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**Presenter: Dr. Kenny “Khensu” Carter: Dr. Warren Leggett**

**Topic: *The Spirit of NADA - National Acupuncture Detoxification Association***

[00:00:00] **Moderator:** Today we're joined by Dr. Kenneth Carter, president and Dr. Warren Leggett, advanced Certified Alcohol and Drug Counselor from the National Acupuncture Detoxification Association (nada). NADA trains people in the NADA protocol and ear acupressure and acupuncture intervention used to support individuals experiencing trauma, substance misuse, and related behavioral and mental health challenges, while advancing access to holistic health as a right for all communities.

[00:00:34] We're excited to have them with us today, Dr. Carter and Dr. Laggett. Thank you for being here. The floor is yours.

[00:00:46] **Dr. Carter:** We're so honored and grateful to be able. To meet with you all today. I'll be talking about, as you see, the National Acupuncture Detoxification Association Organization, our protocol, some of our history we do span about 50 years at this point, more than 50 years of history. But most exciting will also be sharing recent research outcomes and opportunities for you to find out more and for you to learn where you can learn more, get more, get trained, and where all this will be fitting into the work you already do.

[00:01:26] The work you do is so near and dear to me in terms of working with rural America, the heartland of America. I was raised in a rural setting myself in South Central Virginia. On my spending much of my time on my grandfather's farm one of the things that we know with in the field of medicine is that most of the educational institutions, most of the healthcare opportunities and access are located in more urban areas, suburban areas, and often rural areas are left out.

[00:02:03] Our protocol is uniquely valuable and beneficial in those sorts of settings because it is simple, it is easy, and I'll be talking about all of that as we go forward. Please advance the slide for me there, Erica. The spirit of na. Our spirit is one of both love, legacy and business.

[00:02:32] The love side speaks to how we all started in the South Bronx back in the sixties, 70, back in the seventies, late sixties, early seventies, as Lincoln Hospital was searching desperately for a way to impact locally their for their

patients, their communities a severe opiate epidemic. There have been several in the United States, and of course we're in the midst of the most recent one.

[00:03:02] That is leading to massive deaths. In rural areas increased suicide rates, those sorts of things NADA has been addressing these sorts of issues for at least five decades now, very effectively. Please advance Erica. Before getting started into my my personal experience, I wanted to give you an antidote, antidote about how I got started with this before getting into some of the more didactic material.

[00:03:35] But as far as a, any disclosures, I have no financial conflicts at all, of interest at all to disclose. Related to this presentation, all the statements and opinions are on my own as a representative of nada. I do want to point out though that I was employed by the veterans Healthcare System for close to a decade.

[00:03:57] But I did retire in August of 2025. My role there was as a lead psychiatrist in primary care mental health integration, and I was a whole health educator and primary care and in mental health teaching implementation of Whole Health techniques and really emphasizing that and I was a foot soldier for what the VA has declared a revolution in healthcare.

[00:04:27] As the VA is probably the largest certainly one of the largest healthcare institutions in the world. Certainly in the country with vast resources for research looking at data, all of that. When they rolled out the not a protocol, the. Veterans healthcare system, version of the not a protocol that that we worked with them very closely on developing.

[00:04:54] I worked with a very small group within the VA for a number of years, four or five of us to really get this up and going. The group is very wonderful but for them to roll this out within the va, over the all 50 states and seven territories and they started that rollout a couple of years ago, is just fantastic.

[00:05:16] The Dr. Who is in charge of all things acupuncture and the Veterans Administration, were hoping that our fingers crossed that we'll be able to get her to our conference in Detroit this year. But enough on that. This first slide, the spirit of NADA is easy and we'll go through just a nice hook using this as a mnemonic to help you remember where this fits in terms of supporting and helping to enhance what you already do.

[00:05:47] Let me tell you a story. First, I was introduced to the protocol back in 1982. I took a year off from medical school to travel around the country to see of holistic medicine. This whole health approach helped really sick individuals medically ill individuals. Ended up spending most of that time at Lincoln acupuncture, recovery Cent Center, also known as Lincoln Detox.

[00:06:17] Part of Lincoln Hospital Lincoln Recovery Center was treating between two and 300 patients a day. They were training folks from all over the world were coming into to learn the the protocol because of the great benefit that it was demonstrating. But as a medical student there, getting trained in their 70 hour training program that we have preserved until this day, training is still total of 70 hours, 30 hours didactic 40 hours is basically clinical hands-on experience that is supervised.

[00:06:52] So I come in as a student and after learning the basics, the first patient that they referred me to. Was a gentleman who had chronic paranoid schizophrenia, but also a co-occurring substance use disorder of crack. He comes in and they direct me to treat him. He's very clear. He's hearing voices.

[00:07:15] He's having command to hallucinations, telling him to kill himself. He's looking frantic, wide-eyed, wild-eyed. And I'm thinking to myself as a student, if I put a needle in this guy's ear, what is he going to do to me? He already is talking, hearing voices, telling him to kill himself.

[00:07:35] Ironically, he advises me to relax, telling me that he comes there when he's about to go too far. So he falls asleep. I'm sitting there for about a. 30 minutes that he's asleep, just waiting for something negative to happen. Of course, nothing does. He wakes up looking a lot more settled on the verge of looking peaceful, no longer wide-eyed.

[00:08:03] He's still hearing voices, but they are greatly diminished. Most importantly, they are no longer telling him to kill himself. And now we have a person that can really benefit from the psychosocial components of the program that Lincoln had to offer someone who really was not in a psychologically ready mindset to have that sort of a conversation in a productive manner.

[00:08:31] Having worked in dedicated psych emergency room for about 15 years in Charlotte, North Carolina. We know that anyone walking into an emergency room with this story probably would've been treated, intramuscularly with antipsychotic combination of antipsychotic or benzodiazepine.

[00:08:52] Something like Ativan or Valium to help to calm 'em down, get control quickly. But now you have someone who will probably have to sleep for at least several hours. The interventions may certainly have been coercive if he was agitated or not willing to comply. So to have an intervention like this and a setting that is welcoming, that has folks coming back is just so huge in terms of a whole spectrum of considerations that, that we will we'll go through shortly.

[00:09:26] Interestingly enough I asked the gentleman are you ready to come into treatment now? Would you like to speak to one of our peer support specialists, psychologists, social workers? And he's no, I'm not ready for that yet. I come here when I'm getting ready to go too far, getting in trouble with a drug dealer, getting in trouble there, getting in trouble with the law, getting in trouble there, ending up in jail.

[00:09:48] So he uses this in terms of harm reduction anticipating that one day he will be ready, but at least we're keeping him safer, the community safer. We're saving the health system, lots of money and funds, and it's a place that is welcoming that he will voluntarily come back to when he's ready to enter treatment.

[00:10:10] That is huge. Now, in terms of the spirit of NADA, to elaborate that a bit more with the support of the slides here. We can see that the mnemonic easy, the e can stand for economical. A single provider can treat up to 15 patients in an hour very easily. The early effects are very visible within 13, within 30 minutes or so.

[00:10:36] Often groups may go up to an hour, but 30 minutes is about a a minimum. And over that period of time, there are well-documented benefits in terms of anxiety of depression in terms of mitigating withdrawal symptoms. And we have a wealth of data to support all of that. It's efficient again that fi that single provider is.

[00:11:00] Treating 15 to 20 patients over the course of an hour. It's empathic. It's a way to establish engagement and rapport very easily because now that patient knows, Hey, in the course of a half an hour, this person can get me feeling a whole lot better. It's not a question of having to write a prescription they've gotta go fill.

[00:11:22] It's not a prescrip a situation of having to tell their life's story and be trusting enough to do that with someone they don't even know before they can be helped. It is empowering for self-care. We not only treat patients with

needles, we also, that only the trained, not a practitioner can do, but then that a practitioner also introduces patients to the use of acupressure beads.

[00:11:49] Our most popular beads or gold plated magnets on a surgical tape. A piece of surgical tape placed behind the ear, and we can show patients to do that. So they can do that at home for themselves. No reason they can't do it for other or other individuals that may be that they also are responsible for or within their circle.

[00:12:14] Very easy to do. Many patients got a lot of benefit from the acupressure. And in terms of state laws and restrictions, virtually none with regard to the acupressure vs. The E also stands for effective. But I do want to point out here that especially in treatment settings, this is not meant to be used as a standalone treatment.

[00:12:37] There was a major there was a study done a couple of decades ago that erroneously tried to remove the provider from the protocol, tried to remove setting, really just tried to see what are the needles gonna do all by themselves at that time? I'm arguing that to approach the treatment of addiction in that way is like thinking, okay, we have an alcoholic that's in withdrawal about to go in to dts.

[00:13:07] If we simply give them Valium to go home to prevent the DTS and help them relax, that should be enough. No, it's not. We know it needs to be embedded in a treatment program. So in terms of a healthcare system, think about the not a protocol and its use as an adjuvant to be used in addition to what you already do.

[00:13:30] To enhance what you already do. And then within that perspective, we like to say that the protocol helps patients, providers, and programs, patients with that sort of near immediate effect providers in terms of making their roles easier because the patient is more compliant, pliable, and programs because their outcomes are better.

[00:13:57] Next slide. Erica,

[00:14:05] so the A and Easy stands for accessible something that. That is this easy to provide, means that you can use it in a formal setting? We train folks in hospital settings. We train folks in outpatient settings. One of the most gratifying trainings that I did was with a pastor in South Carolina who was using it as part of his outreach ministry for sick and shut-ins.

[00:14:32] Ideal for a rural sort of a setting. With distances between clinics, between patients distances to travel, we really need something that travels well and effectively travels easily. There is nothing out there that can beat this. It's affordable. The cost of the of the needles for a single treatment, maximal cost of about a dollar, \$1.

[00:14:59] If we're talking about the acupressure beads, maximal cost of maybe a dime. So now we're talking about being able to do all of this in a very cost effective way. Adjunctive treatment, I mentioned that we really want to add this on to treatment. As usual, I often get questions regarding how best to approach documenting outcomes.

[00:15:26] We really want to wanna look at at research. What should we do? The the mantra is this if you're going to look at outcomes, you want to compare it to business as usual, to treatment as usual, and compare that to treatment as usual. Plus the protocol. Nice and simple. We don't want to try to control all the different variables that may be involved in providing the protocol.

[00:15:52] Who the provider is what room it's in the discipline of the person involved. All that is not necessary. We get the same outcomes whether it's a peer, and quite frankly, sometimes peers get better outcomes. Then the professionals, although we also use social workers, psychologists, all of this is dependent on states where laws are permissive.

[00:16:18] But in my home state of Virginia which I mentioned the opportunity for peers to support peers is huge. This is so important because not only do I have the psychiatric training board certified in psychiatry, comprehensive acupuncture, also board certified in comprehensive acupuncture.

[00:16:38] But also as, a fellow of psychiatric epidemiology and a degree in public health. And of course the question always in public health and epidemiological questions in terms of intervention is how can we afford to do it? This is huge in terms of its affordability. It's very adaptable in terms of a mental health setting or a substance use treatment setting.

[00:17:04] It is fantastic. You don't have to take your clothes off. We only deal with the ears. So even as a comprehensive acupuncturist I always start with the ears first, especially with the not a protocol, because literally. More than half of what walks in the door, even to see me as a comprehensive acupuncturist can be resolved simply by addressing the ears.

[00:17:31] And before we finish today, I'll share with you some very exciting outcomes that are coming from the Veterans Healthcare System, from their use of this protocol over the past few years. Next slide, Erica.

[00:17:49] The s and how easy including the spirit of naty is, includes simple have a simple kit, no bigger than the size of a lunchbox, and you can travel wherever you need to go. Treat as many people as you need to treat. So the infrastructure is not burdensome at all. The equipment you need is simple and easy.

[00:18:14] It is safe. I'd like to point out that in the 50 years that the ear protocol has been in place, and it was in 1985 that it be that the national organization was incorporated. So officially that's when the not a protocol assumed that name but the ear treatments in terms of its use for helping and substance use actually started back in 1972.

[00:18:44] So in the 50 years that we have used this, there has never been a tort case regarding injury. Never. We can't point to anything in the practice of medicine where that is the case. It is extremely safe. And in terms of groups I'm asked are there any contraindications in terms of who can be treated?

[00:19:08] There's a body of research supporting the safety in pregnant women. And in terms of absolute contraindications, the only one that is an absolute contraindication is think about running a group. Say you have someone who has dementia and cannot be directed to sit still. Say you have someone who is in the throes of intoxication and is either so belligerent or confused or sedated that they can't sit up in a chair essentially.

[00:19:44] That's what it boils down to. Those are the contraindications. Anything that you would leave someone out of a group four and not include them. For any other sort of intervention, whether it's an anxiety group, whether it's a skills training group, you would not include in the in, in the N group. Other than that, it's open to all the group is nonverbal.

[00:20:09] This is the only place in our behavioral health, mental health intervention toolbox, where we actually have a tool where you do not have to gather lots of information. You do not need a diagnosis. The patient can even lie to you. It doesn't matter. And. Because it is a tall order to ask someone with addiction issues to come in and spill their whole life story in a trusting way with full disclosure to someone they don't know at first.

[00:20:41] That first step is to engage and to engage in such a way that they're retained and keep coming back patient's life, patient patients like this and they do keep coming back. The protocol also supports stigma free attention, IE if we have say a petite person who has needles in their ears and they're very relaxed and calm if we have a, a linebacker come in who's nervous about putting needles in their ears, and I don't know about, they look over and they see someone sitting there who's calm and relaxed in the zone. The group kind of does that education itself, that this is calming and relaxing and which. Places less burden on the provider to have to explain all of that.

[00:21:34] Again, the peer-to-peer magic in terms of intervention, in terms of the group participation is huge. And again, I'm not trying to discount our skilled professionals of social work psychologists, the physicians, all other the nurses that are involved. But it is something beautiful when we have peers, treating peers as well.

[00:21:59] And those of us who are scaled on professional side who are most skilled are those who are able to adapt, adopt that sort of horizontal conversation. Now we have a horizontal tool as well. When I, i'm invited into hospital systems to train staff. The best case scenario is when there is a group in which staff can also participate as long as the hospital's comfortable.

[00:22:25] Everyone's comfortable so that patients say, Hey, I do this for myself too. As a self-regulating wellness tool, it is fantastic to have an open group, and I'm inspired to approach it that way because that's the way I was trained. In 82, when I trained at Lincoln, it was basically a room the size of a basketball auditorium.

[00:22:48] Chairs lined up against the wall through the middle of, across the middle of the room. Anybody walking in off the street could come in with providing minimal, information before they got treated in order to engage them there. And it just went very well. It seemed to be very busy, a lot going on, but as my mentor of many years liked to point out it's an inside job.

[00:23:17] Whatever's happening on the outside in terms of in the clinic or elsewhere is really the distractions go away. I remember the story once of how Dr. Smith came into the clinic. And the hospital, in his wisdom had a a noisy jackhammer, believe it or not, in the middle of the floor going at it.

[00:23:39] He comes down extremely angry. Why are you doing this? In the middle of our clinic? You're disturbing the the patients. The patients are still in

that zone looking at him saying, Hey doc, you need a treatment? It's okay. Of course, lots of laughs. But our patients taught us about the magic of this stigma free.

[00:24:01] Also related to that is the fact that although the protocol started addressing opiate dependency very quickly, patients taught us, Hey, it works with alcohol, it works with cocaine, it works with psychotropic meds such as Effexor, Paxil with short half lives, that if you stop them quickly, you get withdrawal symptoms.

[00:24:25] We have nice names for it, like discontinuation syndrome, but it's withdrawal helps with all of that. In terms of a universal intervention that has the most likelihood to help most people, most of the time I know of nothing that is better. And if I had one tool in my medical toolbox and could only have one tool, this would be it.

[00:24:49] Next slide. Next paragraph, Erica. The y I like to point out stands for the idea of yellow of yin. The idea of yellow from a traditional Chinese medical perspective is associated with your center. It's your center point of earth where you get your point of balance, where you find your point of stillness.

[00:25:14] It's a grounding aspect and it is very commonly stated by individuals who are familiar with mindfulness based stress reduction with meditation, that the protocol induces that frame of mind. So now at the end of a treatment hour. For someone who is engaged in treatment. You have someone who is not as defensive, they're not as irritable, they're not as anxious or likely to become agitated.

[00:25:44] They're much more able to hear, receive, and act on what we have to give as care providers. Next slide. This slide depicts our home. This is our academic home. Our business home now is strongly supported on our board and with all our activities through Bowie State University in Maryland.

[00:26:10] Please go on to the next slide. Erica. What is fundamental to what we, conceive of in terms of where the not a protocol fits. And our conventional healthcare system is that it really spans as no other intervention does. Our bio cycle, social model of care that has been in place since the sixties.

[00:26:36] When it came around, of course additionally, now we've added on biosocial, cultural, biosocial, spiritual, all of that. But do we have an operational tool, a physical tool that can do all of that? Do we have some way to

operationalize that? We don't accept, in my mind, for the not a protocol, the biological aspect devolves to the guy with the white coat.

[00:27:01] The doctors write the scripts. ARNPs can write 'em now, but you have to have that credential for the biological intervention. The needling does that for patients. The psychological aspect of it. Our nonverbal approach leans heavily on a patient-centered sense of approaching patients. We teach our trainees never to enter to present themselves as being the one who is responsible for the patient getting better.

[00:27:35] We always say that the patient always had within them the magic that they feel within that not a hour. Within that not a group, all we're doing is helping to unlock it and reveal it. Similarly, we don't give advice or counseling within the not group. We like to say that we help patients to be better able to help themselves.

[00:27:59] IE help them to be in a frame of mind where they are. More able to be receptive and understanding of what we have to give as professionals. Next slide, Eric.

[00:28:18] So these are the five points of the protocol. They are the sympathetic that's number one at the top of the image there. This point is specifically related to muscle relaxation. Like at the end of the day, you get that stressful feeling in your neck. Treating this point helps all that to drop down in turn terms of that muscular relaxation.

[00:28:41] She men is referred to in traditional Chinese medicine as spirit King. We find that this really helps with concentration, helps with focus. It's a master point that we will always treat if we only do one point in terms of the acupressure. We use that and many patients alone with shemen as a master acupuncture point, get a response that's very similar to using the the needles.

[00:29:12] Kidney point metaphorically artistically is associated with fear and the liver metaphorically is associated with anger. Irrit, irritability, the lung point is that metaphorically is associated with with depression and melancholy. And again here you'll see superimposed on the knot ear is a fetus.

[00:29:37] And again, the ear, similar to the motor cortex in the brain is like a humunculus of your entire body. For instance, in the brain, if you have a stroke at one point, it affects the leg. Another points your arm, the ear is exactly the same way. So there's that musculoskeletal correspondence very similar to the

motor cortex in the brain, but there also are other microsystems with which the ear connects in terms of regulating pain, regulating temperature and those sorts of things.

[00:30:11] So the ear is a very powerful organ in the body. And we're gonna look at that a bit more. Erica embryos and evolutionary history. What you see here is often talked about in terms of phylogeny, recapitulating, ontogeny. What does that mean? It means that for those of us on the planet earth to come into being, we had to come from somewhere.

[00:30:40] And there is a similarity across species, fish, reptiles, birds, and humans with regard to the ear and how the ear develops. Where the arrows are pointing to is your gill slits, your gill plates in human beings. At five weeks of gestation, these gill plates start to develop the, this is the area that is going to become your ear at when you become, when you're born.

[00:31:14] It is the only place in your entire body. That still communicates, that still originates from everything that you were as an embryo is huge ne. Next slide. Erica, the somatic the not a protocol. Somatic energetic correspondences includes your derm related to your brain and nervous system.

[00:31:40] Your mesoderm related to your muscles and vessels, your endoderm related to your internal organs. So as you can see, the ear can through the ear alone, you can affect your entire body. Next slide.

[00:32:00] Now being a comprehensive acupuncturist, I wanted to include this as well. In the ancient Chinese texts, they also say something very similar, just a different language, different way of saying the same thing. All the yang meridian channels pass through the year. All the yin meridian channels converge on the ear.

[00:32:21] They're saying the same thing. The ear is huge. I will say this to you though that as for all the beauty and wonder and duration of traditional Chinese medicine, traditional East Asian medicine, it was not until 1979 with a publication out of Lincoln by doctors Matullo Shakur, a doctor of acupuncture, and Dr.

[00:32:46] Michael Smith. At the time a psychiatrist who later became a doctor of acupuncture, that it was articulated the use of the ear as an intervention in substance use treatment and mental health. This was not being used until this was developed in the South Bronx. And it's been over the 50 years, past 50

years and more that we have continued to elaborate this and get the word out to the world.

[00:33:17] Next slide, Erica. From an ancient perspective, disease is not an individual isolated psychophysiological malfunction disease is a personal and social opportunity for transformation of attitude and lifestyle. Sounds like whole health. Clearly the whole health person centered model is an aspirational ideal, but this is the ideal that was guiding those of us at Lincoln before it became embedded in how we approach everything in medicine.

[00:33:56] Now, those our heroes at Lincoln that got this started, introduced the first patient Bill of Health one of the country's first acupuncture schools came out of Lincoln. The same place whether or not a protocol looks to its origins as well. Next slide, Erica.

[00:34:20] So the idea of revolutionary whole health is one that I borrow from the Veterans Health Administration. Interestingly enough, back in 20. 17 Congress passed the law that the VAs, all the VAs, had to include whole health modalities. Why? Because of the strength of evidence that was coming out in terms of how they were able to positively impact outcomes.

[00:34:51] This was so critical. Why would Congress do that? It was because our soldiers were dying more here at home in theater of war, from opiate overdose, from were dying more here at home than they were in theater of war. They were dying more here at home from issues of o of overdose, of suicide and conventional psychiatry was not.

[00:35:16] Optimally addressing these issues that not a protocol has been a value added. That has been tremendous. And before we close today, I'll review with you a systematic review indicating how the protocol has impacted our holy grail in mental health. How do we address suicidal thoughts, suicidal thinking, suicidal ideation in a population based way, in a prophylactic way, not only in a secondary way after the issues of all may have already or tertiary way after someone may have already attempted to complete and then up in an emergency room.

[00:35:54] How do we roll this out in a population way, say even into schools and public settings where students where. Workers are under stress. We're our first responders where we know they are more, more vulnerable. But how do we have a tool to intervene in a way that they will accept it that is effective, cost, effective, affordable, in a way that it's easy.

[00:36:19] This idea of revolutionary healthcare models that our contemporary veterans healthcare system is embracing is not new, is rather new to the Western world. But I'm so proud to have worked with the VA that is really at the forefront of making sure that this becomes a standard of practice here in the US and ancient ChemE, prediagnostic Egypt coming up out of the Sudan, they presented the souls of Aman Rah.

[00:36:50] And in China we have the. Yellow Emperors. Classic. Classic. Both of these never talk about treating individuals isolated. They talk about what's happening in the community, what they're eating, what time of year. It is really embedded in a holistic sort of, of a framework, what their relationships are, how you're managing that sort of stress.

[00:37:15] In East India, we find the same thing in Ayurvedic system of medicine. And now of course, as I've mentioned, we have it here in a wonderful way in our veterans healthcare system, and it is rolling out as a standard here in the United States. Next slide. Erica.

[00:37:40] Here we have again, the gold standard. And again, the not a protocol is what helps to operationalize this physically, psychologically, psycho, and and cycle socially as well. Within the treatment room, we know that addiction is very isolating. How do we get folks to break that sort of isolation?

[00:38:00] The treatment room can do exactly that. Even without saying a word. We know that addiction carries shame. Stigma. How do we show empathy to someone? Simply being able to say a few words to a patient, not trying to get a diagnosis, not exploring symptoms, just cordially person to person, heart to heart before we be begin.

[00:38:25] Treatment is huge for folks that are being ISO used to being isolated and stigmatized. We bring all that to bear and we teach people how to do it. We teach providers and programs how to do it well. Next slide, Erica.

[00:38:44] This slide I included from one of my favorite. Psychiatric journals, and all it's saying is what traditional Chinese medical techs were saying about the ear. All the in meridians pass through the air, all the yang meridians converge on the ear. We're saying that it affects everything that our body unlike back in the 15 hundreds where Decar said, I think therefore I am, which led the western world for so many years thinking we're just, we have a body that we can separate from our minds is not true.

[00:39:19] Everything is connected. We know now that the that with the virtually universal benefit that we find with the NADA protocol, it impacts inflammatory conditions. It impacts mood. It impacts psychosis as I had mentioned earlier, however. We want to be very careful. We do not say that we are treating anything to say that we are treating a specific disease specifically.

[00:39:50] And I mean from a not simply in a speaking in a casual way, but in the way that say I as a psychiatrist might say I'm treating schizophrenia, or I as a acupuncturist might say that I'm treating a sciatica. We do not say that the practitioners of our protocol, if they are not scoped to say they are treating a disease, they never say they're treating a disease because they cannot.

[00:40:19] What we are doing is helping the body help itself better, and from there it helps to clear the field. So now those who do have a higher scope, they don't have as much static to wade through. What do I. Think about that example of the schizophrenic that I mentioned. Who came, the very first person I treated before I, I even knew I wanted to be a psychiatrist.

[00:40:45] At that time I was thinking surgery, but I changed my mind after seeing the same guy three times on a surgical rotation. The first time he came and stabbed, we sewed him up. Second time he came and shot. Third time he came in bleeding from Varial from from Varice, from the drinking. That's what killed him.

[00:41:06] Medications are important. When we need good drugs, we need them. And here I like to say that as a chief resident, I was chief resident of psychopharmacology unit at Monte Fury Hospital in New York. When we need good drugs, we need them. As a caveat, I often give to those who are overly enthusiastic about the protocol.

[00:41:28] Do not make claims that go too far. What we do is simply provide a relaxation treatment. We like to say relaxation because 80, 90% of folks, that's what occurs. Some say that they can think more clearly. I don't know if I felt relaxed or not. Some say, Hey, my energy was low. Now I feel more perky.

[00:41:50] It is a homeostatic treatment, but generally we say relaxation because that's the most, most common, but it truly is homeostatic. We do not predict what the protocol is going to do. We are often surprised by what it does. Folks will come in saying, Hey, I'm anxious. I haven't, drank in three or four days.

[00:42:11] We treat them and they'll say, Hey, my back pain is better. Did you treat my back? Always? No, we're not treating anything. We're simply activating points in your own body system that allows your body to do a and physiology to do a better job of healing itself. Other than that, we pass the baton to those who do the diagnosing to those who do that sort of thing in a more formal way, but then their job.

[00:42:40] Those of us who are scoped in that job, it's easier because a lot of the static is out of the way. Patients already know that they can trust us to help them feel better. We don't have to wade through all of that, and it's just very helpful. Next slide, Eric.

[00:42:59] So we've all, we've already discussed how the protocol is more than a needle. This is a quote from from Michael Smith, Dr. Smith, who was the medical director at Lincoln. And our founder, he was the first president of the National Acupuncture Detox Association. Next slide. This is a textbook.

[00:43:22] We had our, we've had a number of textbooks published, looking at the, specifically at addiction. This one, however, is the most updated collection of data that we have that also looks at the value in mental health. This is my second time as president of nada. The first the first time was in the the the two thousands, excuse me, was in the two thousands.

[00:43:48] And by then we had already established ourselves as a best practice in the use of of the protocol for detoxification and substance use treatment. That was in 2006 when SAMHSA csat included us in tip number 45, treatment improvement protocol number 45 as a best practice in substance use treatment.

[00:44:12] But if you think about it, if the protocol is useful across the board for basically any substance at any stage of the disorder, from crisis to stabilization, to maintenance, to wellness, for the whole spectrum of symptoms that we know substances can induce either through intoxication or withdrawal. I started thinking to myself, we need to push this for mental health because, and seeing it in my own practice, we need to push this for mental health because it does all of that.

[00:44:49] It can basically help whatever we're doing On the mental health side, as the DSM five is a collection of symptoms. The diagnoses are clusters of symptoms, so in simply addressing symptoms, we help the course of illnesses that have a formal diagnosis. Again, we're not interested in making that di

diagnosis, but the data is replete for the benefit that this protocol brings to that situation.

[00:45:19] And setting this book was written by Dr. Kaja. Ren she's based out of Sweden. As you see, I wrote the foreword for her fear for her here, but it is marvelous. I urge you to buy it. It is a required reading for our training. Now. So Erica this is the article that I referred to of in the beginning. It is the very first article on the use of acupuncture in addiction or mental health when an addiction or mental health focus in the United States. It was written again by Dr. Shakur and Smith and the population was at Lincoln Detox.

[00:46:09] Erica. Oh, by the way, that, that was in 1979 when it was published. And here is again a legacy of Lincoln. First, first patient healthcare Bill of rights. First acupuncture based drug mental health program. Implementation, first group acupuncture format as a preferred treatment format for all acupuncture application.

[00:46:35] When I was there in 82, even though we were treating whoever walked in off the street for whatever adom the ear was always preferred as a first treatment. The ACU detox treatment, another name for the n not a protocol was always preferred because it made it easier for us to figure out what we're trying to target, what we're trying and trying to do.

[00:47:00] Also Lincoln first evidence of universal adjunctive adjunctive benefit. And here's a couple of articles here. One on which I'm a co-author that really looks at the history of the protocol and how the rollout contemporarily today is like a deja vu of what myself and Dr.

[00:47:20] Voyles who we trained together back in the 82. And she is now a, the number two acupuncture person in the Veterans Health administration. And and was a centerpiece of the work group that helped to roll out the protocol along with Dr. Julie Olson. The second article there on which first author really is nice in terms of looking at how the protocol fits with our understanding of the use of pharmaceuticals where it fits with psychotherapy substance use, and across the spectrum of d DSM five disorders for a foundation article and where all this fits.

[00:48:01] I would recommend that one. Next pair. Next next item. So the national not a protocol helps providers, patients, and. Programs again you do not need a diagnosis. Still effective. You can have a wrong diagnosis. And again, diagnoses take time. Sometimes you have to really have things unfold.

[00:48:24] It doesn't matter. Still effective. You can use it for wait list controls and we know that mental health programs, substance use programs often operate on a shoestring budget and often wait lists are long. We can be doing something even for those who may not yet have a bed or a place and a program.

[00:48:47] More is not always better. For instance, think about the example of the schizophrenic patient who was addicted to crack that I mentioned to you. He would've gone if he had gone to where I trained at Albert Einstein. If he had gone to our psych, dedicated psych emergency room, we would've get him Haldol.

[00:49:07] We would've get him Ativan, Cogentin. He would've had to sleep for several hours. It may have been contentious. Somebody's gotta pay for all of that. So there's more harm being done to the patient because he's not in a least restrictive environment. There's no environment less restrictive than a not a group.

[00:49:26] Is harm being done to the healthcare system because resources are scarce both in terms of providers and how much those providers cost and how much just the infrastructure costs. So first, do no harm. My recommendation is to always think first, to have a not a protocol group as your foundation for your system, for your treatment program available to all horizontally, as much as your system might allow.

[00:49:55] But but certainly if specialty sequestration is necessary, that's fine too. Next slide Erica. In 2023, I'm proud to say that the Academy of Integrative Health and Medicine the ai that is a compilation of different premier healthcare or organizations around the country, including veterans Healthcare System awarded nada, our first their first organizational award for implementation.

[00:50:28] We received award for implementation. We've been doing this since the seventies, and and we've been helping everyone. One else who's interested to catch up in the meantime again so grateful that this is rolling out in the VA because they have a large presence that we expect will be impacting other large healthcare systems as well.

[00:50:52] Next slide Erica. Okay. So a summary of evidence and observations coming next. I mentioned that in 2006 the US government endorsed not a protocol as a best practice, and here's where SAMHSA CSAT hung its hat as an adjuvant to treatment as usual. For instance, it can be combined with Suboxone treatment.

[00:51:19] Or methadone treatment any sort of a detox incorporated, it'll help make things better, reduces craving for a variety of substances of abuse. Thus, it is not substance specific like a benzo for benzo withdrawal, alcohol withdrawal, like opiates for opioid withdrawal. You don't have to worry about even narrowing that down.

[00:51:42] It is effective across the board because it is homeostatic. It helps your body to regulate itself better. There's improved engagement and retention. This was a huge reason why they recommended it as a best practice, the main one, it keeps patients coming back because they like it, and there is nothing that predicts who gets better, more precisely and accurately, and who keeps coming back.

[00:52:15] It's effective again across the spectrum for substances. It's ritualistic. The practice of addiction is certainly ritualistic, and that ritual itself can be enough to trigger and so to substitute a different ritual come in for your treatment. Many programs will allow patients set up a station where they can get their own alcohol wipes to clean their ears.

[00:52:39] They can get cotton balls to help to wipe their ears if they dip after the alcohol. They can select their seats. Some allow them to select, just as much empowerment as you can incorporate. But again, just coming in and of itself and participating in the group has that same sort of ritualistic impact that say 12 step meetings have in the addition of community.

[00:53:03] And for our, our patients. Next slide, Erica. Here's another, not a protocol, prospective trial in patient of a substance use disorder and seven common health symptoms published in medical acupuncture. Again, this speaks to the fact that this is trans diagnostic pan asymptomatic. Doesn't matter what the diagnosis is, doesn't matter what the symptom is.

[00:53:32] And the outcomes here were positive to a p value of 0.001 over measuring outcomes across the course of an hour before the needles were entered. Take 'em out at the end of that hour. What happened? These were the symptoms that were measured in that study. Next slide Erica. Another. Now this is a a study that was included in the most recent addiction edition of the textbook of substance use disorders treatment by the American Psychiatric Association.

[00:54:11] It is a study performed by my team out of Rock Hill, South Carolina in 2017, again published in the American Psychiatric Association's. Textbook is

only one of two in 2021. This study looked at 100 participants, and I'll speak about this in a bit of detail because I think it's so instructive.

[00:54:34] A hundred participants. 50, were randomized, were randomly assigned to treatment as usual, and the other half to treatment as usual, plus the the not a protocol. Next slide. So the compare, so the comparisons were between those two groups. I'm sorry, Erica, would you go back to the other one there?

[00:54:53] Yeah. And the we looked at measures in terms of quality of life scores. We looked at PHQ nine, we looked at GAD seven across that span. Next slide Erica.

[00:55:08] And we also did I'll mention this, we also did follow up. We, at the end of treatment, it was a month long treatment program, rock Hill psychiatric substance use and disorders program. Most of the patients there were court ordered for treatment. And were there under some degree of.

[00:55:31] Of coercion I'd say about half. And we treated them for the first 30 days. Everybody getting everything the same except for the protocol. At the end of that 30 days, all treatments stopped. There were no more acupuncture treatments. They didn't get any other follow up and we follow.

[00:55:49] And then we gave them phone calls for follow up, re administering the quality of life scale and and also asking where folks were in terms of their substance use disorder. What we found at three months follow up, those in the night of protocol, continued to improve those without it were deteriorating toward baseline.

[00:56:13] At six months follow up, it was unequivocal. There was clear and dramatic separation between those who got the protocol on day one. And those who did not get it, we also had a crossover design. 'cause we didn't wanna leave folks out who didn't get it, who were again, struggling because of the deterioration to baseline and wanted to follow up with them.

[00:56:37] So please be reassured. We did circle back and offer them the treatment as well. But what is it saying? Next paragraph. Erica, next slide please. Yeah, we can stay right here for now. So what was that saying? Our speculation is this, and this is apropos to the question of suicide that we'll be looking at.

[00:57:00] In this next slide, our speculation is this, those who got the protocol on day one. Coming in either with resistance, with stigma, perhaps even having just used before they had to start giving urines whatever they, those who started getting the treatment on day one were immediately in a better psychological state of mind to benefit from the other treatment that the program had to offer.

[00:57:33] Whereas those who did not get that treatment on day one had to go through the usual course if they weren't provided. And this was not primarily a medication assisted program, if they they were already stabilized in that sense. At the end of treatment. Those who did not get the protocol really had more of a slow role in terms of getting themselves together, getting, being able to focus, to concentrate well enough to benefit enough, whereas those from the protocol had a jumpstart.

[00:58:09] That's our thinking about it. Now, none of this is completely new to those at Lincoln that have been doing this for some time to our trainers and practitioners that have been doing this for some decades. But this added some data to the to the anecdotes that we have AI already been getting back, is that the protocol helps those to help themselves better in terms of quality of life.

[00:58:34] Those who got the protocol were more, more likely to have jobs, more likely to have fulfilling family relationships and contacts, et cetera. This also relates to the issue of su suicidality. Most completed suicides we speculate are impulsive. And if we can even surf that impulse for five minutes, a few minutes, often it can be enough to mi to to mitigate turning that impulsive thought into an impulsive action.

[00:59:14] As that same degree of impulsivity is there with substance use. And of course if someone is using substances and having a severe mental illness, they are much more likely to turn to thinking about suicide. This is a study that again, came out recently, a year or two ago, looking at the effectiveness and the safety of acupuncture in suicidal behavior, a systematic review about half of the studies in this review used our protocol.

[00:59:53] Those that did not, of course, still had still were included because they were affected as well. None were as efficient and affordable as the protocol. So what we're teasing out here is interventions that can be effective, but are they really useful for populations population-based care?

[01:00:16] Can, is it safe enough to have peers to administer it? Is it simple enough for peers to administer this protocol is, and again, it is such a blessing

that we have been able to show as well that it helps with the most troubling situation in what we deal with in treating on the mental health and behavioral health side, which is suicidality.

[01:00:40] This is effective. Next slide. Another thing we know we have an aging population. Pain is integral to aging and severely impacts the ability to have a positive quality of life Here. The protocol was compared to medical acupuncture with a finding of no difference. One, one statement could be, okay, it's just as good as medical acupuncture.

[01:01:12] It also could be said that medical acupuncture is just as good as the protocol, but it costs a whole lot more. But medical acupuncture, we're back to that one doctor and one room with one patient for an hour. That is always going to gonna be an exorbitant cost. This is much more efficient especially if you are using your existing staff so you don't have to pay someone to come in.

[01:01:39] And on that note I really want to emphasize that whereas we are a training and advocacy organization. Our goal is to support organizations and systems to developing their own trainers in-house. So you do not have to pay someone from the outside to come in and do all of this. So there again is a cost effective aspect of it, of the protocol, but yes, it is very effective in helping elderly with pain as well.

[01:02:14] Next here we are with the veterans healthcare not a protocol guidance as of 2025. And this, I encourage you to look at their public facing website. This is what the VA is claiming with their access to vast amount of data outcomes and research. This is what they are saying about us. Not a protocol is has broad indications, including, but not limited to pain, anxiety, depression, PTSD, sleep problems, substance use disorders, and other mental health conditions, and also wellbeing.

[01:03:00] That is huge. I have never leaned into the pain statement, quite frankly because I didn't want the protocol. I don't want the protocol to seem like it's competing with anyone. However, the va and it has been enough for us to say that we are effective enough on the mental health, behavioral health side.

[01:03:20] That also includes mood associated with pain. Conditions. If you look at the ICD diagnoses, you can have mood secondary to physiologic issues including substance use disorder. So it, that was enough. But the VA has insisted on leaning into the value of the protocol for pain as well, which as you

can imagine in the veterans system for our soldiers is a huge is huge in terms of the impact that we want to have.

[01:03:56] Next slide.

[01:04:02] **Moderator:** This next slide was a video that I believe we, we passed up last time, Dr. Carter, and for the sake of time I'm assuming you might wanna pass this one again.

[01:04:10] **Dr. Carter:** I think that's the last one. And it's only five minutes. Is that the last slide? I think it

[01:04:18] **Moderator:** is. Think it was, and I apologize. I lost the slide there.

[01:04:21] We are a lit, we're

[01:04:22] **Dr. Leggett:** we way over?

[01:04:24] **Moderator:** Yeah. We'll go a little bit over but we'll make sure that will be in the slide deck.

[01:04:29] **Dr. Carter:** Okay. Alright. Okay.

[01:04:30] **Moderator:** For our viewers. If it's okay, I would still love to do a little q and a and I appreciate you coming back as those viewers who attended the live webinar know we had some technical issues, so we appreciate Dr. Carter and Dr. Legett for trying to fill in last time. And for you coming back and being able to rerecord this, we learned about the not a protocol through the Pearl program in Virginia, which is a women's recovery house for parenting and pregnant women. And when we heard that their peer supports in the home were dually trained as.

[01:05:03] In the NADA protocol. So they were doing that for the residents in the home, but they were also trained as doulas. And we just thought that was such an innovative, holistic approach. And so that's what made me seek you all out and search you out. That's a big part of our audience is recovery house operators, rule operators across the nation and and different folks in the recovery ecosystem that support that work,

[01:05:26] any thoughts, Dr. Carter around why and how the not a protocol is specifically beneficial to recovery house operators?

[01:05:36] **Dr. Carter:** Yes, because it's easy, it's economical, it's efficient, it's effective, it's adaptable, it's affordable, it's safe and it helps to center and still and cause less angst for everybody.

[01:05:54] Providers, patients, and the entire program, and it improves outcomes. So yes,

[01:06:00] **Moderator:** sure. And that was one of the things that was very attractive to me personally, as somebody who's worked in the recovery housing space for a long time, and you alluded to this throughout your presentation the struggle for rural communities and especially rural SUD providers, they're often doing transformational work, but with very little budget and resources.

[01:06:19] So that was something I found very attractive personally, is that it could, it was so cost efficient. It's very inexpensive. Do anything you would tell operators who may be interested in this and maybe what the cost might look like for the training and then how much it would cost to do it on an ongoing basis?

[01:06:37] **Dr. Carter:** Yes. The training is \$500. We have a range of 500 to a thousand dollars for training, depending on the set and setting. And so the i'll say the overwhelmingly we charge the \$500 for the training. There's a hundred dollars member subscription fee, so they can get trained for \$600, and that comes with a year subscription that needs to be renewed annually.

[01:07:03] **Moderator:** Okay.

[01:07:04] **Dr. Carter:** Yeah. And of course, the other thing I'm so glad that your doulas were able to provide this as well, I would say to those of your com of the Fletcher Group community that may be in states that do not have favorable laws, allowing them to practice like yours and mine, EE Erica, that the acupressure beads.

[01:07:26] They can still learn how to do those that is very simple. They can learn how to do that in five minutes. And and since it's a simple bead, could even be a seed on a piece of tape on the ear. There's no contention about that at all. So I'd even encourage those in states that are not yet up to snuff to think about in, in, in incorporating the beads.

[01:07:50] **Moderator:** Oh, you hit on several things there that I also wanted to ask about and because I know I looked in my own state 'cause I was already interested to get trained myself and see if we could start offering it here in

Kentucky. And I did find a website. Can you talk about how they our audience members who may be interested in implementing this in their recovery house, their RCO or other recovery support service option, how they could find out what it looks like in their state and if this is possible for them in terms of acupuncture, but then it sounds like they probably would have the option to use the beads, if not the actual acupuncture with the needles.

[01:08:26] **Dr. Carter:** Yes. Yeah. I would suggest that at, as they look to build support and. A constituency, I would recommend that they not be like me. When I first started, I back, then in the eighties, we had slides, for overhead projector, power, then came to PowerPoint.

[01:08:45] But especially back in the days of slides, I walk in, talk for an hour trying to convince stakeholders, leadership. The first question would almost always be, is it gonna hurt? Yeah. So I suggest wherever they go they always do in incorporate a demonstration, a treatment because hearing how wonderful this is, it's almost unbelievable.

[01:09:10] It's like a universal treatment. I think about it like a glass of water and a plant. You can get the plant all the chemicals and fertilizer and stuff you want sun. If it's not getting water, it's gonna die. But is water enough? No. You need the rest of the things too, if it's gonna thrive.

[01:09:32] But you've got to have the water. And the water. The need for water is ubiquitous. That's the protocol. That's how I think about it is giving a thirsty person a glass of water. Now, if you're in a well-resourced treatment center, that glass of water might not mean a whole lot, if you got fresh squeezed juice and all kinds of of of boutique sparkling waters.

[01:09:56] But if you don't have anything to drink, that glass of water can save your life. Absolutely. And regardless of what you got is easy to get. And. Everybody needs it. I hope I didn't digress too far. Did I answer your question?

[01:10:10] **Moderator:** Yes, you did. Okay. And so I'm hearing is there any states right off the bat that, I know Virginia has a very, they've got very good laws around this.

[01:10:18] It can be done by peers or because they're not doing full acupuncture, they're only doing the not a protocol, which is very simple and easy to do. So is there any states that stand out for anybody who may be watching this today that

wanna know, that stand out to you, that do have good laws around this that's something they could in fact implement?

[01:10:37] **Dr. Carter:** I'm gonna pass the bat tiny here to to, to Dr. Leggett. He's vice president of NADA and our operations Chief Operations Officer. So he's got his finger on the pulse for more of that. So yes, Dr. Leggett

[01:10:52] **Dr. Leggett:** actually, state law vary. For me, a medical doctor or an acupuncturist to like Virginia, not having that, the only place that I've really seen that I think is very reasonable with their laws is Oregon, and that is just coming about in March.

[01:11:09] They've worked on it for a long time, and I think that the directors of the acupuncture centers there were really adamant about getting the, a DSS in and peer recovery specialist type people in. I think that's how they got around the acupuncturist. They wanted to see a DS in their state, they got pushback from the acupuncturists like other states do, but they didn't let that stop them from making the law.

[01:11:38] Where it was pretty comfortable for people to come on a DS. They will have to register with the state, which is great. Here in Maryland our laws are, I call 'em stringent because the mere fact that even if you have a master's degree in the social services field, they want you to have a license.

[01:11:56] And here, if you have a license, then you pretty much on the level with a PhD. So you can almost teach, you can do whatever you wanna do and run your business. So it's really not important to them after, at that point to go through a whole lot just to become an A DS in the state of Maryland. So what a lot of them would do is just, they would get trained by NA and they would go out and do what they wanna do anyway.

[01:12:18] So that is the, that's the disadvantage of when you put too many restrictions on the laws. People would take them out of protocol training and they would just go out anyway. And then just do you know what they feel like they wanna do, particularly if they have their own organization, like a church or any type of community type thing that, that's within there.

[01:12:39] And they're not gonna go through the state to go through all that stuff saying you gotta have a license, you gotta be a licensed so and or whatever. I think that a peer recovery specialist should be allowed to practice there, not a protocol without immense supervision.

[01:12:55] **Moderator:** And we see, we've seen great success with that.

[01:12:57] That was another thing that was very attractive to me. I'm a big believer in peer support specialists and the value that they bring to the recovery ecosystem. And what I loved about Pearl is that they were empowering their peers by getting them trained in this protocol. So it was building their resume, building their skillset, yes and yes, making them even more valuable in the recovery space.

[01:13:21] And I would love to see more pilots of that happening in other states. So I know we've had further conversations about that. So hopefully we can find a way to do that and to pilot this in other peer led top programming so that peers get that benefit. And then also, of course, the clientele gets that benefit.

[01:13:38] But I also think and you really spoke to this a lot, Dr. Carter's, that also helps the professionals for, US folks like licensed clinical social workers, psychiatrists we're our caseloads when I was in the field was there was waiting list. And so to be able to have anything that helped my clients alleviate some of the stress and things they were going through is beneficial.

[01:14:01] For the sake of time, I will probably go ahead and end the q and A here, but I just wanted to thank you all again so much. I'm glad we were able to rerecord this and more from y'all. And if folks would like to get connected to Dr. Carter, Dr. Leggett and learn more about the NADA protocol or how and when and where they can get trained reach out to the Fletcher Group, we'll get you connected.

[01:14:22] And also if you wanna quickly share, I know you all have a conference coming up. Would you like to share about that, where it's gonna be and when,

[01:14:30] **Dr. Leggett:** That conference will be held on June the 27th in Detroit, Michigan.

[01:14:35] **Moderator:** Ok

[01:14:36] **Dr. Leggett:** the Marygrove Institute, but all of that information, you can find it right on the website.

[01:14:41] When you go to the website, it's the first thing you'll see and you can even register from there. And if someone wants to become an A Ds, we'll also

be doing training prior to the conference on June the 24th, 25th and 26th. Okay. So you can get, you can become an a DS or start your a DS training and attend the conference as well.

[01:15:03] **Moderator:** Awesome. Thank you again, doctors Carter and Legett. We appreciate you all and look forward to further collaboration with NADA Protocol. Have a great day.

[01:15:12] Thank you. Thank you. It's a pleasure. Thank.