(Introduction discussion)
Speaker 3

We are ready I think to get started. I will introduce you, this is Christopher Johnson, who will talk about substance use disorder in the Navy, past, current, future perspectives. Serving now as the Navy Bureau headquarters section chief, for Navy medicine substance rehabilitation program, since 2016. Mr. Johnson is a veteran of both the Army launch rocket gun assistant, and as a Navy service Corps officer, Mr. Johnson transferred to the ready reserve as commander in 2019. Earned bachelors of Arts and attended graduate school in University in New York City, postgraduate studies completed to theyou now -- Cornell University and in in ministration, professionally independent licensed and board certified like this, board-certified license, and I will turn it over to you.

Thank you I'm excited to be here today, great presentation so far, so hopefully some of this technical glitch is that plagued some of the other speakers will skip over this presentation, and hopefully the rest the day as well. So my presentation will be a little different, then some others, that you've heard today. I do want to build in time for questions, that I always get just regarding may be specific things, that we have that may be different than experiences in the Army, Marine Corps or Air Force. I know some of our colleagues, counterparts from the and Army and Air Force are probably on the air today, and I love the relationship sharing best practices and ideas amongst us, and we will start with this slide, this is my disclosure, I have not had or my spouse or partner any immediate family member have had in the last 12 months any thing

-- The views in this presentation are mine do not reflect Navy Bureau of medicine and surgery, and department of defense or other US government entities. Okay Learning Objectives today, pretty straightforward identifying major components and structure, we have program clinics and facilities, recalling those four record for early intervention and ongoing recovery support, identifying major challenges and future challenges of the SARP program.
That acronym substance abuse written dilatation -- Substance abuse rehabilitation program.

The SARP location shaded in yellow medical specific and blew his medical forces Atlantic, used to be referred to as medicine West Indies, renamed in part of the structuring of DHA, and we also have on the bottom right corner. This may be small to look at, but we have shift board sites at every Air Force carrier, offering screens, early intervention outpatient treatments, and continuing care specifically, to counselors assigned to a carrier, then they are clinically supervised by the site bus, or the ship psychologists.

I think the only location not referenced on here we have a new location in Bell Cave Louisiana near New Orleans. A success story as we were able to get that up and running to serve more directly, sailors and Marines working out of the New Orleans area, without traveling to Pensacola or

Bellport.

Just a quick overview established in 1971, essentially a waterfront program expanded to 39 MTF based clinics, and before the 11 shipboard locations, around the globe, one of the distinguishing features I think of the Navy substance abuse treatment, is the backbone, the backbone is from the certified counselors from the most part, this is a combination of active duty counselors, contractors, and GS counselors. They will I would say in the upwards of 95% counselors are certified but not licensed and that may be different from some of your experiences perhaps if you work with the Army before or other entities. We do have license independent providers, LIPs, anywhere in some remote location from my flight surgeon to, but typically sometime could be psychologist, nurse Precht dish psychologist, -- Nurse practitioner or psychologist. In 2018 it used to be enlisted counselors, were voluntary recruitment program and essentially anyone could apply for the school that was up in California near San Diego. That was changed in 2018, only the hospital Corps, which are core men come from. As a result of that, we have had ongoing challenges with manning be enlisted counselors. And we are looking at other alternatives to that. We do still have counselors serving that came from other rates, and others referred to here, and other servers, vast majority are now coming from the hospital Corps, to become hospital enlisted counselor not coming in already but certification, they have to successfully graduate the drug and alcohol school currently 10 1/2 weeks, we will talk about those changes coming up with that. Completing 2000 hours of supervised clinical work, then that has to be done in a SARP clinic, taking an examination, awarded the ABC one certification. They can progress on, and there is also a clinical supervisor certification as well. Should they choose to pursue that. As I mentioned before, we have civilians and contractors, also service counselors, and these individuals would be certified at the time of hire, and at the time that the contractor brings them on board. One of the other supports for counselors, again our backbone of the program, currently a support contract, the vendor is international, and they provide on-site and virtual, since we've been in the pandemic. Providing clinical pre-acceptor ship to all counselors, meeting with license providers that work in the SARP clinics, and providing consultation, providing documentation with providers, and it's been a great program very strong and we hope to continue that, okay. I will talk a little bit more about our virtual recovery support program, we title it which is ongoing Navy recovery experience starting in 2010. Contract that we started with, with the Betty Ford foundation, had significant changes over the 11+ years now since we kick this off, in general, any sailors or Marines or other service members and admitted to level II of the SARP clinic are enrolled in the program, in the Navy MORE program. 10 coaches geographically distributed that have certain signed geographic areas, that they will assist the local SARP clinics , and educating the service members with the program, any questions that they may have getting started. We had a major web platform upgrade in August of last year. That is included now smart phone browser compatibility.

A major switch from the task from progressions of modules through support contacts. Then we have retained the ability to have the service members communicate directly with the Navy coaches, for additional guidance. So far going in every day, and more than 4000 sailors and Marines have enrolled in the program, one of the return of investment

we look at with these programs, are we making a difference? Is this concept with having individuals that may have completed treatment and should have struggles down the road, leading to a relapse, or maybe a slip, often times for military population unfortunately they do have a repeated alcohol incident that often times will result in their commands recommending them for administrative separation. So with that 1700 number, what that is tracking essentially, individuals that have been involved in Navy MORE reaching out to their coaches, and getting support that they need. Perhaps even getting reconnected with the local SARP clinic where they're located, or other community resources to get back on track with recovery.

This slide summarizes the changes with Navy MORE from pre-2020, now to the current program, moving to education and completing tasks, to empowering our service members in recovery, to determine through self-assessment, and other tools, what specific areas they may have questions on? May want more information or resources, switching from linear learning and flexible learning. Much more a research hub everyone can come back to a resource hub, we say 18 to 24 months is the max that Navy MORE in these utilized, and however there is no expiration point on this if individuals are participating and logging into the program, then there is really no expiration date even if they would separate from service. There are a number of features that are available to the operational forces as well, which is very important, often times aboard ships and overseas, in those locations, Wi-Fi can be limited or nonexistent, and now there is a capability to be able to go into the site prior to a deployment, and actually download things ahead of time, which is different videos other support programs. They have access to those things without WebEx, or web access. >> We will dive into this, some of the challenges, this is where the rubber meets the road. Many of you are probably familiar with the help behavioral survey, coming out every three years. We did very recently in the last few months have the 2018 HR BS come out. Going back very quickly to the 2015 version. While it is difficult to make direct comparisons, because of the measurements and the definitions of these terms, using these a little bit different in the criteria. It is clear we continue to have an issue with unhealthy use patterns within the Navy and the Marine Corps, you will see that the 30 day period, reporting and, binge drinking or heavy drinking. Then to touch on or other substance misuse, so I did have this on the slide previously. About 75 or 76% depending on the year of the individual in which they come in, are coming in for related to alcohol issues. This is the breaker year calendar 2020, and these are the breakdowns, the metrics are probably a little suspect for 2020, because of the impact of the pandemic and numbers, clinics had to reduce capacity, or in some cases close, numbers may be different than some other years. In 2020 we had 49% who were referred for marijuana issues, 10% cocaine, 11% hallucinogens 7% opioids, and 7% other stimulants outside of cocaine, and then the other 12% other drug abuse, and 4% sedatives. We touched on this earlier regarding our counselors, with that switch to the hospital court, we have had some ongoing challenges, and it is widespread across the Military Health System in general, just having being in the midst of the DHA transition, and having some disruption in staffing, many MTF's, in our program, have been impacted as well. Combine this with a lot of our active duty military populations, being embedded in different

programs, or taken out of MTF settings, and put into operational settings, we continue to look for creative ways to improve that. And still be able to provide the services that we do need.

A couple future initiatives, those who work with the Army, Air Force, Coast Guard will be familiar with pride for life. We are using this with early curriculum, a record for the SARP program, this is the 0.5 , previously we had a program referred to as an impact I forget what the acronym stood for, it was catchy, a contract developed in the 90s, quickly becoming outdated. It was a one-time contract, and we had no review process. In the course of our SARP's just trying to make the best of the curriculum that they had, it lost a lot of standardization and just to give you an idea of how old I was, and held it was, references to , don't ask don't tell, and the reported chain of commands, if there was homosexuality preferences identified during treatment. Even prior to this it was eliminated, and we still lack that standardization that we need. I think one thing I've seen with the DHA transition, and working with my partners and sister services in DHA, we have had a lot of areas that we can standardize between the services, and we all bring great ideas to the table. Having that ability to compare and contrast some of the best practices and some things we are doing, things that may need to be different as well depending on the service just because of the population we are serving. It really goes a long way. One of the ways that we have been able to come into alignment with the Army and Marine Corps, the course guard here, and the Coast Guard having the ability to tailor this for four hours, which can be used as a command military general training, up to the 20 hours, which is how we got these ranges, and how we would use these for the early intervention programs. There is been some research , early research to indicate prime for life has been effective , and a pretreatment as well we are looking at for folks who may be waiting to go into outpatient, or residential outpatient treatment. And mentioned what we talked about in the school, very recently probably not even 30 days ago, we learned that we would be able to increase the course link from 10 1/2 to 14 weeks. As the director there, Dr. Jensen would remind me often, they would be at 10 1/2 weeks for quite a few decades, even though every year they were requesting increases. To the length of time. Because of the broad changes that have happened within the substance use treatment over the years, and evidence-based practices or modalities that need to be extended for time, and for folks who a particularly have not been involved in the substance use field previously, which is the case exclusively with students that go through this, and it is not started but the 14 weeks yet, and a lot of logistics such as curriculum and other things that would be impacted by that course line. Very recently I'm not sure if he is on the call today, but we have been working with Dr. Milliken, and with the voluntary care program, this would be on the level of a no diagnosis, or alcohol use disorder, and an option that gets around this 6408 command, for those substance use programs, and through this process as we adapt it for Navy. Two further -- Adapting it for neighbor to further increase, getting help at an earlier stage for alcohol problems, without the inevitable command notification, which I'm sure is similar for other services, 95% plus, of our refers the referrals, and command has some type of drug related incident. Finally in terms of the new

initiative. We are in early stages as well. Looking at alcohol and substance use treatment, for license providers, and this would be primarily geared towards active-duty providers, often times general mental health providers, but maybe not that type of experience or background education and substance use disorders, that they really need. When coming aboard these clinics, to be able to provide those services, and also the supervision to the counselors as needed.

So I think I'm around 10 minutes, I know we started at an odd time. But I want to take any questions which you all can use the chat window for that. I'm not sure if they have the ability to ask questions -- Thank you so much Chris, this is working into the Navy program, those of you with us today, you will have to join us next year, and then the following year, and the following year, where we will have representatives to talk about Army Air Force, as well as the Coast Guard, working with you many years and it goes without saying the leadership in this area for that we are appreciative sharing with this all today.

I know that the Navy MORE program you have been instrumental in bringing in these partners.

Are relationship goes back many decades prior to 2010. They have worked with us on some other things. I only go back so far in terms of historical knowledge with that relationship, and those things then the loving balance here with this curriculum while we don't require the standardize curriculum, it is taught at the school there was a time I believe when they use to send instructors out to train the counselors on that . It has since been taken over primarily by the in-house instructors which has worked well, still a very successful program, to giving our counselors a base, in terms of getting out in the clinics, and providing treatment, that they have at least that background through the curriculum. I think that really you have leveraged the best of the civilian partners, and bringing that in. The training programs that you have. Those that you have developed for the Navy, are really models.

The other institutions and other types of integrated systems could use to really bring up to some of the success rates that you have demonstrated. That you show us.

Absolutely.
Again I know we are a little bit pressed for time. If we can send you any questions that we may get later on in the day, we can share that with the audience that would be appreciated.

Absolutely.

I want to thank you for putting together this program, and the discussion because it is really, it is helpful for those of us seeing and treating patients every day. To understand to sit back a little bit, and just to see how it is just all over this, and organize, thank you for this Mr. Johnson, we will move on to our last speaker.

Thank you all.