Learning Objectives

1. Describe common trends in alcohol and drug use amongst civilian and military populations.
2. Identify strategies for screening and assessing civilian and military clients for substance use disorders.
3. Discuss evidence-based treatments for substance use disorders.

Disclaimer

The views expressed are those of the presenters and do not necessarily reflect the opinions of the Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. Government.
Presentation Outline

• New Military, DoD, and VA Guidelines (IOM, 2013)
• Prevalence of Substance Use and Problems
• Active Duty Health-Related Behaviors Survey and Use Among Veterans
• DSM-5 SUD Criteria and Symptoms
• Comorbid Conditions with SUDs and Challenges
• Brief Screening Measures and Interventions to Assess SUDs

Presentation Outline (con’t)

• Obtaining Accurate Self-Reports
• Using a Motivational Interviewing Style and Motivational Strategies
• General Trends in SUD Treatment and Stepped Care: Adapting Treatment to Problem Intensity
• Evidence-Based Treatments for SUDs
• Managing and Preventing Relapses
• Medications to Assist in Treatment of SUDs
• Additional Resources

New Military, DoD and VA Guidelines (IOM, 2013)

IOM 2013 Report: Far Reaching Committee Charge

• Substantial and expansive charge involving several areas and subpopulations
• Collected information from several sources
• Compared all information with best practices and modern standards of care in scientific literature
Committee Offered Many Recommendations for DoD, Service Branches, and TRICARE

- Use of evidence-based practices in SUD care integral to ensuring that individuals receive effective, high-quality care
- Policies of DoD and individual branches should promote evidence-based diagnostic and treatment processes
- Best practices for SUD treatment should include use of agonist and antagonist medications
- DoD should conduct routine screening for unhealthy alcohol use, together with brief alcohol education interventions

Institute of Medicine (2013)

Prevalence of Substance Abuse and Problems

What Substances Are Used?

Same as civilians, but military members seem to gravitate more toward:

- **Alcohol**
  - Legal (used to self-medicate)
- **Marijuana**
  - Most used illicit drug lifetime, past 12 mos., & 30 days
- **Cocaine, other stimulants and synthetic stimulants**
  - Can be used to stay alert

National Institute of Drug Abuse

- **Opiates**
  - Vicodin and OxyContin
  - Becoming more widespread;
  - Used to self-medicate
- **Synthetic Marijuana** (e.g., Spice)
- **Synthetic**
  - Cathinones/Amphetamines (e.g., Bath Salts)

National Institute of Drug Abuse
### General Population Prevalence of Illicit Drug Use: Ages 12+

<table>
<thead>
<tr>
<th></th>
<th>Lifetime</th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit Drugs (not Marijuana)</td>
<td>29.6%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>39.8%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Cocaine (including Crack)</td>
<td>14.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Heroin</td>
<td>1.5%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>14.3%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Inhalants</td>
<td>9.3%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Nonmedical Use of Prescription Drugs</td>
<td>20.3%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>5.8%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Crack</td>
<td>3.5%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

### Active Duty (DoD) and Civilians: Any Illicit Drug Past 30 Days by Age Group

<table>
<thead>
<tr>
<th>Age in years</th>
<th>DOD: Illicit Drug Use + Rx Misuse</th>
<th>DOD: Illicit Drug Use No Rx Misuse</th>
<th>CIV: Illicit Drug Use + Rx Misuse</th>
<th>CIV: Illicit Drug Use No Rx Misuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>14</td>
<td>4</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>25-35</td>
<td>12</td>
<td>10</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>36-45</td>
<td>8</td>
<td>5</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>46-64</td>
<td>7</td>
<td>3</td>
<td>13</td>
<td>6</td>
</tr>
</tbody>
</table>

### Active Duty (DoD) and Civilians: Heavy Alcohol Use in Past 30-Day by Age Group

<table>
<thead>
<tr>
<th>Age in years</th>
<th>Alcohol DoD</th>
<th>Alcohol Civ</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>25-35</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>36-45</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>46-64</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

### Substance Use Among Veterans and Comparable Non-veterans

<table>
<thead>
<tr>
<th>Variable</th>
<th>Veterans</th>
<th>Non-Veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use past 30 days</td>
<td>57%*</td>
<td>51%*</td>
</tr>
<tr>
<td>Binge Alcohol Use</td>
<td>23%</td>
<td>22%</td>
</tr>
<tr>
<td>Heavy Alcohol Use</td>
<td>8%*</td>
<td>7%*</td>
</tr>
<tr>
<td>DSM-IV Alcohol Abuse/Dep</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>DSM-IV Alcohol Dep</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Illicit Drug Abuse</td>
<td>2%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Substance Use Tx past year</td>
<td>0.8%*</td>
<td>0.5%*</td>
</tr>
</tbody>
</table>

* Bray et al (2009)  
Active Duty Health-Related Behaviors Survey and Use Among Veterans

• 40% of current drinkers reported binge drinking

• 12% active duty had AUDIT scores ≥ 8 (suggestive of alcohol problem)

• < 1% reported being in treatment or would seek treatment in next 6 months

Active Duty: 2011 DOD Health Related Behaviors Anonymous Survey

• Top 3 reasons for drinking:
  1. To celebrate (50%)
  2. Enjoy drinking (46%)
  3. To be social (33%)

• Only 11% said they drank to forget problems and 14% when in a bad mood
Active Duty: 2011 DOD Health Related Behaviors Anonymous Survey (con’t)

- Any illicit drug use reported past 30 days:
  - < 1% past 30 days
  - 1% past year
  - 28% reported use lifetime

Dept of Defense (2013)

Combat Experience

Having combat experience is associated with increased substance abuse problems

Could be related to:
- Coping with stress/trauma
- Loneliness
- Deployment culture
- Lessen fatigue

*Bray et al. (2009); Jacobson et al. (2008); IOM (2013)

Barriers to Treatment

“Service members commonly reported concerns related to stigma as barriers to treatment, particularly concerns related to their military career, functioning, and relationships with command and peers.”

Institute of Medicine (2013)

DSM-5 SUD Criteria and Symptoms
DSM-5 SUD Criteria

“A problematic pattern of alcohol or other drug use leading to clinically significant impairment or distress, as manifested by at least 2 of 11 symptoms occurring within a 12-month period.”

DSM-5 Substance Use Disorder Symptoms

In the past 12 months:
- Have often used in larger amounts or over longer periods of time than intended
- Have often wanted or tried to cut down or control use
- Have spent a lot of time either using, trying to obtain, or recovering from the substance
- Gave up or reduced involvement in important social, occupational, or recreational activities because of substance use
- Continued to use despite knowing it likely caused or made worse psychological or physical problems

DSM-5 Substance Use Disorder Symptoms (con’t)

In the past 12 months:
- Had to use greater amounts to get desired effect, or affected less by same amount
- Experienced withdrawal symptoms, or used to avoid or relieve withdrawal symptoms
- Did not fulfill major obligations at work, school, or home due to substance use
- Repeatedly used substance in situations that were physically hazardous
- Experienced strong desires, urges, or cravings to use the substance
- Continued to use despite persistent or recurrent social or interpersonal problems caused by or made worse by use

Comorbid Conditions with SUDs and Challenges
Comorbidity Caution

High prevalence of comorbidity with SUDs

Co-occurrence does not mean causality

- Drug abuse can cause one or more symptoms of another mental health problem
- Mental health problems can lead to substance use disorders

Comorbidity in Veterans

“...having PTSD is associated with a higher prevalence of problems with alcohol, pain, and sleep.”

Challenges to Working with SUDs and Other Psychiatric Problems

Three General Treatment Approaches

- Parallel: Strong support for concurrent (in ≥ 2 programs, MH & SUDs)
- Integrated: Both disorders in one program; difficult to implement - requires staff skilled in both problems
- Sequential: In second program after first (SUD then PTSD); issue - can one problem be placed on hold?

Prevalence of Comorbid Military Service Mental Health Problems Associated with Alcohol (AUD) and Drug (DUD) Use Disorders in Iraq and Afghanistan

Seal et al. (2011)
**Brief Screening Measures and Brief Interventions to Assess SUDs**

**% Alcohol Content by Volume**

1 Standard Drink =

<table>
<thead>
<tr>
<th>Alcohol Type</th>
<th>% Alcohol Content</th>
<th>Number Ounces</th>
<th>Total Oz. Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer 5%</td>
<td>x 12</td>
<td></td>
<td>0.6 oz.</td>
</tr>
<tr>
<td>Wine 12%</td>
<td>x 5</td>
<td></td>
<td>0.6 oz.</td>
</tr>
<tr>
<td>Hard Liquor (e.g., gin, whiskey) 40%*80 proof</td>
<td>x 1.5</td>
<td></td>
<td>0.6 oz.</td>
</tr>
</tbody>
</table>

1 standard drink = 14 gm. absolute ethanol

**Alcohol Metabolized at Constant Rate in Healthy Adults**

No matter how much you consume it leaves your body at a constant rate

![Diagram showing blood alcohol level (BAL) and about 1 drink standard drink per hour]

**Why Use Brief Screening Measures to Assess Alcohol, Drug, & Nicotine Use?**

Most measures ......

- Have been lengthy and time consuming to administer and score; thus, cannot provide immediate feedback to patients
- Not sensitive to the full continuum of those with SUDs (e.g., young problem drinkers)
- Consequently, most substance use assessment measures not well-integrated into standard clinical care

Sobell, Sobell & Robbins (2013); Sobell & Sobell (1980); Maisto, Connors & Dearing (2007); Earlywine (2009)
**Brief Alcohol Screening Measures**

- Alcohol Use Disorders Identification Test (AUDIT-10)
- AUDIT-C
- Quick Drinking Screen (QDS)
- Single Binge Drinking (SBD) Question

*Note: Participants have handouts of all these screens.*

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**Brief Drug Screening Measures**

- Drug Abuse Screening Test (DAST-10)
- Opioid Risk Tool (ORT)

*Note: Participants have handouts of these 2 screens.*

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**Obtaining Accurate Self Reports**

**Where Do We Get Most Information About Our Patients?**

- **Answer:** Self-reports, regardless of the SUD
- In addictions field, long-standing distrust by many clinicians - that is, you cannot trust SUD patients’ self-reports.
- **Question:** Is this accurate? **Answer:** No!
- **How do you know?** 60-plus research studies from ’70s on have shown that on a group basis SUD patients report accurately about their alcohol and drug use.
- **So why the distrust?** It might relate to how some practitioners interact with their patients.
- **Accurate information can be obtained from patients when** they’re guaranteed confidentiality, substance use free, and when asked in a clinical or research context.

Why Don’t Substance Abusers Report Accurately Sometimes?

Stigma: Single biggest reason why substance abusers say they avoid or delay entering treatment

- Most individuals with SUDs do not see themselves as severely dependent and they are not
- A motivational approach can be successfully used to help motivate patients to consider changing

Using a Motivational Interviewing Style and Motivational Strategies

IOM (2013); Oleski et al (2010); Kingmann & Sobell (2007)

What is Motivational Interviewing?

- Often thought of as an intervention, but it is NOT a treatment
- Communication skills that are motivational rather than judgmental in nature
- Uses principles and techniques based on models of therapy and behavior change techniques
- Designed to help patients explore their ambivalence about changing

Benefits of Using a Motivational Interviewing Approach

- Significantly reduced health care costs
- Increased compliance with medication and treatment recommendations
- Improved outcomes
- Greater patient satisfaction

Multiple references
Motivational Interviewing

Different Way of Talking with People that Uses a Specialized Set of Communication Skills

- Does not use stigmatizing language (e.g., alcoholic, drug addict, you have a problem)
- Conversational and empathetic
  - Avoids being judgmental
  - Instead of: “How many years have you had an alcohol problem?”
  - Ask: “Do you mind if we talk about your alcohol use? What concerns you most?”

Empathy: Key Feature In Motivational Approach

- **WHY?** High levels of empathy associated with positive outcomes
- **Key to expressing empathy through Reflective Listening**
- Listening in a reflective manner demonstrates an understanding of patients and validates their concerns

Low Therapist Empathy is Toxic

Self-Efficacy

- Self-efficacy is positively associated with SUD treatment outcomes.
- For most patients, substance use is situational, and they have low self-efficacy for handling those situations without using substances.
- *Brief Situational Confidence Questionnaire* is a short easy psychometrically sound way to identify high risk situations.
Main Types of High-Risk Situations

Typology first developed by Marlatt and now supported by other researchers:

- Unpleasant emotions
- Physical discomfort
- Conflict with others
- Testing control
- Urges and temptations
- Pleasant emotions
- Social pressure
- Pleasant times with others

Breslin, Sobell, Sobell & Agrawal (2000); Connors, Maisto, Donovan (1996); Marlatt & Gordon (1985)

READINESS RULERS
Assess Readiness to Change

On a scale of 1-10, how ready are you at the present time to change?

MI Scaling Tool to Build Self-Efficacy

General Trends in SUD Treatment

- Use brief interventions, brief assessments, and stepped care approach
- Use outpatient treatments before intensive options
- Use a less confrontational and more empathic motivational style to interact with patients
- Integrate pharmacotherapy with psychotherapy

Multiple references
General Trends in SUD Treatment (con’t)

- Provide SUD interventions in primary care
- Combine psychiatric and SUDs treatments
- Quitting smoking now addressed with other SUDs
- Use of web-based social networks and gaming approaches to facilitate engagement

Treatment Needs To Be

- Attractive
- Accessible
- Affordable
- Effective

Incorporating patient preference and good customer service are essential principles for this new system of care.

Services and Alcohol Problem Intensity

<table>
<thead>
<tr>
<th>Alcohol Use and Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>Prevention</td>
</tr>
</tbody>
</table>

Interventions

Population newly entering treatment

Matched to treatment based on research and clinical judgment

Treatment "A" Outcomes
- Positive
- Continued positive outcome: Monitor only
- Serious relapse requires further treatment at appropriate intensity

Treatment "B" Outcomes
- Positive
- Outcome

Treatment "C" Outcomes
- Positive
- Outcome

Treatment "D", etc.

Institute of Medicine (1990)
Evidence-Based Treatments for SUDs

• Brief and Web-based Social Media Interventions
• Cognitive Behavioral Therapy (CBT)
• Motivational Enhancement (MET)
• 12-Step Facilitation (TST)
• Contingency Management
• Community Reinforcement and Family Training (CRAFT)
• Behavioral Couples Therapy (BCT)
• Family Systems Approach
• Methadone Maintenance

Dept of VA & DoD (2009); Institute of Medicine (2013); Miller & Wilbourne (2002)

Brief Interventions

Not a single treatment but a collection of interventions

• **Primary Goal**: Reduce alcohol and drug use below risk levels
• **Primary Focus**: Increase motivation to change by weighing the pros and cons of the substance use
• **Intervention Time Varies**: Self-change materials, apps, 5-min discussion with a health care practitioner, one or a few outpatient sessions

Multiple references

Web-based Social Media Interventions

• **iSelfChange App**:
  Evidence-based app for problem drinkers (21-35) based on promoting self-change studies.

Mertenbauer et al. (2013)
Cognitive-Behavioral Therapy (CBT)

- Empirically supported in multiple RCTs and has consistently been superior to most other interventions
- Focuses on modifying thinking and/or behavior for substance use and other areas of life functioning
- Central features
  - Brief time limited
  - Functional analysis of substance use
  - Coping skills training
  - Cognitive restructuring

Motivational Enhancement Therapy (MET)

- Similar to motivational interviewing but with a more directive approach to increase awareness of ambivalence about change, promote commitment, and enhance self-efficacy
- More structured than motivational interviewing

Behavioral Couples Therapy (BCT)

- Focus is on the dyadic relationship
- Goal is to decrease substance use and improve overall marital satisfaction for both partners
- Sobriety Contract is used
- Positive feelings, shared activities, constructive communication are factors conducive to sobriety
Contingency Management Approach

- Incorporates substance users’ social system into the treatment plan
- Uses rewards for specific behavioral recovery goals
- Core of contingency management is reinforcement of abstinence
- Effective with drug abuse to establish early recovery and continuous abstinence

Community Reinforcement And Family Training (CRAFT)

- Goal is to rearrange multiple aspects of one’s life so sober lifestyle is more rewarding than one with alcohol and/or drugs
- Focuses on environmental factors that impact and influence patients
- Uses family, social, recreational, and occupational events to support sobriety

Family Systems Approach

- Members are interdependent
- Patterns of interaction in the family influence the behavior of each family member
- Interventions target and provide practical ways to change patterns of interaction
- 8-24 sessions

12-Step Facilitation Treatment

Developed for NIAAA’s Project MATCH

- Manualized 12 sessions of individual outpatient therapy
- Although based on the 12-Step principles of AA emphasizing surrender and turning oneself over to a higher power, this is a psychotherapy. It is not AA.
- Encourages participation in AA and completing the first 4 steps
Managing and Preventing Relapses

Marlatt’s Relapse Prevention Model

- Hypothesizes that in presence of high-risk situations, if people don’t exercise effective coping response, self-efficacy will be reduced.
- Combined with expectation of short-term positive effects from substance use, this can lead to lapse or slip and becoming a full relapse if patients view a slip as indicating inability to control behavior.

Witkiewitz & Marlatt (2004)

Managing Relapses

- **Stop slip as soon as possible** to minimize consequences and risks
- **View slip as learning experience**; i.e., Why did it occur then? What could be done to avoid a similar slip in the future?
- Do not ruminate. **Take long-term perspective on recovery** and view the slip as a bump in the road rather than the end of the road

Sobell & Sobell (2011)

Identifying High Risks

- **Identifying these types of situations can lead to developing treatment strategies.**

  **Examples:**
  - For persons whose high-risk situations involve negative affect, focus on managing feelings and realistic ways of reducing stress (e.g., being assertive)
  - For persons whose high-risk situations involve social pressure, focus on how to reduce pressure or avoid those situations

Witkiewitz & Marlatt (2004)
Harm Reduction Approach with SUDS

• Meet patients where they are; seek to attract patients who otherwise would not get treatment.
• For patients not willing to commit to abstinence, negotiate reduction in use and develop plans to minimize risks.
• Reduced use means reduced risks and helps keep patients in treatment.
• Avoid high risk settings.

Role of Medications in Management of SUDs

- Detoxification
- Relapse Prevention
- Maintenance (harm reduction)

Role of Medications in Detoxification of SUDs

- Reduce intensity of withdrawals by tapered (gradual) reduction of dose
- Ameliorate withdrawal symptoms

Marlatt (1998); Tatarsky & Marlatt (2010)
Role of Medications for Detoxification of Alcohol Withdrawal

Benzodiazepines
- Cross-tolerant with alcohol
- Minimize withdrawal symptoms
- Some (e.g., Valium) have anti-convulsant properties

Role of Medications for Detoxification of Cocaine Withdrawal

- No proven pharmacologic treatment
- For symptom reduction some use of desipramine, amantadine, and propanolol

Role of Medications for Detoxification of Opioid Withdrawal

- Buprenorphine (Subutex) taper
- Methadone taper
- Naloxone (naltrexone, narcan): antagonist for rapid detox over 12-24 hours and for relapse prevention
- Clonidine (antihypertensive) reduces symptoms

Role of Medications in Relapse Prevention of SUDs

- Naltrexone (Revia, Vivitrol; for alcohol): Reduces high, suppresses craving
- Acamprosate (Campral; for alcohol): Used mainly in Europe; reduces high, suppresses craving
- Antabuse (disulfiram, for alcohol): Interferes with acetaldehyde metabolism causing toxic reaction which is like systemic allergic reaction
- Naltrexone (for opiates)
Role of Medications in Maintenance of Heroin Addiction

• Methadone
  ✓ Longer half-life
  ✓ Can overdose by taking other opiates

• Suboxone
  ✓ Longer half life
  ✓ Agonist-Antagonist

Additional Resources

Major Websites

National Institute on Alcohol Abuse and Alcoholism
http://www.niaaa.nih.gov
National Institute on Drug Abuse
http://www.drugabuse.gov
Substance Abuse & Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov
Web of Addictions
http://www.well.com/user/woa/
Medline Plus (National Library of Medicine)
Center for Substance Abuse Research
http://www.cesar.umd.edu/cesar/drug_info.asp
World Health Organization
http://www.who.int/topics/substance_abuse/en

Key Website Publications and Resources

• Southeastern Consortium for Substance Abuse Treatment (SECSAT)


Key Website Publications and Resources

• SAMHSA publications. http://store.samhsa.gov/facet/Substances

Key SUD Books


CDP Website: Deploymentpsych.org

Features include:
• Descriptions and schedules of upcoming training events
• Blog updated daily with a range of relevant content
• Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
• Other resources and information for behavioral health providers
• Links to CDP’s Facebook page and Twitter feed
Online Learning

The following online courses are located on the CDP website at:
http://www.deploymentpsych.org/content/online-courses

NOTE: All of these courses can be taken for free or for CE Credits for a fee

- Cognitive Processing Therapy (CPT) for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Prolonged Exposure Therapy for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Epidemiology of PTSD in Veterans: Working with Service Members and Veterans with PTSD (1.5 CE Credits)
- Provider Resiliency and Self-Care: An Ethical Issue (1 CE Credit)
- Military Cultural Competence (1.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 1 (2.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 2 (1.75 CE Credits)
- The Fundamentals of Traumatic Brain Injury (TBI) (1.5 CE Credits)
- Identification, Prevention, & Treatment of Suicidal Behavior in Service Members & Veterans (2.25 CE Credits)
- Depression in Service Members and Veterans (1.25 CE Credits)

All of these courses and several others are contained in the Serving Our Veterans Behavioral Health Certificate program, which also includes 20+ hours of Continuing Education Credits for $350.

Provider Support

CDP’s “Provider Portal” is exclusively for individuals trained by the CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

Features include:
- Consultation message boards
- Hosted consultation calls
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and one-on-one interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids

Participants in CDP’s evidence-based training will automatically receive an email instructing them how to activate their user name and access the “Provider Portal” section at Deploymentpsych.org.

How to Contact Us

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