherapy is either not available or not preferred by the patient, then we recommend pharmacotherapy, and the details of that will come later as well, or individual non-trauma-focused psychotherapy, which will also be detailed later. With respect to pharmacotherapy and non-trauma-

focused psychotherapy, there is insufficient evidence at this point to recommend one over the other.

Dr. Riggs: If you have a patient who is declining trauma-focused psychotherapy, you have a couple of directions to go. Pharmacological agents that can treat PTSD or non-trauma-focused psychotherapy that can help alleviate some of the symptoms of PTSD. In choosing whether to move in the direction of the pharmacological agent or the non-trauma-focused psychotherapy, the data to date are not sufficient to recommend one over the other.

Specifically for psychotherapy now, for patients with PTSD, it is recommended that individual manualized trauma-focused psychotherapy with a primary component that incorporates exposure and/or cognitive restructuring be used as the first line of treatment. Those treatments include ones that are fairly familiar to people who have read the 2010 guidelines because prolonged exposure, cognitive processing therapy, and eye movement desensitization and reprocessing were all included as level A treatments in the 2010 guidelines.

There are several other treatments that are trauma-focused and have evidence that they function effectively to reduce PTSD. They are included in this list as well including [inaudible 00:33:27] psychotherapy, narrative exposure therapy, and written narrative exposure. The individual trauma-focused psychotherapies are all included as a recommend strong for.

As a suggestion, a weak positive indication, we suggest the following the individual manualized non-trauma-focused psychotherapies for patients diagnosed with PTSD and remembering recommendation number 10, this is contingent on either not people able to provide the trauma-focused therapy or having a patient who has declined the trauma-focused therapy. The non-trauma-focused therapies that are included and identified are stress inoculation training, present centered therapy, and interpersonal therapy. In this case, in terms of a change from the 2010 guidelines, stress inoculation was included in the A level recommendations in the 2010 and it's now in the weak for as opposed to the strong for list.

There are a number of therapies that have either been suggested in the literature or attempted or clinical experience has suggested that these might useful. We found that there was insufficient evidence to recommend for or against psychotherapies that were not listed in the above recommendations. These include treatments may gain evidence that they're useful, but at this point don't have such evidence. In terms of examples, we identified several that have been in the recent literature with either some indication or people arguing for using them. That includes dialectical behavior therapy, stills training, in effect an interpersonal regulation, acceptance and commitment therapy, seeking safety, and supportive counseling. The literature at this point, the data-based literature does not support using these at this point.

Similarly, there is insufficient evidence for or against using individual components of manualized psychotherapy protocols over or in addition to the full therapy protocol. In essence, this is saying the treatments that have been identified in recommendation number 11 as being effective for treating PTSD have been found effective when they're delivered as the full package, that is the full protocol. Selecting bits and pieces out of those protocols has not been shown to be effective, nor has been shown in any consistent way to be effective to augment the treatment protocols, the standard protocols by adding things to them.

Recommendation 15, we suggest as a weak positive, manualized group therapy over no treatment at all. However, there's not sufficient evidence at this point to recommend using one type of group therapy over any type of group therapy. In this case, we were able to identify data that supported the use of group therapy over nothing at all but no particular type of group therapy or no particular set of particular techniques showed to be more effective than any other.

Recommendation 16, there's insufficient evidence at this point to recommend for against trauma-focused or non-trauma-focused couples therapy for the primary treatment of PTSD. Just to make a point about a number of these things, earlier I highlighted that during the assessment phase we want to acknowledge that there are many things that go on and can create problems for people who have PTSD. Just to take this as an example, it may be that the patient with PTSD is struggling with relationship issues and may benefit from having couples counseling to address those relationship issues, but at this point there's insufficient evidence to suggest that that treatment, which might be very beneficial and particularly beneficial about improving the relationship, will do anything to alleviate the PTSD symptoms.

I'm going to stop there and hand it back to Dr. Schnurr to discuss the pharmacological treatments that were looked at.

Dr. Schnurr: Thanks, Dr. Riggs. If I recall the polling question, at least at that point when we did the poll, most of the people online were unlikely to be prescribers. If that's so, I think the issue of medication is probably still quite relevant because if your patients are anything like our VA patients, many people who are engaging in psychotherapy are also on medication. The medication recommendations are broken into first select medications as monotherapy and then medications for augmentation. There's a specific section on prazosin and then issues of combination.

Starting out with recommendation 17, we recommend sertraline, paroxetine, duloxetine, or venlafaxine as monotherapy for PTSD and this is for patients who have PTSD and choose not to engage in or are not able to access trauma-focused psychotherapy. Those are the four treatments with the best evidence, the recommendation is strong for. There are three additional treatments for which the evidence is weak for that we suggest. They are nefazodone,

imipramine, and phenelzine and they are recommended if the frontline pharmacotherapies that I just mentioned or trauma-focused psychotherapy or non-trauma-focused psychotherapy are ineffective, unavailable, or not preferred by a patient. It's important to note that nefazodone and phenelzine have potentially serious toxicities and need careful clinical management.

Those are essentially the medications that we are either recommending or suggesting. We suggest against treatment with quetiapine, olanzapine, and other atypical anti-psychotics excluding risperidone, which we actually recommend against as well as citalopram and amitriptyline, lamotrigine, topiramate. The reason is either lack of strong evidence and/or known adverse effect profiles or associated risk.

The evidence is stronger against and so we recommend against treating PTSD with divalproex, tiagabine, guanfacine, risperidone, benzodiazepines, ketamine, hydrocortisone, D-cycloserine and again the issue is the lack of evidence or the evidence for the risks and harms associated with these medications. We also make a specific recommendation against treating PTSD with cannabis or cannabis derivatives due to lack of evidence or efficacy, known adverse effects, and associated risks.

Lastly, in terms of monotherapy, there's insufficient evidence for a lot of medications, so we couldn't make a recommendation for or against eszopiclone, escitalopram, bupropion, desipramine, doxepin, D-serine, duloxetine, desvenlafaxine, fluvoxamine. I have trouble pronouncing the next drug, levomilnacipran. I'm sorry to say I never get through that. Mirtazapine, nortriptyline, trazodone, vilazodone, vortioxetine, buspirone, hydroxyzine, cyproheptadine, zaleplon, and zolpidem. Note that this began with two sleeping medications that [inaudible 00:42:37] patients are used which is eszopiclone and zolpidem. The evidence on this medications even though they are widely used is insufficient. That's the story for monotherapy.

In terms of augmentation therapy, which is widely used in PTSD populations, there are no medications that we can recommend or suggest for augmentation. All we can say is that we either suggest against, recommend against, or the evidence is insufficient. We suggest against the use of topiramate, baclofen, pregabalin as augmentation. Again, it's the issue of data, demonstrated benefit, or known adverse events and other risks.

We suggest against combining exposure therapy with D-cycloserine in treating PTSD outside of the research setting. The evidence on this has been mixed with some evidence suggesting no benefit, some evidence suggesting benefit, but one study suggesting harm. It appeared to us that more evidence is needed as to whether there is a benefit and then how to dose and treat patients with this combination in a way that maximizes benefit.

We recommend against using atypical anti-psychotics, benzodiazepines, and divalproex as augmentation. There is some evidence but it's low quality or

there's no studies and then the association with known adverse effects. There is insufficient evidence to recommend the combination of exposure therapy with hydrocortisone outside of the research of the research setting. There's insufficient evidence to recommend for or against the use of mirtazapine in combination with sertraline for treating PTSD. There was one study that was not enough to make a recommendation one way or the other.

Dr. Schnurr: I mentioned earlier prazosin and in VA and in my understanding in DOD, prazosin is widely used both as a primary treatment for PTSD and for nightmares and associated sleep problems. I have to assure you that we thought a lot about this before making the following recommendation. I have to say that even before I present this that if you have patients who are on prazosin and are doing well, we are not recommending that you take them off, but we're offering these suggestions in the guideline based on the most current evidence. For global symptoms of PTSD, we suggest against the use of prazosin as mono or augmentation therapy. The trials generally have not shown direct benefit for PTSD and there is a large VA cooperative study that is in prep showing no benefit for PTSD or clinically global impression.

For nightmares, the evidence is perhaps a bit better from the small trials. We judged this evidence insufficient because the large VA cooperative study found no benefit of prazosin for nightmares. Again, I want to emphasize because we've heard from plenty of people about this already, that we're not recommending that you take people off but we're recommending that you consider this before starting a course of prazosin.

In terms of combination therapy in partial or non-responders to psychotherapy, there is insufficient evidence to recommend for or against augmenting with pharmacotherapy. Conversely, in partial or non-responders to pharmacotherapy, there is insufficient evidence to recommend for or against augmentation with psychotherapy. There is also insufficient evidence to recommend for or against starting patients with PTSD on a combination of pharmacotherapy and psychotherapy. That's a very important research gap in my view and it is a common practice but there's no evidence to support doing it or which therapies should be combined with which medication.

I want to move to non-pharmacologic biological treatments, which are also widely used in some sectors and there's really insufficient evidence for any of these treatments. These include repetitive transcranial magnetic stimulation, this is RTMS as well as proprietary types of TMS such as MER, personalized TMS, or synchronized TMS. Electroconvulsive therapy, hyperbaric oxygen therapy, stellate ganglion blocks, or vagal nerve stimulation, there is either no evidence or no good evidence to suggest using these for PTSD patients.

Now I want to move on to complementary and integrative treatments. There's insufficient evidence, even though it's used in VA and I understand also in DOD, there's insufficient evidence to recommend acupuncture as a primary treatment for PTSD. There's also insufficient evidence to recommend any complimentary

and integrative health practice such as meditation including mindfulness, yoga, and mantra meditation as a primary treatment for PTSD. I'll emphasize for both of these that it is possible that you have patients who are using these modalities for secondary symptoms. Some of that evidence isn't there either. We didn't review it for this guideline although I've looked at it in other contexts. However, if patients are managing well on these interventions, I think there's no reason to take them off. Again, we would ask you to consider this before starting a patient on a course of these treatments as a primary treatment.

Now, moving onto technology. We suggest internet-based cognitive behavioral therapy, ICBT with some kind of feedback or facilitation by a therapist or peer, a qualified facilitator as an alternative to no treatment. These treatments aren't as potent, it appears, as full on psychotherapy but if this is a preference or a resource issue, the way to deliver internet-based cognitive behavioral therapy is using some kind of facilitation and the evidence is weak for that at the present time.

The evidence is strong for using telehealth, video teleconferencing to deliver trauma-focused psychotherapies that have demonstrated efficacy using this modality if PTSD treatment is delivered via video teleconferencing. For this recommendation, we did discuss the fact that by necessity or preference many other interventions are also delivered by video teleconferencing. We felt here given the lack of evidence on whether those interventions worked similarly by video that it was not possible to make a recommendation but if you read the guideline, you will find text indicating the recognition of this as some guidance around the use of video teleconferencing for therapies that have not been tested in that modality.

Now, treatment of PTSD with co-occurring conditions. We recommend that the presence of co-occurring disorders not prevent patients from receiving VA/DOD guideline recommended treatments for PTSD. We were not able to find any evidence that would prevent a patient with any variety of comorbidities from participating in or benefiting from any of the treatments that are recommended or suggested here. Sometimes comorbidities are associated with higher overall severity and so, such individuals may start more severe and end more severe but the treatments are effective and they are not dangerous regardless of comorbidity and that's a strong for.

Also strong for is recommendation that VA/DOD guideline recommended treatments be delivered in the presence of co-occurring substance use disorder. Substance use disorder does not prevent patients from benefiting from or participating in the treatments that we recommend.

With respect to sleep, which is a very significant issue in this population, we recommend an independent assessment of co-occurring sleep disturbance in patients with PTSD, particularly when the sleep problems predate PTSD onset or they remain following successful completion of a course of treatment. For treating sleep problems, also a strong for, we recommend cognitive behavioral

therapy for insomnia in patients with PTSD unless there is an underlying medical or environmental condition that should be addressed or there is severe sleep deprivation warranting the immediate use of medication to prevent harm.

Now, I will turn things back to Dr. Riggs to walk you through the algorithms for implementing the guideline.

Dr. Riggs: Thank you. There are actually a set of three algorithms that are included with the guidelines, flowcharts effectively for what to do when faced with someone who has been exposed to a trauma and potentially requires treatment. There are references module A, B, and C. Module A focuses on acute reactions, acute stress disorder or acute stress reaction. Module B on the diagnosis and assessment of posttraumatic stress disorder and module C on the management or treatment of PTSD.

What's on the screen now that if it's like my screen, nobody can read at all, is the algorithm for acute stress reaction or acute stress disorder. The next two slides take this single algorithm, this single flowchart and break it into two pieces so that it's more legible. I'm going to go ahead and flip ahead and this is the top part of the chart that was shown on the previous slide. The first question, the first box, simply asks was the person exposed to trauma? If the person was exposed to a trauma, one needs to ask did that trauma occur in the previous 30 days or longer ago than that. If the trauma did not occur in the previous 30 days, the person cannot meet the criteria for acute stress disorder or acute stress reaction. That gives them a no, that checks you out to the right there and it says go to module B. Module B will be focused on diagnosis and assessment of PTSD. We'll get to that in a moment.

If the person has been exposed to a trauma in the prior 30 days, the first step that's recommended is to assess briefly based on general appearance and behavior kind of how they're doing. Over to the right here, you see sidebar number one, which identifies several areas in which you may wish to evaluate a patient, just in terms of their current status.

As a result of that assessment, one wants to ask, is this person stable or not? That is, are they at risk of suicide or dangerous to other people? Are they in need of urgent medical or surgical attention remembering that this trauma could have occurred moments ago. If that person is unstable or in need of immediate care, then that checks out to the right again and immediately you want to provide the appropriate care to stabilize or treat those injuries that have occurred. If there are legal issues involved, if there's an issue of dangerousness or otherwise, obviously you want to follow those as well.

If the person is deemed stable following this trauma or at the point that you see them, you would proceed vertically through the no option to then assess for ongoing environmental threats of potential harm. You'll see you get back to that same box once the person is then stabilized. If you deem the person unstable and treat them, then you still want to come back and assess the environment

for ongoing needs or threats. Here we offer again another sidebar, the sorts of things that are often discussed in terms of psychological first-aid that may be required as well. That gets us not even to the point where we're talking about acute stress disorder but just stabilizing the individual, making sure that they're safe and that the environment is as safe as we can make it.

Box number six, which is at the bottom of the slide that's up currently, appears at the top of the next slide and that's our continuation slide. You see again, assess the environment for ongoing stress, that's number six. The next question we're going to ask is whether the individual meets criteria for a diagnosis of acute stress disorder. You'll see in that box it references sidebar four, which is the next slide and I'll get to momentarily. The next slide in sidebar four is basically the diagnosis criteria for acute stress disorder. If the person does not meet criteria for acute stress disorder, you follow the no option out of that box.

You get to box number 14 directly below the ASD diagnosis box and that suggests that one consider either an acute stress reaction identifier or a combat and operational stress reaction identifier. Although the treatment guidelines themselves don't speak directly to the interventions available for either acute stress reaction or a combat operational stress reaction, there are things written that offer suggestions and those again, are offered in this case in sidebar three although you may also be referencing back to sidebar two for interventions that could be done for people in the very immediate aftermath of a stress traumatic situation to help them stabilize.

Going back to box number seven, if in fact you determine that the person does meet criteria for acute stress disorder, then you'll proceed to box number eight, which is to assess their medical and functional status as well as preexisting conditions, both psychiatric and medical and risk factors for developing PTSD. At that point, one can consider initiating acute interventions. Again, as indicated in sidebar three. Note in sidebar three, the fourth kind of bullet point down there, for people who have acute stress disorder, and this harkens back to a recommendation that I went over earlier, brief sessions of individual manualized treatment trauma-focused psychotherapy that have a primary component of exposure and/or cognitive restructuring has been shown, remember, to reduce the risk of somebody who has acute stress disorder converting into posttraumatic stress disorder.

If you've diagnosed them with acute stress disorder, when you get to box number nine and consider initiating treatment for those people who have acute stress disorder, the recommendation would e to initiate individual psychotherapy with a trauma focus if possible.

Continuing on, you need to reassess symptoms and functioning on an ongoing basis and ideally you're going to do that probably around the one month point, may just shortly after that. One month is the requirement for symptom presence. The symptoms need to persist before you can diagnose somebody with PTSD, they need to persist for a month. At that point, you want to identify

those people who have had persistent or worsening symptoms who have significant functional impairment at that point when you reassess them appear to be at risk for developing PTSD. If you've identified them that way, you flip over to the right to box number 12 where you continue management but also proceed onto module B, the assessment and diagnosis of PTSD. If somebody has had a trauma, the symptoms have persisted for a month, we want to flip over to diagnosing them with PTSD or at least assessing them for that.

Dr. Riggs: If at the one month point, their symptoms have largely alleviated or their functional impairment seems to have decreased substantially, you may still want to monitor and follow up with the individual to ensure that things don't develop in a more problematic way over time. That is really going to depend on the situation for that particular patient.

As I mentioned, sidebar four is the diagnostic criteria for a acute stress disorder. I'm not going to go through those but I find I still, even several years after its publication, I need to remind people that the diagnostic criteria for acute stress disorder did change with the publication of DSM-5. Older folks like myself who remembered DSMs that had roman numerals need to remind ourselves that the symptom picture has changed a little bit.

Module B is the flowchart or the algorithm for the assessment and diagnosis of PTSD. Again, the full algorithm on these slides is going to be difficult to read so this algorithm, this flowchart will be replicated across two slides again in much the same way as just done with acute stress. I'm going to skip over this one and focus on the top half of the algorithm remembering that these are individuals ... You've gotten to module B, the second algorithm in one of three ways. Either you've identified somebody who went through a trauma who has not been previously assessed or diagnosed with PTSD but it's been more 30 days since the trauma or you identified a person who was struggling with acute symptoms. You got to the 30-day point and their symptoms have persisted to that point and so the diagnosis is going to shift from acute stress to posttraumatic stress. Or this is a person who is coming in to see you who is either presenting with symptoms or has been previously diagnosed with PTSD and this is where you would enter into the algorithm to assess the PTSD.

Box number two emphasizes the need for a clinical assessment broadly, not simply focused on the PTSD symptoms but looking across functional domains, identifying history, current medication use, current challenges, so a broad-based clinical assessment. You then reach a choice point where you're asked, is the patient at imminent risk of danger to self or others or medically unstable. Again, if the answer is yes to that, the clinically responsible thing is to provide the appropriate care for whatever risk you've identified or if that requires hospitalization for safety or whatever it might be.

If the patient is stable, that is the answer to the danger question is no, then the question becomes do they meet DSM criteria for a diagnosis of PTSD? Those diagnostic criteria are included in sidebar six, which follows two slides hence,

but again, you're really asking at that point after the clinical assessment has been completed, does this person reach criteria for posttraumatic stress disorder?

Moving on to the bottom part of this algorithm, box number five was the last one we talked about, which was do they meet DSM criteria for PTSD? If the answer is no, the appropriate thing to do is either follow up or refer for appropriate treatment depending on what's been determined through the assessment that was completed. If they do meet criteria for PTSD, then it's recommended that when assessed for the existence and severity of co-occurring disorders, PTSD is notorious for occurring with other things going on as well, evaluate the severity of the PTSD symptoms and understand something about where this patient is with regard to their ongoing care, if there is ongoing care or where they perhaps should be in terms of team-based care or integrated care. Oftentimes, patients will be receiving care from multiple sources and that's not always explored or understood. Sometimes those treatments can work at cross purposes if they're not coordinated. You want to know what you can about where they are in treatment, whether they've been treated previously, are they still in treatment, and so on.

Moving on to box number seven, this is the point at which we want to work with the patient to discuss treatment options, the pros and cons of different treatments, what's available at this particular care location. Are there other care locations that might offer something different? What would the transition to that other care facility look like? Working with the patient, reach a shared decision regarding directions forward both in terms of goals and expectations but also an initial treatment plan.

If the patient agrees that PTSD treatment is the direction to go or should be a part of what's going to happen in terms of his or her care, you'll proceed on to module C in terms of the algorithm. If the patient says, "No, PTSD is not my biggest problem" or "I don't like any of the treatment options that you've just offered me" then you may need to refer for alternate care, care focused on different parts of the picture that the patient is dealing with. Sometimes quite honestly, you may end up just having to follow up with this person in the future because they may not be entering into care anyplace even though that might be what we think would be most helpful for them.

These are the diagnostic criteria for posttraumatic stress disorder. Again, reiterate that DSM-5 changed things around a little bit but I'm not going to go through each of the diagnostic criteria for the sake of time. If the patient in working with you or with whomever they've been discussing this with reached the conclusion that treatment for PTSD is the direction to go, the diagnosis confirms PTSD, and they say, "Okay, I want to get treated for it," that starts on in module C of the algorithm.

The first step is to initiate a treatment plan using effective interventions for PTSD. These are the recommended interventions that were mentioned earlier.

They're located here in sidebar seven with references back to the specific recommendation that's touched on. You'll see that first individual manualized trauma-focused psychotherapy. Second, if individual trauma-focused therapy is not available or not preferred, then it references the pharmacotherapy and non-trauma-focused psychotherapies. If neither of those is feasible or if they've been tried and haven't produced change, obviously other therapies or other medications can be tried at that point.

Dr. Riggs: You also want to think about and identify additional treatment or support needs. That might be treatment of co-occurring disorders, it might be counseling around particular functional areas, it might be specific treatments, treating pain or sleep for example, in order to facilitate the treatment of the PTSD.

We recommend that you reassess PTSD symptoms and diagnostic status as well as functional and quality of life issues in an ongoing way as you're going through treatment as well as returning to the question of patient preferences and ensuring that the choice to continue with treatment is informed by how treatment is going for the individual as well as what we know from the research. The question we're asking all along is, is the patient improving? If the patient is improving, the question is, have they improved enough?

If you say the patient is improving, you give a yes, then you kick out to box number five and say, okay, is the patient all better? I will tell you this, there were long discussions when we got to this point about how one defines better or remission or full remission and we finally settled on using the term full remission because the goal here really is treating to the point that the symptoms are not creating problems. They will still remember the trauma, it's not like they're going to forget it but they're not having symptoms that interfere with their functioning.

If the patient has demonstrated that they've gotten better, that's a yes and that kicks us out and says, hey, discontinue treatment because it turns out discontinuing treatment is useful for folks and moving on beyond the treatment they're getting is where we want them to be. Obviously, as you do that, you want to separate in a positive way with them and talk about indications for why they may want to recontact you or contact somebody else about treatment as part of that exit process.

If the patient is not improving or if they have improved but they haven't gotten all the way better, we flip back to box number seven here and it says, address issues that might be interfering with treatment, adherence or side effects, comorbidities, anything that's kind of getting in the way, regardless of what treatment you're using, what might get in the way of that. Are there things that need to be adjusted or modified? Can those modifications be made in a way that's consistent with the therapeutic package that you've got working with this client? Are changes to the treatment plan indicated? Yes. Then you cycle back up to box number two and you begin this process over again. With the

knowledge that you've gained from treating the patient with whatever approach you've taken, what can we do now to modify or adapt or make changes in that treatment to produce greater improvement.

If changes are not indicated in the treatment plan, you also want to make sure you're allowing sufficient time to see the changes that the treatment is intended to make. Often, I find that the patients, because they're in such distress, would like to find an answer that works in a week-and-a-half at the longest. When they come back for session two of psychotherapy and things have not gotten completely better, they sometimes think that it's not working. But psychotherapy and medications are going to take longer than that to actually have the desired impact. You want to make sure that patients are knowledgeable about that, that they're informed about what to expect in terms of treatment gains. If you need to cycle back at that point and check on how they're doing and perhaps modify treatment because enough time has gone along but they're still not getting better, then you're going to cycle back through this decision process again.

I apologize, I did not flip through the slides as I should have, but that's the end of the algorithms. I will pass this back to Corrine and let her finish things up with some of the tools that have been developed.

Ms. Devlin: Thank you, Dave. I appreciate that. We just need to share with you that after we finish the Clinical Practice Guideline in collaboration with the Veterans Health Affairs, the DOD sponsors the toolkit development with DCoE and so they quite honestly did the yeoman's work in terms of updating our family guide to posttraumatic stress disorder, which can be found both on the VA's website as well as the DOD's website. They also recently updated the Patient's Guide to Understanding Posttraumatic Stress Disorder and Acute Stress Disorder. We have these currently located on both of our websites. We're in the process of having hard copies that can be ordered from our DOD QMO website.

The next two guideline tools that were also updated were the Posttraumatic Stress Disorder and Acute Stress Disorder Pocket Guide as well as the Management of Posttraumatic Stress Disorder and Acute Stress Disorder clinical support tools. For those of you who are interested in seeing them, they can be viewed virtually as well as we're in the process of getting them printed through the government printing office. I'll be followed by Dr. Paul Schnurr.

Dr. Schnurr: Thank you. This is the home stretch now. I'd just like to emphasize, you've taken in a lot and I saw in the chat box that people were looking for the guideline and the slides and I do recommend getting ahold of them as reference materials because there is a great deal of information. But here are some key takeaways: For patients with suspected PTSD, we recommend an appropriate diagnostic evaluation that includes a determination of the DSM criteria, acute risk of harm to self or others, functional status, medical history, past treatment history, and relevant family history.

For the indicated prevention of PTSD in patients with acute stress disorder, we recommend an individual trauma-focused psychotherapy that includes a primary component of exposure or cognitive restructuring. For patients with PTSD, we recommend individual manualized trauma-focused psychotherapies that have a primary component of exposure and or cognitive restructuring. We recommend these individual manualized trauma-focused psychotherapies over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD.

But when individual trauma-focused psychotherapy is not readily available or it's not preferred, we recommend pharmacotherapy or individual non-trauma-focused psychotherapy. With respect to pharmacotherapy and non-trauma-focused psychotherapy, there is insufficient evidence to recommend one over the other.

Lastly, for the primary medication, we recommend sertraline, paroxetine, fluoxetine, or venlafaxine as monotherapy for PTSD in patients diagnosed with PTSD who choose not to engage in or are unable to access trauma-focused psychotherapy.

I think I'm scrolling to the end for questions. I see there's already a number of questions in the Q&A section and I guess our moderators will help us get through those question. Thank you.

Dr. O'Reilly: Thank you Mrs. Devlin, Dr. Riggs, and Dr. Schnurr for your helpful presentation. If you have any questions for our presenters, please submit them via the Q&A pod located on the screen. It's now time to answer questions from the audience. If you have not already done so, you may submit questions now via the Q&A pod located on the screen. We will respond to as many questions as time permits but we only have a few minutes left. I see here a number of questions and I'll just kind of start with the first ones that appear. The first question I see is what curriculum do you recommend for trauma-focused groups?

Dr. Riggs: I'm sorry, Holly. Could you repeat that?

Dr. O'Reilly: Of course. The question I see is what curriculum do you recommend for trauma-focused groups?

Dr. Riggs: When we reviewed the literature for the guidelines, there was no indication that any particular curriculum worked any better than other curricula for groups. It is the case that while group therapy seems to be better than no therapy at all, the recommendation is that individual trauma-focused psychotherapy be provided if at all possible. All that being said, there are data that have indicated groups can be helpful and one I particular is cognitive processing therapy as a group. However, the most recent study of group

cognitive processing therapy found it to be not as effective as cognitive processing provided to an individual.

Dr. Schnurr: If I could jump in, this is Paula Schnurr. There is one trial showing that group CPT was better than group present-centered therapy on self-reported PTSD although not on clinician reported. The effect size was really quite a bit smaller for clinician reports. Putting these two bodies of evidence together, it seems it wasn't possible. I guess, Dave, we could say that the evidence is strongest if there had to be a single one, the evidence is strongest for group CPT but it was not enough to push us over the line, especially in light of the study suggesting that individual CPT is better.

Dr. O'Reilly: I also see a question, was art therapy reviewed as a complimentary treatment for PTSD?

Dr. Schnurr: To be sure of that, I would need to flip through the guideline to look at the search term, but it is the kind of intervention that would broadly be captured when looking at complimentary and integrative treatment. For a different reason, I did a bit of a dive into that literature and I don't think there's sufficient information about it in terms of trials that are definitive, either as a primary treatment for PTSD or as an adjunctive treatment for symptoms of PTSD.

Dr. O'Reilly: I have another question, was there any assessment of QEEG neurofeedback?

Dr. Schnurr: We would have considered that if we had found randomized-controlled trials. We had a minimum number of participants, so that we excluded trials. Dave, was it with less than 10 people per arm? But I don't believe there were any trials that were ... I know there were no trials that met the criteria we had and I am not aware of any RCTs that have been performed for PTSD.

Dr. Riggs: I would agree with what you said.

Dr. O'Reilly: I have a question that's rather long, so bear with me. It seems that many patients with an active or recently resolved substance use disorder have a great difficulty with trauma processing. If one's only method of coping has been taken away, how can we ask them to cope during the process of trauma processing? Is there research explaining how or why treating both PTSD and SUD is now recommended?

Dr. Schnurr: The research is reviewed in detail in the guideline and I know anyone who has treated these patients can think of individual patients for whom this was challenging. I would say we were quite convinced when we looked at the literature that led us to make this recommendation, that in fact in the main, patients who have substance use and PTSD can tolerate and benefit from that combination. It used to be thought that you had to stabilize the substance use before you could get into the PTSD treatments but it seems that that has not held up in terms of evidence. In the interest of time, I would say the evidence is

reviewed in greater detail. I also see there's a question about seeking safety and relevant references are provided there. We're also glad to take followup questions from anybody in the audience if the guideline doesn't answer everything.

Dr. Riggs: I would just add to Dr. Schnurr's comments that there are now multiple trials of concurrent treatment of PTSD and substance use using trauma-focused therapies for the PTSD part of that with different types of substance abusers. That is, different substances of choice. There are trials with alcohol dependent folks, there are trials with cocaine dependent folks, there are trials with any and all substances allowed in. The review was fairly convincing that treating these concurrently is better than trying to do them sequential.

Dr. O'Reilly: I think that leads us to nearly the end of the webinar. I'd like to briefly conclude what we've said and then we'll leave the chat open for a few more minutes.

The 2017 CPG is strictly based on the available evidence and the cultural needs of each organization, both the VA and the DOD. We considered seriously the cultural needs of each organization and that's reflected in both the guidelines and the recommendations. It's important to note the emphasis of this guideline on engaging patients and shared decision making including educating patients about effective treatment options. We had several questions about utilization including [inaudible 01:27:25] ratings, alternative and complimentary therapies, as well as co-occurring disorders.

I want to thank everyone again for your attention and your time today for this excellent webinar. After the webinar, please visit dcoe.ces.pesgce.com to complete the online CE evaluation and download or print your CE certificate or certificate of attendance. The online CE evaluation will be open through Thursday, December 28, 2017. Remember, you will be able to download today's presentation next week on the PHCOE website in the education and training section. The chat function will remain open for about 10 more minutes so that you can still continue to network and discuss with other people who attended today's webinar. The next [inaudible 01:28:28] traumatic brain injury webinar titled Traumatic Brain Injury in the Military After Transition to ICD-10 is scheduled for January 11, 2018 from 1:00-2:30 p.m. eastern time. This will be the final psychological health webinar. Going forward. The Psychological Health Center of Excellence will collaborate with the Center for Deployment Psychology to support its monthly webinar series. A schedule of upcoming CDP webinars can be found on their website at deploymentpsych.org/webinars. Thank you again for attending today's webinar. Have a great day.