COMMANDERS DIGEST

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DoD learns some lessons about DRUG ABUSE

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The rapid increase in drug abuse in the Armed Forces in 1970 and 1971 created many problems for which the Department of Defense initially lacked the experience to cope. In the ensuing campaign to combat drug abuse, the Armed Forces gained experience and learned many lessons which can be profitably studied by members of the military and civilian agencies still occupied in waging the struggle.

While the problem of drug abuse in the military population has not been totally defeated, the indications are that it is on the wane. The percentage of clinically confirmed positive urinalyses has exhibited a gradual, steady decline; the number of men applying for treatment for drug abuse under the exemption policy peaked in late 1971 and is now slowly decreasing.

The most important lesson that the Department of Defense has learned in its current fight against drug abuse is that the problem can be solved.

Significant general lessons learned include:

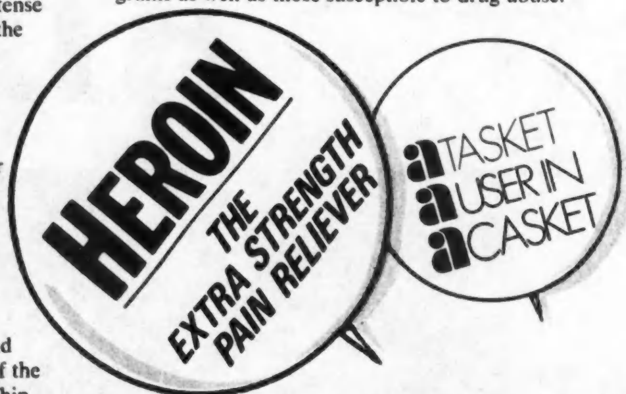
- that command support is vital to the success of any program,
- that each drug program needs a designated manager with clearly established responsibility, and
- that professional, dedicated middle managers are required.

Education/Prevention

The DoD drug abuse education/prevention program operates on a decentralized basis, with overall policies and responsibilities established by DoD directives and each of the Military Departments administering its own program within the DoD-established policy framework. Flexibility is an absolute necessity. As the needs change, so do the programs, and in the past few years the emphasis in all of the programs has shifted from punishment, to drugs, to people. At present, emphasis is placed on aiding individuals to define their personal goals and to distinguish between reality and rationalization in their efforts to accomplish these goals.

Early in the DoD program, a problem quickly became apparent—a large credibility gap existed between the group of potential drug abusers in the younger age group and the military hierarchy when the subject of drug abuse was raised. The primary factor appeared to be the use of incorrect or biased information concerning the use and effects of certain illegal drugs.

In the drug education and prevention area, the basic lesson learned was that information about drugs and their effects must be both factual and objectively presented to be credible. In addition, educational information must be kept up to date and must be presented to the intended audiences in a manner which will encourage them to read it. It was discovered that to be effective, preventive drug education programs must go beyond simply transmitting information about the legal and medical dangers of drug abuse and must provide alternatives and stimulate attitude and behavioral changes on the part of those responsible for drug abuse programs as well as those susceptible to drug abuse.



In this important area of the DoD program, educating the educators was one of the first steps taken. A basic problem encountered was that those charged with educating others to the harmful aspects of drug abuse were not always fully knowledgeable or credible. Special training programs were set up for these soon-to-be educators. Some were courses taught at established universities, but each of the Military Departments also set up in-house training programs for its own personnel.

Educating the leaders was another important phase of the DoD-wide effort. In addition to conferences and seminars, formal educational efforts were made in noncommissioned officer academies, preparatory schools, officer candidate schools ,and Reserve Officer Training Corps schools. Medical and legal officers and chaplains also received specialized, intensive training. Two significant lessons learned were that command support behind a clearly defined program was a

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must and that in manning drug abuse positions, the staffer must be assigned on a full-time basis.

In the area of education for potential drug abusers, a basic lesson learned was that no one approach was effective with all groups; on the other hand, a combination of many techniques—presentations by exaddicts, hotline counseling, workshops, rap sessions, films, brochures, etc.,—proved effective.

DoD early recognized the need for additional special training for medical and legal officers. The advent of the military drug problem quickly highlighted a need for training which would permit medical personnel to recognize drug problems. A tri-Service publication—"Drug Abuse (Clinical Recognition and Treatment, Including the Diseases Often Associated)" January 15, 1973 (Army Tech Pub MED No. 290, Navy Pub No. P-5116, Air Force Pam No. 160-33)—provided detailed guidance on the identification, evaluation, and treatment of drug abusers. Another problem noted—and solved—in this area was that medical administrators also needed additional training.

All too often individuals in drug treatment programs were not provided information about the programs or motivated to continue as they moved from one place (and program) to another. The same lack of continuity appeared when an individual was transferred to the Veterans Administration. The individual was seldom well informed about that program or motivated toward continuing the VA treatment; consequently he often would not stay long enough for full rehabilitation. This was a credibility gap which was identified and closed through special training.

Extension of the DoD educational and preventive program to dependents of members of the Armed Forces was also a vital part of the effort. Both in the U.S. and overseas, dependent schoolchildren now receive drug abuse education. One peer education program—Teen Involvement—uses volunteer high school teen counselors to provide information to students in elementary and junior high school grades. In addition, the DoD encouraged members and dependents to participate in civilian community programs in order to both learn and share their knowledge.

In summary, the goal of the education programs is to help the individual realize that he, and only he, is responsible for the decision to use drugs, while at the same time providing the individual with the facts about the consequences if he does choose to abuse drugs.

Identification Of Drug Abusers

The identification of those who chose to use drugs was an early step in the DoD program.

Prior to the middle of 1973, the most effective means of chemically detecting drug abuse was by urinalysis using the free radical assay technique (FRAT), thin layer chromatography (TLC), and gas liquid chromatography (GLC) methodologies. While these systems were effective in identifying drug abusers who had drugs in their bodies at the time of the tests, they were laborious, expensive, and time consuming where millions of specimens were involved. They were also limited to the three major classes of drugs—barbiturates, amphetamines, and opiates.

Gen. Clay Heads DoD Drug Program

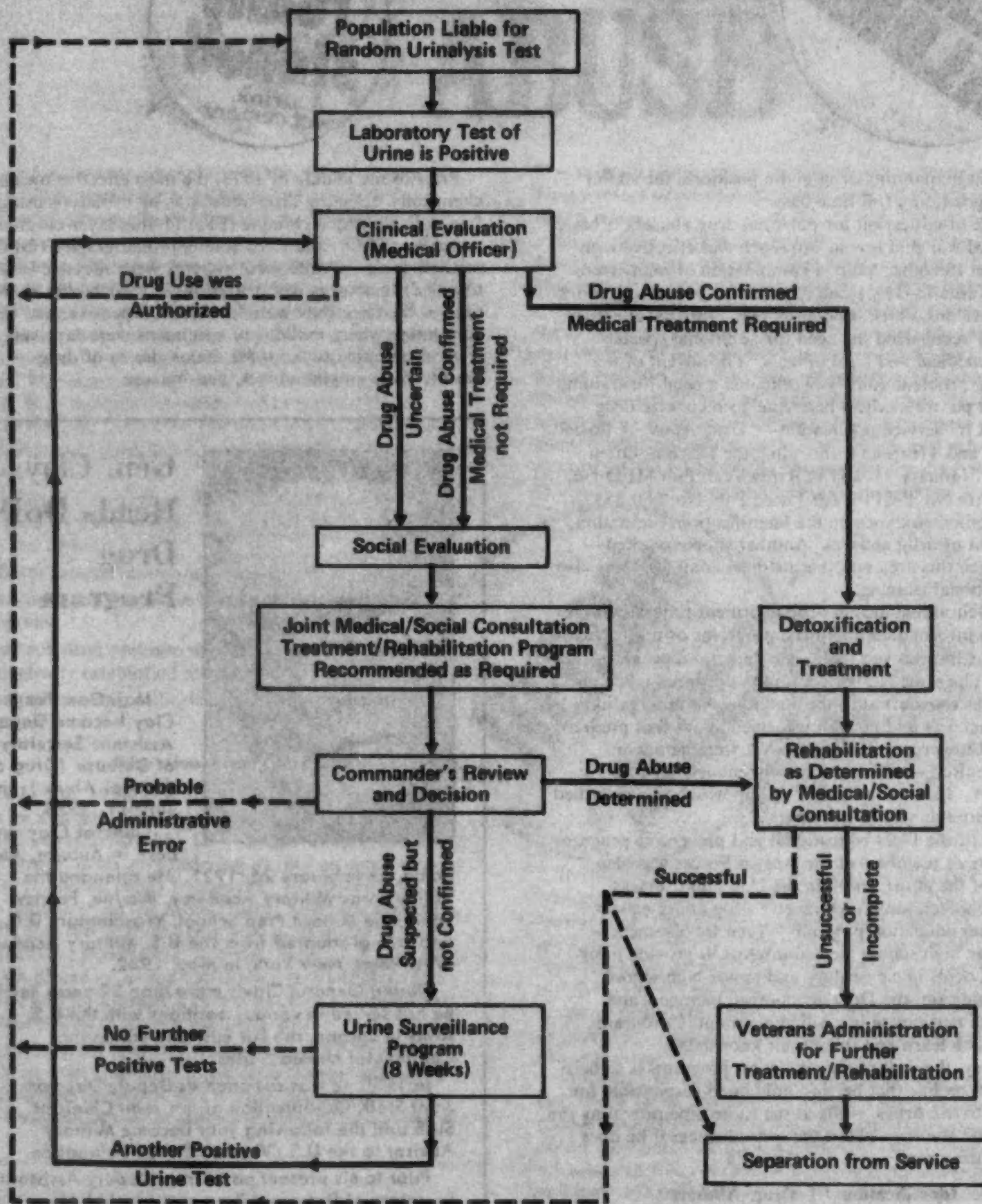
Maj. Gen. Frank B. Clay became Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse) on July 11, 1973.

General Clay was born in Auburn, Alabama, on February 26, 1921. He attended the Valley Forge Military Academy, Wayne, Pennsylvania; the Millard Prep School, Washington, D.C.; and was graduated from the U.S. Military Academy, West Point, New York, in May, 1942.

During General Clay's more than 30 years service he has served in various positions with the U.S. Army in Europe, the Far East and within the Continental United States.

In 1970 he was assigned as Deputy Director, Joint Staff, Organization of the Joint Chiefs of Staff and the following year became Military Advisor to the U.S./Vietnam Peace Delegation.

Prior to his present position as Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse) he served as Chief, U.S. Army Audit Agency.


EVALUATION PROCEDURES
Population Liable for Random Urinalysis Test
Laboratory Test of Urine is Positive
Clinical Evaluation (Medical Officer)
Drug Use was Authorized
Drug Abuse Uncertain
Drug Abuse Confirmed Medical Treatment not Required
Drug Abuse Confirmed
Medical Treatment Required
Social Evaluation
Joint Medical/Social Consultation Treatment/Rehabilitation Program Recommended as Required
Detoxification and Treatment
Commander's Review and Decision
Probable Administrative Error
Drug Abuse
Determined
Rehabilitation as Determined by Medical/Social Consultation
Successful
Unsuccessful or Incomplete
Drug Abuse Suspected but not Confirmed
Urine Surveillance Program (8 Weeks)
No Further Positive Tests
Veterans Administration for Further Treatment/Rehabilitation
Another Positive Urine Test
Separation from Service

As a result of new advances in the art of drug testing, the new radioimmunoassay (RIA) technology will receive its large-scale screening application in the DoD drug abuse testing program. RIA offers a highly automated testing technique for a wide array of abusable dangerous drugs plus greatly improved test sensitivity and the ability to prevent misidentifications.

Significant savings in time and laboratory personnel have also been demonstrated. As a result of a recent large-scale operation evaluation by the Department of the Air Force, the entire tri-Service drug testing laboratory system will soon incorporate RIA screening.

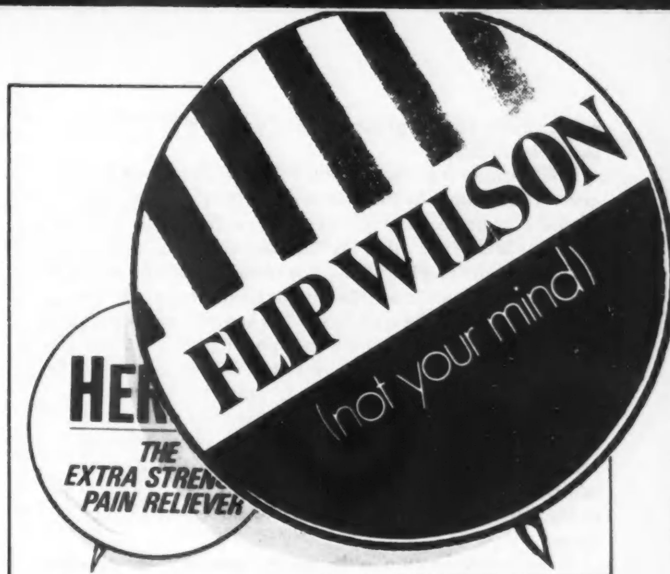
Immediate advantage of the urine testing program was that it gave the Department of Defense a reliable indicator of the overall magnitude of the drug abuse problem. Second, urine testing permitted the early identification of drug abusers prior to the point at which physiological and psychological dependence occurs as well as the removal of drug abusers as sources of infection in units. Finally, random urine testing on an unannounced basis, as is now the policy of the Department of Defense, serves as a deterrent to would-be drug abusers.

Another category of the urinalysis program is "event tests" given at particular times during a member's tour of duty, such as upon return to the U.S., or on being ordered to an overseas area, or at reenlistment. The differing ease and price with which drugs may be obtained in various parts of the world influenced the Department of Defense to vary the frequency of random testing according to the "risk" area. In high risk areas (Vietnam, Thailand, Philippines, Okinawa, and Taiwan) the average test frequency was set at 3.0 tests per person per year; in moderate risk areas (Korea, Panama, Europe, and the Middle East) the frequency was 1.6 tests per person per year; and in minimum risk areas (all other geographic areas) the test frequency is 1.2 tests per person per year.

A potential problem with the urinalysis program was that an individual might be falsely accused of being a drug abuser due to laboratory error. Since this could have serious consequences, both in and out of the military, a confirmatory procedure was put into effect to reduce the possibility of unjust drug abuse accusation to near zero.

When a urine specimen arrives at a laboratory it is subjected to the radioimmunoassay procedure. If a positive result is indicated, the specimen is retested by RIA. A negative RIA result eliminates the specimen from any further procedures. If a positive indication is received on both RIA tests the specimen will be subjected to a third or confirmatory procedures by the highly accurate gas liquid chromatography. If found negative in this test the urine specimen is adjudged drug free. If positive, action is undertaken to determine whether or not the donor is a drug abuser through medical diagnosis and social evaluation prior to a commanding officer's decision regarding a future course of action.

In the social evaluation phase, a person experienced in the evaluation of drug abuse sees the donor and after a series of meetings prepares a recommendation. The physician and the social evaluator then confer regarding their separate findings and prepare recommendations for the future course of action for the use of the commander in making his final determination.



Based on the report submitted to him, the commander makes one of the following determinations:

- The Serviceman is a drug abuser or is drug dependent and is entered into the treatment and rehabilitation program;
- The individual cannot be medically confirmed as a drug abuser or drug dependent or cannot provide satisfactory evidence of authorized drug use and so should be placed in a urine samples surveillance program; in this program the individual submits 3 urine samples a week for 4 weeks. If a subsequent sample is reported positive, reevaluation takes place; if all tests are negative, the individual is released from the program; or
- Support confirmation is lacking and the individual is released from any further consideration.

Lessons learned included:

- A system of obtaining a valid specimen was necessary through direct observation of the process,
- A strict policy had to be followed in handling and securing the specimens so that there could be no destruction or exchange of the sample,
- All laboratory work must be conducted in an efficient, organized, and timely manner and there must be close communication between the laboratory and the physicians handling actual or suspected drug abusers.

Another aspect of the urinalysis program which contributed to the success of the program was that because of the Department of Defense policies, detection of a drug abuser did not lead to punitive measures. The drug abuser was given detoxification treatment and rehabilitation treatment instead of being turned over to police authorities.

Laboratory Urinalysis

Quality control of the urinalysis laboratories' output was recognized from the outset as a prerequisite for a successful program. From an early start in Vietnam, where the officer or noncommissioned officer in charge of the laboratory inserted morphine samples with donor's samples, to the complex system used today, quality control has played an important part in the success of the DoD program. Today the Armed Forces Institute of Pathology is the DoD-desig-

nated agency for the quality control program of all participating laboratories.

The institute uses the "double blind" system in its quality control program. As the first step, the institute prepares stocks of urine containing varying quantities of the drugs of interest. Sets of the urine are then dispatched to collecting stations, points at which bona fide urine samples from the field are gathered for distribution to laboratories. At the collecting station, the quality control samples are repackaged and recorded so that they are indistinguishable from the collected samples and the entire shipment is then sent off to the drug testing laboratories. At the laboratories, all the specimens are tested and then the entire shipment is returned to the collecting station where the quality control sample reports are extracted and forwarded to the quality control laboratory. Weekly and quarterly reports are then prepared to show the level of the proficiency of the various laboratories.

A vital consideration in the quality control program which contributes to its objectivity is the fact that the quality control laboratory director has no enforcement function over the laboratories being tested. His task is to prepare and dispense samples and to report the results to the test laboratories and Service representatives; changes and improvement come from them.

The first efforts to identify drug abusers centered on the exemption policy whereby an individual identified himself as a drug abuser and volunteered for treatment. Under the exemption policy, evidence of drug usage or possession for personal use which was produced as a direct result of volunteering for treatment may not be used in any disciplinary action under the UCMJ or as a basis for supporting, in whole or in part, an administrative discharge under other than honorable conditions.

Similar exemption is granted for evidence produced as a direct result of urinalysis tests administered for the purpose of identifying drug users. The exemption policy does not exempt Servicemen from disciplinary or other legal consequences resulting from violation of other applicable laws and regulations. However, the information gained as a result of the policy may be used, if deemed advisable, in other administrative actions, such as removal from flying status, reassignment, denial of security access, and administrative discharge under honorable conditions.

To solve the problem of credibility—initially the policy with all of its ramifications was not understood in detail by officers, noncommissioned officers, and the target group of drug abusers—a program of education and publicity was used to inform all concerned of the details and to convince the drug abuser that it was to his benefit to volunteer for treatment. By using a "personal or human approach," counselors convinced the target group of drug users that the "establishment" was sincere in its efforts to help them.

In August 1971, the Secretary of Defense directed that administrative discharges under other than honorable conditions issued solely on the basis of personal use of drugs or possession of drugs for personal use were to be reviewed for recharacterization upon application by the individuals concerned.

If the discharge was recharacterized, the individual became eligible for assistance from the Veterans Administration.

In April 1972, the Secretary of Defense expanded this recharacterization policy to include punitive discharges and dismissals resulting from sentences of courts-martial adjudged solely for personal use of drugs or possession of drugs for such use.

Treatment and Rehabilitation

The Department of Defense policy regarding treatment and rehabilitation of identified drug abusers uses as its governing factor the potential of the individual for further useful military service. Because of the DoD missions it is not considered advisable to assume responsibility for long-term, in-Service rehabilitation. Therefore, DoD policy provides for treatment in Service facilities for those who can be rehabilitated in a short time, have further Service potential, and have time remaining in the Service.

Those who do not fit into this category are phased into Veterans Administration programs for continuing treatment. Pursuant to this policy an identified drug dependent individual will not be separated from the Service until he has completed a minimum of 30 days of treatment. Amplifying this policy, the Assistant Secretary of Defense (Health and Environment) stated that:

- The 30-day period may start with detoxification but the Services have the right to select the treatment starting date,
- The objective of the 30-day period is to attain 30 days of treatment free of drug use to insure that the Services are not releasing drug dependent personnel into society without a significant effort to eliminate the dependency,
- A Serviceman may remain beyond his normal term of service in order to complete 30 days of treatment if he voluntarily extends his active service or if he is required to make up time lost under applicable Service regulations,
- The VA is responsible for the completion of the 30 days minimum treatment free of drug use for those active duty Servicemen transferred to the VA who have not already completed such treatment, unless that treatment is precluded by expiration of term of service.

The decision of whether or not a drug dependent Serviceman is assigned to a VA facility or to a military facility for treatment depends upon the circumstances of each individual case.

The manner in which treatment and rehabilitation programs are operated varies from Service to Service. Each Service administers its own programs within the guidelines and policies established by the Department of Defense. The tasks necessary to effect rehabilitation were common. Each Service recognized that the identified drug abuser had to be detoxified if necessary. Then a decision was required as to the seriousness of involvement, and on the basis of that decision, assignment to appropriate treatment/rehabilitation was made.

PROGRESS REPORT

from the Services

The Army treatment and rehabilitation program is operated on a decentralized basis at installations throughout the United States and overseas. Certain hospitals in the U.S. have been designated to receive drug abuse patients returning from overseas. Detoxification, if required, is accomplished in an Army medical facility and varies with the individual. Rehabilitation is a command responsibility and is accomplished in a unit environment. For success, the soldier, his commander, and the medical and nonprofessional personnel in the rehabilitation program work together as a team.

The Navy offers basically two levels of rehabilitation. Personnel found to be drug dependent are referred to one of the two Naval Drug Rehabilitation Centers. One center uses a multimodality approach with track determination

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based on the demonstrated interest of the patient and the staff's evaluation; the other uses a one-track, two-phase program which goes from group therapy, didactic teaching and behavior modification techniques, to self-governing responsibilities and continued rehabilitation counseling in a halfway house atmosphere.

In the Marine Corps program, nondrug-dependent individuals are retained in the parent command for treatment and rehabilitation; others are sent to the Navy centers for treatment. Upon completion, the center makes a recommendation on the Service potential of the individual and upon that recommendation the Marine Corps determines whether to retain or separate him.

The Air Force system includes five basic phases—identification, detoxification, medical evaluation and treatment, behavioral reorientation, and follow-on support.

In medical screening of drug abusers, it was found that problems arose through failure to diagnose drug abuse for fear of stigmatizing the individual, through lack of professional knowledge, failure to determine what drugs were being abused, and failure to diagnose secondary pathology. To solve these problems, the DoD depended on an information and training program to motivate the medical screening personnel to the seriousness of the drug abuse problem and the important role they play in solving the problem.

Several modalities of treatment are used in the Services' program, but early in the program the DoD rejected the use of methadone maintenance as inappropriate for the type of drug abuser found in the Armed Forces. Most of the Service members found to be drug abusers were young, and few had an extensive history of heroin use. Early it was discovered that detoxification procedures were not always sufficient because only a limited clinical evaluation was made. This led to later problems through use of improper detoxifying agents. Further, there was a failure at times to combine therapeutic treatment with detoxification; the treatment was begun after detoxification, resulting in loss of time and opportunity. From these problem areas it was learned that a complete medical examination is required on all drug abuse patients. The rehabilitation of detoxified drug abusers took many forms, proving there is no single modality route to success.

Drug Abuse Control

Summary of Lessons Learned

Summary of Lessons Learned:

Education And Prevention

• Information material must be tailored to the target group and every channel used to disseminate the information,

• Personal involvement and special training are required for those working in the program, including physicians, educators, chaplains, etc.,

• Factual, up-to-date information must be supplied to be credible.

Identification

• The urinalysis test is the most effective means of detecting users of opiates, barbiturates, and amphetamines,

• Early identification, a measure of the size of the problem, and early removal of "infectious sources" of drugs result from the use of the test,

• A high order quality control program is required to maintain standards,

• The commander is the best individual to confirm drug use,

• Research is needed to devise a means of detecting users of *cannabis sativa* derivatives and hallucinogenic agents.

Treatment and Rehabilitation

• Rehabilitation can be accomplished in a structured environment, and line and combat area officers can successfully operate such programs,

• Counselors used in such programs must be individuals who can relate to their peers,

• Rehabilitation is best done in a group setting,

• Successful rehabilitation efforts focus on the whole man, his physical and mental being, his sense of responsibility, and his obligations,

• A program must have a structured balance, with unscheduled time held to a minimum,

• Follow-up after release is necessary; it must provide some pressure to counter the drug peer pressure.

Records

• Reports and records requirements are a vital part of the program,

• Clear, accurate, up-to-date records must be maintained for each patient and must be provided to the receiving facility when a patient is transferred,

• Confidentiality of drug abuse records must be maintained.

Finally, the drug abuse problem can be solved within the Armed Forces and elsewhere if the program is coordinated and has the support of the authorities at all levels.

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