THE DEPARTMENT OF DEFENSE

EXPERIENCE IN DRUG ABUSE PROGRAMS

JUNE 1973

PREPARED IN THE OFFICE OF
THE DEPUTY ASSISTANT SECRETARY OF DEFENSE
(DRUG AND ALCOHOL ABUSE)

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PREFACE

The rapid increase in drug abuse in the Armed Forces in 1970 and 1971 created many problems with which the Armed Forces initially lacked the experience to cope. In the ensuing campaign to combat drug abuse the Armed Forces gained much experience and learned many lessons which have possible use in the fight against the drug problem in civilian society. This volume was written to present in one source document the more significant of the problems encountered and how they were solved. It was prepared with the expectation that it would receive wide distribution among those involved with drug abuse programs, both military and civilian, so that they and the nation might benefit from the experience of the Armed Forces.

The Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse) wishes to thank the responsible authorities in each of the Military Departments for furnishing much of the original material upon which this document is based. The DASD(DAA) is particularly grateful to the same officials for providing so many knowledgeable individuals to a March 1973 Department of Defense workshop on drug abuse programs in Vietnam. The experience, professionalism and interest of these participants increased the substance of this publication manyfold.

The Department of Defense welcomes comments, additions and corrections to this document. They should be addressed to:

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INTRODUCTION

Because the members of the Armed Forces are a reflection of the society from which they come, the recent rise of the drug culture within the United States saw a corresponding rise in drug abuse in the military services. The missions of these services lacked compatibility with drug abuse and so the Department of Defense and the Military Departments launched a concerted program against it. Every conceivable approach was, and is continuing to be, explored in this campaign. These experiences and knowledge gained are used to revise, improve, and expand the military services programs in drug abuse education, prevention, identification, treatment, and rehabilitation.

The problem in the military has not been totally defeated. The indications are, however, that it is on the wane. The percentage of clinically confirmed positive urinalyses (indicating drug abuse) has exhibited a gradual, steady decline. The number of men applying for treatment for drug abuse under the exemption policy seems to have peaked in late 1971 and is now slowly decreasing. In Vietnam, prior to final withdrawal, the number of patients discharged from hospitals with drug-related diagnosis declined far more rapidly than can be attributed to troop withdrawal alone. There are other indicators of the trend: the percentage of apprehensions for drug abuse in Vietnam declined steadily in 1972, and the number of servicemen admitted to Veterans Administration hospitals for drug problems continues to drop. Finally, there is firm belief among those who were in touch with the problem in Vietnam that the massive efforts exerted there definitely paid dividends. In day-to-day discussions with commanders and others at unit level, it appeared that the service drug abuse programs were instrumental in bringing an increasing amount of reverse peer pressure to bear on drug abusers. Also, while it cannot be demonstrated conclusively from statistics, the effects of education, and deterrence through random uninalysis testing in particular, are credited with significantly reducing the problem of drug abuse world-wide.

None of the items above should be accepted as absolute proof that the DoD has solved the drug abuse problem. However, when viewed in their entirety, all indicators point toward a very definite downward swing in the improper use of drugs by members of the Armed Forces. There is no room for complacency or relaxation of effort. Undoubtedly, new problems will arise which will require new solutions, but it is felt that the military services have the means and expertise to handle new problems as they surface.

In devising and operating the drug programs in the military, there has been a great deal of experience obtained from both the successes and the failures. This experience provides a wealth of information about drug programs, how to plan them, how to organize them, and how to

operate them. Much of this information has accumulated in the Office of the Deputy Assistant Secretary of Defense for Drug and Alcohol Abuse where it furnishes a data base of knowledge which should prove of value to any authority involved with drug abuse. Accordingly, the knowledge has been gathered in this report for the benefit of anyone wishing to use it. For convenience the material has been broken down into the natural categories of education and prevention, identification of drug abusers, treatment and rehabilitation, and records handling.

The fact that much of the information included here may be known to some is recognized. However, that which is obvious to one person or group is not always obvious to others and so this report was written with the view toward including as much substantive information as possible at the risk of being too basic or repetitive.

SECTION 1

Summary

General

This section is a summation of the many leasons which the Department of Defense and the Military Departments have learned from their experiences with drug abuse control programs.

Probably the most important lesson which the Military Establishment has learned in its current fight against drug abuse is that the problem of drug abuse can be solved. Given the proper ingredients of education and prevention, law enforcement, identification, treatment and rehabilitation the young, susceptible non-user can be kept from drugs, and the detected drug abuser can be detoxified (without agonizing withdrawal aymptoms), treated, and rehabilitated to become a useful member of society today. And, this can all be accomplished in a structured, disciplined environment which includes authority figures as well as clinicians and counselors.

Although they are truisms, three other points deserve emphasis because they are all important to a successful drug abuse program. Command support is the first of these; complete, active support of the command drug program by every leader from the most senior through the entire chain of command to the most junior. Unless the commander does place his support squarely behind his drug program, his staff officers and other workers will direct their energies toward that which the commander does support, and the drug abuse program will falter.

The second point of emphasis is the requirement that each drug program have a designated program manager with clearly established responsibility for the entire program at his level, and with adequate authority to coordinate and operate the program without interference. The manager should not be given additional duties which would drain his time and energies nor should outside forces be permitted to confuse the program, undermine or challenge the manager's authority, or create conflicting movements.

Third is the need for professional, competent, honest, dedicated middle managers to supervise the numerous elements of a drug program. The drug abuaer is often oblique; once detected he sometimes does not wish to be treated and rehabilitated. The urinalysis test requirements are stringent, and urinalysis laboratory test standards are higher than heretofore considered practical. These and other constituent parts of

the program demand men who can plan and innovate, who can attend to fine detail, and who can conquer routine and boredom in day-to-day operations.

Recapitulating, the more significant general lessons learned are:

- The drug abuse problem can be solved.

- One person must be given the responsibility and the authority to coordinate and operate the drug abuse control program.

- Honest, professional, dedicated middle managers are required to supervise drug abuse control program activities.

- Support of the authorities at all levels is absolutely essential to the success of the drug abuse control program.

Education and Prevention

The military drug abuse education and prevention target group is all-embracing. It includes the potential drug abuser and the practicing drug abuser as well as the commander and his staff, the physicians, chaplains, legal officers, law enforcement officers, all other officers, noncommissioned officers, dependents, civilian employees and members of adjacent civilian communities. To be effective, the education process requires the tailoring of educational materials for that portion of the target group at which it is directed; material which might appeal to the potential drug user may have little effect on the physician or commander. Fortunately, a variety of media exists to propagate the word about drug abuse -- for complete and sustained coverage all should be used.

Early in the effort to counter unlawful drug use it was learned that a large credibility gap existed between the drug abuser and the establishment. The user more often than not knew more about drugs and their effects than did his mentor. Even if he did not actually know as much, he believed that he did and thereby downgraded what information came to him from the authorities. The educators problem is one of first penetrating the awareness of the drug abuser and then of providing him with factual, believable, up-to-date information. It is necessary to convince the user that he alone is responsible for his decision to use drugs, even though that decision may be irrationally arrived at, and to provide him with the facts of drug abuse and its consequences. Additionally, the drug education effort must provide the user and potential user with alternate choices to drug use. It must provide him with methods of achieving personal satisfaction and it must stimulate attitude and behavioral changes.

Personal involvement and special training are required for teachers, educators, leaders and others that come into contact with the potential drug abuser. It is not enough to simply provide them with the written facts of the subject. There has to be a consideration of the overall social problem and a counterplay of knowledge and ideas concerning the methods of effectively applying the lessons learned to the community

before the would-be educator is prepared for his task.

Physicians present a special case. They require additional training to recognize and treat the problems peculiar to drug use and drug overdose situations. They require additional training to counter the manipulative skill of those seasoned in the drug culture. They must recognize that the circuitous drug abuser often does not want to be treated, that he prefers his drug habit and so the physician must be trained to penetrate his drug subculture shield. Finally, the physician who avoids drug abuse diagnosis for fear of stigmatizing an individual must be trained and motivated to record his drug findings accurately and correctly for he does the abuser and society nothing but harm by failing to face facts.

Among youthful dependents the Teen Involvement program has proved to be effective. Under this youth teaching youth concept, high school teenagers are used to guide elementary school students in making rational decisions regarding drugs and their use. For maximum effectiveness it was found that active, intelligent, mature teen counselors with reasonably high grades were best able to relate to the younger students. Further, for maximum program worth a dedicated faculty sponsor and a firmly established counselor -- teacher relationship based on mutual knowledge and understanding are required.

The significant lessons learned by the Military Establishment in the area of drug education and prevention are:

- Educational materials must be tailored for the target group at which they are directed.

- All news media should be used for the dissemination of drug abuse information.

- Personal involvement and special training are required for educators, leaders and others that interface with potential and actual drug abusers.

- Physicians require special training to enable them to recognize and cope with problems peculiar to drug abuse and drug related situations.

- Physicians must be trained to record their drug findings and diagnoses correctly and accurately.

- The educators must penetrate the awareness of the potential and active drug abuser, provide him with factual, believable, up-to-date information, convince him that he alone is responsible for his decision to use drugs and provide him with alternate methods of achieving personal satisfaction.

- Youths can successfully teach youths to make rational decisions about drug abuse using the Teen Involvement concept.

- The Teen Involvement program requires mature, intelligent volunteer teen counselors; dedicated school faculty sponsors; and a

rapport between teen counselors and classroom teachers.

Identification

Drug abusers are identified by several means, chief among them being the urinalysis test and the exemption policy. Some abusers are found as a result of medical examination for non-drug injury or disease and still others are found through other means and methods.

Today, the urinalysis test which can detect opiates, barbiturates and amphetamines in a person's urine is the most effective detector of drug abusers. Actually, the urinalysis test program serves several functions. It provides a measure of the magnitude of the drug problem. It permits the early identification of drug abusers at which time they are more easily rehabilitated. It permits the removal of infectious sources of drug use from units; and it provides a deterrent to would-be drug abusers or individuals who need an excuse to withstand peer pressure.

For maximum effectiveness in detection and deterrence the urinalysis test program or screen must be applied in a mathematically random and unannounced fashion. The target individual or unit must have absolutely no advance warning of the impending test.

It can be profitable to test at other events. The drug dependent individual is unable to refrain from drug use and his urine will contain traces of drugs even though he knows he is going to be tested. For example, the services screened each individual before he was allowed to return to the United States from Vietnam hoping to detect drug abusers, primarily those who were drug dependent. The same philosophy can be applied to events in civilian life -- to illustrate, urinalysis tests for drugs may be administered at the physical examinations required before youngsters can participate in organized sports in school.

The military services learned that not only must the suspect group be subjected to the urinalysis screen but the staff of drug treatment and rehabilitation facilities must also be checked on a random basis. Drug abusers apparently encourage others to use drugs and sometimes the rehabilitation staffer succumbs.

Once the military urinalysis screen procedures got underway, the drug abusers began to look for ways to circumvent them. Some simply failed to appear for the scheduled tests -- command action solves this problem. Some flooded their system with fluids to reduce the concentration of drugs in their bodies to an undetectable level. Others tried fruit juices or vinegar. One by one the test administrators and laboratories uncovered each stratagem and devised a counter to it.

The drug abuser will try to alter or destroy urinalysis screen records to avoid detection; he will resort to bribery if need be. The need for a secure, well managed system of urine collection, transportation, testing and report keeping is apparent.

Some difficulties were experienced when a man with a drug positive

urine test appeared before a physician for confirmation of his drug abuse. For one reason or another, the physician was sometimes reluctant to confirm a diagnosis of improper drug use. This problem was met when there was doubt about drug abuse by placing the responsibility for the confirmatory decision in the hands of the commander. He obtains and uses the opinions of a physician and a social worker to assist him in arriving at his decision.

Quality control programs were instituted with the Armed Forces Institute of Pathology as monitor to raise and maintain a high order of detection capability on the part of all participating urinalysis laboratories. Weekly, the AFIP prepares and inserts sample lots of urine, both with and without drugs, into the system. These samples arrive at the urinalysis laboratories anonymously where they are tested, and the reports of test sent back through the quality control system to the AFIP. The AFIP reports the results of the quality control program weekly and quarterly to the military services who are responsible for maintaining the laboratories performance at an acceptably high level. The quality control program not only keeps laboratory performance up but it also establishes a measure of credibility for the urinalysis screen in the minds of the risk group, the commanders and staff, the drug rehabilitation workers and the medical authorities. Factual publicity of the quality control effort can serve to boost the acceptance of the urine test program by everyone who is touched by it.

The next most effective means to date of uncovering drug abusers in the Armed Forces has been through exercise of the exemption policy. This policy prohibits prosecution of anyone who admits to drug abuse and volunteers for treatment, or who is detected as a drug abuser in a urinalysis screen. It does not exempt the user from accountability for other wrong doing, nor does it prohibit administrative action such as removal from flying status or denial of security access. By applying for assistance under the exemption policy the individual is assured that he will get help with his drug problem, no disciplinary action under the Uniform Code of Military Justice will be forthcoming, and his drug use will not be used in whole or in part as a basis in denying him a discharge under other than honorable conditions.

Although much progress has been made in the field of drug abuse detection, much ground remains to be covered. In particular, detection methods for users of cannibis sativa derivatives and hallucinogenic agents are urgently required.

In summary, the more important lessons learned from the military services efforts to identify drug abusers are:

- The most effective means for detecting abusers of opiates, barbiturates and amphetamines is the urinalysis test.

- The urinalysis test program:

  -- Permits the early identification of drug abusers at which time they are more easily rehabilitated.

-- Provides a measure of the magnitude of the drug problem.

-- Provides a deterrent to would-be drug abusers.

-- Permits the removal of infectious sources of drug use from the community or unit.

- For maximum effectiveness the urinalysis test screen must be applied in mathematically random fashion.

- Rehabilitation facility staff must be tested as well as their drug abuse patients.

- Urinalysis test administrators, laboratory personnel and others connected with the urinalysis test program must be alert to detect and nullify drug abuser stratagems to escape identification.

- A high order quality control program is required to maintain high urinalysis laboratory standards as well as to establish urinalysis test credibility in the minds of the risk group, the leaders and staff, the medical authorities and the drug rehabilitation workers.

- Responsibility for the confirmatory decision that an individual is or is not a drug abuser is best placed in the hands of the commander.

- An exemption policy whereby drug abusers may volunteer for assistance without fear of punitive action is an effective means of identifying drug abusers.

- Research is urgently required to devise means of detecting users of cannibis sativa derivatives and hallucinogenic agents.

Treatment and Rehabilitation

An early lesson learned with respect to the treatment and rehabilitation of drug abusers was that physicians required guidelines to follow when seeing drug patients. Having perceived the need, it was alleviated with the publication of a tri-service document entitled Drug Abuse (Clinical Recognition and Treatment Including the Diseases Often Associated). It is distributed as Army Technical Bulletin MED No. 290, Navy Publication No. P-5116 and Air Force Pamphlet No. 160-33.

A most valuable element of information derived by the armed services from their rehabilitative efforts was that rehabilitation of the drug abuser can be accomplished in a military setting complete with regulations, uniforms, discipline, and service customs and courtesies. In fact, it is imperative that rehabilitation be conducted in a military atmosphere. The goal is to return the serviceman to a useful service life so that rehabilitation conducted in a non-military setting is artificial and a simple avoidance of reality. The professional military approach works -- no catchy phrases, drug jargon or psychedelic posters are required.

The services also learned that dedicated, experienced line and combat

arms officers can succeasfully operate a rehsbilitation program. They require professional aasistance from physicians, psychologists, chaplains, counselors and social workers, but the experienced line officer has all the qualities necesaary for succesaful drug rehabilitation work.

While it is true that succeasful rehsbilitation requires the coordination of command, community, medical and spiritual efforts, the bulk of the task falls on the shoulders of an energetic, enthusiastic rehabilitstion facility staff. The staff must have desire and persistence, motivation snd a sense of loyalty to the goals of the group. If any stsff member does not have these attributes, he should be released. Not only will he fail to do his psrt, but he will also -- unwittingly or not -- contribute to a counter-productive mood and will be s contaminating influence on the established program.

Among the staff, the counselors require special care in selection. They associate with and relate to the drug patients on a day-to-day basis and must be exemplary in all respects. Formal schooling and training has value, of course, in preparing the counselor for his job; however, it was found that other qualities were equally, if not more importsnt. These qualities are the ability to experience snd express human feelings; the ability to relate to people -- seniors, subordinates and peers alike; realistic but optimistic sttitudes; oral articulateness; correct military bearing and courtesy; and most of all, emotional maturity. With these qualities, any individual has a high probability of success as a drug rehabilitation counselor.

Counselors, like any other staff member should be released or replaced if they cannot conform to the rehabilitation fscility approach or goals, or cannot cooperate with or relate to the remainder of the staff. A rehabilitation center tends to assume an individuslity or identity of its own. Counselors and other staff must accept and assume that identity; they must conform. A non-conformist hss no place in the handling of drug abusers -- he is s contaminating influence. The same is true of those who tire of the job, and the mortality rate of those who do become exhsusted is higher than may be imagined.

The military services found that, in general, ex-drug abusers do not make satisfactory counselors. They possess many of the traits of the typical drug abuser and may still be suffering from the throes of drug abstinence themselves.

Rehsbilitation efforts were found to be most succeasful when they focused on the whole man, his physical well being, his mental well being, his sense of responsibility and his obligation to himself, to others, and to society. Treatment of his problems is best done in a group setting. In Vietnam centers where a limited time was available for trestment and rehabilitation it was found best to organize the incoming drug sbusers into a fairly heterogeneous mixture of sges, ranks, educational level, ethnic groups snd marital status. This group wss assigned a team of social workers snd counselors who remained with the group throughout its stay in the center. The individuals in the group suffered their reverses and successes together and from these experiences sprang a group identity

and integrity, a cohesiveness whereby each one helped one other through the rehabilitation process. The goal was to increase the sense of maturity through a program of self awareness and discipline evolving from group interaction and mutual obligation engendered by life within a structured society. The group approach was basic to the therapeutic processes used by the rehabilitation centers in Vietnam. One treatment modality which was used with success reminded the patient constantly that he and he alone is responsible for his behavior and for his choices in life; he is responsible for the decisions he makes.

Rehabilitation programs must be carefully planned and organized; they must have a structured balance of instruction, physical exercise, group therapy, and work sessions, all directed toward a common goal. Patients should not play a part in the organization and planning -- this was seen in some installations; it did not work. Unscheduled time should be kept to a minimum or eliminated completely. The typical drug abuser is not highly self-motivating; he has little ability to effectively use his unscheduled or unplanned time.

The staff in rehabilitation facilities found that the recidivists among their charges will try anything for a high -- glue, paint thinner, toothpaste, spray deodorant. Every substance is suspect and care must be taken to keep such items out of the grasp of the potential recidivist and the weak-willed. The staff also found that after detoxification the drug abuse patient will develop a voracious appetite and will gain back much of the weight lost while using drugs. Extra rations are required. Moreover, the patient's bowel movements will increase in numbers requiring that more than the normal number of toilet facilities be provided.

Follow-up after release from rehabilitation is an absolute necessity. Further, there must be some pressure to counter the drug peer pressures that the rehabilitated abuser is sure to encounter. The services meet this problem by establishing post or base level rehabilitation programs with halfway houses; rap centers; and carefully selected, trained social workers and counselors. In Vietnam, the situation was different; there, units were deployed to the field or work locations and so the Army devised the unit counselor concept. Men were selected by the unit commander, sent to a rehabilitation center for training and then returned to the unit as a unit counselor, a resource within the unit to counter the drug scene. The unit counselor advised the commander on the drug problem in his unit; he briefed incoming men on the drug problem; he counseled men in the unit on their drug and social problems; and he attempted to build a counter drug force in the unit to sustain the returned, rehabilitated drug abuser. He also served as a source of believable information for the men in the unit.

The unit counselor program had its problems. Selection of counselor candidates was crucial. They had to be motivated, dedicated, mature individuals who were willing to take on the task. To select anyone else was a waste of time, money and manpower resources. It was found to be a mistake to attempt to teach the unit counselor to be skilled in the use of counseling techniques in the time allocated for training. Rather, the counselor was taught to be a sensitive listener and skilled referral agent

who could make maximum use of his knowledge of the many resources available to assist with the human problems of the men in his unit. He served well as a listening post, someone to whom anyone with a human problem could come for advice, and many times, for assistance.

The more meaningful lessons learned by those engaged in drug abuse treatment and rehabilitation activities are:

- Physicians require guidelines to follow when seeing drug abuse patients.

- Drug rehabilitation can be accomplished in a structured, disciplined environment which includes authority figures as well as clinicians and counselors.

- Experienced line and combat arms officers can successfully operate drug rehabilitation programs.

- Rehabilitation facility staff must conform to the identity and goals of the facility, and must cooperate fully with the rest of the staff.

- Counselors require special care in selection; they must be exemplary in every respect.

- Counselors need not have formal, college level counseling schooling. Any individual with the ability to experience and express human feelings, the ability to relate to people, realistic but optimistic attitudes, oral articulateness, correct military bearing and courtesy, and emotional maturity can be trained with a high probability of success as a drug rehabilitation counselor.

- Ex-drug abusers most often do not make satisfactory counselors.

- Drug abuse rehabilitation is best done in a group setting.

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

- Rehabilitation programs must have a structured balance of instruction, physical exercise, group therapy and work sessions, all directed toward a common goal.

- Unscheduled time in rehabilitation programs should be kept to a minimum or eliminated completely.

- Care must be taken to insure that substances which might produce a high are kept out of the hands of rehabilitation patients.

- Follow-up after release from rehabilitation is necessary. It must provide some pressure to counter the drug peer pressure which the rehabilitated abuser is bound to encounter.

Records

Reports and records are necessary elements of any drug abuse control program. They are required to identify and follow drug users, to measure the progress of treatment and rehabilitation, and to measure the degree of success or failure of the program. Collection and release of accurate, complete drug abuse data can do much to dispel unrestrained rumors as well as to provide a firm basis for advanced drug program planning.

Data requirements should be incorporated into program planning at the outset. Records planning must be complete and thorough, and must take into account the views and requirements of all factions taking part in the program. Problems must be anticipated and provided for; possible future use of automatic data processing systems must be foreseen and planning initiated; and the data requirements for the inevitable follow-up and program review must be anticipated in the early planning.

For proper medical care, 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 from one to another. Accurate records are necessary so that one can determine what treatment modalities were used, which were successful and which were not. The patient cannot be relied upon for this factual information. Many drug abusers are unreliable individuals who have little interest in telling the complete truth about themselves. Finally, studies are sometimes done on the data recorded in the medical records. Obviously, a bias-free study demands accurate source data.

Situations like the military drug abuse experience in 1971 and 1972 attract researchers with their multi-page questionnaires and surveys. Their goal is to analyze the problem for causes and solutions, and the basis for their investigations is complete, honest data. Sometimes the collectors of the data are those who must do the day-to-day drug program work; they may view the data collection requirement as an imposition on their time. They will require motivation for proper, accurate data collection as well as an explanation of the need for the data and the good which can be derived from proper data collection. They also require explicit instructions and uncomplicated forms. The patients require a clear-cut guarantee of confidentiality.

Reports, whether periodic or aperiodic, are vital to a drug program. They can be disruptive or not depending on the care that goes into the planning for them. Where possible, different report requirements should be combined to make one report serve several purposes. Adequate time must be allowed to permit report preparation, investigation of suspected mistakes and transmission to the receiving office. The period of the report should be long enough to gather meaningful data but not so long as to permit significant fluctuations in the data to be lost. Report changes must be held to a minimum -- they have a tremendously disrupting influence on the staff which already views all reports as a not-so-necessary evil. Good advance planning can reasonably be expected to anticipate requirement changes and to provide for them in the beginning.

Reports and records are necessary to an effective drug program but maintenance of them can be time consuming. Automation can assist to a degree but is dependent upon complete, accurate source data. The need for care and accuracy in preparing reports and records highlights once more the requirement for detailed planning and quality personnel to operate drug abuse programs.

In the field of records and information handling the most significant lessons learned are:

- Complete, accurate reports and records are required to identify and follow drug abusers, to measure the progress of rehabilitation, and to measure the degree of success or failure of the program.

- All drug abuse program factions should be represented in program planning from the beginning.

- Reports and records requirements should be incorporated into program planning at the outset.

- Automatic data processing of information should be anticipated and planned for.

- Follow-up and program review should be anticipated and data collected accordingly.

- 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 from one to another.

- Considerable motivation and supervision are required when medical or rehabilitation staff collect statistical data to insure data completeness and accuracy.

- Confidentiality of drug abuse records must be maintained.

- Whenever possible, different report requirements should be combined so that one report serves several purposes.

- Adequate time must be allowed for report preparation.

- Report changes must be held to a minimum.

The following sections address in detail the specific elements of these summary comments. They provide the interested or concerned person with the experiential knowledge required to establish and operate drug abuse control programs, programs which capitalize on the lessons learned -- sometimes painfully -- by the Department of Defense.

SECTION 2

Drug Education and Prevention

General

The Department of Defenae ia keenly awsre of the problems associated with the abuse of druga in the Armed Forces. From thia awareneas atems the established DoD policy to prevent and eliminate drug abuae wherever found. In furtherance of this policy the DoD isaued definitive instructions in early 1968 which emphsaized preventive drug abuse education; in 1970 a DoD tsak force reaffirmed the DoD concern for drug sbuae and recommended atrengthening the drug education programs of the servicea.

The DoD drug abuse education/prevention program operates on a decentralized basis. Overall policies snd responsibilities are established by DoD directives. Each of the services then administers its own program within the DoD-established policy. The military aervicea provide objectives and guidelines for their education programs through regulations which promulgate the concepts enumerated in the DoD directives. Major operating commands and inatallations within each service deaign snd implement drug educstion programs within the eatablished guidelines to meet local needs. The approachea vary, but the fundsmentals remain the aame.

Flexibility ia an abaolute necessity in desigaing programs to meet the identified needs. As the needa change, so do the programa. In the laat few years the emphaaia in all of the programs has shifted from punitive, to drugs, to people. Preaent efforts are directed toward providing objective, realistic informstion about drugs of abuae and their effecta and helping individuals to know and understand the reaaons for drug taking. Emphasia is placed on helping individuals define their personal goals and to distinguish between reality and rationalization in their efforta to accompliah theae goala.

Experience haa proved that drug education must be emphasized for all segmenta of the population, not just for the ausceptible group of potential drug abuaera. Commandera snd aupervisors of all gradea muat be thoroughly grounded in knowledge of the drugs being abuaed. They muat alao have an underatanding of the multiple reaaons for drug abuae. Lacking thia background, aupervisors will find that the drug abuaers in their unita know much more than they about the methoda of uae and effects of particular drugs. In auch situations the leadera have a difficult time retaining effective communication or leadership. In their efforta to point out the negative aspects of drug abuae, they can easily be duped, confounded, or discredited by the knowledge of

those who they are trying to educate to the point of drug abstinence. Physicians also must be provided specialized drug education. They must have the knowledge necessary to recognize and handle overdose situations as well as the insight to penetrate the cultural shell established by the drug abusers. Many times the drug abuser is devious and must be recognized as a poor source of information about himself. Physicians must be educated to cope with this fact. Other individuals form specialized target groups at which specialized drug programs must be aimed: laboratory technicians form such a group; parents, children in their early teens, criminal investigators, and attorneys form other target groups.

A problem which quickly became apparent as the drug abuse situation in the military unfolded was the large credibility gap which 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. This lack of credibility was supported by several factors. The primary factor appeared to be the use of a large amount of obviously incorrect or biased information concerning the use and effects of certain illegal drugs. This was caused in part by the failure of much of the more current material to reach its intended target audience at the small unit level. A supporting factor was the lack of emphasis placed on alcohol and other socially accepted drugs in initial military drug abuse prevention programs. An additional supporting factor was the first approach used in these programs. This approach employed scare tactics based on incorrect or incomplete information about drugs and their effects. In this approach, threats of personal harm based on incorrect information were coupled with the implied threat of punitive action and possible imprisonment. These factors resulted in limited effectiveness of the early drug abuse preventive education programs. The basic lesson learned was that information about drugs and their effects must be both factual and objectively presented to be credible.

The methods by which the credibility problem was attacked, and the alternatives to an emotional scare approach based on incorrect information are many and varied. They are discussed below in detail in connection with specific education/prevention problems.

In the course of the service drug education programs, use has been made of all media. Factual and objective educational and informational materials have been presented in the form of handbooks, pamphlets, video tapes, radio broadcasts, newsletters, posters, special issues of Commanders Digest, and articles in Armed Forces newspapers. Lectures, presentations to large and small groups, discussions, and individual counseling have also been used and well-received. A lesson learned was that education materials must be kept up to date. There are new facts constantly being established in the drug abuse field and the news dissemination media must be constantly updated to reflect the new information. Failure to do so contributes to the credibility gap and results in setbacks to the education/prevention process. Another lesson learned was that information must be presented in a style that fits the taste of the intended audience. Informal and formal presentations must be mixed. Attempts should be made to involve individuals in communicating with the informational and departmental policy agencies.

Informal periodicals have been provided in many areas to focus on local drug abuse problems and the community facilities available to provide help, advice, or counsel. They furnish the reader with up-to-date information on the local drug situation. Many also contain question and answer sections whereby an individual may submit a question on drug use or departmental policy which will be answered in a following issue. Comments and topics for future inclusion are likewise encouraged.

Drug information is frequently disseminated over the Armed Forces Radio and Television Service stations overseas. These include full programs as well as spot announcements relating to drug abuse. Service newspapers also publish articles on drugs and their abuse, as well as information on the DoD exemption policy, the activities of various drug rehabilitation centers, and the urinalysis testing program. A good example is the Pacific Stars and Stripes, the newspaper most widely read by the military in Southeast Asia. This paper once published a series of almost daily articles on the DoD drug abuse programs over a three-month period.

A basic lesson learned from the information dissemination effort was that effective preventive drug education programs must go beyond simply transmitting information about the legal and medical dangers of drug abuse. The program 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. Many previously believed that the decision to abuse drugs was a decision which the abuser reached through a rational decision process. Experience has proved this is not always the case; the actual decisions can be casual or irrational. This makes programs necessary which are aimed at clarifying personal goals, providing effective decision making tools and exploring values and lifestyles as well as providing drug facts.

Educating the Educators

A basic problem with those who were charged with educating others to the harmful aspects of drug abuse was that the educators were not always fully knowledgeable or credible in the drug abuse area. Consequently, their message could be discredited by the drug abusers in the target audience who had direct personal knowledge of specific drugs and their effects.

Thus, a basic lesson learned in drug education was that special training must be provided to the teacher or leader to equip him with the latest information about specific drugs of abuse. It was also learned that simple provision of written material for study was inadequate; there had to be discussion of the overall social problem and a counterplay of knowledge and ideas concerning methods of effectively applying lessons learned to the military community in which the individual worked before the would-be educator was fully prepared for his task. It was quickly learned that full-time personnel were necessary to develop and manage an effective drug program, and that careful screening was required in the selection of these personnel.

Young officers and noncommissioned officers were selected from a group of volunteers in each service to function as the education middleman

or educator. Their selection was based on communication ability, interest in the field, and proven capability to relate with diverse groups. These selected educators attended a variety of civilian and military academic institutions.

Some of the drug abuse prevention courses were taught at established universities and were funded by National Institute of Mental Health grants. Additionally, the Army conducted its own in-service program of four 13-day cycles to train military and civilian personnel as an instructional cadre in Army drug education programs. The Navy and Air Force established continuing drug abuse education courses of approximately one month duration to provide special training to qualify selected individuals for drug abuse education duties, and the Marine Corps utilized Navy facilities to educate their instructional personnel.

The purpose of the education at this level was to prepare individuals to educate members of the Armed Forces of all grades. The training encompassed history and scope of the drug problem; policies and directives; pharmacology; psychological, cultural and legal aspects of drug abuse; and related approaches to counseling and treatment. The major portion of the work developed skills in program design and development. Subject areas included were program and community resources, constructive alternatives, educational and rehabilitation program models, local program development, communication techniques and small-group process skills, program and resource evaluation, and follow-on training.

The material was presented through a combination of varied techniques to include lectures, movies, group discussions, role playing, and demonstrations of programs developed by small groups or individuals. At the end of the course work, the participants were asked to critique the training, whereupon this critique was used to evaluate and alter the programs as appropriate.

Educating the Leaders

The transmittal of drug abuse knowledge to the leader group is accomplished in many ways and varies by service. There is formal education in the military school curricula, e.g., at noncommissioned officer academies, preparatory schools, officer candidate schools, and reserve officer training corps schools. Professional military education at basic, advanced and senior levels also includes specific courses in drug abuse education. Drug education is provided to medical and legal officers and to chaplains as a portion of their overall general military instruction upon entry into the military and at their advanced courses. Specialized conferences and seminars are conducted by each service for command and supervisory personnel on a command-wide basis. These meetings establish a forum for the exchange of ideas and information among responsible officers and to improve support for imaginative and effective drug education programs.

One of the major methods of supplying commanders and their staffs with up-to-date information and advice in drug abuse prevention is through the use of drug education specialists on the commander's staff. In the Army, the personnel officer is the principal staff coordinator for drug

matters. However, it has proved useful to appoint an Alcohol and Drug Control Officer as the operational director of the drug and alcohol abuse program. He is responsible for implementing and conducting education, identification, and rehabilitation functions. The ADCO normally has operational control of, and provides administrative support for, installation halfway houses and rap centers, while a clinical director, usually a medical corps officer, serves as a consultant and assists the ADCO by supervising the professional aspects of the program. In Army brigades and battalions in Vietnam, Drug Abuse and Rehabilitation Teams were used to keep commanders informed of the local drug situation.

The Navy employs a large number of Drug Education Specialists to assist commanders in designing and implementing drug abuse programs in their command. All of these personnel are graduates of the Navy school in San Diego. The Marine Corps officers and noncommissioned officers are trained with the Navy and provide the same service to their commanders.

Air Force commanders and staff are advised by Air Force personnel who complete training at the Social Action School at Lackland Air Force Base and return to their home stations to develop and conduct drug education programs. They work directly for the commander at each level and provide him and his staff with up-to-date information concerning local drug problems. When major problems arise, the Mobile Assistance Branch of the Drug Education and Counseling Course can be called for assistance. This branch provides an assistance team which is available to Air Force bases throughout the world to provide technical assistance to field commanders and Social Action personnel. They are primarily education and training officers and technicians. The Air Force also provides a Social Action Traveling Team to help commanders identify problems. This team is composed of five interdisciplinary professionals -- a personnel officer, judge advocate, information officer, chaplain, and psychiatrist. They visit Air Force installations to conduct seminars, assist their counterparts, discuss policy and communicate identified problems to the local commander for his solution.

In addition to the drug specialized staff assistance provided to the commander, each military service established local councils and committees to help the local commander in preparing, coordinating, and implementing drug abuse control programs. These groups took many forms. The Army established Alcohol and Drug Dependency Intervention Councils in the major Army commands. This is an attempt to involve the total Army community in the drug problem and to improve communications on the subject at higher levels of command. Participants are the chaplains, preventive medicine officers, judge advocates, law enforcement officers, behavioral science specialists, and General Staff representatives of the commander.

In the Navy, major shore commands are establishing Drug Abuse Control Councils with senior line or command chairmanship. Membership of the Council is made up of chaplains, medical and legal officers, investigators, enlisted men, civilian employees of the Navy, dependents, and members of the surrounding civilian community.

The Marine Corps established a Drug Awareness Analysis Team in order to provide commanders with a means for evaluating the overall drug abuse situation in the Marine Corps.

The Air Force established Drug Abuse Control Committees at installation, major command, and headquarters levels. These function to coordinate and direct drug abuse prevention programs and coordinate drug abuse control efforts with the local civilian community agencies.

Command awareness of personnel and management problems in the drug abuse prevention area is now facilitated through a series of newsletter articles on current programs, policies and actions in the area of drug abuse. These include the design, preparation and dissemination of preventive drug abuse information; special management information; and educational articles directed to commanders.

A significant lesson learned in applying drug education/prevention emphasis to the command structure is that in the military system, command support behind a clearly defined objective and program is a must for any effort to be fruitful. The drug program is a command program, devised and promulgated in the name of the commander and it must be supported by him in all its aspects.

Another important lesson learned in manning drug abuse positions is that the staffer must be assigned on a full-time basis. Many individuals responsible for drug education had numerous other duties which the commander felt were important; consequently, the educators were unable to perform effectively as educators. It was soon learned that when an individual's efforts were directed solely to the drug problem, the program was more effective. The commander's problems in this area were lessened as qualified individuals became available for full-time assignment as drug abuse education specialists.

Educating the Potential Drug Abusers

As time went on and the awareness of the drug situation in the military services increased, studies and surveys were performed to determine the characteristics of the potential drug abuser. In Vietnam, as an example, he was found to be a young man in the lower enlisted grades, a draftee or enlistee in his first enlistment who, in the majority of cases, used drugs before entering the service. Many features of the potential user were thus isolated and this knowledge was used to shape the programs aimed at preventing the improper use of drugs. The target audience may vary by size, profession, age level, background, interests, and informational needs but these differences must all be considered when deciding upon an appropriate program. The programs which have evolved are as varied as the audience and its interests. The lesson learned is that no one approach is effective with all groups. On the other hand, a combination of many techniques has proved effective. These techniques include presentations from ex-addicts from therapeutic communities; hotline counseling and use of rap centers; workshops, lectures, films, brochures, news media, tapes, theatrical productions, panel discussions, variety shows, and rock festivals.

One example of a program model that provides factual information and discussion of facts and issues is the "decision search" oriented program. The objective is to insure that every man has the facts he needs to make an intelligent decision concerning use or abuse of drugs. It provides drug information kits in which audio and visual aids are utilized. Each kit contains an audiovisual projector with 14 films and eight tapes covering the spectrum of drugs and drug usage. Each kit also has seven to eight books which address drug areas in depth. Also, there is a series of "quick fact" handouts that can be read in a period of three to four minutes; each addresses a particular portion of the drug spectrum. The table model projector throws an image on a small viewing screen and has the added capability of projecting onto a larger screen for use with audiences of up to 30 people. Of the 14 films, six are brief film episodes which bring out the need for further knowledge. Utilizing this vehicle, the educator can address the issues raised by showing one of several five-minute, single-concept films.

Another example of a useful program model which provides a resource trained in rehabilitation methods as well as reliable information concerning drugs and their effects is the training program for selected, highly motivated, young enlisted men in drug abuse education. Part of this training includes "live-in" experience at a therapeutic community. Upon completion of training, the individual returns to his unit to serve as an informational source in support of drug abuse prevention efforts. His experience in the therapeutic community provides him with valuable information concerning drug abuse problems and also establishes credibility for him in the drug abuse field. His contemporaries look to him as an expert in this field.

A well-received program that provided information and assistance to both supervisors and potential abusers was the Drug Education Field Teams. These teams were organized in Vietnam with two civilian ex-addicts, two military educational specialists (an officer and an enlisted man), and a Vietnamese national. They traveled to company-size units in the field. There they provided guidance and assistance to the unit drug education specialists and commanders and carried out extended discussions with the target audience of potential abusers. The team also provided information to the commanders and supervisors concerning the size and type of drug problem in his unit as well as advice on ways to approach the problem. The technique used divided the unit into one group of officers and non-commissioned officers (the "establishment"), one group of younger enlisted men, and the group of local Vietnamese. The team officer and one ex-addict talked to the first group while the enlisted team member and the other ex-addict talked to the enlisted group. The Vietnamese national talked to the Vietnamese group. The goal was to dispense credible information and to establish rapport with a resulting meaningful exchange of ideas.

Educating the Medical Personnel

DoD early recognized the need for additional special training for medical and legal officers and chaplains and provided for such training in the various service schools. The advent of the military drug problem quickly highlighted a need for additional training for medical personnel.

In many cases, the physician was not knowledgeable of the manipulative skill of those seasoned in the drug culture and was easily controlled by the drug abuser. Medical personnel had to be trained to recognize that the drug abuser is not the best source of information about himself and his habits, and the the more addicted he is, the more devious he is likely to be in his attempts to avoid abstinence or unpleasant realities concerning his own responsibility in the negative results of drug abuse.

Crisis situations involving drug overdoses often created problems for medical personnel due to a lack of standard information concerning drug effects, cultural patterns and methods of abusing specific drugs. This led to a recognized need for standard crisis management guidelines and special training in their use for the medical population. Medical support programs did not provide adequate education for physicians who were not familiar with the identifying symptoms in drug abuse cases, particularly those involving multi-drug use.

Another problem was the tendency among some younger physicians to avoid stigmatizing an individual by identifying him as a drug abuser if there was no evidence of physical deterioration due to drug abuse. This caused hardships for individuals attempting to cope with their own drug abuse problem in its early, more easily curable stage.

Solutions to the medical problems involve further in-depth training in recognition of drug problems, crisis intervention, and diagnosis and training. Training must be given to physicians, nurses, emergency room technicians, pharmacists, and similar medical professionals. The training should develop a set of guidelines to be followed in drug abuse crises just as there are guidelines for heart attack cases, strokes, etc. The benefits of early identification and treatment must be stressed to overcome any hesitancy on the part of medical authorities to identify individuals with drug abuse problems.

As a result of the need for drug abuse guidelines for medical personnel, the DoD initiated the preparation of a tri-service publication which provided guidance for medical officers concerned with the identification, evaluation and treatment of drug abusers, including management of intoxication and withdrawal syndromes, and clinical identification and treatment of diseases often associated with drug abuse. The publication is entitled Drug Abuse (Clinical Recognition and Treatment Including the Diseases Often Associated), is dated 15 January 1973, and is distributed as Army Technical Bulletin MED No. 290, Navy Publication No. P-5116 and Air Force Pamphlet No. 160-33.

Another problem noted was that medical administrators also need additional training. It was found that all too often no official means existed to provide information about or to motivate an individual toward continuing treatment as he moved from one place (and program) to another, e.g., from his unit in Vietnam to a treatment center and then to the United States. In addition, those methods of treatment which had a higher rate of success with certain groups were not known to all treatment personnel. This same lack of continuity appeared when an individual was transferred to the Veterans Administration. When a man was transferred

to the VA for treatment, he 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. These examples point out a clear need for efficient handling of medical and personnel records and for truthful, knowledgeable counseling of the drug abuser on what he can expect from each phase of his treatment. Stated otherwise, here is another credibility gap which has been identified and which can be closed given special training and efficient administration.

Educating the Dependents

The same DoD directive which prescribed special training for medical and legal officers and chaplains recognized that drug abuse among dependents can also be a problem. Consequently, the instructions for attacking the drug problem in the military included provisions for program extension to civilian employees and dependents. Included were the development and procurement of drug abuse materials such as films, pamphlets, posters, and radio and television programs. Further, the opportunity for drug abuse education and training was made available to the total military community.

Within the United States, with rare exception, dependents receive drug abuse education in the local public schools. Overseas, they also receive instruction. In the European area, for example, the school system reports that all junior and senior high schools teach drug education units and 86% of all schools teach drug education. Peer programs have been inaugurated in the majority of overseas dependent schools. One peer education program called Teen Involvement, utilizes volunteer high school teen counselors to provide effective drug abuse information to dependent students in the elementary and junior high school grades. Such programs were established in 1971 in the Marine Corps school at Quantico, Virginia; in the Air Force schools in the Philippines; and in the Army and Air Force schools in Germany. They have since been expanded throughout the rest of the United States, Pacific and European areas.

The DoD strongly encourages its members and dependents to participate in civilian community programs in order to both learn and share their knowledge and experience. For example, the Teen Involvement program came to the military through the teachings and experience of a nonmilitary group. This effort had its beginning in Phoenix, Arizona where carefully selected military dependents were sent for training. They then returned and implemented the approach in military-operated dependent schools. It is also offered to local public schools servicing military families.

Teen Involvement utilizes the concept of youth teaching youth. It provides a valuable lesson learned. Carefully selected and trained high school teenagers from the community can be used to guide elementary students to make effective rational decisions concerning the use and abuse of drugs. This approach is not wholly devoted to drug abuse. It may include decision making in any fundamental area. The program devotes itself to the basic concept that an elementary student will be approached some time in the near future and that a personal decision concerning drug abuse will be required. The teen counselor, through positive alternatives, role playing, etc., helps the elementary student form his personal decision about illegal drug abuse in the future.

From the Teen Involvement program it was learned that intelligent, mature, active counselors with reasonably high classroom grades are required for a successful program. A motivated faculty sponsor is also required as well as a firmly established counselor-teacher relationship based on mutual knowledge and understanding of each other's problems and goals. Parental involvement is desirable, but normally it is difficult to obtain.

At Appendix A is an account of four Teen Involvement counselors who spent a year traveling throughout the United States and introducing the Teen Involvement concept to interested military and civilian communities. This account describes the program, its evolution, the techniques used, the lessons learned and concludes with the young counselors' recommendations.

Adult education is being provided to wives' clubs and parents' organizations. The objective is to understand drugs and their abuse better so they may understand and cope with the younger generation.

At the command level, councils and committees have been formed to afford interaction with the civilian sector of society. The Military Departments encourage maximum participation with the civilian community as part of their drive against drug abuse as well as an exercise in good public relations. Programs have been instituted whereby the neighboring civilian community utilizes military facilities and vice versa. The net effect is an awareness of each other's problems and capabilities and an amalgamation of the effort against drug abuse.

In summary, the present thrust of the service educstion programs encompasses the many lessons learned in recent yesrs about drug education and prevention. These education programs strive to help the individual realize that he, and only he, is responsible for his decision to use drugs, while at the same time they provide him with the facts about the consequences if he does choose to abuse drugs. These efforts are not restricted to the military alone. Many programs are designed to include the entire military community as well as those segments of civilian society with which they interact.

SECTION 3

Identification of Drug Abusers

General

Although much was learned about drug education and prevention in the armed services, no program proved to be 100% effective and so identification of those who, in spite of all, elected to abuse drugs became a situation of concern. It was readily apparent that if subsequent treatment and rehabilitation were to prove effective and timely enough to allow return of the detected drug user to full duty, identification of the drug abuser would have to be accomplished while he was still an experimenter or occasional user and before he became firmly addicted. How this identification problem was attacked is described below, as are the various means by which identification is accomplished, the associated problems, and their solutions.

Preliminary Screening

Clearly, if drug abusers are detected at the time they appear for induction or enlistment and are refused entry into the armed services, the drug abuse problem within the services will be abated to that extent. Therefore, procedures were established at the Armed Forces Examining and Entrance Stations to identify drug dependent individuals by evaluating the results of the initial physical examination (which does not include urine testing for drugs) and through psychiatric consultations. Detection of drug abusing prospective recruits was stressed, and those measures which are used to identify them were given special attention, such as needle marks, thrombosed veins, or bizarre behavior. When drug use is detected the physician discusses the report of medical history with the processee to determine the history of drug use and its extent. If applicable, the processee is requested to provide additional documentation from medical sources to assist in an accurate diagnosis of his drug situation. Finally, the medical evaluation is used to make a judgment of whether or not to accept the individual for duty in the Military Establishment.

Upon leaving the AFEES, the new recruit proceeds to his initial duty station for his introductory or basic military training. Within 48 hours of his arrival at that station, he is subjected to a urinalysis test for drug abuse. Those found with a positive urinalysis are considered for separation on a case by case basis.

With the physical examination at the AFEES and the more detailed examination at the initial receiving station, a number of those individuals who abused drugs in civilian life are identified and refused entry into the armed services. This has two salutary effects: first, drug abusers who would almost certainly emerge as problems to themselves and their service

are denied entrance into a service; and second, a drug-contaminating influence on the susceptible younger population of the service is kept from that population.

Diagnosis of drug dependency when entering a service was and is particularly difficult because of the lack of complete and reliable medical information. It was found necessary to effect extensive coordination between the medical and moral waiver sections of the AFEES to insure that all available corroborative information was screened to assist in the identification of drug dependent individuals. It was also found necessary to promulgate extensive guidelines for the examining medical officers at the AFEES and to stress to recruiters the necessity for identifying the drug dependent applicant.

Urinalysis

The most effective means devised to date for detecting users of opiates, amphetamines, and barbiturates are three urinalysis tests: the Free Radical Assay Technique, the Thin Layer Chromatography system, and the Gas Liquid Chomotography system. Unfortunately, no such operational systems exist at present for the detection of users of hallucinogenic agents and cannibis sativa derivatives. Because of their demonstrated potential, these systems were selected for world-wide use in the Department of Defense campaign against drug abuse in the military services. However, many problems arose with their use, and the solutions thereto constitute a compendium of experience which should be noted and weighed by any agency contemplating or engaged in a similar program. One problem, that of quality control of the urinalysis testing effort, is so complex and so important that it is treated separately in a later portion of this report.

The urinalysis testing program provides several advantages which were not initially recognized and which can accrue to any agency involved in a similar program. First, a reliable indicator of the overall magnitude of the drug abuse problem is generated. Second, urine testing permits the early identification of drug abusers prior to the point at which physiological and psychological dependence occurs. This in turn increases the chances of success in treatment. Third, testing and identifying drug abusers permit the removal of sources of infection in units and prevents reinfection by identifying drug abusing replacements before they reach their units of assignment. Finally, random urinalysis testing on an unannounced basis serves as a deterrent to would-be drug abusers.

One of the early issues which arose when the urinalysis program was initiated in mid-1971 centered around the legality of requiring a serviceman to submit to a urine sample for test. This situation was resolved by referrence to a Court of Military Appeals ruling that it was permissable in the armed services to require an individual to submit a sample of his body fluids for health examination.

In general, urinalysis screening is done for two purposes: identification of drug abusers and laboratory support in treatment and rehabilitation programs. With regard to the latter use, it has been learned that the urinalysis test is a meaningful measure of an individual's progress in

rehabilitation as long as all the cautions which pertain to a successful urinalysis program are followed. It has also been learned that it is imperative that the rehabilitation facility staff be tested as well as the patients; such testing serves as a deterrent to drug use by the staff and permits early detection of those who are inclined or encouraged to experiment.

Experience has shown that the time and frequency of testing play a significant part in the success of the screening program. The most sensitive time requirement, of course, is the random screen, tests conducted so that the target unit or individuals have no advance warning. The random screen not only identifies those who have ingested drugs in the preceding two or three days, but it also acts as a deterrent for the experimenter or one who can not otherwise withstand peer pressure. Certain precautions must be taken, however. In order to be truly random and to be effective, the test must be administered with absolutely no prior indications to the population being tested. In the past, the randomness has sometimes been destroyed by events such as open stockpiling of urine test materials; by tests being announced in advance at large formations; and by some personnel - those living off-post for example - being excused. The selection of those to be tested must be made by a bona fide random process; each individual must understand that he may be subjected to a urinalysis test at any time - with absolutely no hint of an advance warning. Only then will a random program work as it should.

Another category of the urinalysis program is event testing, i.e., tests given at particular times during a serviceman's tour of duty. It was found useful to screen those returning to the United States from Vietnam. Normally, the experimenter would refrain from drug use in order to pass this screen but the drug dependent individual should have been detected at this time and referred for treatment. Other event tests have been used to good advantage: the urinalysis test administered upon entry into a service bars many drug abusers from entry; tests administered to men ordered overseas identifies many drug dependent servicemen who are seeking transfer to areas of high drug availability; and tests administered at reenlistment single out those who wish to remain in a situation where drugs are available and affordable.

The differing ease and price with which drugs are obtained in various parts of the world influenced the DoD to divide the world areas into high risk, moderate risk, and minimum risk areas, and to vary the frequency of random urinalysis testing according to the risk area in which a serviceman is serving. In the high risk areas (Vietnam, Thailand, Philippines, Okinawa and Taiwan) the average test frequency was set as 3.0 per person per year. In the moderate risk areas (Korea, Panama, Europe, the Middle East, and the West and Northeast coasts of the United States) the average frequency is 1.6 tests per person per year, and in the minimum risk areas (all other geographic areas) the test frequency is 1.2 tests per person per year.

It was decided at the beginning of the urinalysis test program that the level of detection of ten micrograms of morphine per milliliter which was required of civilian laboratories was not sensitive enough for the

military program. Therefore, the laboratories doing drug urinalysis for the services were required to operate at sensitivity levels 1/20th of that of the civilian laboratories. The reasoning behind this decision stems from the fact that in civilian life one deals with addicts who have seldom gone more than a few hours, or at most a day, since their last drug use. In the military experience it was found that the greatest percentage of users were experimenters and casual beginners. It was highly desirable that the military be able to detect this type of person, one who had used a relatively small quantity of drugs two or three days before. If this non-addict can be detected before he is hopelessly dependent, he is a less difficult treatment and rehabilitation problem.

A very real problem with the urinalysis program is that an individual might be falsely accused of being a drug abuser due to laboratory error. This, of course, could have serious consequences for him, both in and out of the service. Therefore, a confirmatory procedure was prescribed which reduces the possibility of an unjust drug abuse accusation to near zero. When the urine sample arrives in the laboratory it is subjected to the FRAT (for opiate detection) and TLC (for other drug detection) tests. If both produce negative results, the testing of the urine sample is concluded. If either test is positive, the urine is subjected to a confirmatory test with the GLC system. If the GLC test is negative, the urine sample is judged to be drug free; if positive, action is undertaken to determine whether or not the donor is a confirmed drug abuser.

Originally, if an individual had a laboratory confirmed positive urine specimen, that fact was reported to his unit commander, whereupon medical personnel began a period of observation and clinical evaluation to confirm the individual's drug use. Only at the conclusion of that medical evaluation could the suspected drug abuser be clinically confirmed as a bona fide drug abuser. He was reported as such and detoxification and treatment began.

The military drug abuser was seldom completely drug dependent. Consequently, he exhibited few of the symptoms that mark the civilian addict. This lesser dependency on the part of the serviceman created diagnosis problems for the military physicians because they seldom had the necessary training to diagnose a drug abuser of the type found in the service. As a result, many drug abusers with laboratory confirmed positive urinalysis were not clinically confirmed as drug abusers because the examining physician was either hesitant or unable to make the diagnosis.

Two approaches were taken to rectify this situation. First, efforts were made to include more training in drug diagnosis and drug-related problems in service medical schools; second, the confirmation decision-making procedure was broadened to include a social evaluation and a commander's decision. When a urine specimen is laboratory confirmed as positive, the individual is referred to a physician for an interview and physical examination. In the course of the examination the medical officer takes one of the following actions:

- If he determines that the use of the drug identified in the service member's urine was authorized, he may dismiss the member from any further evaluation.

- If medical treatment is required for drug dependency or abuse or drug related illness, he immediately enters the service member into detoxification or treatment.

- If he confirms drug abuse, but the service member does not require medical treatment, the service member is referred for social evaluation.

- If he is unable to medically confirm drug abuse or verify the authorized use of the identified drug(s), the service member is referred for social evaluation.

A person experienced in the evaluation of drug abuse (social action officer, psychologist, sociologist, rehabilitation counselor, etc.) is designated by the commanding officer to conduct a social investigation of those members referred to him by the medical officer. The social evaluator prepares a recommendation for use in the final determination utilizing all available information such as command or supervisory comments related to performance of duty and conduct; the service member's personnel record; and any other demographic or investigative data available.

The physician and the social evaluator then confer regarding their separate findings and prepare recommendations for a future course of action for the use of the commander in making his final determination. In the event clinical evidence of drug abuse has been found by the medical officer, the joint consultation results in a recommendation for a specific course of treatment and rehabilitation for the service member.

Based upon the medical officer's report of clinical evaluation or the joint consultation, the commander makes one of the following determinations:

- The service member who has been medically diagnosed as a drug abuser or drug dependent is entered into the appropriate course of treatment and rehabilitation following the advice of the evaluators and in accordance with Military Department directives.

- The service member who has a positive urine test but who cannot be medically confirmed as a drug abuser/drug dependent and has not provided satisfactory evidence of authorized drug useage is placed in a urine surveillance program.

- If additional evidence, either medical or social, is completely lacking to support confirmation of drug abuse, the commander may assume an administrative error was made in the testing process and release the service member from any further consideration.

The serviceman who denies the abuse of drugs despite a positive test result and the absence of a convincing explanation is placed in a urine surveillance program wherein he submits three urine samples a week for eight weeks for examination. If a subsequent urine speciman is reported positive, the serviceman is reevaluated. If all surveillance tests are negative, the man is released from the program.

Figure 1 is a graphic presentation of the evaluation procedures. The use of the exact procedure to be followed may vary somewhat between the military services and commands due to the availability of qualified and experienced personnel, but the principles of the evaluation process apply throughout.

Another problem associated with the urinalysis program is that of the individuals who simply fail to appear for a urinalysis when notified to do so. Obviously, these men are highly suspect as drug abusers. The solution to this problem lies squarely in the commander's realm. As soon as senior commanders learn of a unit with this problem, corrective action is demanded and the so-called "no-show" rate drops dramatically.

The drug testing laboratories were originally established to aid in the DoD drug abuser identification program wherein any individual identified solely by involuntary urinalysis was automatically sheltered under the exemption policies of the services. However, on some occasions the capabilities of the laboratories were utilized for forensic purposes, that is, for law enforcement or disciplinary purposes. It soon became apparent that the credibility of the health aspects of the testing program would suffer from too close an association between laboratory analysis of samples generated by the drug abuse testing program, and the testing of samples for law enforcement purposes, i.e., for disciplinary action under the Uniform Code of Military Justice or for the purpose of supporting board action that could result in an administrative discharge under other than honorable conditions. Accordingly, urine specimens in the forensic category are not accepted for testing in the DoD urinalysis testing system. Other laboratories, apart from the DoD drug testing laboratories, are assigned the forensic testing responsibilities.

The problems noted above and their solutions deal mainly with policy and administration of the urinalysis program. Another area with many problems to tax the ingenuity of the program administrators is that of the actual collection of the urine samples and the physical handling of them after collection. Also included in this category are the series of problems encountered in the installation and use of the urinalysis laboratory equipment.

The Armed Forces Vietnam experience is rich in problems unique to the laboratory and to the collection and handling of urine samples. These problems and their solutions provide a myriad of lessons learned. Consequently, the majority of the remaining discussions in this Urinalysis portion of Section 3 relates directly to the problems encountered by the military services in Vietnam.

The first problem encountered in establishing the first urinalysis program in Vietnam was that no precedent existed - there was no text to follow, no experience to fall back on. Thus, each situation had to be forecast as well as possible and a solution prepared. Unforeseen problems had to be solved as they arose. The solution in this situation was to assign experienced, professional individuals who had the capabilities of foresight, ingenuity, initiative, and the energy and will to do the job quickly and correctly.

EVALUATION PROCEDURES

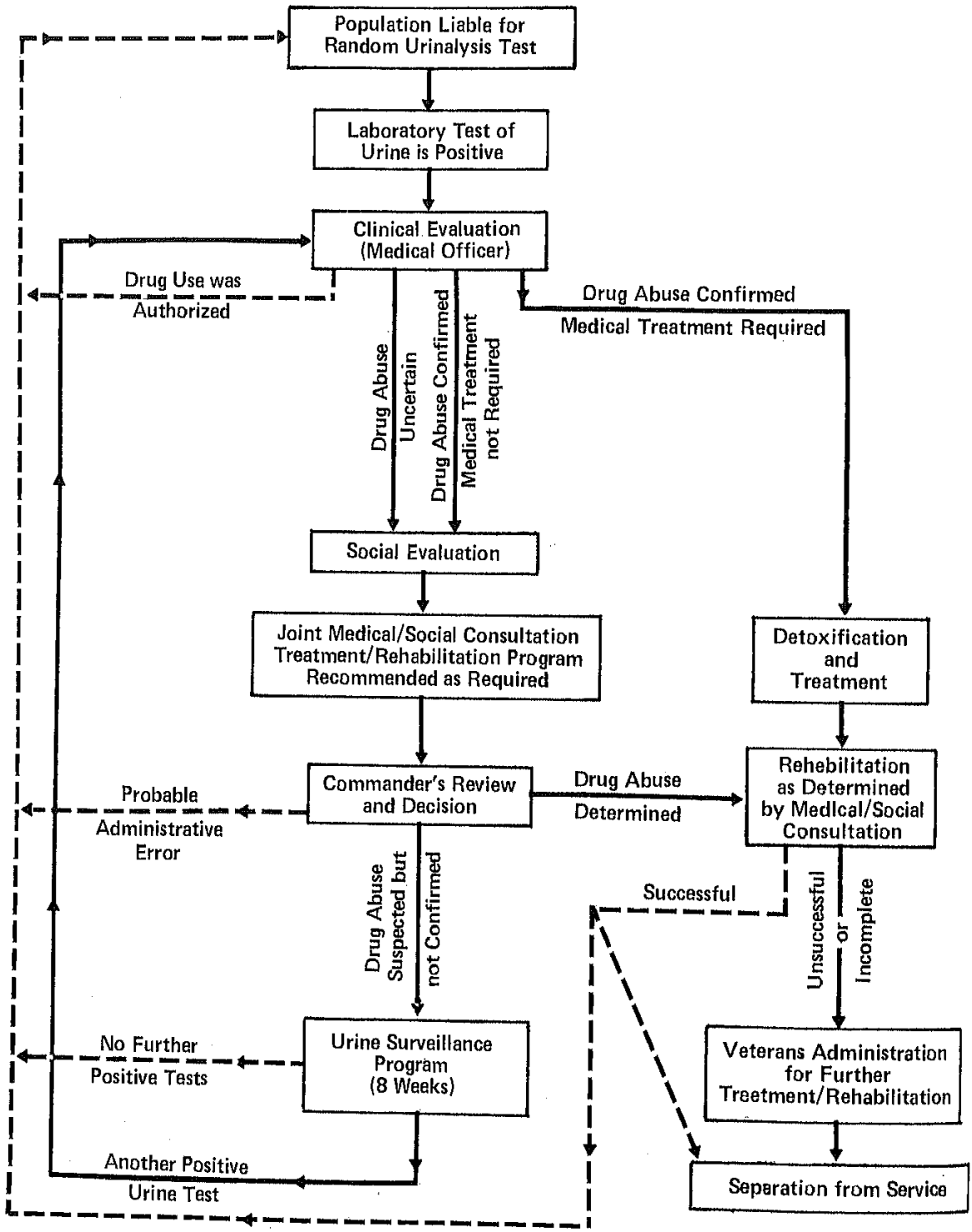

Figure 1

Other problems arose in learning the sensitivities of the new urinalysis equipment. For example, the Chloroquine tablets which are taken once a week in Vietnam as a malaria suppressant caused positive readings on the TLC equipment similar to those of morphine. Using laboratory personnel who were known not to be using drugs as a sample population, a urinalysis experiment was conducted to determine the proper negative level of the equipment so as to be able to differentiate between Choloroquine and morphine.

Another problem was that of obtaining a valid urine sample from the donor. Where the donor had no drug involvement, there was no problem. However, a confirmed drug abuser is wary and may employ deceptive means to escape detection in the urinalysis screen. Bribing medical corpsmen was a means used to avoid detection; the solution demanded honesty on the part of the corpsmen and close supervision by their supervisors. Next, the supervisors learned that it was essential to observe the donor directly when he was giving his sample; otherwise, he might substitute a drug-free urine - which he could buy - for his own. Urine containers were found secreted on the persons of the donors so that a physical search was required before the urine sample was taken. Donors added water to their urine sample thus diluting it to the point where the laboratory equipment could not detect a positive. Thereafter, all water was removed from the specimen collection area. Men would drink enough fluids before the test to produce a diluted sample; this ploy was successfully countered by measuring and requiring a urine specific gravity of 1.010 or greater. If the specific gravity is too low, the donor is required to submit another sample.

Some learned that drinking fruit juices before the test reduced oxidation in the system and caused inaccurate FRAT readings. The medical technicians met this challenge by adding dichromate which oxidizes the reducing fruit juices.

Vinegar was tried. If there is a wait between the time the dichromate is added and the time the FRAT test is performed, the vinegar overwhelms the dichromate oxidizer and the FRAT morphine signal disappears. This situation is readily apparent to the medical technician. He has only to prepare another sample of the same urine for test and to place it in the FRAT machine immediately. The vinegar does not have time to react with the dichromate and the true FRAT signal is obtained.

Collecting urine samples from women proved a problem because the women objected strenuously to the direct observation provisions of the early testing directives. This requirement was later eased to permit alternate procedures for collection of urine samples from women as long as the procedures insured that the speciman obtained was a valid sample.

After collection of the urine samples, the next problem of magnitude which arose in Vietnam was the physical handling and securing of the samples and the related records. Great care had to be taken to properly identify each sample and to physically secure it throughout its entire travel from the sample collection point through the testing laboratory. Experience proved that the devious drug abuser will employ all possible means to destroy or exchange his sample. The same care had to be taken with the urinalysis records; they too were physically secured so that they could not be altered by unscrupulous individuals.

Within the laboratory, the supervisory personnel learned that they must, in addition to securing all samples and records, insure that all collected samples are tested. Not to do so destroys any randomness of the collection scheme. They learned that all laboratory work must be done promptly; backup equipment should be on hand to prevent backlogs in the event the primary equipment is inoperative due to malfunction or maintenance. To keep equipment downtime at a minimum in Vietnam required a controlled laboratory environment. The excessive heat and humidity caused equipment breakdowns and necessitated an air-conditioned, controlled humidity laboratory facility. Finally, reports must be dispatched promptly from the laboratory after the urinalyses are completed. In summary, all laboratory operations must be conducted in an efficient, organized, timely manner. If they are not, the laboratory credibility will be reduced, which in turn destroys the credibility of the urinalysis program, not only in the eyes of the men being tested but also in the eyes of the professional staff administering the program.

It was learned that the maximum possible communication between the laboratory and physicians handling actual or suspected drug abusing individuals is desirable. Where this has been done, it has improved the physician's understanding of the capabilities and limitations of the laboratory procedures and has reduced his suspicion of laboratory error when he receives unexpected positive or negative results. Among physicians and others assisting in the treatment and rehabilitation of drug abusers maximum publicity must be given to the existence of a centralized quality control program, explaining how this, and other special measures such as use of special supervisory personnel in laboratories, assist in maintaining laboratory performance at the highest level of proficiency. Communication with the physician benefits the laboratory in another way, by alerting the laboratory to hitherto unrecognized technical problems such as commonly prescribed drugs mimicking closely the characteristics of drugs of abuse in detection procedures. Examples are Darvon confused with methadone and Valium confused with opiates.

After the urine testing program was under way, subsidiary areas of interest and bits of knowledge came to light. For example, it became obvious that the dispensing of drugs for legal use required a close scrutiny. With the multitude of common ailments in Vietnam many drugs were dispensed on a routine basis without a doctor's prescription. Paregoric is such a drug, dispensed in many instances by medical aid men for common diarrhea. Of course, paregoric is tincture of opium which produces a positive urinalysis reading. Consequently, in order to reduce the number of positive urinalysis reactions which detected legally used drugs, a program was initiated to identify the drugs which caused positive readings and the drugs which could be substituted for them. After this was done, the effort turned to convincing the medical community to dispense the substitutes for the positive producing drugs.

Another aspect of the urinalysis program which proved to be contributory to the success of the program was the fact that detection of the drug abuser did not lead to punitive measures. That is, if detected through urinalysis the drug abuser could expect nothing worse at the moment than detoxification followed by treatment and rehabilitation; he knew he would

not be turned over to the police authorities. This manner of handling the situation is credited with averting many problems.

Another move to eliminate a source of trouble before it began was the separation of those maximally involved with drugs from those who were experimenters or beginners. It was felt that the latter group had a much better chance for rehabilitation if they were divorced from the debilitating influence of the hard-core addict.

The implementation of the urinalysis program for drug abuse detection throughout the DoD served to isolate two principles of management, which although known for years, have now been thoroughly highlighted again. The first of these is the need for unwavering command support for the program. Where the commander provided his wholehearted backing, the program succeeded and the drug abuse situation subsided. Where command support was lacking, resolution of the drug problem required more work. Similarly, the layer of middle managers was surfaced as extremely important in the detection of drug abusers by urinalysis detection. There are innumerable opportunities for the urinalysis scheme to be rendered invalid in the steps from specimen collection to clinical confirmation, reporting and treatment. Honest, professionally qualified technicians and supervisors are an absolute necessity if the program is to succeed. This was visibly demonstrated in Vietnam where heroin was the primary drug of abuse, and was liable for detection by urinalysis screening. Some of the means by which drug abusers sought to escape the screen have been described above. In situations of this nature, and situations like these must be expected where drug abusers are involved, a quality layer of well-trained, motivated middle management is one of the essentials to success.

In addition to the obvious lessons which can be derived from the episodes described above, the DoD experience in establishing a urinalysis program in Vietnam produced several other recommendations which should be considered by any agency embarking on a similar program. First of these is the recommendation that a movable urinalysis laboratory be established, manned and equipped at the national level. Such a laboratory would be ready to move to any site in the country where an onset of drug abuse similar to that which occurred in Vietnam might break out. An advantage of such a laboratory is that it provides a quick detection capability which has been proved invaluable in combatting drug abuse. Another advantage is the deterrent effect. It has been found that the threat of a urinalysis screening with the attendant high probability of detection is a high order deterrent.

Another recommendation centers around the need for continued research to expand, improve and refine the drug abuse detection technology. A means of positive detection for hallucinogenic agents and marijuana is urgently required. As this research progresses toward the final goal of 100% detection of all drug abuse, it should be accompanied by credible factual publicity. Reliable laboratory results coupled with widespread, understandable knowledge of the accuracy of this drug detection capability will add another measure of worth to the deterrent effect of the detection process.

Finally, there is a need seen for tighter control in the production of commercially produced drugs. This recommendation is best illustrated by the following example: an individual's urinalysis indicated a barbiturate had been ingested. Through investigation it was found that the only medication taken by that individual was a vitamin. Analysis of the vitamin tablets revealed traces of a barbiturate leading to the speculation that the barbiturate trace came from using the same pill press for both the vitamins and the barbiturates. The barbiturate found was not sufficient to cause a problem to the person, but the detection of the barbiturate in his urine could possibly lead to problems with his present and future employers.

Quality Control of Laboratory Urinalysis

Many times when a new program is instituted the personnel who work with it do not understand it in all its aspects and therefore tend to disregard or discredit it. The urinalysis program was no exception. One of the means used to increase the credibility of the urinalysis program was the establishment of a visible, believable quality control program for the urinalysis laboratories.

The need for quality control is underlined by the fact that laboratories experienced in support of methadone maintenance programs are not necessarily proficient in detection of new drug users. Methadone maintenance programs yield large numbers of positive urines containing high concentrations of methadone which are easily detected. In this population a negative urine is unexpected, and, if found, can be checked easily because the individual usually can be contacted quickly for another urine specimen. In the DoD program the great majority of urines are genuinely negative for drugs and positives, when found, usually contain very low concentrations of drugs. Considerable effort is required to reorient a laboratory from the relaxed atmosphere which surrounds largely positive urine identification to the tense atmosphere which should underlie the search for infrequent, low concentration positives in a sea of negatives.

Quality control of the urinalysis laboratories output was recognized from the outset as a prerequisite to a successful urinalysis program. During the first three weeks of testing in Vietnam quality control testing was exercised by the periodic insertion into each laboratory of urine samples containing known added amounts of morphine. The FRAT was used for screening, with TLC and ultraviolet spectroscopy used for confirmation. Later, when two screening laboratories arrived from the United States, GLC was used for confirmation and the quality control procedures were expended to include the following:

- Daily standards were applied to FRAT, TLC and GLC procedures for all detectable categories of drugs.

- Pooled morphine samples were inserted in the system by the laboratory officer in charge or noncommissioned officer in charge. These were coded by number to appear exactly as a urine sample would when it arrived at the laboratory. At least one such sample was inserted during each operating shift.

- Amphetamine and barbiturate specimens were prepared by spiking a drug-free urine with known quantities of the compound.

- In order to evaluate performance among laboratories, at least 50 samples were shipped from laboratory to laboratory biweekly for examination by all technology. Results of this interlaboratory comparison were evaluated by the drug laboratory consultant and a summary of the performance reported to Headquarters, United States Army, Vietnam.

Quality control of the contract laboratories in the United States was initially done by the area medical laboratories of the area in which the contract laboratory was located. In the next step, a Tri-Departmental Subcommittee on Laboratory Methodology (a subcommittee of the DoD Tri-Departmental Coordinating Committee) was formed and chartered to accomplish the following tasks:

- Examine all current drug detecting methodologies and establish standards.

- Establish quality control procedures and practices, and prepare and implement a worldwide quality control plan.

- Establish drug detection sensitivity levels for all classes of compounds of interest.

- Prevent unnecessary duplication of effort.

The Armed Forces Institute of Pathology was designated as the DoD quality control laboratory and resources were allocated to it. The remarks that follow pertain to the knowledge gained by the AFIP in instituting the worldwide quality control program and operating it at an acceptable level; however, before proceeding further, it is best to describe briefly the current quality control procedures.

As the first step, the quality control laboratory prepares stocks of urine containing varying quantities of the drugs of interest according to prescribed formulas. From these stocks, sample sets are made up for each laboratory in the program. Further, one set of samples is chosen at random for analysis by the quality control laboratory and a set is put aside in storage for reference and backup purposes. The analysis or standard set is analyzed by the quality control laboratory. The sample sets being dispatched are coded so that the quality control laboratory knows the quantity and type of drug present in each sample. The sample sets are then dispatched to collecting stations, points at which bona fide urine specimens are collected and sent to the participating laboratories. At the collecting station, the quality control samples are repackaged and recorded so that they are indistinguishable from the bona fide samples emanating from that station and they are then forwarded with other samples to the drug testing laboratory. At the laboratories the samples are analyzed and the results reported to the collecting station. There the quality control sample reports are extracted and forwarded to the quality control laboratory, and weekly and quarterly reports are then prepared of the results obtained from each participating laboratory. These results are furnished to the participating laboratories and to the

military service laboratory control officers for whatever corrective action may be required.

Initiation and operation of the quality control program has been of inestimable value in demonstrating once more the absolute need for quality management. This need first became apparent during the establishment of the program when space, equipment and personnel had to be located and worked into an efficient team in a minimum of time. Professional, dedicated middle management personnel at the collecting stations also proved to be a necessity. The lack of such dedicated personnel caused many growing pains in the program. Many operations are performed at the collecting stations: urine samples must be repackaged, they must be coded, the code numbers must be recorded, the laboratory reports of urinalysis must be scrutinized for the quality control specimens, and the report to the quality control laboratory must be prepared. All of these operations are hand operations, tedious and tending toward routine and boredom, but all must be done without error for program success.

The report form and a set of instructions are included with each shipment of urine samples to the collecting station; they are simple and easy to follow but oftentimes the work is not done properly which makes it difficult to correlate the reported results with the sample and other requested information. Without the proper care at the collecting station an unfair error rate may be attributed to a laboratory. The situation demands managers who can set up a routine at the collecting station complete with the requisite checks, and then exercise the necessary degree of supervision to make the system work without error.

Another location which requires first class management is the participating urinalysis laboratory. In those laboratories where the management has been forceful, knowledgeable, enterprising, interested in producing a good job and willing to spend the time to insure a good output the quality has been high and vice versa.

In the physical arrangement of the quality control laboratory it was found essential to house the facility in its own work area, to physically separate the people, laboratory equipment and operations from other elements in the same location, and then to physically secure the laboratory area from outside intrusion. A walk-in, refrigerated cold room for sample and chemical storage is also necessary. Supplies proved they could become a unique problem, e.g., large quantities of drug-free urine are required. A suitable container for shipping urine samples is required, one that does not leak, spill or react with reagents -- the AFIP settled on a glass bottle with a crimped top.

Handling of data became a major pursuit in the program. Many different data items are involved such as schedules for dispatch of sample sets, concentration levels of drugs in samples, randomization of samples in a set, code numbers for bottles, labels for bottles -- all of these come up for preparation each week for each participating laboratory. With the tremendous amount of data handling it was decided that the situation was best handled by digital computer. A program was prepared and the required data inserted so that when the time comes to begin the cycle of dispatching a

sample set to the field, one input card identifying the laboratory to be tested and its work load is inserted into the computer. The machine then prints out the samples required and the concentrations of drugs to be used; it performs the required randomization and preprints the labels.

Handling of incoming reports of quality control results was also found best handled by the use of automatic data processing procedures. The results returned by the participating laboratories are placed in a computer system, and weekly action and quarterly summary reports are generated for distribution to the laboratories and the service program directors.

A feature which enhances the fairness and reliability of the quality control system is the so-called "double blind" system. This system was briefly described above; it is the process whereby the sample sets are sent from the quality control laboratory to the collecting station. The collecting station knows the samples are quality control samples but does not know what drugs and what concentrations are used. This is the first step in establishing the anonymity of the sample set. At the collection station the samples are repackaged and recoded to appear as normal bona fide specimens and are then sent on to the analyzing laboratory. That laboratory cannot identify the quality control samples among the bona fide specimens. This is the second step in the anonymity establishment procedure which completes the double blind method of providing sample sets to the laboratory.

A final 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 tested laboratories and the service representatives; changes and improvements must come from them. Serving as an impartial referee without any stake in the outcome removes the stigma of possible bias from the quality control laboratory and its director.

Exemption Policy

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. In October 1970, the DoD authorized the Military Departments to establish amnesty programs on a trial basis. Under these programs individuals were told that if they had a drug problem and sincerely wanted help with it, medical assistance would be made available to them, action under the Uniform Code of Military Justice may be suspended for the unauthorized use of drugs and a discharge under honorable conditions may be considered. As the extent of the drug problem in the armed services became more and more apparent, the DoD policy was changed from that of a trial basis to implementation service-wide. In so doing, the word "amnesty" was supplanted by the word "exemption" since use of the word "amnesty" connoted total exoneration which was not the intent. Under the exemption policy, evidence of drug usage or possession 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 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 violations of other applicable laws and regulations. These include those laws and regulations relating to the sale of drugs or the possession of significant quantities of drugs for sale to others. However, the information gained through use of the exemption policy may, if deemed advisable, be used in other administrative actions such as removal from flying status, reassignment, denial of security access, and administrative discharge under honorable conditions.

A problem with the exemption policy was that of credibility. Initially, the policy with all of its ramifications was not understood in detail by the officers, noncommissioned officers and the target group of drug abusers. Lacking knowledge, the credibility gap was large. Some exemption participants were undoubtedly subjected to harrassment. Some felt that there were no incentives or rewards to apply under the exemption policy and no true guarantee; others had pressures applied by drug users and distributors not to apply; and still others felt there was nothing physically or morally wrong in using drugs. The task then became one of defining the legalities of the exemption policy, translating them into operational criteria and then mounting a program of education and publicity first of all to inform all concerned of the exemption policy details and then to convince the drug abuser that it was to his benefit to volunteer for treatment. To succeed in the latter the drug abuser must believe that the exemption policy benefits are greater and its liabilities less than continued drug abuse. Further discussion of the education problems, procedures and techniques is contained in Section 2, Drug Education and Prevention.

The solution to the credibility situation was found in the personal or human approach. Drug abusers need counseling to convince them that the "establishment" is sincere in its efforts to help them, that they are worth helping, and that they have something to contribute to their unit and to society. Moreover, they have to be convinced that they can enter treatment under the exemption policy through officials other than their commander -- a physician or chaplain, for example; the point to be made was that the official acted as a liaison element to get the drug abuser into treatment and not as an exemption approving authority.

Posters, radio and television announcements, lectures, and conferences can explain the points of the exemption policy to the target audience, but, for real effectiveness, it is necessary to employ a personal, man-to-man approach. Further, there must be close coordination and cooperation among the leaders, counselors, medical personnel, criminal investigative personnel, and chaplains so that they all present the same exemption policy and establish it as a credible program.

At first it was thought that anyone entering treatment under the exemption policy was probably sincere in wishing rehabilitation. As experience was accumulated it was learned that many who availed themselves of the exemption policy volunteered rather than take the risk of being detected

and were merely biding their time with no serious intent of committing themselves to rehabilitation. That some of those volunteering under the exemption policy are devious manipulators is borne out by a recent study of drug abusers in Vietnam where the men in the exemption group were found to have higher incidence rates of school suspensions for drug abuse and courts-martial than those drug abusers who were detected by other means. The insincere individuals applying under the exemption policy dwindle in number as tougher and more exacting surveillance procedures are used in treatment and rehabilitation.

Apart from the credibility problem was one of the lack of real concern for the drug problem by many officers and noncommissioned officers. They often felt that a problem of any magnitude did not exist and so they did not direct their best efforts toward it. In such an atmosphere the chances of success of the exemption policy can only suffer. The solution to an apathy situation of this type is education to present the drug problem and the exemption policy in their true light and imposition of command emphasis from more senior leaders so as to focus the attention of the junior supervisors on the problem and the part they are expected to play in its solution.

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 use were to be reviewed for recharacterization upon the application of the affected individual. If his discharge is recharacterized the individual becomes eligible for VA aid. 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.

Other Means of Identifying Drug Abusers

The urinalysis screen and the exemption policy are the primary means whereby drug abusers in the military services are identified. However, there are other ways. One of these is through the medium of criminal investigation. Many drug abusers are identified in the course of the investigations conducted by the military investigative agencies.

Another method uses dogs trained to detect cannibis sativa derivatives. A pilot program was initiated in the Army in 1969 and proved successful. Since then dog teams have been employed by the Air Force and Marine Corps, and the Navy is in the process of implementing a dog program. The use of dogs not only serves to locate marijuana and hashish but also serves as a deterrent. The sight of the dog and handler often is sufficient to cause users to dispose of their drug stocks, and, as was pointed out by one former division commander, the dog need not always be trained to detect cannibis to function in the deterrent role -- the drug abuser cannot tell the difference between a trained and an untrained dog, and he cannot afford to take a chance on making a mistake.

There are problems, however, with cannibis detecting dogs and their use which should be considered before embarking on a detector dog program.

Dog handler training involves the matching of a dog and a man, who will thereafter work as an inseparable team. A well-conceived plan for dog use should exist. A dog which after training is not worked or is overworked because of inadequate planning will soon lose his effectiveness.

Adequate kenneling is necessary for success of a detector dog program. Without proper kennels a dog's desire to work will diminish. Experience has shown that dogs maintained in kennels away from the handler's quarters have a better attitude toward work each day. Proper kenneling security is also necessary to protect dogs from injury or mishandling by drug traffickers or others.

A very critical element in a detector dog program is the follow-up proficiency training. No matter how thorough the initial training, a dog will become unreliable if the handler is not faithful to proficiency training requirements. This must take place every day to assure that the dog continues to associate with the odor of the drug and not begin looking for something else, such as the odor of plastic wrapping material. If this problem is not dealt with adequately, the dog's initial level of proficiency may never be regained.

Although the urinalysis program has proved effective in identifying the abusers of opiates, amphetamines and barbiturates, and dogs have had some success in detecting cannibis derivatives, research must continue to find methods whereby the abusers of other drugs can be identified. When these methods are established the DoD will be in a position to take another significant step toward eradicating the drug problem in the Armed Forces.

SECTION 4

Treatment and Rehabilitation

General

Implementation of the DoD control programs regarding drug abuse was accelerated following the President's mid-1971 announcement of a national drug abuse counteroffensive. Prior to the President's announcement, the policy was largely oriented toward law enforcement. Then, in his memorandum to the Secretary of Defense of 11 June 1971, the President emphasized his desire that the military services not discharge addicted servicemen into society without treatment and efforts at rehabilitation. Thereafter, the DoD policy turned toward rehabilitation.

The DoD 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 for the Department of Defense to assume responsibility for long-term, in-service rehabilitation of servicemen whose potential for continued useful service is doubtful. 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 service. Others are phased into Vetersns 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 thirty days of treatment. In implementing this program, it was learned that several factors interrelated and so amplifying instructions were issued.

First, it was stated by the Aasistant Secretary of Defense for Health and Environment that the drug dependent service member would go into either a military service treatment program or a VA facility via the Armed Services Medical Regulating Office. Further, he would not be separated from his service until he had completed a minimum of thirty days of treatment for his condition subject to the following:

- The thirty-dsy period may start with detoxification but the services have the prerogative to select the treatment starting date.

- The objective of the thirty-day period is to attain thirty days of treatment free of drug use by the individual prior to his release to civilian life to asaure that the services are not releasing drug dependent personnel into society without a aignificant effort to eliminate the drug dependency.

- A aerviceman may remain beyond his normal term of service in order to complete thirty days of treatment if he voluntarily extends his active

service or if he is required to make up time lost under applicable service regulations. In the event that neither of these conditions apply, he is released to meet his original expiration of term of service date.

- The VA is responsible for the completion of the thirty 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 whether a drug dependent serviceman is assigned to a VA facility or to a military facility for treatment depends upon the circumstances in each case. Following are the general policies for assignment:

- The drug dependent serviceman who has sufficient time remaining in the service for short-term rehabilitation is provided treatment in service facilities. During or at completion of the service rehabilitation, an evaluation is made regarding retention in the service and extent of rehabilitation required. If it is determined that long-term rehabilitation is necessary or the serviceman will not be retained in service for a period adequate to complete his short-term rehabilitation, he is processed for administrative discharge and transferred to the VA for treatment with separation effective fifteen days or more subsequent to arrival.

- The drug dependent serviceman who fails to respond to service rehabilitation efforts is processed for administrative discharge and transferred to the VA for treatment with separation effective fifteen days or more subsequent to arrival.

- The drug dependent serviceman who is approaching his expiration of term of service date and has insufficient time for service rehabilitation is processed for discharge and transferred to the VA for treatment with separation effective fifteen days or more subsequent to arrival. This fifteen-day minimum requirement may be waived when it is determined to be in the best interest of the patient and is agreeable with the receiving VA facility.

- Personnel not in any of the three categories above are treated by the services until completion of the minimum thirty days of treatment or expiration of term of service is reached.

- Any serviceman who is transferred to the VA for treatment and after admission becomes recalcitrant to such an extent that his presence is disruptive to the operation of the hospital, and VA personnel determine that he would not be receptive to further treatment, is returned to service control. Military Departments are responsible for the immediate movement of such serviceman from the VA to service facilities.

Existing procedures for providing the separation date and other pertinent data to the VA on ASMRO transfers are carefully observed. In addition, the number of days of completed treatment free of drug use is provided to the VA for each individual at the time of transfer.

A problem which arose with the DoD policy of treatment and rehabilitation dealt with the status of service members while they were assigned to facilities designed to evaluate, treat or rehabilitate drug abusers. At first, individuals who were assigned to such facilities under identical circumstances were being treated differently with respect to the application of 37 U.S.C. §802. Section 802 of Title 37 provides that a member of the Armed Forces who ". . . is absent from his regular duties for a continuous period of more than one day because of disease that is directly caused by and immediately follows his intemporate use of alcoholic liquor or habit-forming drugs is not entitled to pay for the period of that absence. . . ."

Policy requires that individuals identified as drug users either as a result of urine testing or because they admitted their use under the exemption policy be provided appropriate evaluation, treatment, and rehabilitation. In some cases, this policy may require that the individual be absent from his normal duties. Such absence does not necessarily have any relationship to the presence of a disease, the direct cause of any disease that may be present, the length of time subsequent to use of any substance, the habit-forming aspects of any substance used, or the ability of the individual to continue to perform the duties that were assigned to him prior to his identification as a drug user. Because of this policy, the fact that a member is in a drug treatment or rehabilitation facility does not mean that the law requires a forfeiture of his pay.

For the reasons stated above, it was determined that a member of the Armed Forces who is assigned to a drug treatment or rehabilitation facility as a result of the exemption policy or the urine testing program is absent from his assigned duties because of administrative policies and that the forfeiture provisions of 37 U.S.C. §802 do not apply to the period of time he spends in a treatment or rehabilitation program. In other situations, the determination is made on a case-by-case basis.

This interpretation of the time forfeiture provisions of Section 802 was provided to all the Military Departments to standardize the manner of handling "bad time" situations throughout the DoD.

Experience quickly established the fact that treatment and rehabilitation programs are not simply a medical problem. To produce a truly rehabilitated individual requires the efforts of spiritual, community, command, and medical personnel. Further, in some cases it was found that the better treatment was being provided by para-medical or para-professional personnel. Thus, it appears that the success of a treatment or rehabilitation program is less a function of the degree of medical knowledge brought to bear and more a function of the degree of energy and enthusiasm of the treatment personnel coupled with a knowledge and understanding of the drug culture, why people enter it, and why they succumb to its abuses. By attacking the attitude and behavior problems of the drug abuser as well as his medical problems, the success rate of rehabilitation turned upward.

Military Service Programs

The manner in which treatment and rehabilitation programs are operated varies from service to service. Each administers its own programs within the guidelines and policies established by the DoD.

The rehabilitation plans developed by the military services during mid-1971 had a number of points in common as well as one major difference in approach. 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 his involvement and on the basis of that decision an assignment to an appropriate treatment or rehabilitation center was made.

The one major difference in service approach was the degree of centralization of the rehabilitation efforts for those personnel who were found to have a more serious dependency on drugs. The Army chose to rely on a decentralized model for rehabilitation, whereas the other services developed plans on a centralized model.

Regardless of the agreement or differences in the rehabilitation plan and approaches, the problems experienced in developing drug abuse programs were common to all the services. Before proceeding to the problems and their solutions, a brief description of each service program is presented so as to provide a base for the comments to follow.

The Army treatment and rehabilitation program is operated on a decentralized basis at installations throughout the United States and overseas locations. Thirty-three hospitals in the United States have been designated to receive drug abuse patients returning from overseas.

Following the identification of a drug abuser, detoxification, if required, is accomplished in an Army medical treatment facility. The time spent in detoxification varies with the individual, his degree of drug dependency and the drug or combination of drugs involved.

During the process of detoxification and initial treatment, a medical evaluation is made to determine the drug abuser's individual rehabilitation needs. Rehabilitation is accomplished in a unit environment with halfwsy houses and rap centers used for transitional and supportive assistance as required. Rehabilitation is a command responsibility and involves all elements of the community to provide support to the soldier to restore him to effective military duty. For success, the soldier, his commander, and the medical and nonprofessional personnel in the rehabilitation program work together as a team.

Halfway house facilities provide a more structured environment for the individual who does not require inpatient care but who is not ready to assume his full duties. Such facilities provide for a man to live-in either full-time for a short while, or part-time while performing duty in his unit. Although treatment is conducted under medical supervision, the halfwsy program is a command responsibility.

Rap center activities add to the outpatient rehabilitation program. Many soldiers do not need contact with a halfway house and others respond better to s less structured program.

Those drug abusers who cannot be rehabilitated in a reasonable period of time are transferred to VA hospitals as described earlier or are referred to other established civilian programs for long-term care.

The Navy offers basically two levels of rehabilitation for the identified drug abuser. Naval personnel determined to be drug dependent are referred for inpatient treatment at one of the two Naval Drug Rehabilitation Centers at Miramar, California, or Jacksonville, Florida. The Miramar facility utilizes a five-track (multi-modality) approach to rehabilitation. Track determination is based on the demonstrated interest of the patient and the professional staff's evaluation of the level and intensity of treatment required. A detailed discussion of the Navy experience in establishing the NDRC at Miramar with a complete description of the five modalities is found at Appendix B. The Jacksonville facility utilizes a one-track, two-phase program of treatment. Rehabilitation commences with Phase I (group therapy, didactic teaching and behavior modification techniques) and progresses into Phase II (self-governing responsibilities and continued rehabilitation counseling in a halfway house atmosphere).

Those Navy members who evidence other than serious dependency or who are labeled experimenters and are capable of maintaining command directed job responsibilities are rehabilitated locally at one of the many Navy Counseling and Assistance Centers or are counseled within the individual unit. The CAAC provides a resource through which an integrated program of education, prevention and counseling service is made available to local commands in a coordinated effort to combat drug abuse and to return the drug abuser to productive service. Specific services offered include the screening, counseling and evaluation of identified drug abusers, drop-in crisis intervention and referral, exemption representative training, follow-up counseling for personnel returned to duty from an NDRC, and drug information dissemination.

If an identified drug abuser in the Marine Corps is found not to be drug dependent, he is retained in his parent command and undergoes treatment and rehabilitation at the local level. Local rehabilitation programs vary among commands depending on their resources, personnel and operational commitments. While participating in the local program, the serviceman is evaluated as to whether or not he has further service potential warranting retention on active duty.

If the Marine drug abuser is determined to be drug dependent, he is medically evacuated to one of the NDRCs at Miramar or Jacksonville. Upon completion of his treatment, the NDRC makes a recommendation on the service potential of the individual; the Marine Corps then determines whether to retain or separate him.

The Air Force treatment and rehabilitation program is considered to be a centralized system of sequential activities into which each known drug user is introduced. Drug abuse rehabilitation is offered to all servicemen and is limited only by the member's willingness, capacity for rehabilitation, and time remaining in service. The Air Force concept of drug abuse rehabilitation includes five basic phases: Phase I - identification; Phase II - detoxification; Phase III - phychia-evaluation; Phase IV - behavior reorientation; and Phase V - follow-on support.

Phase I identification is accomplished through urinalysis testing, apprehension or investigation, the Limited Privileged Communication Program (exemption policy) and identification incident to normal medical care.

Phase II of the rehabilitation process is physiological detoxification. It involves placing the drug dependent individual in a patient status at the nearest medical facility. The time required for detoxification is dependent on the individual circumstances. Average time at present is five to seven days. During detoxification the decision is made on further treatment or evaluation needed. The most severe cases are referred to the USAF Special Treatment Center, Lackland Air Force Base, Texas. Those that require further evaluation then enter Phase III.

Phase III is psychiatric evaluation. When further psychiatric or neurological evaluation is needed and is not practical at the local installation, individuals are referred to the Special Treatment Center. Initial psychiatric and neurological evaluation, treatment, and disposition requires an average of seven to ten days but may be extended to as many as twenty-one days. The evaluation results determine the next step. If no further medical treatment or behavioral reorientation is needed the individual is returned to normal duty. If appropriate he is entered into the behavioral reorientation phase either at the local installation or the STC. If in-service rehabilitation is precluded he is referred to a VA facility for rehabilitation prior to separation from the service.

Phase IV is the behavioral reorientation process and is a nonmedical approach to rehabilitation. At the Special Treatment Center, the team concept is used. At base level, Phase IV is primarily educational in nature and will usually not require the intensiveness applied at the STC. Upon completion of this phase, the individual may be evaluated and returned to duty, discharged upon completion of service, administratively discharged or transferred to a VA facility or other civilian agency. In all cases successful rehabilitees who are returned to duty are entered into the final follow-on support phase.

Phase V, follow-on support is the process by which rehabilitees return to normal duty. Duration of this phase is one year from date of entry. Its function is to monitor and facilitate the reentry of rehabilitees into normal military life and help them avoid a return to drug use. This phase always takes place at base level under the guidance of the base Social Action Office.

Medical Screening

Drug abusers are identified primarily through urinalysis screening and the exemption policy. Once detected, they enter a drug detoxification or treatment program where they are processed through some form of medical screening. Several problems arose at this stage which required correction and which should be borne in mind by anyone directing a drug abuse program. The more important screening problems are listed below.

- There were failures to diagnose drug abuse for fear of stigmatizing an individual or through lack of professional knowledge -- these situations are discussed more at length in Section 2, Drug Education and Prevention.

- There were failures to clinically evaluate the extent of an individual's use of drugs or his drug dependency; sometimes positive urinalysis results were accepted without further examination.

- There were failures to attempt to determine what drugs were being abused.

- There were failures to diagnose pathology which was directly or indirectly secondary to the drug abuse, e.g., a failure to examine the patient for hepatitis in drug abuse cases.

- There were failures to diagnose drug abuse as a secondary diagnosis to other pathology.

The screening done when a suspected drug abuser enters a medical facility must be thorough, accurate, and not dependent upon the testimony of the individual being examined. The part played by medical personnel in the screening process must be clear; their instructions must be specific and detailed, and all concerned must be adequately trained in the part they play in the screening process. Finally, all must be motivated with the understanding that drug abuse is a serious problem, and it is their responsibility to fight that problem regardless of their personal convictions.

Detoxification and Treatment

Within the military services, several modalities of treatment have been used. One, that of methadone maintenance has been rejected by the DoD as being inappropriate for the type of drug abuser found in the active Military Establishment. Most servicemen who are drug abusers are young and few of them have an extensive history of heroin use. It is the policy of the DoD that these men will be given the opportunity for rehabilitation in a drug free program.

It was learned early in the drug abuse control program that detoxification procedures were not always sufficient because only a limited clinical evaluation was made after a urinalysis test was judged positive. Consequently, the drug or drugs with which involved and the degree of involvement were not completely determined. This led to later problems through use of improper detoxifying agents or improper use of detoxifying agents.

Further, there was a failure sometimes to combine therapeutic treatment with detoxification; the therapeutic treatment was begun after detoxification resulting in loss of time and opportunity. In other instances, patients did not receive treatment for the medical problems they might have because those problems were not detected or diagnosed properly, or standard medical follow-up procedures were not observed. From this it was learned that a complete medical examination is required on all drug abuse patients.

The comments above illustrate the point that although the planning may be sound, the execution in all cases may not be adequate, possibly because it is not completely understood. Sometimes, programs become so enmeshed in day-to-day problems that the prime goals relative to drug abuse are not realized. The solution to the situation centers around the structuring of realizable goals and the definition of the medical responsibility and relationship for the drug treatment program. Following this, guidelines for the medical support of the program have to be established and published. Service medical schools can perform this function admirably. The final steps in the

solution are full and complete command support for the drug program and dynamic execution by the individuals in charge of specific areas. Where dynamism, energy and enthusiasm are lacking, the programs are seldom adequate.

At Appendix C is an account of the problems, with their solutions, arising from the establishment and operation of treatment centers in Vietnam. This account grew out of a DoD workshop held in March 1973 which brought together many of the Army officers and enlisted men who were associated with drug abuse control programs in Vietnam in 1971 and 1972. Their comments and recollections were enriched by the drug experiences of knowledgeable officers from the Navy and Air Force.

Rehabilitation

The rehabilitation of detoxified drug abusers took many forms, proving that there is no single modality route to success. In Vietnam, for example, where different units tried different approaches, the success of the program seemed to depend mainly upon the enthusiastic work of dedicated volunteers, most of whom were nonprofessionals, with the encouragement and support of their commanders. Their programs cannot always be institutionalized. Some mistakes were made, of course, but the experience provided much knowledge of value to any rehabilitation program.

One rehabilitation facility in Vietnam used a number of ex-addicts as counselors, and they were considered to be the key to the program's success. After a number of bad experiences, however, most of them were removed. The ex-addicts tended to be weak and dependent personalities themselves, as evidenced by their having become addicts in the first place. Often they lacked leadership qualities and refused to conform to Army rules. They did not get along with the "straight" counselors and showed little sense of responsibility. They still needed to receive a good deal of support themselves. Some reverted to heroin use. One after doing so recanted all the bad things he had said about heroin with considerable impact on those who listened. Presence of ex-addicts as counselors also discouraged a number of well-trained and educated enlisted men from serving as counselors themselves, since they did not wish to become identified with former users. Those in charge of the facility agreed, however, that it was essential to have some ex-addicts participating in the program, but these had to be given close supervision. There was a consensus also that ex-addicts can work effectively in information campaigns, where the strains are less and they have good credibility with soldiers.

Another Vietnam facility operated on the theory that changing the environment helps to drop the drug habit. The atmosphere was somewhat sterile and ascetic, as contrasted with the more psychedelic tone of other installations. The counselors here noted that heroin addicts often had little capacity to cope with frustration. They tried to provide a supportive environment, with medical, physical, psychological, and spiritual help. Residents of the house were encouraged to participate in athletics such as volleyball. An effort was made to give them mental rehabilitation -- the assurance that they could face their everyday problems. A unique feature of the program was the strong religious emphasis. The men were encouraged but not required to engage in religious discussions and Bible study.

One division handled its program differently. Because of limited resources, only one-fourth of the drug abusers received the full rehabilitation program after detoxification. The others were followed up by unit drug teams which had been established in each battalion. The drug teams, which also give drug abuse instruction to their units, were enlisted men trained by the surgeon. Most had background in psychology, social work, and similar disciplines. Very few were ex-addicts.

An aviation group had the most structured of the programs and the longest in duration. It involved counseling and evaluation before a man was permitted to enter the program, a withdrawal phase, and then physical rebuilding combined with group therapy. A man was not allowed to begin the program unless he was believed to be strongly motivated to stop abusing drugs. A staff of thirteen men handled a maximum of eleven new drug abusers who entered the program each week. The first week of the three-week program consisted of withdrawal. In the second week the man entered the "rebuild platoon " where he received a good deal of physical exercise, and an effort was made to give him goals and to build up his self-esteem. The final week concentrated on work therapy -- painting a building, for example -- and classes on military subjects and matters of interest to soldiers such as VA benefits. Following the three-week program the man returned to his unit where he received counseling on a weekly basis for five more weeks.

The men in the aviation group program were not harassed, but they were required to maintain a neat appearance and to keep their belongings in order. There was discipline as well as sympathy and understanding. Any who refused to conform were dropped from the program. The rehabilitees moved through the three stages as a group; the counselors considered this group identity to be important. A nurse also participated in the program. It was noted that she was often able to elicit information from the men that doctors and counselors could not.

Appendices D and E are two accounts of drug rehabilitation efforts in Vietnam. Appendix D is a summary compiled from the experiences of several individuals associated with the Army Drug Rehabilitation Centers, and Appendix E is a condensation of the after-action report of the Commander of the U.S. Army Drug Rehabilitation Center in Danang.

As described earlier under Military Service Programs all services conduct rehabilitation in hospitals or special drug centers for those who are more deeply involved than those treated at base and unit level facilities. Experience has produced some items of interest here also. The Navy, for example, has demonstrated conclusively that rehabilitation can be accomplished in a military environment, e.g., the Naval Drug Rehabilitation Centers at Miramar, California and Jacksonville, Florida. (It has been held by some that the military atmosphere was distasteful to the drug abuser to the point where attempts to rehabilitate him in a military environment were not feasible.) The Navy's experience is that the rehabilitation efforts can be profitable using a staff which includes physicians, line officers and civilians.

The Air Force has exhibited success with their five-phase program and concentration of the most heavily involved drug abusers in the Special

Treatment Center at Lackland Air Force Base. The Air Force program and the STC provide a viaible, structured model for conaideration by any community embarking on a drug treatment and rehabilitation program.

In some instances programa did not succeed; the knowledge gained in these situationa is likewise applicable to military and civilian programs alike. First, it was learned that it is necessary to define specifically the goals of the rehabilitation process and then to structure the program to accomplish these goals. Specific taboos which were unearthed are:

- No individual was designated aa the person in charge of the program.

- Drug abusera were running some programs themselvea.

- Drug abuse patients were permitted to diagnoae their own illnesses.

- No program was planned for those acheduled to be in treatment for a short period.

- Clinicians were not permitted to counsel individuals during detoxification.

- There were failures to shift treatment from one modality to another when the first did not succeed, and failurea to use multi-modality approaches.

- There were failurea to define the roles of the counselor, therapist, and group leader, and to train them adequately for their taska.

- There were failures to provide outpatient and outreach services.

- There were failures to establish a proper follow-up system so that the rehabilitation of an individual could be evaluated on a continuing basia.

The solutions to the deficiencies noted above lie in proper program preparation and training. Organizera and leaders are required to lay the ground work, to do the planning, and then to supervise the execution; the miatakes of othera should be observed and avoided, and their lessons used in structuring new programa.

Coordination with Veterans Administration Facilities

The proceedings whereby servicemen may be transferred to VA hospitals for further drug treatment was described in the opening paragraphs of thia aection. As this program got under way problems and misunderstandings, primarily administrative, arose with respect to the DoD policy associated with the transfer of active duty aervicemen to the VA. Some of these were:

- Patients arrived at VA hospitala without proper recorda.

- Patient records did not contain adequate data to assure continuity of treatment, i.e., the records lacked information on the type of drugs involved, the modalities of previous treatment and the amount of treatment completed.

- Patients arrived at VA hospitals without prior notification to the hospital staff.

- Patients arrived at VA hoapitals without adequate clothing or with an excess of clothing; the latter situation caused storage problems at the hospitals.

- Patienta stated upon arrival at VA hospitals that they were to be placed on leave or to be discharged which was uaually false. In some cases these statements were not verified by the hospital staff.

- Patients arrived at VA hospitals during off duty hours or during weekends without advance notification to the hospital staff.

- Patients were not adequately briefed by the military servicea on the assistance which would be provided at the VA hospitals.

In evaluating the causes of these difficulties, it was clear that a closer working relationship between the staffs at the military installations transferring patienta and the VA facilities receiving these patients would minimize the problems. Accordingly, the Assistant Secretary of Defense for Health and Environment established the following policies:

- Esch service would establish direct communication between the installation sending a drug abuaer serviceman and the VA facility receiving the patient. Prefersbly, communication ia accomplished through the medium of service staff viaita to the VA facility. When circumstances limit staff visits, telephone contacts with the VA authorities are established as a minimum. These contacts and staff visits are maintained on a continuing basis.

- The person to be contacted at the military installation when problems or unresolved administrative procedures arise would be identified to the VA authoritiea as part of the direct communicstion procedure. Alternate contacts are also provided.

- The services would encourage staff visits by members of the VA facility to the military installation and would provide appropriate orientationa on the service drug problems and the handling of personnel being transferred to the VA.

In a similar fashion the VA hesdquarters directed the VA subelements who were receiving drug sbuse servicemen to initiate s similar program of staff visits to the military installations.

The prescribed personal contacts and liaison viaits significantly eased the problema attendant to sending active duty servicemen to Veterans Administrstion hospitals.

SECTION 5

Records and Information Handling

General

In any program with the scope and breadth of the DoD drug abuse control program, it is mandatory that records and statistics be kept in order to be able to judge the degree of success or failure of the program. In a drug abuse program it is doubly important to devote considerable attention to records keeping; the typical drug abuser is not necessarily interested in being identified as such and having his drug habit curtailed. It requires an extensive effort to identify him and to detoxify, treat and rehabilitate him. Accurate, up-to-date records are necessary to keep him from escaping the identification screen and to keep track of him once he has been identified. Similarly, much effort must be expended in acquiring accurate statistics of drugs of abuse, degrees of involvement, treatment modalities provided, and the success of rehabilitation efforts. These statistics should not be considered as absolute measures of success or failure; because of the many variables involved, they can only be accepted as relative indicators of trends. This in itself is valuable.

A paradox which arises in the records area is that there is a situation where it is advantageous not to keep too many records. In rap centers and similar installations, servicemen often come in for counseling and help but wish to preserve their anonymity. Delving into their past and personal data too deeply can be counterproductive by frightening off those who require help. Some records probably will always be required, such as attendance figures and the type of drugs used, but recording too much personal data in an anonymous type of situation is self-defeating.

Recognizing that semantics alone could cause unnecessary problems in drug discussions, the DoD promulgated a set of common drug terms in 1970. Other lists of definitions were published, usually by memorandum, as the need arose. By so doing, a common drug abuse language was created for use among the DoD and the Armed Forces. When one speaks of an addict, an experimenter, or casual supplier, his audience knows exactly to what category of person he is referring.

Drug Abuse Data Collection and Recording

Any program with the complexities and variables of the services drug abuse programs requires a maximum planning effort during the initial stages. Early, successful planning saves time and money and helps to ease the detected drug abuser into and through the several programs efficiently, thereby assisting in the establishment of program credibility in the minds of patients and staff alike. A properly planned program anticipates problems which may emerge as time goes on and provides for them in advance -

changing a program after it is under way typically is more difficult than preparing for the same contingency beforehand.

It was learned that the composition of planning groups should include representation from each of the significant categories of the effort being planned. Where drug abuse programs are concerned, medical personnel and counselors should join the administrators in planning the program. Each group represented has different interests and possibly different goals so each viewpoint must be considered in arriving at an efficient, workable, integrated program plan.

As masses of data accumulate it becomes more and more difficult to sift and extract specific items by hand. With digital computers available it has proved much more rapid to handle the reduction of data by machine. Therefore, planning a data collection and recording effort should take into account general machine requirements and formats from the outset.

Another element of data collection and recording is patient follow-up. It is easy to predict that any situation with the ramifications of the drug abuse problem will see studies and surveys conducted in order to dissect the problem and search for solutions. An enterprising planning group will keep the follow-up eventuality in mind and will plan to collect that personal and medical data which will facilitate follow-up studies.

Medical data is a category of information which is required from all drug abusers who enter some form of detoxification or treatment program. The armed services medical records and formats are, for the most part, prescribed by regulation. The difficulty lies in having the documents prepared properly and accurately. In the military, sick or wounded servicemen may enter one medical facility, be processed or stabilized there, and then moved on to one or more subsequent facilities. Sometimes this movement is quite rapid so preliminary planning is necessary to provide for quick and efficient, but accurate recording of all necessary data. Because of this movement, a requirement also exists for complete, factual, accurate documentation of diagnoses and treatment at each facility which handles the servicemen, and for forwarding that information to the gaining facility at the same time or before the serviceman arrives there.

Accuracy of data plays an important part in the several studies and surveys which have been conducted to examine specific aspects of the drug problem in the Military Estsblishment. Often the studies use existing medical records as sources for their base data thus emphasizing once more the need for accuracy in recording information. The physician who is concerned about stigmatizing an individual as a drug abuser will create problems if he fails to factually report his findings and disposition. He must be convinced that he will do his patient and the effort against drug abuse more good by recording complete, factual and accurate data.

Although information must be made available for authorized research projects, the medical records of patients must be protected from deliberate or inadvertent unauthorized disclosure. There are laws and service directives to regulate this problem; all must be rigorously observed and enforced. It was learned early that the confidentiality of the health record had to be

guaranteed to the drug abuser as one element in establishing the credibility of the drug program in his mind.

In October 1971 the Army initiated a survey of drug abusers in Vietnam using an 84-question questionnaire as the instrument of data collection. This illustrates another common type of information collecting and recording which has produced some problems and solutions worthy of consideration by those responsible for drug programs.

The Army questionnaire is long and requires some care for proper preparation. Imposition of a work load which the questionnaire represents will encounter resistance unless adequate preventive measures are taken. These measures include advance explanations to establish credibility and need for the questionnaire and the data it will gather so that commanders, staff and workers, understanding the importance, will be motivated to do the job well. The support of commanders and supervisors is particularly important since they must oversee the continued high level of data collection performance after the task has been reduced to tedious routine.

It was learned that interviews need not be conducted by physicians or psychiatrists. Social workers and counselors are well qualified to handle interviews of drug abusers. The patient should not be permitted to fill out questionnaires by himself. He will not understand all questions and will make mistakes - an interviewer can explain questions and elicit more accurate answers. Further, the typical drug abuser probably has little if any motivation to extend himself to complete a questionnaire correctly, and accuracy in collected data is essential for a bias free study.

Another reason for the use of an interviewer experienced in the ways of drug abusers is to detect and counter obliqueness in the answers given by the drug abusing patient. For example, it was found in Vietnam that some drug users exaggerated their drug use in the hope that they would be returned to the United States early whereas others minimized their use hoping to stay in Vietnam where drugs were plentiful.

In addition to collecting and recording data, certain information must be disseminated. Each management level must be furnished with the program information required to measure progress and to make decisions. However, report requirements must be realistic. If the report period is too short, the report data will have little statistical validity. If the report is required too soon after the end of the report period there will be insufficient time to examine the data, investigate suspected mistakes and have questions answered. This contributes to incorrect reports and an inaccurate data base upon which to base decisions.

Further, for efficiency, the number of different reports should be kept to a minimum. Where different requirements must be met, e.g., from command, medical and police agencies, the reports content and format should be examined with the goal of combining as many requirements as possible into a single report.

Finally, the report planning should be as thorough and foreseeing as it can possibly be. Report changes after the original instructions have

been promulgated create turmoil beyond belief throughout the entire reporting system.

Experience has shown that sophisticated automated data collection and processing equipment can be used to good advantage in drug programs. When one begins to collect data on individual drug abusers, the quantity of data collected quickly outstrips the capability for manual reduction of the data to meaningful results in a reasonable time. The use of automated data processing permits the application of sophisticated statistical techniques to masses of data and provides results which are credible from a statistical point of view. The resulting output can then be used with assurance as a basis for policy and program decisions.

The need for accurate statistics and the use of automated data processing equipment has been touched on above. However, as studies go deeper into the drug abuse situation, more and more data are required; this in turn leads toward the use of automated data processing equipment to store, retrieve and manipulate vast quantities of information. One military service, the Army, has prepared and is implementing a plan for a computerized drug abuse collection system, a system which has considerable potential for civilian drug abuse program use.

The objective of the Army system is to provide a confidential, centralized method of collecting data on identified drug users to meet research and medical management requirements of the Army drug programs. In concept it establishes a comprehensive data base on identified drug users. This data base will have information on each drug abuser pertaining to his:

- Past medical and drug history.
- Physical examination.
- Withdrawal and treatment.
- Demography.

A standardized questionnaire data form is structured to meet the requirements. Information sought on the form is obtained during a personal interview by a counselor or medical technician familiar to the user, and after the early phase of any abstinence syndrome. As a credibility check similar questions concerning the user's abuse of drugs are placed in different formats on other medical records used in recording the evaluation and treatment of the individual. The data collected is sufficient to facilitate the following analyses and evaluation of users on an individual and collective basis.

- Personal profile.
- Drug abuse history.
- Physical findings.
- Abstinence syndrome.

- Medical complications of drug abuse.
- Psychological assessment.
- EEG and EMG during withdrawal.
- Hematological assessment.
- Biochemical studies, i.e., glucose, bun and creatinine, calcium and phosphate, liver function, serum proteins, and immuno electrophoretic pattern of serum proteins.
- Endocrinological studies, i.e., catecholamines before and during withdrawal, and 17-keto-steroids before and during withdrawal.

Categories of information to meet local requirements can be analyzed according to the type of drug facility where the data is originally collected. A complete summary of any category of information can be furnished on collected data for any layer of management desired. Further, the problem of observing rehabilitation results on a long term basis can be facilitated by programming to isolate recidivists.

Urinalysis Program Quality Control

After the urinalysis program was under way, a quality control system was instituted to police it. It quickly became apparent that with the masses of data required for the samples going to laboratories and the masses of replies coming back to the Armed Forces Institute of Pathology, some automated means of information handling had to be devised. Such a system was devised and activated in the AFIP early in 1972. A description of the entire quality control program and the part automated data processing plays in it may be found in Section 3, Identification of Drug Abusers.

Information Materials

Many drug abuse education and prevention programs prepare their own informational materials; however, the DoD operates an Office of Information for the Armed Forces, a central facility for all of the Armed Forces which prepares and provides informational materials to support service drug education programs. This support includes films, pamphlets, brochures, and posters as well as tapes and records of radio and television programs, all dedicated to drug abuse material. In addition, subscriptions to publications such as Grass Roots and Addiction and Drug Abuse Report are provided to interested drug education offices. The advantages of the OIAF stem from the centralized organizational location where it can deal on a DoD-wide basis with outside agencies, e.g., artists and entertainers, and can handle the coordination and administrative functions of providing materials. This relieves the services from that burden, reduces costs, and assures a coordinated service-wide approach in the story which the informational materials present.

A great amount of drug abuse material is presently available in the National Institute of Mental Health Clearinghouse for Drug Abuse Information

and the Buresu of Narcotics and Dangerous Drugs. The Clesringhouse for Drug Abuse Information hss inserted the drug information into an automated data bank and st least one service, the Air Force, has found that source of information so valuable that they have installed a computer terminal at Lacklsnd Air Force Base, Texss (home of the Air Force Special Treatment Center) connected to a data link to the Clearinghouse data pool.

In summary, records keeping to evaluate progrsm progress is an sbsolute necessity. Automation can assist this process to s marked degree but the first, and most important requirement is the complete, sccurate recording of the data bits at the source.

Once again, the need for csre snd accuracy in first hand dealings with the drug abuser highlights the requirement for detailed planning, quality personnel assigned to drug abuse programs, and supervision by dedicsted, professionally competent managers.

SECTION 6

Concluaion

This report has examined the various components of an overall drug abuse program. It has also examined the experiences of the Armed Forces in coping with the drug abuse situation as they found it and the problems which arose as they went along. And, it attempts to document the military experience for the benefit of others who have an interest in drug programs. Some of the experiences which have been recorded here are unique to the military -- most are not. In any event, it is the desire of the Department of Defense to provide the general public with the lessons learned in the drug program education process which the Military Eatsblishment has undergone in the hope that this knowledge may be applied to good advantage in the nationwide fight against drug abuse in all its forms.

APPENDIX A

Report of Department of Defense Teen Involvement Activities

In the summer of 1972 the Department of Defense employed four recent graduates of the Quantico High School (Quantico, Virginia) to introduce an education program for school children to interested communities throughout the United States. This effort operated for about one year. Following is an account of the Teen Involvement program, its history, concepts and techniques, lessons learned and certain recommendations. This account was written by the four teenaged counselors at the completion of their work.

Program Outline

In February of 1971, four juniors (three of whom are military dependents) at Quantico High School on the Marine Base at Quantico, Virginia, were approached by the administration of that school and asked to examine a drug education program in Phoenix, Arizona, for possible implementation in their community. The basic concept of this program was youth reaching youth. Specially selected high school students were being trained to help educate elementary school students in subjects including drug abuse. The four students agreed and were sent to Phoenix, where they underwent training in a program then called "Dope Stop." At the end of the training the four returned to Quantico and, being impressed with the program's concepts, adapted it to their community, changed the name to "Teen Involvement," and implemented a pilot program which included only sixth grade elementary students.

The pilot program at Quantico was begun on March 17, 1971, and continued until the school year ended. The following spring, thirty other high school age counselors were trained in the Quantico school system. These students were chosen from some fifty who had volunteered during the previous May and June. The four original counselors, with these students, were then able to expand the program to reach all fourth, fifth, and sixth grades in the Quantico elementary school system.

Upon graduation from high school, the original team was offered a position with the Department of Defense introducing the Teen Involvement approach to interested military/civilian communities throughout the United States. The team accepted and has been introducing their program to interested communities since July 1972.

During the summer months, the team traveled throughout the United States briefing commanders and school administrators at major military headquarters about the program. With the beginning of the 1972/1973 school year, the team began a series of two-week visits to school systems which had invited them to help in establishing Teen Involvement programs. There have been more requests for their services than time available

within the school year. Their travels have taken them to schools from coast to coast. By the end of the school year, they have helped establish Teen Involvement programs in more than fifteen communities, and introduced program concepts and classroom techniques to over two hundred new teen counselors.

Factual Information

During the period from July 4, 1972 to September 4, 1972, the DoD Teen Involvement team traveled to military command headquarters at Patuxent Naval Base, Maryland; the Presidio of San Francisco, California; Fort Campbell, Kentucky; Military District of Washington Headquarters, Washington, D. C.; Fort Belvoir, Virginia; Fort Meade, Maryland; and El Toro Marine Corps Base, California. These headquarters had representatives from the bases under their command liaten to the team's presentations, and then go back to their posts and decide whether the Teen Involvement program was needed in their community. If they were interested, they submitted their request for the team to help them establish a program in their community, including their choice of dates. Priorities were then established for scheduling.

From September 4, 1972 until May 11, 1973 the DoD team visited fourteen military installations for the purpose of establishing Teen Involvement programs in each community. Excluding El Toro, every installation visited was an Army post. The programs at this time are centered in twenty high schools which have enlisted the services of over four hundred teen counselors. The team itself taught 115 example classrooms in sixty-seven elementary and junior high schools. Ninety-four elementary and junior high schools are presently enjoying the services of these established Teen Involvement programs.

Two teams were formed for follow-up technical assistance visits. From May 21 to June 3rd, these teams revisited seven different communities that had requested assistance in areas including the selection of teen counselors and formulation of expanded programs for the following year. For further information on expansion of programs see Enclosure 1.

Concepts and Techniques

In order to establish a Teen Involvement program, the community must involve and enlist the support of several fundamental groups. If involvement or approval of these sources is not gained then the chances of the program's success are drastically reduced.

The first and primary group is the administrators involved in the decisions concerning the program's initial existence. These administrators may be either military or civilian. It is essential that every effort be made to explain the program in detail to the school district officials who are interested in establishing a pilot program.

Following clearance from these higher echelons and having received permission to enter a high school, one must concentrate on gaining full approval from the second group -- the interested school. It is evident that there must be some genuine interest or desire from within that community before the program has a worthwhile opportunity for success.

The quality of any program of this nature depends directly upon the third group, the teen counselors. These are the personnel with the largest influence on the quality of the program. In the crucial and most important task of selection one must remember that only a very highly motivated and capable person will become an effective teen counselor. For suggested criteria in selection of a teen counselor see Enclosure 2.

Best results in the classroom itself have been achieved by forming teams of two counselors, consisting of one boy and one girl. This provides an elementary student of either sex with a counselor with whom he can confide. These teams should be trained extensively prior to entering their first classrooms for the simple reason that the responsibility of teaching lower grade levels is enormous. The training should provide the individual with ample factual information on topics which may be of interest to the age groups in these classrooms. Drug abuse information is only one of these varied topics. Group techniques and training for the counselors in recognizing small group interaction may prove to be most beneficial in working with younger children. See Enclosure 3 for a list of suggested training sources.

In making visits to classrooms, the frequency suggested is once every three weeks for approximately an hour. If each team took a class load of two to three classes, that would mean the counselors would be missing at least four hours per month of school. This of course does not include the time a counselor must sacrifice for training and classroom planning. This in itself suggests the need for a person with great desire and ability.

Administratively, a program like this requires a great deal of coordination and diplomatic action. To provide this a sponsor must be appointed, preferably from within the school itself. The role of a sponsor is multifaceted. He must coordinate all classroom visits with the counselors and the teachers. He must also provide training for the counselors and continue this training during the year. In the case of teacher, parent, or administrative difficulties, the sponsor must be available and capable of handling them. This job is sometimes very time consuming and therefore someone willing and able to fulfill the time requirement should be selected.

The most effective way of dealing with the teachers and their classrooms is to inform them of the existence of the program and allow them to decide if they would desire a team for their classroom. Teams are then used only in classrooms where they have been invited, and not forced upon the uncertain or unwilling teacher. The suggested grade levels best suited for the program are grades four to eight. It is in this age group that the students are not quite firm in their basic foundations and can still be led to or shown other paths or alternatives. It is a must that the counselors and their teacher meet prior to the start of their sessions to make sure that their goals and ideas coincide. To insure that this relationship remains positive it is further suggested that the counselor discuss his or her class with the teacher both before and after class. A question that arises often is whether the teacher stays in the classroom or not. If the counselors operate under the policy that they are invited into the teacher's classroom it will have to be left up to the teacher as to whether

or not she wishes to leave her class for any of the sessions. It is hoped that the counselor and teacher will have achieved a relationship that will allow free discussion concerning this topic.

Parents are notorious for being totally uninterested in any parent meeting other than those in which their children are performing. Still it is the responsibility of those involved in any program of this sort to make every effort to inform and enlist support from the parents and other adults in their community. The ideal situation would be to involve the parents as much as their own children by holding regular meetings to answer any questions they might have and also to inform them of what was done during the most recent classroom meetings.

Lessons Learned

In revisiting some of the installations where Teen Involvement programs were established by the DoD team, certain observations were made that might be applicable to Teen Involvement programs in general.

During the revisits, it became obvious that programs with more active, intelligent, and mature counselors were doing much better than programs where students were not so outstanding. Therefore, it follows that in the selection and screening of the teen counselors, standards should be set as high as possible. It was also observed that teen counselors were more secure in the classroom when their training had been extensive in all areas. A solid basis of training is necessary.

The faculty sponsor showed possibilities of being the weak link in the program. Overwork and lack of time for all necessary duties were the problems. Proper selection of a motivated faculty member is a great asset to the program.

It must be remembered that the teen counselor could not function at all if not invited into the elementary classroom by the teacher. Therefore excellent counselor-teacher relations are a must.

In some communities the military establishment was weak in making its willingness to support the program clear through personal visits and through administrative channels to the school administration. Continued contact and clear communication is a necessity for a successful program.

Parental involvement in this program has been consistently poor. We have only observed two instances in which parents have turned out in large numbers to be informed about the programs. At one Army post a commanding general requested all parents to attend a meeting and then took the roll. In another situation information on Teen Involvement was presented as a prelude to a song and dance extravaganza performed by the audience's children. Different methods will be successful in different communities, but a continual effort to involve the parents is necessary.

Recommendations

In accordance with the need for above average teen counselors, we would recommend primary consideration be given to students who have

already demonstrated their abilities in high school work and extracurricular activities.

The training of teen counselors should contain sufficient factual information so as to make them at least conversationally knowledgeable in subjects common to their student's age level. More important than this, however, is the need for training in group understanding and leadership. This enables the counselors to accomplish their goals with a minimum of chaos.

To strengthen the role of the faculty several alternatives are available. Selection of a person with more free time than the average teacher is a workable solution. A sharing of responsibilities between two or more teachers is another satisfactory arrangement. A teen coordinator could act as a go-between between the sponsor(s) and counselors. This would eliminate a great deal of legwork for the sponsor. The sponsor should also be sure that his counselors receive sufficient in-service training to keep them up-to-date and refreshed on all topics and techniques.

In order to prevent unnecessary complications in teacher-counselor rapport, the counselor should make every effort to consult the teacher before and after each class. Suggestions from the teacher should be incorporated into the teen counselors presentations whenever possible.

In order to provide the civilian community with a constant and reliable resource, the military should state its willingness to support the program and make clear to exactly what extent. It is also necessary that the counselors make clear to the administration and the teachers their definite plans and goals for the class.

Parental involvement is of such importance that in some cases it may be necessary to employ unusual tactics to receive sufficient response. Every effort should be made in this endeavor; close cooperation between the school administration and the military command structure is very helpful in fulfilling this objective.

Proposed Future Actions

There are two recommendations that we have for the future of the Teen Involvement program. The first of these is that more teenagers not be hired to fill the job we will be leaving. Because the programs that we have started this year are scattered geographically throughout the United States, we feel that it would be more economical for any place that desires this program to send their teen counselors to a program already established in their local area rather than have another team fly from Washington, D. C. In this way, the instruction they receive will deal more closely with topics and problems in their own area. A team from the Pentagon would not know the social and cultural topics and problems unique to each area. On this same subject, we suggest the DoD Drug and Alcohol Abuse office continue to play a part in the coordination of the programs throughout the United States as well as giving full support to any base interested in Teen Involvement.

The second recommendation that we have is that a national or international Teen Involvement convention be held annually, inviting representatives from all programs throughout the United States.

Expanded Teen Involvement Programs
(To Begin September 1973)

Fort Campbell

Fort Campbell High - 25 counselors
4 grade schools - 30 classes

Fort Hood

Copperas Cove and Killeen High - 162 counselors
21 grade schools
52 classes

Fort Sam Houston

Macarthen, Cole, Roosevelt High - 150 counselors
2 grade schools - 15 classes

Fort Riley

Xavier, Junction City High - 9 counselors
2 grade schools - 4 classrooms

Fort Leavenworth

Leavenworth, Immaculata High - 50 counselors
4 grade schools - 22 classes

Fort Sill

Lawton High - 18 counselors
2 grade schools - classes

Presidio of San Francisco

Washington, Rafael High - 25 counselors
2 grade schools - 12 classes

Fort Knox

Fort Knox High - 25 counselors
3 grade schools - 50 classes

Enclosure 1 to
Appendix A

Fort Dix

Pemberton Township High - 12 counselors
1 grade school - 5 classes

Fort Carson

Fountain High - 40 counselors
4 grade schools - 24 classes

Fort Ord

1 counselor
statistics not applicable

Fort Lewis

Lakes - 25 counselors
10 grade schools - 40 classes

Fort McClellan

Jacksonville, Aniston Academy, Aniston High,
one other - 44 counselors
4 grade schools - 16 classes

Fort Jackson

Dent Junior High, Spring Valley High - 30 counselors
35 grade schools - 120 classes

Fort Devens

5 high schools - 120 counselors
no number of elementary schools - 63 classes

Criteria for Selection of a Teen Counselor

A. A Teen Counselor must be a volunteer to insure that his motives are based on his own personal convictions and vitality.

B. A Teen Counselor must be able to relate with poise and confidence to both adults and young people.

C. A Teen Counselor must be willing and able to handle the responsibilities imposed by the role he takes on in his assigned classes. This includes the distribution of objective information and a genuine personal interest in kids.

D. A Teen Counselor should be a natural leader from within his high school's social population.

E. The grade level suggested for counselors has ranged from 9th through the 12th grades. It must be remembered, however, that the upper classmen being more mature will, most likely, be more confident in the classroom.

F. A Teen Counselor should have an open attitude which will aid him not only in the classroom but also in discussions about his classroom.

G. To be a Teen Counselor one must be able to miss time from school and therefore must be able to keep up with his work. A steady grade point average is essential.

Enclosure 2 to
Appendix A

Local Personnel Useful in Training Teen Counselors

Psychologist and/or psychiatrist

Elementary school teacher

Elementary school counselor

Drug "experts" - pharmacists, researchers, etc.

Lawyers - laws concerning drug abuse

Doctors involved in field

Group therapists or professionals

Sex education teacher and/or planned parenthood

Persons involved in values clarification

Experts in group interaction methods

Experts in role playing - problem solving

Community organizations that might be needed for referral

Experienced teen counselors

Persons involved in supplying recreational facilities - positive alternatives

Enclosure 3 to
Appendix A

APPENDIX B

Experiences Establishing a Drug Rehabilitation Center in the Navy

CDR A.M. Drake, MC, USN*
and
Douglas Kolb, MSW**

The Naval Service has shared with the other uniformed services and the civilian community of the United States a growing concern with the problem of drug abuse among its members. It was therefore a natural evolution of this growing concern that planning for the establishment of the first permanent Naval Drug Rehabilitation Center was begun in response to Presidential directive on 12 June 1971. The site selected for this pioneering venture was the Naval Air Station, Miramar, California.

Previously, drug abuse in the military had been considered primarily a disciplinary problem and for the most part, individuals with a history of significant drug utilization were separated from the service through administrative channels. However, the generally widespread utilization of drugs by the youth subculture of the late 60's and early 70's, as well as mounting concern over the prospect of Vietnam veterans who had ostensibly become addicted to cheap, high-purity heroin while overseas and who might continue their drug use patterns upon return to CONUS, led to the realization that forceful and innovative approaches to the problem were mandatory and urgent.

The Naval Drug Rehabilitation Center, Miramar was formally established as a line command, manned by a staff of Navy line officers, physicians, psychologists, chaplains, Navy and Marine Corps enlisted men, civilian counselors, social workers, and several ex-addicts who were themselves graduates of civilian treatment programs. This mixture of staff, altogether unorthodox by traditional Navy standards, was to provide the basis for a multi-disciplinary approach to the treatment of drug-related problems, allowing much greater scope for the program than would have been possible had a more monolithic orientation been proposed. While the staff was being assembled, two large triple-deck barracks were undergoing conversion to house offices for staff and quarters for over two hundred patients.

The patient population which soon began arriving at the center -- too soon for comfort for the staff was still in the process of being ordered in and the barracks were still undergoing renovation -- was an heterogeneous

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collection. Heuristically, they could be separated into six major categories. First were those patients considered to be drug-addicted. Many of the early arrivals from Vietnam had been sniffing cheap, easily-obtained heroin which was 95-98% pure. They had not developed the criminal life-style of the street addict, nor did they manifest any severe degree of withdrawal symptoms. As the Navy's engagement in Vietnam diminished, this population of addicts receded in importance to be replaced by addicts with more established drug-taking patterns, who were using the impure heroin available in the United States, usually were mainlining, and had developed the manipulative, sociopathic life-style associated with the street addict.

The second and more numerous classification were those men considered poly-drug abusers, and who had included in their spectrum of drug use experiences with psychedelics, glue, amphetamines, barbiturates, marijuana, alcohol, and a variety of other substances sometimes identified with only the haziest of accuracy. The scope of poly-drug abuse extended from casual experimentation to daily use of multiple doses of whatever happened to be available.

The third major classification comprised the military malcontents, disciplinary problems, and manipulators. These were young men with histories of repeated, although often relatively trivial, military offenses. They were anti-establishment in orientation, dress, and grooming, unhappy with the military, and anxious to press for early discharge into civilian life. They manifested a tendency to blame society in general, and the military in particular, for their drug usage and offered the glowing anticipation that all would be well once they had shucked the uniform and relocated themselves in a milieu which would permit them to "do their thing." Their histories of drug abuse sometimes were fabricated or grossly exaggerated, and there was often a pronounced element of machismo in their stories of four and five hundred "acid trips" and voluminous consumption of psilocybin, cocaine, THC, STP, etc.

Fourth was a large segment of patients who were simply struggling through the normal rebelliousness, experimentation, and identity diffusion of adolescence. They had become involved in drug abuse because of boredom, peer pressure, curiosity, job dissatisfaction, or the pursuit of altered and more ecstatic states of consciousness. Their backgrounds revealed poor social relations with family and peers, poor work and vocational orientation, and a tendency to avoid personal problem areas, but did not otherwise support a diagnosis of specific psychiatric disorder.

Fifth was a contingent of character and behavior disorders, with well-established patterns of maladaptive social relations, self-defeating behaviors, poor impulse control, and failure to recognize personal responsibility for the course of their lives. Drug abuse came easily to them as a manifestation of other, ongoing difficulties in adapting to society and formulating self-satisfying goals.

Last was a small number of patients considered to be bordering on more severe psychiatric illness, who were using drugs in an attempt at self-medication for long-term problems with depression, anxiety, low self-esteem, and social alienation.

An analysis of background information obtained from the first 458 Navy men to enter the Miramar program supports the clinical impressions of many of the patients. Although most had ostensibly "volunteered" for service, many did so on the spur of the moment or for negative reasons, e.g., to break home control or because they were unemployed. Their average length of time in service was two years and more than two-thirds had attended at least one service school. Approximately three-fourths of them, however, had never achieved a pay grade above E-3. The majority reported strong negative feelings about the service in general and expressed dissatisfaction with their Navy duties, with half believing that their abilities were not employed and with almost nine-tenths expressing boredom with service responsibilities. While quarterly marks were in the 3.2-3.4 range, more than half admitted to at least one disciplinary offense, chiefly nonjudicial punishment.

Pre-service histories would indicate marginal school adjustment for many with over half having been expelled or suspended and as many "playing hooky" more than six times. Forty-four percent of them did not graduate from high school. At least a third had been arrested and almost as many had spent time in jail. A quarter of them admitted to emotional problems prior to entering the service; more acknowledged having trouble with their temper and moodiness.

Detailed drug abuse histories of these men will be reported elsewhere. Suffice it to say, this population reported heavy use of a variety of drugs: heroin - 58%, barbiturates - 46%, amphetamines - 61%, LSD - 81%. Daily use of heroin was admitted by a third of the total group. Marijuana was used by 96% of the men with 64% claiming daily use.

In order to provide the flexibility necessary to provide a therapeutic range broad enough to encompass such a heterogeneous population, five separate therapeutic programs, called therapy tracks, were developed over the first three months of the center's existence. Each program tended to focus upon particular problem constellations which had become evident among the patients. The tracks were designated the Project, the Community, the SHARE Program, the SALT Company, and Our Family.

The Project is a therapeutic community headed by a medical officer with the assistance of a line officer, a psychologist, and civilian counselors as well as Navy enlisted men, both corpsmen and nonmedical rates drawn from the fleet. The program stresses individual responsibility in dealing with a man's life, and utilizes small and large groups as well as individual sessions to assist in effecting a change. Members of the therapeutic community have the opportunity to move through four graduated levels of responsibility which carry with them different obligations to the group and rewards for the individual. The basic thrust is toward encouraging increased maturity through self-awareness and discipline as it related to group interaction and the mutual obligations engendered by life within a structured society.

The staff mix of line officers, mental health professionals, and military and civilian counselors has been found to be extremely useful. The line officer in the therapy tracks has administrative responsibilities

and handles discipline. His presence maintains the reality of the military situation, a reality which may become obscured if the patient is confronted by mental health professionals only. The civilians, primarily individuals holding masters degrees in social work, counseling, and psychology are thus able to deal with therapeutic matters, unencumbered by the necessity for fulfilling a double role of therapist and disciplinarian. This seems to reduce opportunities for patient manipulation. One additional benefit of this staff mix is that social reentry appears to be facilitated. The patient has an opportunity to observe and relate to a variety of individuals from a variety of disciplines and backgrounds, some of whom are admittedly "square." It is our impression that this contributes a wider scope of life experience than is possible in programs which are run entirely by and for individuals who are themselves immersed in the drug subculture and who cannot provide a broader spectrum of alternative life styles.

The Community is also a therapeutic community under medical direction, utilizing a similar mixture of civilian counselors and line staff. The primary emphasis is directed toward self-understanding through the use of group and individual therapy. Self-understanding is facilitated by a video tape system used to study the interpersonal reactions and dynamics of the group. The patients clearly become quite interested in reviewing their own tapes, and the confrontation with their own provocative behavior provides a rare opportunity to "see ourselves as others see us." The track modus operandi is predicated on the observation that many of the patients have long histories of extremely poor interpersonal relations with family, peers, school authorities, and employers, and also that one of the almost universal characteristics of our population is low self-esteem. Vocational counseling and educational opportunities are encouraged on an individual basis. Initially the time scheduling within this program permitted considerable flexibility so that patients would have time for introspection and reflection. It was discovered that the time so allocated was poorly used, often producing boredom. A revision of the program schedule has now provided structured activities throughout the entire day, which appears to be working more satisfactorily. Our patients do not tend to be very highly self-motivating, resulting in inability to utilize unstructured time. The dilemma for the therapist is that free time is dismissed as boring while scheduled activities are denounced as hassling.

The SHARE Track is an acronym for Self-Help, Assistance, Rehabilitation, and Exploration. This track is led by Navy line personnel and stresses personal motivation, role modeling, and military leadership. Instruction concerning drug education and communication is offered along with motivational courses, field trips, and lectures by guest speakers. The patients, referred to as Shareholders, are encouraged to take maximum advantage of the educational and vocational resources available at the NDRC, such as General Education Development completion, Project Step-up, Project Transition, and various on-base construction projects. The rationale for the SHARE Track approach is that not all individuals involved in drug use will require therapy within a standard medical model. Not all men are amenable to standard psychotherapy in the first place, and for some, the simple act of associating with more mature and successful men may help to form useful identifications. As the track evolved, however, it was learned that a simple line approach emphasizing leadership and good example did not appear

to provide a completely rounded approach. The patients expressed a desire for a more active psychotherapeutic experience, which the line staff did not feel qualified to provide. As a consequence, two civilian counselors holding masters degrees in mental health professions have been added to the SHARE program, and provide the men with group and individual counseling.

As one of the center's major problems is trying to obtain a commitment to therapy from the patient, the SHARE Track emphasizes this aspect of commitment by requiring formal signature of a contract between the individual patient and the therapy program, emphasizing his responsibilities, outlining the restrictions to which he must commit himself, and specifying the discipline which may incur if track policies are broken. Active participation by Shareholders is encouraged via a patient government organization which permits the men to contribute to track policy and athletic committees, and exercise peer control over minor disciplinary infractions. The discretionary limits of the member government are established by the track administrator, a Navy Lieutenant.

Discipline within SHARE is confrontive and prompt, and limit-setting is firmly established and exercised. In accordance with the patient's emphasis upon the development of self-motivation, all members of the track are required to publicly announce and discuss in a group setting a formulation of prospective life goals, and delineate possible ways of attaining them.

The SALT Track is a chaplain-directed community utilizing a staff including a clinical psychologist, civilian counselors, and enlisted men. It is based upon the premise that values and ethical problems are important aspects of today's world, often overlooked in the conventional psychotherapeutic program. SALT is an acronym for Self-respect, Acceptance, and Trust. The program is predicated upon the consideration that an existential approach is of benefit to many troubled adolescents who find themselves adrift in a society undergoing upheaval, widespread questioning of formerly accepted values and institutions, and the much publicized "Future Shock." A reflection upon some of the opinions widely voiced around the nation over the past five to ten years reveals a preoccupation with social alienation and fragmentation; i.e., God is dead and religion is no longer viable or relevant; government and industry are characterized as corrupt, irresponsible, and self-aggrandizing; the so-called "generation gap" proposed that a youngster trust no one over thirty, etc. Without becoming embroiled in a diatribe over the validity of any of these attacks upon the current state of society, it nonetheless becomes apparent that a total and unquestioning acceptance of these positions may ultimately end up cutting off a young person from any of the customary supports and structures which our culture provides. The void so created, perhaps more often than not, is filled by boredom, depression, and heavy drug utilization. The SALT Company, then, works toward an understanding of the problems of existence and the development of more positive alternative life styles. Both the chaplains assigned as track leader and assistant track leader have extensive backgrounds in counseling, and theological dogma does not enter prominently into the formulation of their program. Evidence for the desirability of providing a quasi-spiritual approach to rehabilitation is afforded by the interest which the young themselves currently display in seeking out a variety of religious and cultist experiences as substitutes for drug usage.

The prevailing philosophy in SALT is that one's existence is at stake. Accordingly, all aspects of the program are designed to challenge the individual to look at his life style. Through group and individual sessions, opportunities to exchange ideas with staff, educational classes, and exposure to successful persons in the broader community, the individual learns how others approach and deal with life's problems.

The Family Track is under the direction of a Navy clinical psychologist and employs a staff of three ex-addicts as counselors in addition to two military enlisted men. The three counselors are themselves graduates of similar programs in the California state hospital system which are philosophical outgrowths of the Synanon approach. The Family functions in a very highly structured and disciplined milieu in which unsuccessful and undesirable modes of behavior and thinking are confronted in a group setting. Creative discipline is conducted with an eye to emphasizing the nature of a man's problems, rather than following standard military types of discipline. Thus, a patient in the Family may wear a placard for one week proclaiming that he is "a big-mouth and a wise-ass," thus maintaining continuous attention to the type of maladaptive behavior which must be discouraged. Because of the rigorous therapeutic approach, the Family is an entirely voluntary program and is the most selective of all the tracks. As a consequence, the Family is numerically the smallest of the programs, and its continuing operation requires the presence of the remaining therapeutic programs to absorb the less highly motivated patients who leave the track. The very rigorousness of the program, although highly beneficial to those who complete the entire four-month course, discourages those individuals whose motivation for self-inspection and change is low.

Prior to placement in one of the therapeutic programs, patients entering the Miramar Naval Drug Rehabilitation Center are placed in the Evaluation Unit where they undergo approximately five days of screening. During this period, psychological testing, biographical questionnaires, and personality inventories are administered under the guidance of the Navy Medical Neuropsychiatric Research Unit. Medical and service records are examined, and standardized interviews are conducted; some of this information is utilized for clinical purposes, and the remainder is recorded for later research analyses. During this evaluation, the patients are assigned to small groups at which time staff members meet with them to discuss their problems, orient them to the center, and ultimately assign the man to a therapeutic program.

The program extends for a maximum of 120 days. Cross-transfer between tracks is effected if it is thought that a man may benefit more from a different approach.

After successful completion of the program, patients may either be returned to duty or discharged to civilian life, depending upon the subject's demonstrated capacity and the needs of the Navy. A high return-to-duty rate is not regarded as the sine qua non of therapeutic success. All recommendations for return to duty or for discharge from the service are evaluated by a special board consisting of two line officers and one medical officer and by the Commanding Officer. The qualifications of those men returning to duty must conform to high and stringent standards; thus, at the present time most patients completing treatment are discharged to civilian life.

If there is evidence that treatment has not been successful and that a drug problem continues to exist, pstients are transferred directly to the VA.

Both Marines and Navy men are treated at NDRC, Miramar. The Center received the majority of its clientele through the so-called Exemption Policy which provides for the withholding of punishment for those men who voluntarily seek treatment for the use of drugs. The program is not set up for drug detoxification, and all personnel requiring medically supervised withdrawal will do so at a Naval hospital. Patients wear uniforms of their respective services, and adhere to all Naval and base regulations. Staff also are in appropriate uniform. The question is often raised as to whether the flavor of s military setting imparted by uniforms and the hierarchy designated by rank is antithetical to therapy. It has been our impression that such is not the case, and in fact, if a realistic confrontation and resolution of problems with rank, authority, and military structure is to occur, the wearing of the uniform is essential. In any event, once s therapeutic relationship has been established, uniforms tend to become irrelevant.

In addition to the therapeutic programs, the rehabilitation center contains educational and vocational training services. A man's service record is reviewed shortly after his arrival, his educational and vocational deficiencies are noted, and an appointment is scheduled with the Educstional Services Office which can offer him high school equivalency training, college level courses, and a wide variety of occupational placements. The object here is that whether a man remains or leaves the service, his chances of maintaining his self-esteem and realizing life goals are enhanced if he has acquired some education and/or vocational skills which he can turn to useful purposes. As with many other areas of the total program, consideration is directed toward the needs of the whole person, rather than focusing exclusively upon his extent of drug involvement.

Perhaps the greatest single problem encountered by the staff of the rehabilitation center is the fact that most of the patients arrived without motivation for either rehabilitation or for continued military service. Young, healthy, and receiving regular pay checks, most of the men are still involved in drug sbuse at a stage where it appears to be fun. Almost none have had the degrading personal experiences which become the lot of the addict whose luck has run out. As a result, many of the men sre initially loath to take their drug usage seriously. Many claim that their drug abuse is primarily situational and will resolve itself if they are separated from the Navy/Marine Corps. A few claim that drugs might possibly constitute a source of future trouble, but they express a desire for follow-up care at civilian agencies of their own choosing. Many patients are initially hostile to the idea of rehabilitation, expecially rehabilitation in a military setting. Administrative difficulties with the trial Amnesty Program instituted in Vietnam in May 1971, and the Exemption Policy which subsequently replaced it, resulted in a majority of the early patients arriving at NDRC with the intention of obtaining separation from the military. They had the expectation that claiming exemption from prosecution for their confessed -- real or fabricated -- drug abuse would guarantee them s discharge under honorable conditions regardless of their participation in a rehabilitation program. The drug abuse program, by being associated

with the possibility for premature separation, thus became an avenue of attempted escape for those young men disenchanted with the military and desirous of finding a quick and easy way out of an unhappy situation. It has been discovered, however, that if even the most verbally abusive and uncooperative patients are retained at the center beyond the first one or two weeks, their initial apprehension, hostility, and uncertainty begin to dissipate and they begin to explore in a more realistic light the internal problems existing within their own personalities instead of issuing blanket denunciations of society and the world at large. When capable of lowering their defensive barriers, the patients then expose feelings of low self-esteem, identity problems, inability to handle intimacy, and frustrated strivings for acceptance and recognition in a world which appears too complex and indifferent. Once these basic conflict areas have been confronted, it is then possible to deal with the patients in the spirit of mutual respect and confidence which is necessary for therapy to exist. The fact that this has occurred is a tribute to the sincerity and obvious concern and dedication of the staff of the entire center.

A second major problem was the dramatic influx of patients during the first hectic weeks of operation. By the end of September 1971, more than 500 men had been admitted to the center and approximately 348 were still in residence. This number exceeded the capacity of the original facility by 75%. Admission to the Miramar Drug Center was limited in October, and an accelerated and intensive screening of the men in residence took place so that the poorly motivated men could be released from the program. Because of these circumstances, any effort to assign men to the various therapy tracks on any systematic basis at that time was impossible. Currently, with the patient population reduced to a more manageable level, assignments are made more in accordance with the patient's specific needs and problem areas.

Control of drug traffic is an ongoing problem. Drugs can become available wherever the demand exists, even in prisons and on locked psychiatric wards, and it was inevitable that they should also become available at Miramar. The center is not a security area; there are no fences, spotlights, or guards. There are 16 outside doors in the barracks, and none of the windows are locked. Despite periodic urine screens which occur randomly twice weekly and inspections of the living spaces, drugs continue to appear from time to time, depending primarily upon the complexion of the patient population and the extent to which peer pressure in the therapy tracks can be mobilized against their importation. In a rehabilitation setting some back-sliding is to be expected normally, and when this occurs it is dealt with initially within the therapeutic community, ultimately by the Commanding Officer if the extent of drug use has become flagrant or a question of dealing is involved. Excessive positive urines and/or continued drug trafficking is considered to be indicative of poor motivation and may become grounds for disciplinary action and/or dismissal from the program.

Another significant problem area, faced by any drug treatment center of whatever type and wheresoever located, is the matter of gaining acceptance by the local community, in this case the military population stationed at the Naval Air Station. There was an initial tendency to project many

fears and worries upon the rehabilitees, and there was slso s tendency to resent the renovsted barracks in which they lived snd the imagined pampered quality of their life style, to ssy nothing of the multiple misconceptions regsrding "therapy," s term which is often subject to the broadest of interpretations even in professional circles. To the Center staff, a group of patients sitting with their primary counselor under s tree constituted a valid discussion group; to a psssing sailor putting in a 12-hour day at work, they were "goofing off." The situstion wss not aided by the fact thst on occasion, especially during the esrly months of the program, the rehabilitees drew sttention to their own presence, thereby proclaiming to the air station at lsrge that they were the "Druggies" from "Rehab." These problems, wholly understandsble, are not unusual in any progrsm which establishes a facility to care for persons regsrded with suspicion by the local community. This unique situation hss been hsndled by maintsining good relations with the other facilities on the base snd by ensuring that the rehsbilitees obey the same rules and standsrds of appesrance, behavior, and conduct as do the other residents of the air station.

Considering the unique character of the center and the diversity of the Center staff, some considersble emphasis hsd to be placed upon maintsining internal communications. A line command in which a physician administers the major operational department, which employs civilisns rsnging in background from Social Workers to ex-addicts, and which is tasked with the job of providing s rehsbilitation effort to a group of angry snd rebellious young men who aren't altogether certain they wish to be rehsbilitated, is by its very nature an unusual beast and requires great flexibility, patience, snd forbearance on the part of sll staff members. As professional groups, neither military officers nor physicians are especially noted for their humility, and sdjustments had to be made and many staff meetings called in order to establish the atmosphere of mutual trust and respect which now exists. That this has occurred is, agsin, a tribute to the staff who weathered the initial throes of uncertainty and confusion.

In view of the considersble effort which the nation has lately msde in promulgating drug education, our patients, as a whole, manifest a general lsck of realistic information about drugs they have been using, despite their claims of expertise gained from extensive self-administrstion. Most are ignorant of significsnt medical side effects of the drugs, or took comfort in the belief that "it can't happen to me." Many sre critical of the customsry forced didactic lecture sessions to which they have been exposed, both in the military and in civilian schools, and they indicste they got much more from informal drug discussion groups. One of the frequently raised srguments is the claim by the young enlisted man thst he csn not trust the establishment suthority figure who has been assigned the task of disseminsting information snd lecturing, often times inaccurately, on drugs snd drug abuse.

The success of a program such as this is hard to quantify, although one of the stock questions invarisbly asked by visitors is "How much success are you having?" Evaluation of success is at least partly s function of time -- how long has the pstient remained off drugs -- snd this is, of course, impossible to ssy st the present. Follow-up questionnaires sre planned for those pstients who hsve returned to civilian life snd will be

mailed at intervals of six months, one and two years. Over thirteen hundred patients have come through the Center since its inception, snd the process of follow-up has just begun. Determinations of the status of patients returning to the military is more easily derived, and so far only three csses of unsucceasful adjustment to the military are known, although the time factor is so short that this figure is scant cauae for exultation. It must ultimately be admitted that many, perhaps most, of our accomplishments will turn out to be relatively intangible -- a msn who feels better, who has a better relationship with himself and hia aociety, whose pattern of drug use has shifted from harmful drugs to more innocuous substances, or who has simply grown up a bit because someone was willing to spend aome time with him. These results are difficult, if not sometimes impossible, to measure. Recognizing this, the Center is now embarking upon an extensive program evaluation which hopefully will provide new insights to the drug abuse problem.

APPENDIX C

Observations and Impressions Gathered in a Drug Treatment Center

In June and September of 1971 the U.S. Army, Vietnam established Drug Treatment Centers at Cam Ranh Bay and Long Binh, Vietnam, respectively. These centers operated through the worst of the drug situation in Vietnam; the Cam Ranh Bay DTC closed in April 1972 and the Long Binh DTC finally closed in October 1972. In March 1973, the Department of Defense convened a workshop, one segment of which addressed the problem of drug treatment. The attendees at the treatment sessions of the workshop were for the most part involved in the Army's drug treatment programs at the DTCs during 1971 and 1972. These men and women prepared an outline of the observations and impressions which they gained during their Vietnam experience, an outline which later was filled out by one of their number. That paper is reproduced below; it offers an excellent summary of the views of the professional men and women who were charged with the day-to-day business of establiahing and operating a center to treat drug abuse patients in a far from ideal environment.

The Patient

When one is confronted with a mass of confusing, somewhat impressionistic data it becomes an imperative task to classify and categorize the problem. The problem of the drug abuser in Vietnam aroused in most participant observers a curious ambivalent mixture of fear, hate, envy and disguat which further complicated the quest for clarity. Attempts to stereotype him according to demographic variables or personality characteristics proved to be a frustrating challenge. In time, however, a general picture began to emerge which allowed us to begin to think of treatment approaches. This outline served as a working hypothesis in understanding the etiology of this behavioral disease and the implications it held for us in our efforts to interrupt the progression of the disease.

Broadly speaking, we knew we were dealing with a young enlisted man who may or may not have been thinking of the Army as a future career. He was Mr. Hometown USA when considering his geographic origin, religious preference, and level of education. There was a tendency toward a larger representation of minority groups, primarily black, than might have been anticipated by their percentage within the Armed Forces. There seemed to be a trend toward a family background history of disruption by divorce or death of important family members. The history of adjustment in other social apheres such as work, school, and community leaned toward inconsistent completion. These expected findings, however, were not significant to a degree that would suggest a basic characterological pattern disturbance. Other pieces of information began to give form to the puzzle.

A rather large percentage of those soldiers detected as heroin users admitted to prior drug experimentation or abuse in the United States. In contrast to its use within the U.S., heroin in Vietnam was used in a group setting rather than as an individual preoccupation. The primary modes of ingestion were nasopulmonary rather than the intravenous route. There were strong hints that a social subsystem was developing complete with its own language, dress style, free time pursuits, myths, mores, and taboos. The peer pressure that it placed on incoming personnel was evident in the discovery that most were introduced to heroin use within their first few months in Vietnam.

Individually, most of those identified as users seemed to be in varying stages of intrapsychic regression. The stress of separation from family and friends, familiar surroundings, and the usual avenues of dealing with frustration were common to all those who rotated through Vietnam. The exposure to death or injury in a combat zone was an unpredictable factor depending on one's military occupational specialty, in-country location, and time of rotation. The gnawing pressure of boredom engendered by a static defense became a subtle undermining force. Depression based both on loss of external ego support and internalized rage was a universal response. Evidence of regression was more prominent in those who had not yet matured developmentally to a degree that their response could be a persistent, yet flexible one. Earlier, more primitive forms of adaptation to stress were reintroduced into their life styles.

The clinical state of depression is a physiological conservation of energy allowing the individual to withdraw to a less anxiety prone state. Other forms of withdrawal or retreat were present in our patient population. A pervading attitude of challenging the limits of authority more in keeping with an early adolescent rebellion was noted. They attempted to split authority figures collaboration by manipulating one against the other. The groups they formed tended more toward a loosely defined gang or informal family rather than an organized team. Their individual relationships had a superficial, transient, uncommitted quality to them. Their demand for immediate solutions to complicated questions suggested a conceptual reorganization to a concrete, black or white simple answer level. Comics were the preferred form of literature. Fantasies, rumors, and myth formation were considered superior to reality interpretations. As in a child the control over aggressive impulses was related more to the situation rather than to internal control.

Fortunately, as a group they retained many of the redeeming qualities which permits adolescence to be a tolerable phase for those who must deal with it. The energy behind the basic developmental drive was awesome once it could be released. The search for an older person, a model to identify with, was prevalent. The need to band together with a definable, cohesive group or organization in a hierarchal pattern was present. The strong sense of imagination and drama and the groping for idealism were evident. A longing to develop a close relationship with another human being had not been lost in most.

We all strongly felt that this was not one mass problem or stereotype but rather a continuum where the use of heroin as a symptom and the

interpersonal/intrapsychic development of the individual were cross valencea in a matrix. At one end of the spectrum was the primary, antecedent, physiologically addicted individual who used the drug heavily (intravenously) to meet a basic recurring flaw in his character structure. At the other terminus we found the reactive, accidental, social user who smoked periodically in response to peer pressure or transient emotional needs. Somewhere in between fell the majority of our patients in a roughly shaped Gaussian curve combining many of the developmental arrests or regressions mentioned before with a moderate degree of heroin usage. Along these lines we developed a system for diagnosis which is represented thus:

DEGREE OF INVOLVEMENT

PROGNOSIS	MILD	MODERATE	SEVERE
GOOD			
FAIR			
POOR			

It is a roughly correct and appropriate schema to use in categorizing this diagnostic dilemma but in practice it suffered from its generalization. It was fairly easy to establish definitive guidelines concerning the degree of involvement with heroin based on level of reported use, severity of the withdrawal syndrome, and the presence or absence of objective physical findings. The problem we found was in judging the prognosis on the data we had available to use. There was no reliable way to check on an individual's prior mode of functioning under stress. Judging the degree of social and intrapsychic regression or arrest requires a measure of clinical psychiatric sophistication and time investment that was not generally available or realistic.

Additionally, the judgement of motivation is a risky business whatever the field of human endesvor. Even so, attempts were made to resolve this point. Check lists and question and answer forms were administered to broaden our knowledge of the individual patients. We reviewed their personnel records to evaluate their general aptitude scores, schools attended, awards and decotions, and history of judicial and nonjudicial punishment. Informal tests were administered to check for level of commitment to change. At one installation patients were allowed an overnight pass to determine their readiness for further progression in a realistic manner. Although difficult, we found this diagnostic exercise to be an important one as a constant reminder that we were dealing with an infinitely variable group of individuals whom we had arbitrarily placed under one diagnostic classification - heroin abuse.

The Staff

The selection of a staff may become the crucial variable in determining the eventual success or failure of a drug treatment program. Early in the

history of the program large numbers of people with little training and negative motivation were pushed into positions to fill out the personnel roster. Through this ordeal we began to realize that individuals with specific personality traits were necessary to accomplish the mission. For those dealing directly with the patients these assets were necessary ingredients for therapeutic effectiveness.

Positive motivation can overcome a host of personality inadequacies and training deficits. Those replacing our original staff were volunteers fully aware of the hazards and responsibilities they faced. Their persistence in the face of considerable frustration was a tribute to this characteristic. The ability to delay immediate gratification for a more distant abstract goal was a necessary trait in order to maintain oneself through the various stages of staff development. A strong sense of loyalty to group goals with a suppression of absolute individuality eased strains within the treatment team.

In dealing with the patient, clinical training is an absolute must. Its great advantage to the staff member was that it provided a necessary sense of confidence in dealing with ego threatening patients. In spite of prior experience, specific in-service training is advisable to further supply a fund of objective knowledge and a subjective feeling of competence. With the use of training techniques to focus on group process and therapeutic strategies it will enable the potential therapist to gain timing and balance in the delivery of ideas of change. A degree of objectivity is helpful in order to distance oneself from many emotionally laden situations. Equally, self-discipline is provoked by those testing the outer limits of control. When one is challenged by the "mind game," hopefully he is mentally alert to the point that he is able to respond quickly with a twist of humor. In order to do this he must feel reasonably comfortable with verbal aggression, both giving and taking. A quality of empathically "tuning in" to a patient's feeling and thoughts hidden behind his surface veneer will allow the staff member a therapeutic patience to persist. Lastly, a broad tolerance of different life styles and solutions to life's problems is essential to survive the culture shock of trying to understand the drug user's view of the world.

Staff Development

A new staff embarking on an uncharted course of developing a treatment program for drug abuse patients will pass through many phases. Some staffs may become fixated at a particular stage and may be unable to move forward unless outside pressure and leadership is exerted.

One will find certain elements of the treatment team lagging behind the others with a section or informal leader being stuck at a certain point. Then a pointed effort must be made in education, persuasion, or coercion to help them catch up so the staff as a whole mutually supports one another. On rare occasions a staff member may become so intransigent that reassignment may be the desired course.

Whatever, the steps are progressive, well defined ones and may appear as stumbling blocks or transient episodes in the staff's developmental march.

A thorough working through of each phaae ia the preferred pace; the completion of one phaae will atimulate movement to the next.

Twelve Phases of Staff Development

1. Naive - Helpful

The ahock of entering a field where the balance of feelinga ia weighed negatively toward the patient arouaes in moat an intereated, protective responae. The deaire to help ia usually tempered with a realiatic asaessment that the staff haa little knowledge or training in thia clinical area. They approach the problem with an air of optimistic miagivings. Soon they are enthralled with the experience of viewing another peraon'a breaking of a aocial taboo, the uae of heroin. The hiatoriea are detailed and explicit but they aoon find that there exiata a language barrier which preventa them from really getting into the aubject. Soon one hesra akag, amack, downers, capa, heavy habit, shooting up, etc., bsndied about aa if they are really "rapping" and "getting down" with the patienta and begin to aak the inevitable question, "Why?" The patient'a reaponse ia a mixture of curiosity and mirth, "Becauae I like it, man." "But don't you know it will hurt you?" The patient leana back with a look of knowing diadain for thia riciduloua neophyte and laugha. This aymbolic interchange aeta the ataga for the moat difficult and longeat phaae of ataff development.

2. Anger - Rejection

"If the patient doean't need me, I certainly don't need him." What follows runa the gamut from aubtle sarcaatic cuta to brutal aadiatic handling of the problem. "They're juat animala ao what did you expect." "I locked him up in a Conex container for a week." "Put them out to aea for a week and bring back one peraon - the guy who pulled the plug." The supply of fantaaies and black humor will be endleaa. It is important to allcw the staff to vent thia rage without allowing them to act it out at the patient'a expenae. Jokea, humor, aonga, and akita are healthy waya to hsndle this reaction to diaappointment. The danger with this atep ia that it msy become rationalized and institutionalized if allowed to peraist. The staff will be frightened by their anger and try to run. The ataff may even encourage the patienta to run. Requesta for reaasignment will inundate the superviaor.

3. Control of Anger

Slowly, with encouragement and understanding reaaon will prevail and the ataff will begin to take ateps to control their unwilling patienta. It will be a time when outaide control forcea will make themaelves known snd actively available. They are neceaaary but care ahould be taken that they do not become the eaay aolution and the treatment center assume the trappinga of a penal colony. Phyaical methoda including fences, guarda, locka and aeparation areas will aeem reaaonable alternativea. Rules and regulationa will be more clearly drawn. The levels of medication for withdrawal symptoma will begin to riae. Ideaa concerning organizing the patient groupa in a more controllable fashion will begin to emerge. Thia stage, even with hard work may take up to two months for complete reaolution.

4. Exploration of Anger

The staff will begin to wonder why their own reaction was ao intenae and what it is in the nature of the patient that provoked such a response. Their intellectual curiosity will show itself - a handy supply of good literature would be helpful at this time. The creation of in-service training programs and discussion groups is encouraged to enhance this educational process. Those with a more active interest will initiate research projects with surveys, psychological tests and laboratory tests of physiologic responses leading the way. They will want to know what can be done.

5. Goal Formation

This phase is an interesting one in that it runs concurrently with the following one of role formation; both seem interdependent on one another. As the staff begins to speculate on the realistic possibilities for their program the goals they set are very simple and concrete. An example is 1) detoxification, 2) research, 3) rehabilitation. It is important that these initial goals be very clear and well within the reach of the group's talents. Small successes are a necessary ingredient for an optimistic push toward a group's ultimate aim.

6. Role Formation

The discussion of the team's goals becomes the form but a battle for territory becomes the content as everyone tries to carve out as large a role as he can for his section. Care must be taken that everyone who has a potential role is included at this stage and has a fair chance to participate. They may drop out later but it is easier to allow that than to make room for a newcomer. Once the pushing and shoving has subsided a test case, usually trivial, will arise.

7. Cohesion - Problem Resolution

Should the patients be allowed to write letters home while on the intensive care ward? A discussion will ensue that will tempt one to cut it short with an arbitrary decision. Everyone will become involved and every ramification of the problem will be explored. Compromises will be offered and rejected. No solution seems possible but one must insist on a resolution. One by one, minor points will be solved and the staff will exhaustively agree that the patient should be allowed to write home on the third day, late evening shift, with the Red Cross supplying the pencil and paper, and supply and services the stamp. The staff has just taken their first step, shaky, but without a doubt a step. The ensuing battles will be spirited but will share one overriding characteristic. Compromises will be found and will occur more and more easily. Formal and informal channels of communication will appear. A nursing report can become a common line for interdisciplinary contact. The coffee lounge, officers mess, or a particular enlisted man's quarters become meeting places that buzz with the exchange of ideas. Problems that would have seemed to be a crisis in the past are handled routinely. A strange calm settles in.

8. Group Ego Ideal

Calm becomes boredom and it in turn leads to restlessness. Vague noises of disaatisfaction begin to be heard. A slow distinct rumble is heard, "Why can't we do more for the patient?" The staff has found they can work together and now they want to reach for the limits of their capabilities. It is an exciting period for them because they have committed themselves to extend themselves. This extension may simply be shifting emphasis from detoxification to treatment but in their eyes it is important. Careful thought is given to restructuring the therapeutic approach. Familiar and unfamiliar terms with creative modes of presentation are heard -- group therapy, psychotherapy, behavior modification, confrontation, occupational therapy, tranaactional analysis, implosion therapy, transcendental meditation, psychodrama, yoga, and so on. What emerges is a carefully structured, highly integrated plan with the staff utilizing their individual backgrounds and skills to the utmost.

9. Implementation

A difficulty arises in having the plan approved relatively unchanged and having it coordinated with all the supporting elements. Eventually it is accepted with some resistance and considerable doubts. As the day for implementation approaches, tension runs high. There is minor confusion as staff members check and recheck their schedules to make sure they are following their part of the plan. Woe be to the staff member who doesn't appear at the right time or who takes too long.

10. Success

The plan is workable. The staff can't believe it at first but the mounting evidence becomes undeniable. Depending on the degree of diagnostic research and the accuracy of the treatment response the relative success runs from acceptable to fantastic. Sullen, resentful patients are suddenly cheerful, laughing young men. The use of methadone and tranquilizers for withdrawal falls to a minimum. The separation area becomes an uninhabited shell. The staff and patients begin working together as if they are in a common venture and not caught in an adversary system. The control element begins to wonder what their purpose is in life. It is a euphoric moment that should be allowed to linger. Soon enough the staff will be hatching fantastic unrealistic schemes that must be considered while maintaining both feet firmly on earth. A correction back to reality will ensue and a feeling of realistic satisfaction begins to show. An occasional staff member is discovered in his office after hours and unrequested projects come forth. What happened? The patients are the same people who were treated months before.

11. Evaluation

The staff knows the patients are doing well in the treatment program but how long does it last and what happens to them after they leave the center? Forms are developed to pass on information to the succeeding rehabilitation unit or to the patient's line commander. Questionnaires sent to the commander will probe the follow-up success

or failure of the individual. The authorities will demand to know what the success ratio is and how it can be improved.

Subtle adjustments are made in the program structure. The staff wants to know if other follow-on treatment and rehabilitation are successful and may wish to keep the patients longer if they think they are not.

12. Termination

The end of the treatment program will at first be denied and then resisted. Eventually, the staff will accept the inevitable dissolution of the team. Parties, going away gifts, skits, and awards help to soften the blow and send them on their way hopefully better prepared to participate in or form new treatment teams should the need arise.

A Model Program

If a treatment program is well integrated into an overall plan for rehabilitation it must have a time frame. It has been commonly reported that the fifth or sixth day is a period of irritability, insomnia, and of wavering resolution in the withdrawal syndrome. It may be due to the cellular surrender of bound morphine or to a dawning awareness that one is truly drug free. In any event, this reason plus the need to give the individual an opportunity to begin to take the realistic long view of life's problems and to develop habits makes it advisable to allow at least ten days for the initial stage of treatment. What follows is a detailed description of the therapeutic philosophies, techniques and interdigitating roles of a treatment model.

1. In Processing

Invariably, this routine but essential task is best performed by the control element in the form of military police, customs inspectors, or narcotic control officers. Their search must be thorough without demeaning the patient. The patient's belongings must be carefully accounted for so that his initial contact with the institution is one that reflects careful concern for his problem. At this point it is important to separate the individual from his prior symbols of identification to include beads, medals, crosses, combs and probably hair. A new set of fatigues without unit insignia or a pair of patient's pajamas is another neutralizing move. The admitting paperwork is usually the next step; it should be done as rapidly as possible so that those in severe withdrawal or with complicating medical problems are not denied proper medical care. The next stop is the physician's examining room and here a drug use and medical history is obtained. Although they are essentially healthy young men, care should be taken in the physical examination to check for obvious complications of drug use such as hepatitis, endocarditis, and abscesses, plus the many minor ailments overlooked in personal care by a person enmeshed in drug abuse. A check list is a helpful reminder and time saver. Those with serious medical complications or fevers of unknown origin and those requiring nursing care should be separated at this point and sent to the acute ward. Judgement of the withdrawal state should not be made at this moment unless the person is markedly dehydrated, vomiting, or has signs of diarrhea. A calm supportive

attitude should be used in response to questions about medication for their pains. This is not the time to administer long questionnaires or psychological tests. This is the time to consider the character of the patient group with an attempt to form a mildly heterogeneous mixture of ages, ranks, educational level, ethnic groups, and marital status. A number of factors should be considered to achieve a positive therapeutic blend.

2. Orientation

This is an important task which should continue throughout the patient's stay in the program. It may open with an introductory welcome and comment by the team leader, doctor, or nurse. A clear outline of the drug program and therapeutic intent written in normal English, not drug jargon, is helpful. Anticipating a seemingly endless barrage of questions one is advised to preempt them by a presentation from the various sections that are best able to explain and answer the questions. Signs, charts, posted questions and anawers all reinforce the initial orientation. All the members of the treatment team, its structure, and their roles should be introduced. Rules, regulations and expectations should be made absolutely clear and should be provided in written form. The time required for this orientation may last from one hour to one day depending on the amount of confusion preaent in the patient.

3. Treatment Team Structure

Remembering the patient's manipulative resourcefulness and his recurrent challenge to symbols of authority it is wise for lines of responsibility and communication to be made crystal clear. There should be no interference and no compromise with competing outside chains of command. These will only invite administrative confusion.

The control element is an external, symbolic member of the treatment team whose contribution can be supportive or disruptive depending on the success of the in-service clinical training. The control element is responsible for controlling entrance and exit to the treatment compound; this may require badges, name tags, and staff rosters. Control members must be quickly available to handle any loss of individual impulse control to avoid larger group involvement. Most infractions can be treated with a simple time out in the separation area and recycling to the next time frame. The program should reward cooperation, completion and success adequately so that little time or motivation is left for disruptive purposes. Finally, the control element has the unenviable responsibility of controlling the entrance and abuse of contraband. Periodic searches should be held to a minimum.

The leader of the therapeutic team must have sufficient rank and position so that there is no question of his authority. In the military structure the Medical Corps officer or physician is the logical choice for this position. He sets the tenor of the therapeutic thrust through his direction of the team meetings, supervision of the group therapy, and active participation in daily activities. The more traditional areas of diagnosis and prescription, medical management and drug abuse education will be his daily calling. A general medical officer or partially trained specialist

is better utilized in this post than is a fully trained specialist, even a psychiatrist.

The nurse's usual role of attentive observation can supply an enormous amount of information if she is properly trained. Her very presence has a calming, tension reducing effect in helping the patients establish a more normal male/female relationship. This can be used to dramatic effect in therapy where role playing and psychodrama may be used. A young energetic nurse with a flexible sense of humor best fills this role. She can be a great help in filling in on activities that need an extra push at times.

The ward master must be an experienced handler of men. He provides a sense of continuity with the Regular Army structure and coordinates the daily formations and work details to maintain the living areas. Forceful encouragement of the patients to complete activities will also fall to him as does the supervision and coordination of the corpsmen under his immediate control.

There is a need for someone to be responsible for directing and supplying the sports activities program. He must be an organizer, coach, referee, and enthusiastic participant who will show patients who think they are having withdrawal cramps that they are simply pangs of boredom and lassitude.

A person skilled in working with simple but imaginative crafts plays an important role for evening activities and rainy days. The American Red Cross is often available for this task. It is vitally important that these crafts be the type that can be used constructively in the patient's unit as hobbies and not just time fillers. Music, study groups, art, gardening, and fishing, for example, can all provide tangible alternative pursuits to the patient.

The leadership of therapeutic groups is best handled by a psychiatrist, chaplain, or social work officer. Unfortunately, they are in scarce supply and it is necessary to look to others to train for a wider application of these skills. The doctor, nurse, and ward master are the second line of trained personnel, but these require special courses as most of them probably have not had training in group techniques. It is a mistake to turn to the enlisted social work technician whose basic and advanced training hardly qualify him to control and direct the complex interactions of a group therapy experience. Further, by using him, one places a peer in the position of advising another peer and the inevitable response is a counter-attempt to expose and humiliate the technician. He can be trained to lead a very structured group with the support of written materials; simple techniques, such as role playing; music therapy; didactic sessions; and to administer and discuss forms and questionnaires. To ask him to be a group therapist is making improper use of available resources. Another error common in early programs is to turn over the heavy group therapy responsibility to an ex-drug abuser. He supposedly knows "from where they're coming" but unfortunately he rarely knows where they should be going. He often sounds articulate and committed, but that usually represents a reaction formation whereby the individual is trying to convince himself to stay off drugs by helping others to do so. It is an unpredictable defense

mechanism and often falters leaving everyone embarrassed including the "ex" drug abuser.

A number of consultants should be readily available to the treatment team. Specialists should include an internist and a psychiatrist to advise and teach in their related areas. A clinically trained psychologist is helpful in developing clinical and research questionnaires. The social work officer and chaplain are strong supports in the group work. Finally, an administrative officer or noncommissioned officer can advise and forestall many administrative problems.

4. Goals of Treatment

One of the great and surprising lessons learned in Vietnam was that the withdrawal syndrome from heroin was a myth of exaggerated proportions. The return of the autonomic system after its prolonged inhibition by this depressant was usually akin to nothing more than a bad cold and rarely as bad as a case of the flu. Approximately six percent of the patients required fluid and methadone support. Even then it took only two or three doses of 20 mg of methadone at six-hour intervals, a day of intravenous fluids, and bed rest in an air-conditioned ward. The remainder of the patients did quite well with symptomatic relief in the form of Valium for cramps and insomnia, Tigan for vomiting and kaopectate or Lomotil for diarrhea. It was found after a number of episodes of tonguing the Valium tablets that a liquid preparation with the addition of a slight taste of quinine for a bitter taste discouraged the abusers. Barbiturates for sleep are contraindicated and dangerous to have around a ward. Phenothiazines showed no superiority to Valium and one had to watch for the hypotensive and extrapyramidal reactions. In short, the less mention made of withdrawal, the better, and everybody out on the baseball field. If a patient complained of severe withdrawal symptoms he was simply checked for objective clinical signs such as tachcardia, hyperperistalsis, goose flesh, dilated pupils, hyperpyrexia, vomiting and diarrhea. The muscle cramps were real but they did not prevent one from spiking a well set up volleyball.

A conceptual approach to treatment of the heroin abuser must be presented at a level that is understandable to staff and patients alike. This is not the time or place for therapeutic mystery or aloof theorizing. One might view drug abuse from an intrapsychic, interpersonal, or cultural viewpoint or even a mixture of the three. Each plays its role in the process and a strategy to interrupt it at each level increases the possibility of success. An example of examining drug abuse from an intrapsychic point of view might be to compare it to something everyone has had some experience with, breaking a habit. If one thinks about the emotional and attitudinal shifts one must make to give up cigarettes, for example, he must:

- Become aware of the destructive aspects of the habit.

- Accept the habit as an integral part of his learning process - a part of him.

- Begin to experience a sense of guilt for the danger he is placing himself, and reflectively those who are concerned about him, in.

- Develop an internalized rage at his inability to control or reverse his habit spontaneously.

- Consolidate his rage to a directed, workable anger.

- Make a decision or resolution to direct one's energies to control and redirect this habit.

- Establish a plan to support that part of him that wants to relinquish the habit.

- Carry through with the plan.

One might object that comparing a heroin addict to a cigarette habit is akin to the difference between a hornet and a mosquito sting. The answer is that if the heroin habituation is not caught when it is an inadequately reinforced learned response one can forego attempting to reverse the dependency in a three-week or even a three-month treatment program. A similar approach can be worked out for the interpersonal choice one makes for friends or why he chooses to join the "head" subculture and what he can do to look for another.

If a therapist looks to helping effect an internalized shift in another's attitude and wishes to bring it to his awareness he may be subtle or direct. If time is short or denial is strong a direct exposure of contradictions may be necessary. Various forms of confrontations are used ranging from an objective delivery of the facts to calling one a liar in the presence of his peers. Secondly, the therapist must help the patient assume personal responsibility for the fix in which he has placed himself. Again, pointing out his personal actions and choices leading to his involvement is superior to emphasizing guilt but with some the latter is necessary. Explaining cause and effect relationships is a revelation to most. A refusal to accept a rationalization or a displacement of the blame to others brings the cause back home. A careful, reasoned delineation of the full impact of the effect (detention, withdrawal, medical dangers, personal and family shame, future job compromise) help bring closure to the thought process. A further push in this direction helps him to see that he is capable of change and that it is expected of him. The patient may be angry now because he has been shown a bit of truth and has been challenged to deal with it. The therapist accepts his fury and allows the new idea to sink in. Then he goes back to his task pressing home the concept of accountability and showing the patient through focusing his anger and aggressive push on small challenges that success is a possibility and a euphoric fruit in its own right. This can be done in an endless variety of ways from speaking up for the first time in a group meeting to finishing building a small mobile for his living area to getting a base hit for his team on the field. What these small accomplishments share in common is that they must be recognized as significant and good by the therapeutic team members and reflected back to the patient as realistic praise. As one might suspect this takes sensitive attention and much giving on the part of the staff. This occurs at about the same time the patient begins to emerge from the withdrawal state and a combination of relative hypoglycemia and emotional dependency needs place large demands on the food service. It was found that the patients required almost twice

the amount of food that is supplied to a normal hospital population. This total kind of support tends to drain the staff's energies and predictable, recurrent periods of time off duty are imperative.

Hopefully, the patient is now beginning to wonder what can be done about his problem. It is the therapist's job to show him in detail what problem solving, goal oriented behavior is all about. This can be done by setting up plans for athletic teams, developing competitive strategies, organizing craft projects from materials to the finished product, teaching him how cohesion can be built into a group interaction, and indicating to him the steps of internal change he has achieved in getting to his present point. He is gently chided and pushed when he gets irritable or discouraged. At times, this may take an evangelic zeal to maintain the forward momentum. Using his naturally acquired goal oriented skills helps him to see that other goals may be more rewarding than the pursuit of hard drugs, and to broaden his spectrum of choices to reveal to him the myriad pathways from which one has to choose in life. He is left with this cultural overload long enough to stimulate him but not to the point of confusion. He must be forced to commit himself to a reasonable number of physical, social, emotional, and recreational avenues that share nothing with drug use or its culture. The rest depends on the enthusiasm and quality of the teachers. Hopefully, the staff and the program have gained the cooperation, trust, and respect of the patient, and his innate drive for health and self fulfillment will propel him forward, possibly with an occasional boost.

The Patient Group

One of the strongest weapons at one's disposal is the intense need of the young men to band together in a defined group. An associative need to this is the desire to have at the head of the group a somewhat idealized leader as a model for identification. These two naturally occurring phenomenon give one a tremendous leverage in fashioning forces to introduce healthy, more natural solutions to life's conflicts. Ideally, therapy is a recapitulation of the individual's normal course of maturational development. A one-to-one relationship merges with a family numbered group or setting. With a natural evolution one then sees externalized family or friends, adolescent gangs, teams, clubs or fraternities, organizations, political movements, nation states. A roughly similar pattern can be seen within the military structure minus the formalized family and individualized grouping. Recalling that a significant proportion of our population comes from a disrupted family background one can speculate that his experience with groups other than a one-to-one relationship is limited or disordered. A family group of six to eight with a "parent" at the head, available to give individual attention would hopefully include ninety-five percent of the patients. At the very least one should organize a gang of ten to fifteen and help them develop into a team. Now that your family or gang is going, it is necessary to give it a group identity. Team colors, a gang cheer, family traditions, a secret code or "dap," are all tools of the trade in building the system. They should eat, sleep, work, plan, play, and pray together. A commonly shared experience, either traumatic or successful, builds ties that are extremely resistant to external forces. If the ego ideal is the kind of man one hopes he is, a tradition of trial and error, success and failure, flexibility, patience, persistence, creativity,

and humor will slowly develop as the group's response to their common fate. One's strength will compensate for another's weakness and will act as a stimulant for further individual growth. Soon the family or gang are pulling together and finding that by modifying their individual differences their success as a group is increased. Each success feeds the desire for another and the system becomes self-perpetuating.

The problem is not whether one can successfully build a tight group, but how it can be translated into the more complex organizational strata of the military system. One has the choice of either extending the original group and developing it as in basic military or advanced training, gradually easing out the ego ideal as a natural leader emerges, or training the individual to the point where his instinctive response is to enter an advanced group system. Rehabilitation is built on these premises.

Proposal for Prevention

When subsystems begin to develop within an organization, and they were rampant in Vietnam, one can either treat the results of it or give the system the tools and flexibility within the structure to deal with it. The family group (with a military name) could be a fairly easy shift led by an ego ideal senior noncommissioned officer for a period of training when symptoms of a system breakdown are evident. The noncommissioned officer would have to be cross trained in group dynamics and development as in the treatment model. Preferably, he would be with his group day and night structuring their lives in a fashion similar to the treatment model. The problems one would face in a venture of this sort lie in the resistance of the system to the increased personal investment required. However, the additional training supplied to the noncommissioned officer should lessen the resistance. It would make an interesting experiment in relieving disparate stresses on the system. If it was found through the follow-up that no treatment system, however sophisticated, can cure a person once he is addicted to heroin, a preventive approach becomes the only approach.

APPENDIX D

Lessons Learned from the Operation of Drug Rehabilitation Centers in Vietnam

In addition to two Drug Treatment Centers, standardized Drug Rehabilitation Centers were established throughout Vietnam in the latter part of 1971. Some of the officer and enlisted members of the staffs of these DRCs were gathered together at a March 1973 Department of Defense workshop. Their collective experiences and observations are recorded below.

From June 1971 to June 1972 those individuals who were engaged in the task of rehabilitating heroin abusers gained invaluable experience from the standardized program of the U.S. Army, Vietnam, Drug Rehabilitation Centers. The organizational structure provided staffing of one combat arms major as the commanding officer of the rehabilitation center and one medical officer as the center physician. Also provided were a noncommissioned officer in charge, administrative personnel, thirteen branch immaterial counselors and two noncommissioned officer field representatives. These enlisted men were recruited from units in the area supported by the rehabilitation center. As augmentation, the Medical Command provided four corpsmen and four enlisted social work specialists. It should be emphasized that the Drug Rehabilitation Center was a nonmedical facility under the command and control of the area commander. While the responsibility of operating the center rested with the commander of the area in which the center was located, professional medical consultation and supervision were provided by professional medical officers from the Medical Command and other medical facilities near by. The normal period of rehabilitation lasted fourteen days, during which time extensive medical evaluation was done and physical and psychological rehabilitation attempted.

It was found that an experienced combat arms officer had the prerequisites to inaugurate and operate a program which was judged to be successful in all aspects. He provided the experienced leadership which was so necessary to establish and maintain a constructive and stable military milieu within the center. At rehabilitation centers where strong, experienced leadership was present, staff morale was high, and intrastaff communication was facilitated. At these centers it was made explicitly clear to the patients that mature and soldierly conduct was expected of them. It was found that unit commanders who found high military standards in their local center used that Drug Rehabilitation Center and supported the rehabilitation activities. On the other hand, centers where military courtesy and conduct were substandard and where strong leadership was absent suffered a lack of credibility and outside support which were so essential to the operation of a rehabilitation center.

The majority of centers in Vietnam found the assignment of a medical officer essential to treat secondary medical problems in addition to

performing the initial medical evaluation of the patients. Doctors also played a key therapeutic role by providing technical and psychological support to other aspects of the rehabilitation program. They provided advice on physical reconditioning, group activities, counseling, and drug pharmacology. It was rare to find a doctor who had received specialized training in the rehabilitation of drug abusers. Further, in Vietnam many physicians lacked knowledge of simple military subjects such as Army organization, Army sociology and established operating procedures; this at times discouraged otherwise willing medical officers and reduced their effectiveness. At centers commanded by experienced officers, however, this particular problem was reduced.

In spite of the command emphasis and publicity airing the drug abuse problem as a serious social problem in the Army, commanders at all echelons continued to view the Drug Rehabilitation Center as a medical facility and expected that the drug abuse patient would be cured by its doctors. Medical officers assigned to drug rehabilitation centers experienced a great deal of frustration at this unrealistic expectation. The commanders' expectation that the medical officer would cure the immaturity which was often found to be the core of the drug abuser's problem was the result of inadequate dissemination of information to the commanders in the field. The societal or cultural myth that the doctor is the healer of all sickness to include the social problem of drug abuse also contributed to the commanders' expectation.

The physicians found their traditional medical methods were minimally productive in dealing with drug abusers. They learned that the routine use of psychiatric diagnostic classification of character and behavior disorder created anti-therapeutic nihilism which only served to dispel the enthusiasm and motivation of physicians and counselors alike. The traditional medical approach placed the drug abuser in a dependent role, implying that he was dependent upon the doctor to cure him. The Vietnam experience reversed this view when it adopted as a treatment modality the constant reminding of the drug abuser that he was responsible for his behavior and the choices that he makes in dealing with life situations. When this adult-like expectation was made clear to him, he often responded constructively and positively, provided a strong emotional support was provided by counselors and the abuser's peers.

Another lesson learned deals with the criterion for selection of counselors for the Drug Rehabilitation Centers. It was found that civilian and military occupational specialties in such fields as social work, neuropsychiatry and occupational therapy were not necessarily the most important requirements for an effective counselor. While previous experience in social work, psychology and other human relations fields merits some consideration in the selection of prospective workers, certain personal qualities contribute more to a good counselor. These qualities are the ability to experience and express human feelings, the ability to relate to people -- seniors, subordinates and peers alike, realistic but optimistic attitudes, verbal articulateness, correct military bearing and courtesy, and most of all, emotional maturity. All of these qualities contributed to increased credibility with drug abusers who sought help. While enlisted social work specialists who had previous experience as social workers or counselors

contributed to the program by assuming leadership roles, they at times had obvious feelings of inadequacy and disappointment. Only the innate personal qualities cited above seemed to sustain these enlisted paraprofessionals through the long hours of labor. On the other hand, the thirteen branch immaterial counselors who were recruited locally and screened by the center commander, medical officer and social work specialist proved themselves to be more capable than originally expected. These individuals showed enormous enthusiasm, compassion and endurance. The college-educated counselor sometimes created a barrier between himself and the drug abuser, who may be a high school dropout with an apathetic attitude toward the future. On the other hand, a former infantry soldier counselor with a high school or general education development diploma seemed to provide a realistic relationship with the drug abuser with the absence of professional jargon. With constant psychological support from the center commander and his staff, the branch immaterial counselors were quite productive when working in a team approach with the enlisted social work specialists. Each complimented the other.

Each Drug Rehabilitation Center had its own distinctive style and emotional overtone, in spite of the basic standardization directed by the U.S. Army, Vietnam. The rehabilitation center was tailored by the personalities and attitudes of the commander and his staff members. It had its own center insignia, and cultivated its own unique language and mode of expression. Counselors who were able to fit into the style of a particular Drug Rehabilitation Center tended to be successful.

The use of ex-drug abusers in rehabilitation work was tried in Vietnam and failed. This was due in large part to the fact that with few exceptions ex-drug abusers lacked many of the essential counselor qualities already listed. Further, the civilian counselors sent from the United States were generally not productive. The majority of them had little knowledge of the Army, its organization and procedures; consequently, their credibility with commanders was weak.

Among the counselors there was the occasional manifestation of what came to be called the "burned-out syndrome." The "burned-out syndrome" was not necessarily a reflection of poor personality traits of the counselor. It was the result of a series of disappointments over the low success rate of rehabilitation when a counselor had unrealistically high expectations of himself and of other counselors, or when he had his savior fantasy shattered by his experiences. When the "burned-out syndrome" was seen in a counselor or staff member it was found best to remove him from the program. This type of staff breakdown was contagious and spread to other staff members as well as to the patients.

In the Army one finds many young soldiers who can relate comfortably to his peers; however, among these young soldiers there are a number who have a considerable difficulty in relating to individuals in positions of authority. As long as the rehabilitation program is going to be operated within the Army structure, a counselor who has difficulty relating to authority figures is basically noneffective no matter how well he relates to his peers. This type of counselor found himself lacking credibility with the commanders who were the providers of the all-important command support.

An important activity of counselors charged with the responsibility of day-to-day rehabilitating of drug abusers was found to be the maintenance of open communications with other staff members on the progress of each patient. At centers where the program was considered successful, the staff consistently held daily meetings of considerable length to share the events of the day and to exchange viewpoints and observations with others. This daily meeting not only served the purpose of disseminating administrative information, but it also provided the therapeutic opportunity to air frustrations and to solicit tangible and intangible intrastaff support to strengthen the cohesiveness among staff members. This was believed to be the essence of the therapeutic community principle under which the program was conducted in Vietnam.

When the drug abuser was admitted to the DRC he was immediately assigned to a group led by a social work specialist and one or two counselors. Successful rehabilitation was seen when the social work specialist and counselors alike joined the patients in all aspects of the center activities including the individual and group counseling sessions, physical reconditioning, work details and meals. Where the center commander, medical personnel and noncommissioned officers participated in center activities with patients, morale was high among all participants. Further, the psychological games of manipulation by patients seemed to diminish.

Counseling activities at the DRCs were mainly group oriented. Individual counseling, when it was done, was by and large ineffective because many patients used it as a means of avoiding involvement in group activities. The group encounter experience was found to be much more effective. It focused on the expression of feelings related to here-and-now situations. Self-awareness was encouraged. The technique of role playing was found to be extremely useful. It was not only realistic and applicable to immediate situations with which drug abusers had to learn to cope, but it also appealed to the dramatic qualities of young soldiers who otherwise were incapable of using theory or abstract ideas in their dealings with people and everyday living. Since military organization and its unique culture traditionally values adult behavior and individual responsibility, strong emphasis was placed upon the patient to assume responsibility in his decision making.

All rehabilitation centers also used activity oriented group programs, such as carpentry, drawing and other goal-oriented work details. When patients labored and produced a finished product, their self-esteem was heightened.

Regression and passive dependency was not tolerated, but the backsliding individual was not harassed. Increased support was given to such an individual in the form of constant encouragement in the expectation that he could grow up if he so desired.

The unit counselor program deserves mention because it is believed to be a major contribution to the drug rehabilitation effort in Vietnam, and has potential for application throughout the Armed Forces as well as the civilian community. The unit counselor concept was conceived to create an effective counter drug abuse resource within the unit. The program

provided drug education orientation, preventive programs, and much needed rehabilitation follow-up services for rehabilitated drug abusers who had returned to their home units after a stay in a rehabilitation or treatment center. The program operated through interpersonal communication among the men at all echelons of the unit.

Prior to the summer of 1971, DRCs were operated by various units and organizations in Vietnam; these units reported a high recidivist rate among soldiers who were returned to duty from rehabilitation centers. The causative factors were numerous. There was a marked lack of drug education for men of all grades. As heroin abuse became a social group phenomenon among abusers, a former abuser returning from a rehabilitation center was faced with drug-using peer pressure in the absence of an organized and functioning drug-free peer group to help him maintain abstinence. Ideological and attitudinal conflicts between noncommissioned officers and lower grade enlisted men existed. Troops were not fully informed of drug abuse, rehabilitation programs, and the policies of the commander. The traditional modality of outpatient clinic follow-up was attempted by centers and was unsuccessful in the face of the problems which existed in the combat zone, namely great geographical distances, unpredictable mission demands, long working hours, and lack of transportation.

On the other hand, it became clear that a soldier's successful abstinence from drugs during his tour in Vietnam depended on an effective counter-drug abuse program within his unit. All soldiers needed credible information about drug pharmacology and the command policy and program. Just as important, he needed effective, personal support to initiate and maintain his membership in a drug-free peer group throughout his tour. Some organizations attempted to deliver constructive services to meet the educational and interpersonal needs of their men through the use of battalion surgeons, chaplains, battalion drug coordinating teams and coffee houses. Their approaches had varying degrees of success depending largely on the personal interest of the designated workers and the commander. Sometimes, these attempts failed to reach the critical target audience of drug abusers in the small unit who had already psychologically alienated themselves from communication outside their drug-oriented life style.

The foremost advantage of having the helping resource within the unit was the unit counselor's ready availability. The unit counselor was readily available to assist the commander in taking care of his mens' human needs because he belonged to and lived in the unit of his assignment. He was the compassionate peer counselor to individual soldiers and an influence for desirable social action and change for the unit's welfare. Next he had the requisite knowledge to qualify him to act as a catalyst in influencing the psychological climate within the unit.

In addition to maturity, genuine interest in human beings and compassion for them, which are essential prerequisites, the unit counselor had to be capable of effective interpersonal communications and relationships. He had to have an ability to reach out to the impressionable target clientele of lower enlisted ranks and relate effectively to his seniors. He had to be a resourceful individual to bring to bear the available resources of the organization to assist his fellow soldiers. Furthermore, he was

expected to seek and create human interpersonal realtionships as dynamic helping resources to meet the paychological needs of the soldiers.

Upon selection, the unit counselor was trained at the local DRC in the subjects related to his assigned mission. Thereafter, he assisted the unit commander and his subordinate leaders in gaining an understanding of the whole drug abuse problem in the unit. He briefed each newly assigned man on the drug scene in Vietnam, the hazards and consequences of drug abuse, and the urinalysis and rehabilitation programs, and he encouraged drug abusers in the unit to seek help.

A basic lesson learned in the unit counselor program centered on the selection of the prospective unit counselor. That selection reflected the commander's attitude and interest toward drug abusers and the command program. When the commander was interested, he selected good men to be trained as unit counselors. Unfortunately, the commander was not always interested and the program in his unit suffered. Some selected counselors were nonvolunteers who had little interest in assuming the counseling duty. Since the positive and constructive use of interpersonal relationships in counseling and consultation is an important tool of the unit counselor, the employment of nonvolunteers as counselors was found to be counter-productive.

Some commanders selected former drug abusers as their unit counselors; generally, these made inappropriate candidates for the part.

The depth of involvement of the unit counselor in carrying out the unit drug education, prevention, and follow-up services depended on the degree of commitment of the individual unit counselor, his skills and ingenuity, and most important, the support of his unit commander. Unit counselors faced human problems other than drug abuse. Soldiers who were in psychological shock after receiving bad news from home needed emotional support and ventilation. Some voiced concern over a marriage or engagement after a long break in correspondence. Soldiers planning on a post Army future were interested in discussing college plans and veterans benefits. Still others simply needed someone to listen to their stories of loneliness and anxiety after being away from home. Many unit counselors met these human needs of fellow soldiers, thus expanding their role from drug-related counseling and related activities to a wider sphere encompassing the whole spectrum of human relations problems. Some full time unit counselors had duty hours which began at 2 o'clock in the afternoon and lasted until midnight; they found that soldiers predominantly sought counseling and rap sessions during the late afternoon and evening hours.

An invaluable lesson learned was that the unit counselor should be trained to be a sensitive listener and skilled referral agent who can make maximum use of his knowledge of available resources to assist with his unit's human problems. To set the goal of teaching him to be skillful in counseling techniques in the time available is unrealistic.

Finally, just as the counselors and staff members of the Drug Rehabilitation Centers needed emotional support and professional supervision, so also did the unit counselors, but to a greater extent. No other factor was more demoralizing to a unit counselor than his feeling of isolation, his needs for supervision and consultation unmet.

APPENDIX E

After Action Report
United States Army Rehabilitation Center - Danang

In March 1972 the officer who established, organized and commanded the U.S. Army Drug Rehabilitation Center in Danang, Vietnam submitted a report of his experiences to the Corps Commander. That report has much of value in it for anyone concerned with drug abuse programs and so it is reproduced below. It has been edited slightly, primarily to remove irrelevant material.

History

Personnel - The decision was made that a combat arms officer would establish and command the Drug Rehabilitation Center, and on 30 September 1971, I was informed (on a remote firebase southwest of Duc Pho) that I was to report to G-1, XXIV Corps on 1 October. I did so and in an interview with the Commanding General, XXIV Corps the next day I was directed to open the Center on 11 October. Notwithstanding the formidable administrative and logistical tasks to be accomplished, including approving a facility, relocating its tenants and renovating it to be suitable for a Drug Rehabilitation Center, the first priority was selecting and training a staff. On 2 October two Army Private First Class social workers especially trained in drug rehabilitation reported for interviews and were selected. Major subordinate commands in the Danang area were required to submit nominees for counselors for the Center for interviews, and the interviews began in earnest. On 4 October the Medical Director was finally selected. As he and I traveled to other rehabilitation centers in operation and to Headquarters, U.S. Army, Vietnam for guidance, a program began to take shape. The small staff now moved to the new facility to begin the long hours of hard work necessary to clean the facility and to renovate it. By 11 October, one ward had been constructed, the staff numbered twelve of twenty-eight authorized, and three patients were admitted. Eight more patients were admitted on Thursday, 14 October, but because of insufficient staff, no patients were admitted the following Monday. Standards for selecting the staff were high, and even when an enlisted man was found acceptable for the staff, an inordinate amount of time was required for coordination between USARV and the unit before the individual reported for duty, if he ever did. Admissions dates on 9 December and 31 January 1972 were also missed because of insufficient staff. The staff was organized into three operational sections: social workers, counselors, and wardmaster (see Inclosure 1). The social workers consisted of a noncommissioned officer-in-charge and four enlisted men, one for each of the four patient groups which would be in the Center at once. The counselors consisted of a noncommissioned officer-in-charge and four teams of counselors, one team for each of the four patient groups. The Wardmaster Section attended to patient care and such minor medical care for the staff as was required.

Program - USARV Manual No. 600-10 directed that the Drug Rehabilitation Center "provide billeting, messing, group psychotherapy, minor medical treatment, administration, modest recreational activities and a program of rehabilitation" in the fourteen days authorized for the program. From the beginning, this Center used the first three days of each group's stay for detoxification. This simply involved putting the patient in hospital pajamas and leaving him in a special detoxification ward under medical supervision for three days. All his meals were served him in the ward. Some medication was available for alleviating symptoms of withdrawal but was used sparingly. Placebos were found to work almost as well as tranquilizers. Should the patient need to leave the ward to go to the latrine, he was escorted there and back individually. After three days in the detoxification ward, the patient was anxious to get outside and start his rehabilitation. Each of the eleven days devoted to rehabilitation included activities for physical as well as psychological rehabilitation (see Inclosure 2). Physical rehabilitation was thought to be a very important part of the program, and was approached through one ninety-minute organized athletics period daily, and two ninety-minute periods of "work therapy" or work details daily. This was designed not so much to keep the patient occupied or to tire him out as to rehabilitate him physically, and they all needed physical rehabilitation. The most important aspect of the program, however, was psychological rehabilitation, and the basic tool was the group psychotherapy session. Using any one of a number of proven themes and techniques developed for the group session (see Inclosure 3), the social worker guided his group, the individuals working on each other, towards the goal of providing each patient an objective look at himself and an understanding of his true relationship with drugs. The social worker, through the group sessions and also through daily individual counseling of each of his charges attempted to reinforce the patient's resolve to stay off drugs. Nightly rap sessions and the arts and crafts program were also part of the psychotherapy. Two nights a week each group participated in a group session directed by a chaplain. The religious approach, which has some value in some cases, was tried, but only on a voluntary basis on the part of the patients. Other features of the Center's program were:

- The Team Approach - patient group integrity was found to be important. An amorphous group with constantly changing identity may function well in a long term effort, but with just fourteen days with which to work, group identity and integrity were thought to be critical factors. Consequently, the social worker assigned to each group received it into the Center and stayed with it to the end of the fourteen-day program as did the three staff counselors. These four staff members constituted a team with the patient group which makes attaining the psychological objectives possible and facilitates the resocialization efforts as well.

- Comprehensive Records - patient records were carefully kept. Each patient's personnel file and health records were scrutinized upon entry and extracts made for the Center's records. The social worker's intake interviews, his daily counseling records, comments by medical personnel and a daily comment by each counselor on the team became part of the patient's records at the Center. Finally, a lengthy interview with each patient was conducted by the senior social worker as the patient neared the end of the program; this completed the patient's file. A detailed profile of each patient could be obtained at any time by referring to his file.

- Follow-up - from the very first day of operation, we realized the importance of follow-up on graduates. Our goal was to see each graduate at least twice monthly, counsel him, help him with any problems he may have and give him the opportunity to prove that he is atill on the program through urinalysis tests. If trends current then continued, well over 50% of the Center's graduates would return to the United States without returning to heroin. In addition to follow-up, the liaison noncommisaioned officers alao effected continuing liaison with the units served by the Center.

- Unit Counselor Training - rehabilitation muat continue in the unit if it is to have a good chance of auccess. USARV Manual 600-10 directed each company-size unit to have two unit counselors and directed the Drug Rehabilitation Center to train them. Unit counselors enhance a unit's ability to approach the drug abuse problem and permit a continuation of rehabilitation started in the Drug Treatment Center as well as in the Drug Rehabilitation Center. More than 300 men were sent to the Center for this training, and each of the 120 who completed the course received a letter attesting to this completion for inclusion in his personnel file.

- Facility - an area with excellent potential was made available for the DRC. It was surrounded by a barbed wire fence which served to keep visitors out and also functioned aa a psychological barrier to the patients. The location was isolated from the great majority of units served by the Center. It provided ample space for wards, and adequate space for billeting the entire staff. It also featured an outside patient patio, and space for weight lifting, horseshoes, touch football, volleyball, and basketball. It proved to be an eminently satisfactory facility.

- Support - peraonnel services support was provided by Headquarters, XXIV Corps and was adequate. Logistical support (property, mess and transportation) was initially provided by 1st Battalion, 44th Artillery and then by 58th Transportation Battalion and was alao adequate. Additional support was provided by 45th Engineer Group and Headquarters, XXIV Corps (supply and special services). Particularly helpful was the support volunteered by U.S. Army Support Command which provided 16,000 sand bags and two vehicles, among many other items.

Problems

A modeat request for Engineer assistance, involving about $4,500 was turned down by USARV. As a result the small staff had to undertake the monumental task of rebuilding the facility without the requisite skills, tools, or materials, and at the same time conduct a drug rehabilitation program. Often working thirty-six hours at a stretch, the staff persisted. The facility was completely renovated, and represents a tremendous accomplishment.

Selection of staff, especially military occupational specialty immaterial counselors, was most difficult. Those nominated should be intelligent, mature, and have an interest in helping the drug abuser. Those interviewed and selected should be immediately made available, but most often were not. Coordination between USARV and the unit was lugubrious and ineffective. The

Center Commander must have virtual carte blanche for selecting his staff, and those he has selected must be made immediately available.

A potentially serious problem were "drop-outs," those who entered the program professing motivation, but left soon after detoxification. These individuals contributed nothing to the program and in fact seriously detracted from the rehabilitation effort made on the others in the program who may have been sincerely motivated. This problem was identified early and the command emphasis placed on it by the Commanding General of XXIV Corps virtually eliminated the problem.

A major concern at any drug center is maintenance of a drug-free environment. Every effort must be made to stop the flow of drugs into the area. No Vietnamese were allowed to enter. No visitors were allowed the patient, except officers, senior noncommissioned officers and unit counselors (who should regularly submit to urinalysis). All mail was suspect, and opened in the presence of a staff counselor. No packages or in-country letter mail were allowed the patients. Absolutely no contact was allowed the patient with personnel outside the Center and as little as possible with other patients not in the group. Upon admission, a new patient was stripped of all his belongings which were returned to him when he completed the program. These included cigarettes, watches, bracelets, cigarette lighters, and toilet articles (except razor), to reduce the chance of his smuggling anything in. Notwithstanding this, patients and staff submitted to a urinalysis at least twice a week (and the days were varied from time to time), and the staff was constantly on the alert to changes in the mood of the patients, as well as to guard against ourside contacts.

Unit counselor training was a very important aspect of the Center's operation, yet it is only as good as the men selected from the unit to receive the training. Of more than 300 men sent to the Center to receive the training, only 120 completed the course and less than one-fourth of them, or thirty could be said to have good potential for unit counselors.

Lessons Learned

The purely professional approach works. No catchy name was given the Center (The U.S. Army Rehabilitation Center - Danang), no evocative slogans were used, nor psychedelic posters displayed. We were all business from the start leaving no doubt in the patient's mind that our mission was to return him to his unit as a functioning soldier. From all reports this approach worked well.

Once the tone of the Center was set, changes in key personnel such as Center Director, Medical Director, or Senior Social Worker were carefully approached. Unless all key personnel can generally agree on the direction of the rehabilitation effort, chaos will result.

Former drug abusers are not necessary nor even desirable as staff members. They enjoy no advantage over the nonuser in showing the "junkie" that he need not resort to drugs. The character and behavior disorders that invariably characterize the drug abuser are often still present although he may not be on drugs presently. Three former users selected for the staff

were released, not because they reverted to drugs, but because they were unstable.

Withdrawal syndrome was found to be minor. Fewer than five percent of the patients exhibited significant withdrawal symptoms.

Placebos work almost as well to relieve discomfort during withdrawal as do potent medication.

So sorely tested is the resolve of even the most sincerely motivated of patients during the first few days of the program that not more than one man from any one company should be admitted with each group. If two men knew each other, invariably they would both drop out.

Everything is suspect - glue, paint thinner, toothpaste, spray deodorant. If it is possible to get a "high"on it, they will try it.

Visual deprivation is an important feature for the group session room. The room should be plain and the walls unadorned so there will be no distractions from participation in psychotherapy sessions.

The patient will have a voracious appetite after detoxification and in the fourteen days will gain back from fifteen to twenty-five of the pounds he lost while on heroin. Extra rations should be requested and approved.

The patient's bowels will move and with a vengeance, often for the first time in weeks. More than the normal number of accommodations must be made available.

The patient profile is not representative of the American soldier in Vietnam or anyplace else.

The drug abuser problem is not substantially a heroin problem - it is a personnel problem; sixty-five percent of the Center's patients abused drugs (not counting marijuana) prior to coming into the Army. Most of them had sociopathic personalities.

Fifty percent of the problem, as we saw it, could be eliminated in basic and advanced training; for example, more than half of our patients received nonjudicial punishment in their first sixteen weeks. Procedures should be implemented to void the enlistment contracts of such individuals at that time.

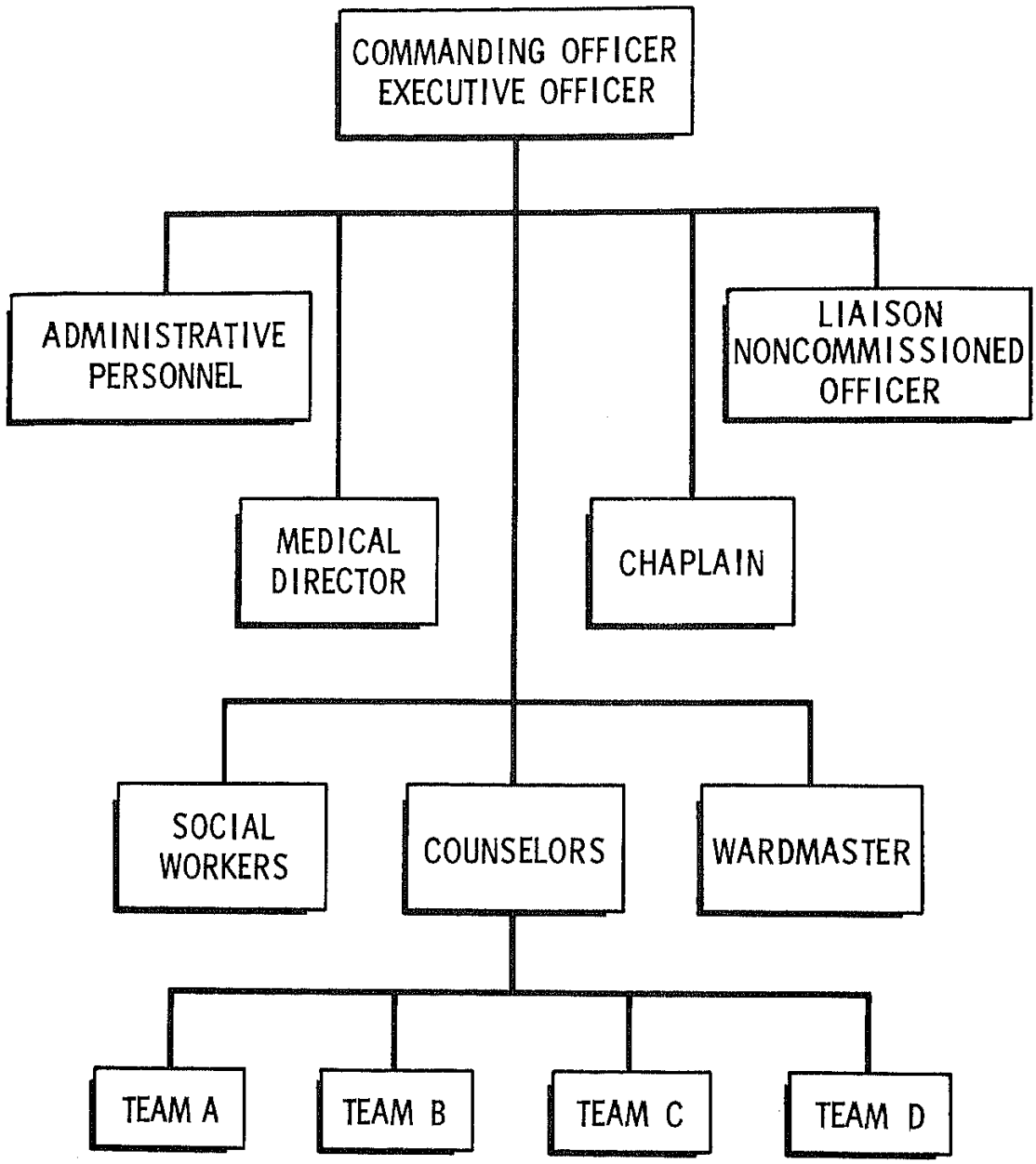
Seventy percent of the problem, as we saw it, could be eliminated by selective recruiting (sixty-one percent of the patients were high school drop-outs and sixty-nine percent had civilian police records).

Probably ninety percent of the problem, as was presented to us, could be eliminated by using a test to identify the sociopathic personality, coupled with selective recruiting.

Major, Infantry
Commanding

3 Inclosures
Incl 1 - Organizational Chart
Incl 2 - Schedule
Incl 3 - Group Counseling and Therapy
Isaues, Themes and Techniques

UNITED STATES ARMY REHABILITATION CENTER
– DANANG –



ACTIVITIES SCHEDULE

Thursday 17 February 1972

	0730-0900	0900-1030	1030-1200	1200-1230	1230-1400
GROUP 30	Work Details	Group Session	Arts snd Crafts	L U N C H	Work Details
GROUP 31	Group Session	Arts and Crafts	Work Details		Group Session
GROUP 32	Move to Rehabili-tation Ward	Work Details	Group Session		Athletics
GROUP 33	I N P R O C E S S I N G				

	1400-1530	1530-1700	1700-1800	1800-1900	1930-2100
GROUP 30*	Group Session	Athletics	S H O W E R S	D I N N E R	Chaplain's Session
GROUP 31	Athletics	Work Details			Day Room
GROUP 32	Work Details	Group Session			Chsplain's Session
GROUP 33	D E T O X I F I C A T I O N				

* Group 30 will clean the Dining Room and Day Room

Inclosure 2 to
Appendix E

Group Counseling and Therapy
Issues, Themes and Techniques

1. Group discussions with the patients about themselves and their lives without mention of drugs or the war in Vietnam.

2. "Loser syndrome: the constant need to get high." Explore reasons why some individuals need a synthetic high (whether heroin, barbiturates or alcohol) and how their lives are wasted by the constant drive to obtain and use the drug.

3. Compare care, compassion and love -- search for the definitions of each term and how these emotions apply to everyday living. Discuss the role each has played in their lives (both present and past) and what they could do to improve their relationships with others.

4. "Trust" -- who do they trust and why? What actually is trust and how can a person earn another's trust? Does a person have to trust himself and how much should a person trust another if he wants help? (Some physical trust exercises are applicable -- for example, the outstretched hand waiting response from the other person.)

5. "Rebirth" -- how an individual must change his ways and life pattern if he hopes to lead a constructive life. Discuss how a person must be "reborn" to the straight world from the drug oriented life.

6. "Dope fiend attitudes and ways" -- how drug culture ways have affected life styles and ways of thought, and why such habits should be broken and amended to live a drug free existence.

7. Put an individual in a circle, and (a) have each member discuss how he feels about the person and what he likes and dislikes about him; (b) describe the person as an animal, mineral or vegetable -- best fitting his personality and actions; and (c) attack him for his inadequate performance and attitude and have him try to defend it in front of every one.

8. "Blow your image" -- have different individuals do or say something that they are unaccustomed to doing or which is foreign to their personality. The goal is to break down the person's inhibitions.

9. "When you're looking good, you're looking bad -- and when you're looking bad you're looking good" -- examine this statement and how it applies to their activities and their "image."

Inclosure 3 to
Appendix E

10. Role playing -- have the individual take the part of the social worker, a parent, his wife, his commander, an employer, a "straight," or a friend. In this role, he attempts to determine how the other person thinks and acts and what his responsibilities are.

11. Have those present name three persons (living or dead, famous or perhaps just a relative) that he would like his son to be like and why -- explore his reasoning and the characteristics he admires most in a person.

12. "Where I came from -- where I am going" -- goal discussion and planning take into consideration how a person must strive daily for a certain ultimate goal or ideal. Put into perspective how a person can build on his past and present experiences to create a productive future.

13. "What goes around, comes around" -- discuss how a person can be swept up into a movement or thought without really accepting it. Have the patient interpret the saying in the way he thinks best as it pertains to heroin use and abuse.

14. "Today is the first day of the rest of my life" -- aim for the patient to think about his future and to construct his everyday life for a profitable future.

15. "Friendship" -- who is a friend? How does a person become a friend to another? What are the basic rules of friendship and when are they violated?

16. Discuss projects completed in arts and crafts sessions. The purpose is to help the patient gain a better insight of himself through nonverbal communication. Topics that apply well are the completed projects exhibited to the group during discussion: (a) "The Me Nobody Knows," (b) finger painting exercise, (c) "The Year 2000", (d) self-portrait.

18. "With what can you replace drugs?" -- examine ways a person can lead his life without using drugs by interacting with people, taking pride in one's work, hobbies, concern for family, and self-awareness.

19. Presentation of photographic art (subjects may vary but should deal with a central figure in an unnatural or threatening situation) -- give each person a picture, have him decide on an interpretation and then defend it in front of the others. Have the individual put himself into the picture and explain how he would act or think and then have him put another group member into the picture and describe how he thinks he would act.

20. "You've got to give it away to keep it" -- a look at selfishness and how a person must interact and share himself with others before he can become a "complete" individual.

21. "Individuality" -- what comprises an individual and what makes him different from others? What is expected of him from others? Can people be alike and yet still be an individual?

22. "If you could be anyone or anything in the world, what would it be and why?" -- this inveatigates the ideals the patient had and what he perceives himself of being.

23. What does the patient like the most about himself and what does he like the least?

24. "If . . . " -- explore the patient's sttitudes and ideas on different situations if he was confronted with them. (Example: Where would you go if . . ., What would you do if . . . .)

25. "The most important thing is . . ." -- examine the priorities the patient has in his life.

26. "Success" -- what does it mean and who is one?

27. Work within a system (Army, school, law, and even society) -- have the discussion center on the need of system, what is enough to get by, responsibility of a person to the system, and making the system work for you.

28. "Family" -- what has the patient done for and to them, and what has the family done for and to him.

29. "Love" -- how does it feel to give and receive it? Also, look at the patient's concept of it and what role it played in his life a year ago, a month ago, and now.

30. "Why he" -- knock down the "picked-on-attitude" and discuss the point that the only one the patient is really hurting or depriving is himself and not the world. Try to focus on how most of their problems evolved out of something that they had done previously.

31. "What are you doing for the rest of your life" -- goal construction; have the patient look at his life if it would continue in the same way. Also, confront the patient with the fact of how soon he would be dead if he continued drug use; or how long he would have to spend in jail if he continued his criminal way.

32. Have each of the patients (after about a week of group experience) take the responsibility of the group upon himself and lead it in a worthwhile discussion/interaction. (Time limit -- not less than ten minutes.)

33. "Changes that I've gone through" -- discuss the changes a person goes through in life, since he has been in the Army, since Vietnam, since drug or heroin use, and since he has been in the rehabilitation program.

34. "What would I do with a million dollars?" -- let the patient use his imagination and see what he would do or buy with such an amount. A daydream exercise that can check the patient's wants and desires, interests and priorities in life.

35. "I've been down so long, it looks like up" -- ask for the patient's interpretation and how it applies to himself - especially when he was on heroin, and before he began any type of drug abuse.

36. Have each of the patients compare and contrast their backgrounds, life styles, and habits with the other members.

37. Have the patients look at how they have coped with their problems in the past -- and see how they would like to have coped with them.

38. "Running away" -- when does a person finally catch up with himself? From what or whom is he running?

39. Have a member of the group sit outside of the group and let the group discuss the individual in any manner they wish; the topic person can not interrupt the inner group's discussion. (Checks on how others perceive an individual and what they would say about him "as if he was not there." Can be tried on a single individual on a rotation basis or when the need arises or to several if a clique has arisen within the group to have them see and hear what they are doing.)

40. "How does it feel to be drug free and can it last?" -- usually done after being in the Center for over a week; it examines the feelings of being straight to the memory of being on drugs -- and the future of it.

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THE DEPARTMENT OF DEFENSE

EXPERIENCE IN DRUG ABUSE PROGRAMS

JUNE 1973

PREPARED IN THE OFFICE OF
THE DEPUTY ASSISTANT SECRETARY OF DEFENSE
(DRUG AND ALCOHOL ABUSE)

THE DEPARTMENT OF DEFENSE

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June 1973

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TABLE OF CONTENTS

PREFACE

The rapid increase in drug abuse in the Armed Forces in 1970 and 1971 created many problems with which the Armed Forces initially lacked the experience to cope. In the ensuing campaign to combat drug abuse the Armed Forces gained much experience and learned many lessons which have possible use in the fight against the drug problem in civilian society. This volume was written to present in one source document the more significant of the problems encountered and how they were solved. It was prepared with the expectation that it would receive wide distribution among those involved with drug abuse programs, both military and civilian, so that they and the nation might benefit from the experience of the Armed Forces.

The Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse) wishes to thank the responsible authorities in each of the Military Departments for furnishing much of the original material upon which this document is based. The DASD(DAA) is particularly grateful to the same officials for providing so many knowledgeable individuals to a March 1973 Department of Defense workshop on drug abuse programs in Vietnam. The experience, professionalism and interest of these participants increased the substance of this publication manyfold.

The Department of Defense welcomes comments, additions and corrections to this document. They should be addressed to:

The Deputy Assistant Secretary of Defense
(Drug and Alcohol Abuse)
Office of the Assistant Secretary of Defense
(Health and Environment)
Washington, D. C. 20301

INTRODUCTION

Because the members of the Armed Forces are a reflection of the society from which they come, the recent rise of the drug culture within the United States saw a corresponding rise in drug abuse in the military services. The missions of these services lacked compatibility with drug abuse and so the Department of Defense and the Military Departments launched a concerted program against it. Every conceivable approach was, and is continuing to be, explored in this campaign. These experiences and knowledge gained are used to revise, improve, and expand the military services programs in drug abuse education, prevention, identification, treatment, and rehabilitation.

The problem in the military has not been totally defeated. The indications are, however, that it is on the wane. The percentage of clinically confirmed positive urinalyses (indicating drug abuse) has exhibited a gradual, steady decline. The number of men applying for treatment for drug abuse under the exemption policy seems to have peaked in late 1971 and is now slowly decreasing. In Vietnam, prior to final withdrawal, the number of patients discharged from hospitals with drug-related diagnosis declined far more rapidly than can be attributed to troop withdrawal alone. There are other indicators of the trend: the percentage of apprehensions for drug abuse in Vietnam declined steadily in 1972, and the number of servicemen admitted to Veterans Administration hospitals for drug problems continues to drop. Finally, there is firm belief among those who were in touch with the problem in Vietnam that the massive efforts exerted there definitely paid dividends. In day-to-day discussions with commanders and others at unit level, it appeared that the service drug abuse programs were instrumental in bringing an increasing amount of reverse peer pressure to bear on drug abusers. Also, while it cannot be demonstrated conclusively from statistics, the effects of education, and deterrence through random uninalysis testing in particular, are credited with significantly reducing the problem of drug abuse world-wide.

None of the items above should be accepted as absolute proof that the DoD has solved the drug abuse problem. However, when viewed in their entirety, all indicators point toward a very definite downward swing in the improper use of drugs by members of the Armed Forces. There is no room for complacency or relaxation of effort. Undoubtedly, new problems will arise which will require new solutions, but it is felt that the military services have the means and expertise to handle new problems as they surface.

In devising and operating the drug programs in the military, there has been a great deal of experience obtained from both the successes and the failures. This experience provides a wealth of information about drug programs, how to plan them, how to organize them, and how to

operate them. Much of this information has accumulated in the Office of the Deputy Assistant Secretary of Defense for Drug and Alcohol Abuse where it furnishes a data base of knowledge which should prove of value to any authority involved with drug abuse. Accordingly, the knowledge has been gathered in this report for the benefit of anyone wishing to use it. For convenience the material has been broken down into the natural categories of education and prevention, identification of drug abusers, treatment and rehabilitation, and records handling.

The fact that much of the information included here may be known to some is recognized. However, that which is obvious to one person or group is not always obvious to others and so this report was written with the view toward including as much substantive information as possible at the risk of being too basic or repetitive.

SECTION 1

Summary

General

This section is a summation of the many leasons which the Department of Defense and the Military Departments have learned from their experiences with drug abuse control programs.

Probably the most important lesson which the Military Establishment has learned in its current fight against drug abuse is that the problem of drug abuse can be solved. Given the proper ingredients of education and prevention, law enforcement, identification, treatment and rehabilitation the young, susceptible non-user can be kept from drugs, and the detected drug abuser can be detoxified (without agonizing withdrawal aymptoms), treated, and rehabilitated to become a useful member of society today. And, this can all be accomplished in a structured, disciplined environment which includes authority figures as well as clinicians and counselors.

Although they are truisms, three other points deserve emphasis because they are all important to a successful drug abuse program. Command support is the first of these; complete, active support of the command drug program by every leader from the most senior through the entire chain of command to the most junior. Unless the commander does place his support squarely behind his drug program, his staff officers and other workers will direct their energies toward that which the commander does support, and the drug abuse program will falter.

The second point of emphasis is the requirement that each drug program have a designated program manager with clearly established responsibility for the entire program at his level, and with adequate authority to coordinate and operate the program without interference. The manager should not be given additional duties which would drain his time and energies nor should outside forces be permitted to confuse the program, undermine or challenge the manager's authority, or create conflicting movements.

Third is the need for professional, competent, honest, dedicated middle managers to supervise the numerous elements of a drug program. The drug abuaer is often oblique; once detected he sometimes does not wish to be treated and rehabilitated. The urinalysis test requirements are stringent, and urinalysis laboratory test standards are higher than heretofore considered practical. These and other constituent parts of

the program demand men who can plan and innovate, who can attend to fine detail, and who can conquer routine and boredom in day-to-day operations.

Recapitulating, the more significant general lessons learned are:

- The drug abuse problem can be solved.

- One person must be given the responsibility and the authority to coordinate and operate the drug abuse control program.

- Honest, professional, dedicated middle managers are required to supervise drug abuse control program activities.

- Support of the authorities at all levels is absolutely essential to the success of the drug abuse control program.

Education and Prevention

The military drug abuse education and prevention target group is all-embracing. It includes the potential drug abuser and the practicing drug abuser as well as the commander and his staff, the physicians, chaplains, legal officers, law enforcement officers, all other officers, noncommissioned officers, dependents, civilian employees and members of adjacent civilian communities. To be effective, the education process requires the tailoring of educational materials for that portion of the target group at which it is directed; material which might appeal to the potential drug user may have little effect on the physician or commander. Fortunately, a variety of media exists to propagate the word about drug abuse -- for complete and sustained coverage all should be used.

Early in the effort to counter unlawful drug use it was learned that a large credibility gap existed between the drug abuser and the establishment. The user more often than not knew more about drugs and their effects than did his mentor. Even if he did not actually know as much, he believed that he did and thereby downgraded what information came to him from the authorities. The educators problem is one of first penetrating the awareness of the drug abuser and then of providing him with factual, believable, up-to-date information. It is necessary to convince the user that he alone is responsible for his decision to use drugs, even though that decision may be irrationally arrived at, and to provide him with the facts of drug abuse and its consequences. Additionally, the drug education effort must provide the user and potential user with alternate choices to drug use. It must provide him with methods of achieving personal satisfaction and it must stimulate attitude and behavioral changes.

Personal involvement and special training are required for teachers, educators, leaders and others that come into contact with the potential drug abuser. It is not enough to simply provide them with the written facts of the subject. There has to be a consideration of the overall social problem and a counterplay of knowledge and ideas concerning the methods of effectively applying the lessons learned to the community

before the would-be educator is prepared for his task.

Physicians present a special case. They require additional training to recognize and treat the problems peculiar to drug use and drug overdose situations. They require additional training to counter the manipulative skill of those seasoned in the drug culture. They must recognize that the circuitous drug abuser often does not want to be treated, that he prefers his drug habit and so the physician must be trained to penetrate his drug subculture shield. Finally, the physician who avoids drug abuse diagnosis for fear of stigmatizing an individual must be trained and motivated to record his drug findings accurately and correctly for he does the abuser and society nothing but harm by failing to face facts.

Among youthful dependents the Teen Involvement program has proved to be effective. Under this youth teaching youth concept, high school teenagers are used to guide elementary school students in making rational decisions regarding drugs and their use. For maximum effectiveness it was found that active, intelligent, mature teen counselors with reasonably high grades were best able to relate to the younger students. Further, for maximum program worth a dedicated faculty sponsor and a firmly established counselor -- teacher relationship based on mutual knowledge and understanding are required.

The significant lessons learned by the Military Establishment in the area of drug education and prevention are:

- Educational materials must be tailored for the target group at which they are directed.

- All news media should be used for the dissemination of drug abuse information.

- Personal involvement and special training are required for educators, leaders and others that interface with potential and actual drug abusers.

- Physicians require special training to enable them to recognize and cope with problems peculiar to drug abuse and drug related situations.

- Physicians must be trained to record their drug findings and diagnoses correctly and accurately.

- The educators must penetrate the awareness of the potential and active drug abuser, provide him with factual, believable, up-to-date information, convince him that he alone is responsible for his decision to use drugs and provide him with alternate methods of achieving personal satisfaction.

- Youths can successfully teach youths to make rational decisions about drug abuse using the Teen Involvement concept.

- The Teen Involvement program requires mature, intelligent volunteer teen counselors; dedicated school faculty sponsors; and a

rapport between teen counselors and classroom teachers.

Identification

Drug abusers are identified by several means, chief among them being the urinalysis test and the exemption policy. Some abusers are found as a result of medical examination for non-drug injury or disease and still others are found through other means and methods.

Today, the urinalysis test which can detect opiates, barbiturates and amphetamines in a person's urine is the most effective detector of drug abusers. Actually, the urinalysis test program serves several functions. It provides a measure of the magnitude of the drug problem. It permits the early identification of drug abusers at which time they are more easily rehabilitated. It permits the removal of infectious sources of drug use from units; and it provides a deterrent to would-be drug abusers or individuals who need an excuse to withstand peer pressure.

For maximum effectiveness in detection and deterrence the urinalysis test program or screen must be applied in a mathematically random and unannounced fashion. The target individual or unit must have absolutely no advance warning of the impending test.

It can be profitable to test at other events. The drug dependent individual is unable to refrain from drug use and his urine will contain traces of drugs even though he knows he is going to be tested. For example, the services screened each individual before he was allowed to return to the United States from Vietnam hoping to detect drug abusers, primarily those who were drug dependent. The same philosophy can be applied to events in civilian life -- to illustrate, urinalysis tests for drugs may be administered at the physical examinations required before youngsters can participate in organized sports in school.

The military services learned that not only must the suspect group be subjected to the urinalysis screen but the staff of drug treatment and rehabilitation facilities must also be checked on a random basis. Drug abusers apparently encourage others to use drugs and sometimes the rehabilitation staffer succumbs.

Once the military urinalysis screen procedures got underway, the drug abusers began to look for ways to circumvent them. Some simply failed to appear for the scheduled tests -- command action solves this problem. Some flooded their system with fluids to reduce the concentration of drugs in their bodies to an undetectable level. Others tried fruit juices or vinegar. One by one the test administrators and laboratories uncovered each stratagem and devised a counter to it.

The drug abuser will try to alter or destroy urinalysis screen records to avoid detection; he will resort to bribery if need be. The need for a secure, well managed system of urine collection, transportation, testing and report keeping is apparent.

Some difficulties were experienced when a man with a drug positive

urine test appeared before a physician for confirmation of his drug abuse. For one reason or another, the physician was sometimes reluctant to confirm a diagnosis of improper drug use. This problem was met when there was doubt about drug abuse by placing the responsibility for the confirmatory decision in the hands of the commander. He obtains and uses the opinions of a physician and a social worker to assist him in arriving at his decision.

Quality control programs were instituted with the Armed Forces Institute of Pathology as monitor to raise and maintain a high order of detection capability on the part of all participating urinalysis laboratories. Weekly, the AFIP prepares and inserts sample lots of urine, both with and without drugs, into the system. These samples arrive at the urinalysis laboratories anonymously where they are tested, and the reports of test sent back through the quality control system to the AFIP. The AFIP reports the results of the quality control program weekly and quarterly to the military services who are responsible for maintaining the laboratories performance at an acceptably high level. The quality control program not only keeps laboratory performance up but it also establishes a measure of credibility for the urinalysis screen in the minds of the risk group, the commanders and staff, the drug rehabilitation workers and the medical authorities. Factual publicity of the quality control effort can serve to boost the acceptance of the urine test program by everyone who is touched by it.

The next most effective means to date of uncovering drug abusers in the Armed Forces has been through exercise of the exemption policy. This policy prohibits prosecution of anyone who admits to drug abuse and volunteers for treatment, or who is detected as a drug abuser in a urinalysis screen. It does not exempt the user from accountability for other wrong doing, nor does it prohibit administrative action such as removal from flying status or denial of security access. By applying for assistance under the exemption policy the individual is assured that he will get help with his drug problem, no disciplinary action under the Uniform Code of Military Justice will be forthcoming, and his drug use will not be used in whole or in part as a basis in denying him a discharge under other than honorable conditions.

Although much progress has been made in the field of drug abuse detection, much ground remains to be covered. In particular, detection methods for users of cannibis sativa derivatives and hallucinogenic agents are urgently required.

In summary, the more important lessons learned from the military services efforts to identify drug abusers are:

- The most effective means for detecting abusers of opiates, barbiturates and amphetamines is the urinalysis test.

- The urinalysis test program:

  -- Permits the early identification of drug abusers at which time they are more easily rehabilitated.

-- Provides a measure of the magnitude of the drug problem.

-- Provides a deterrent to would-be drug abusers.

-- Permits the removal of infectious sources of drug use from the community or unit.

- For maximum effectiveness the urinalysis test screen must be applied in mathematically random fashion.

- Rehabilitation facility staff must be tested as well as their drug abuse patients.

- Urinalysis test administrators, laboratory personnel and others connected with the urinalysis test program must be alert to detect and nullify drug abuser stratagems to escape identification.

- A high order quality control program is required to maintain high urinalysis laboratory standards as well as to establish urinalysis test credibility in the minds of the risk group, the leaders and staff, the medical authorities and the drug rehabilitation workers.

- Responsibility for the confirmatory decision that an individual is or is not a drug abuser is best placed in the hands of the commander.

- An exemption policy whereby drug abusers may volunteer for assistance without fear of punitive action is an effective means of identifying drug abusers.

- Research is urgently required to devise means of detecting users of cannibis sativa derivatives and hallucinogenic agents.

Treatment and Rehabilitation

An early lesson learned with respect to the treatment and rehabilitation of drug abusers was that physicians required guidelines to follow when seeing drug patients. Having perceived the need, it was alleviated with the publication of a tri-service document entitled Drug Abuse (Clinical Recognition and Treatment Including the Diseases Often Associated). It is distributed as Army Technical Bulletin MED No. 290, Navy Publication No. P-5116 and Air Force Pamphlet No. 160-33.

A most valuable element of information derived by the armed services from their rehabilitative efforts was that rehabilitation of the drug abuser can be accomplished in a military setting complete with regulations, uniforms, discipline, and service customs and courtesies. In fact, it is imperative that rehabilitation be conducted in a military atmosphere. The goal is to return the serviceman to a useful service life so that rehabilitation conducted in a non-military setting is artificial and a simple avoidance of reality. The professional military approach works -- no catchy phrases, drug jargon or psychedelic posters are required.

The services also learned that dedicated, experienced line and combat

arms officers can succeasfully operate a rehsbilitation program. They require professional aasistance from physicians, psychologists, chaplains, counselors and social workers, but the experienced line officer has all the qualities necesaary for succesaful drug rehabilitation work.

While it is true that succeasful rehsbilitation requires the coordination of command, community, medical and spiritual efforts, the bulk of the task falls on the shoulders of an energetic, enthusiastic rehabilitstion facility staff. The staff must have desire and persistence, motivation snd a sense of loyalty to the goals of the group. If any stsff member does not have these attributes, he should be released. Not only will he fail to do his psrt, but he will also -- unwittingly or not -- contribute to a counter-productive mood and will be s contaminating influence on the established program.

Among the staff, the counselors require special care in selection. They associate with and relate to the drug patients on a day-to-day basis and must be exemplary in all respects. Formal schooling and training has value, of course, in preparing the counselor for his job; however, it was found that other qualities were equally, if not more importsnt. These qualities are the ability to experience snd express human feelings; the ability to relate to people -- seniors, subordinates and peers alike; realistic but optimistic sttitudes; oral articulateness; correct military bearing and courtesy; and most of all, emotional maturity. With these qualities, any individual has a high probability of success as a drug rehabilitation counselor.

Counselors, like any other staff member should be released or replaced if they cannot conform to the rehabilitation fscility approach or goals, or cannot cooperate with or relate to the remainder of the staff. A rehabilitation center tends to assume an individuslity or identity of its own. Counselors and other staff must accept and assume that identity; they must conform. A non-conformist hss no place in the handling of drug abusers -- he is s contaminating influence. The same is true of those who tire of the job, and the mortality rate of those who do become exhsusted is higher than may be imagined.

The military services found that, in general, ex-drug abusers do not make satisfactory counselors. They possess many of the traits of the typical drug abuser and may still be suffering from the throes of drug abstinence themselves.

Rehsbilitation efforts were found to be most succeasful when they focused on the whole man, his physical well being, his mental well being, his sense of responsibility and his obligation to himself, to others, and to society. Treatment of his problems is best done in a group setting. In Vietnam centers where a limited time was available for trestment and rehabilitation it was found best to organize the incoming drug sbusers into a fairly heterogeneous mixture of sges, ranks, educational level, ethnic groups snd marital status. This group wss assigned a team of social workers snd counselors who remained with the group throughout its stay in the center. The individuals in the group suffered their reverses and successes together and from these experiences sprang a group identity

and integrity, a cohesiveness whereby each one helped one other through the rehabilitation process. The goal was to increase the sense of maturity through a program of self awareness and discipline evolving from group interaction and mutual obligation engendered by life within a structured society. The group approach was basic to the therapeutic processes used by the rehabilitation centers in Vietnam. One treatment modality which was used with success reminded the patient constantly that he and he alone is responsible for his behavior and for his choices in life; he is responsible for the decisions he makes.

Rehabilitation programs must be carefully planned and organized; they must have a structured balance of instruction, physical exercise, group therapy, and work sessions, all directed toward a common goal. Patients should not play a part in the organization and planning -- this was seen in some installations; it did not work. Unscheduled time should be kept to a minimum or eliminated completely. The typical drug abuser is not highly self-motivating; he has little ability to effectively use his unscheduled or unplanned time.

The staff in rehabilitation facilities found that the recidivists among their charges will try anything for a high -- glue, paint thinner, toothpaste, spray deodorant. Every substance is suspect and care must be taken to keep such items out of the grasp of the potential recidivist and the weak-willed. The staff also found that after detoxification the drug abuse patient will develop a voracious appetite and will gain back much of the weight lost while using drugs. Extra rations are required. Moreover, the patient's bowel movements will increase in numbers requiring that more than the normal number of toilet facilities be provided.

Follow-up after release from rehabilitation is an absolute necessity. Further, there must be some pressure to counter the drug peer pressures that the rehabilitated abuser is sure to encounter. The services meet this problem by establishing post or base level rehabilitation programs with halfway houses; rap centers; and carefully selected, trained social workers and counselors. In Vietnam, the situation was different; there, units were deployed to the field or work locations and so the Army devised the unit counselor concept. Men were selected by the unit commander, sent to a rehabilitation center for training and then returned to the unit as a unit counselor, a resource within the unit to counter the drug scene. The unit counselor advised the commander on the drug problem in his unit; he briefed incoming men on the drug problem; he counseled men in the unit on their drug and social problems; and he attempted to build a counter drug force in the unit to sustain the returned, rehabilitated drug abuser. He also served as a source of believable information for the men in the unit.

The unit counselor program had its problems. Selection of counselor candidates was crucial. They had to be motivated, dedicated, mature individuals who were willing to take on the task. To select anyone else was a waste of time, money and manpower resources. It was found to be a mistake to attempt to teach the unit counselor to be skilled in the use of counseling techniques in the time allocated for training. Rather, the counselor was taught to be a sensitive listener and skilled referral agent

who could make maximum use of his knowledge of the many resources available to assist with the human problems of the men in his unit. He served well as a listening post, someone to whom anyone with a human problem could come for advice, and many times, for assistance.

The more meaningful lessons learned by those engaged in drug abuse treatment and rehabilitation activities are:

- Physicians require guidelines to follow when seeing drug abuse patients.

- Drug rehabilitation can be accomplished in a structured, disciplined environment which includes authority figures as well as clinicians and counselors.

- Experienced line and combat arms officers can successfully operate drug rehabilitation programs.

- Rehabilitation facility staff must conform to the identity and goals of the facility, and must cooperate fully with the rest of the staff.

- Counselors require special care in selection; they must be exemplary in every respect.

- Counselors need not have formal, college level counseling schooling. Any individual with the ability to experience and express human feelings, the ability to relate to people, realistic but optimistic attitudes, oral articulateness, correct military bearing and courtesy, and emotional maturity can be trained with a high probability of success as a drug rehabilitation counselor.

- Ex-drug abusers most often do not make satisfactory counselors.

- Drug abuse rehabilitation is best done in a group setting.

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

- Rehabilitation programs must have a structured balance of instruction, physical exercise, group therapy and work sessions, all directed toward a common goal.

- Unscheduled time in rehabilitation programs should be kept to a minimum or eliminated completely.

- Care must be taken to insure that substances which might produce a high are kept out of the hands of rehabilitation patients.

- Follow-up after release from rehabilitation is necessary. It must provide some pressure to counter the drug peer pressure which the rehabilitated abuser is bound to encounter.

Records

Reports and records are necessary elements of any drug abuse control program. They are required to identify and follow drug users, to measure the progress of treatment and rehabilitation, and to measure the degree of success or failure of the program. Collection and release of accurate, complete drug abuse data can do much to dispel unrestrained rumors as well as to provide a firm basis for advanced drug program planning.

Data requirements should be incorporated into program planning at the outset. Records planning must be complete and thorough, and must take into account the views and requirements of all factions taking part in the program. Problems must be anticipated and provided for; possible future use of automatic data processing systems must be foreseen and planning initiated; and the data requirements for the inevitable follow-up and program review must be anticipated in the early planning.

For proper medical care, 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 from one to another. Accurate records are necessary so that one can determine what treatment modalities were used, which were successful and which were not. The patient cannot be relied upon for this factual information. Many drug abusers are unreliable individuals who have little interest in telling the complete truth about themselves. Finally, studies are sometimes done on the data recorded in the medical records. Obviously, a bias-free study demands accurate source data.

Situations like the military drug abuse experience in 1971 and 1972 attract researchers with their multi-page questionnaires and surveys. Their goal is to analyze the problem for causes and solutions, and the basis for their investigations is complete, honest data. Sometimes the collectors of the data are those who must do the day-to-day drug program work; they may view the data collection requirement as an imposition on their time. They will require motivation for proper, accurate data collection as well as an explanation of the need for the data and the good which can be derived from proper data collection. They also require explicit instructions and uncomplicated forms. The patients require a clear-cut guarantee of confidentiality.

Reports, whether periodic or aperiodic, are vital to a drug program. They can be disruptive or not depending on the care that goes into the planning for them. Where possible, different report requirements should be combined to make one report serve several purposes. Adequate time must be allowed to permit report preparation, investigation of suspected mistakes and transmission to the receiving office. The period of the report should be long enough to gather meaningful data but not so long as to permit significant fluctuations in the data to be lost. Report changes must be held to a minimum -- they have a tremendously disrupting influence on the staff which already views all reports as a not-so-necessary evil. Good advance planning can reasonably be expected to anticipate requirement changes and to provide for them in the beginning.

Reports and records are necessary to an effective drug program but maintenance of them can be time consuming. Automation can assist to a degree but is dependent upon complete, accurate source data. The need for care and accuracy in preparing reports and records highlights once more the requirement for detailed planning and quality personnel to operate drug abuse programs.

In the field of records and information handling the most significant lessons learned are:

- Complete, accurate reports and records are required to identify and follow drug abusers, to measure the progress of rehabilitation, and to measure the degree of success or failure of the program.

- All drug abuse program factions should be represented in program planning from the beginning.

- Reports and records requirements should be incorporated into program planning at the outset.

- Automatic data processing of information should be anticipated and planned for.

- Follow-up and program review should be anticipated and data collected accordingly.

- 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 from one to another.

- Considerable motivation and supervision are required when medical or rehabilitation staff collect statistical data to insure data completeness and accuracy.

- Confidentiality of drug abuse records must be maintained.

- Whenever possible, different report requirements should be combined so that one report serves several purposes.

- Adequate time must be allowed for report preparation.

- Report changes must be held to a minimum.

The following sections address in detail the specific elements of these summary comments. They provide the interested or concerned person with the experiential knowledge required to establish and operate drug abuse control programs, programs which capitalize on the lessons learned -- sometimes painfully -- by the Department of Defense.

SECTION 2

Drug Education and Prevention

General

The Department of Defenae ia keenly awsre of the problems associated with the abuse of druga in the Armed Forces. From thia awareneas atems the established DoD policy to prevent and eliminate drug abuae wherever found. In furtherance of this policy the DoD isaued definitive instructions in early 1968 which emphsaized preventive drug abuse education; in 1970 a DoD tsak force reaffirmed the DoD concern for drug sbuae and recommended atrengthening the drug education programs of the servicea.

The DoD drug abuse education/prevention program operates on a decentralized basis. Overall policies snd responsibilities are established by DoD directives. Each of the services then administers its own program within the DoD-established policy. The military aervicea provide objectives and guidelines for their education programs through regulations which promulgate the concepts enumerated in the DoD directives. Major operating commands and inatallations within each service deaign snd implement drug educstion programs within the eatablished guidelines to meet local needs. The approachea vary, but the fundsmentals remain the aame.

Flexibility ia an abaolute necessity in desigaing programs to meet the identified needs. As the needa change, so do the programa. In the laat few years the emphaaia in all of the programs has shifted from punitive, to drugs, to people. Preaent efforts are directed toward providing objective, realistic informstion about drugs of abuae and their effecta and helping individuals to know and understand the reaaons for drug taking. Emphasia is placed on helping individuals define their personal goals and to distinguish between reality and rationalization in their efforta to accompliah theae goala.

Experience haa proved that drug education must be emphasized for all segmenta of the population, not just for the ausceptible group of potential drug abuaera. Commandera snd aupervisors of all gradea muat be thoroughly grounded in knowledge of the drugs being abuaed. They muat alao have an underatanding of the multiple reaaons for drug abuae. Lacking thia background, aupervisors will find that the drug abuaers in their unita know much more than they about the methoda of uae and effects of particular drugs. In auch situations the leadera have a difficult time retaining effective communication or leadership. In their efforta to point out the negative aspects of drug abuae, they can easily be duped, confounded, or discredited by the knowledge of

those who they are trying to educate to the point of drug abstinence. Physicians also must be provided specialized drug education. They must have the knowledge necessary to recognize and handle overdose situations as well as the insight to penetrate the cultural shell established by the drug abusers. Many times the drug abuser is devious and must be recognized as a poor source of information about himself. Physicians must be educated to cope with this fact. Other individuals form specialized target groups at which specialized drug programs must be aimed: laboratory technicians form such a group; parents, children in their early teens, criminal investigators, and attorneys form other target groups.

A problem which quickly became apparent as the drug abuse situation in the military unfolded was the large credibility gap which 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. This lack of credibility was supported by several factors. The primary factor appeared to be the use of a large amount of obviously incorrect or biased information concerning the use and effects of certain illegal drugs. This was caused in part by the failure of much of the more current material to reach its intended target audience at the small unit level. A supporting factor was the lack of emphasis placed on alcohol and other socially accepted drugs in initial military drug abuse prevention programs. An additional supporting factor was the first approach used in these programs. This approach employed scare tactics based on incorrect or incomplete information about drugs and their effects. In this approach, threats of personal harm based on incorrect information were coupled with the implied threat of punitive action and possible imprisonment. These factors resulted in limited effectiveness of the early drug abuse preventive education programs. The basic lesson learned was that information about drugs and their effects must be both factual and objectively presented to be credible.

The methods by which the credibility problem was attacked, and the alternatives to an emotional scare approach based on incorrect information are many and varied. They are discussed below in detail in connection with specific education/prevention problems.

In the course of the service drug education programs, use has been made of all media. Factual and objective educational and informational materials have been presented in the form of handbooks, pamphlets, video tapes, radio broadcasts, newsletters, posters, special issues of Commanders Digest, and articles in Armed Forces newspapers. Lectures, presentations to large and small groups, discussions, and individual counseling have also been used and well-received. A lesson learned was that education materials must be kept up to date. There are new facts constantly being established in the drug abuse field and the news dissemination media must be constantly updated to reflect the new information. Failure to do so contributes to the credibility gap and results in setbacks to the education/prevention process. Another lesson learned was that information must be presented in a style that fits the taste of the intended audience. Informal and formal presentations must be mixed. Attempts should be made to involve individuals in communicating with the informational and departmental policy agencies.

Informal periodicals have been provided in many areas to focus on local drug abuse problems and the community facilities available to provide help, advice, or counsel. They furnish the reader with up-to-date information on the local drug situation. Many also contain question and answer sections whereby an individual may submit a question on drug use or departmental policy which will be answered in a following issue. Comments and topics for future inclusion are likewise encouraged.

Drug information is frequently disseminated over the Armed Forces Radio and Television Service stations overseas. These include full programs as well as spot announcements relating to drug abuse. Service newspapers also publish articles on drugs and their abuse, as well as information on the DoD exemption policy, the activities of various drug rehabilitation centers, and the urinalysis testing program. A good example is the Pacific Stars and Stripes, the newspaper most widely read by the military in Southeast Asia. This paper once published a series of almost daily articles on the DoD drug abuse programs over a three-month period.

A basic lesson learned from the information dissemination effort was that effective preventive drug education programs must go beyond simply transmitting information about the legal and medical dangers of drug abuse. The program 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. Many previously believed that the decision to abuse drugs was a decision which the abuser reached through a rational decision process. Experience has proved this is not always the case; the actual decisions can be casual or irrational. This makes programs necessary which are aimed at clarifying personal goals, providing effective decision making tools and exploring values and lifestyles as well as providing drug facts.

Educating the Educators

A basic problem with those who were charged with educating others to the harmful aspects of drug abuse was that the educators were not always fully knowledgeable or credible in the drug abuse area. Consequently, their message could be discredited by the drug abusers in the target audience who had direct personal knowledge of specific drugs and their effects.

Thus, a basic lesson learned in drug education was that special training must be provided to the teacher or leader to equip him with the latest information about specific drugs of abuse. It was also learned that simple provision of written material for study was inadequate; there had to be discussion of the overall social problem and a counterplay of knowledge and ideas concerning methods of effectively applying lessons learned to the military community in which the individual worked before the would-be educator was fully prepared for his task. It was quickly learned that full-time personnel were necessary to develop and manage an effective drug program, and that careful screening was required in the selection of these personnel.

Young officers and noncommissioned officers were selected from a group of volunteers in each service to function as the education middleman

or educator. Their selection was based on communication ability, interest in the field, and proven capability to relate with diverse groups. These selected educators attended a variety of civilian and military academic institutions.

Some of the drug abuse prevention courses were taught at established universities and were funded by National Institute of Mental Health grants. Additionally, the Army conducted its own in-service program of four 13-day cycles to train military and civilian personnel as an instructional cadre in Army drug education programs. The Navy and Air Force established continuing drug abuse education courses of approximately one month duration to provide special training to qualify selected individuals for drug abuse education duties, and the Marine Corps utilized Navy facilities to educate their instructional personnel.

The purpose of the education at this level was to prepare individuals to educate members of the Armed Forces of all grades. The training encompassed history and scope of the drug problem; policies and directives; pharmacology; psychological, cultural and legal aspects of drug abuse; and related approaches to counseling and treatment. The major portion of the work developed skills in program design and development. Subject areas included were program and community resources, constructive alternatives, educational and rehabilitation program models, local program development, communication techniques and small-group process skills, program and resource evaluation, and follow-on training.

The material was presented through a combination of varied techniques to include lectures, movies, group discussions, role playing, and demonstrations of programs developed by small groups or individuals. At the end of the course work, the participants were asked to critique the training, whereupon this critique was used to evaluate and alter the programs as appropriate.

Educating the Leaders

The transmittal of drug abuse knowledge to the leader group is accomplished in many ways and varies by service. There is formal education in the military school curricula, e.g., at noncommissioned officer academies, preparatory schools, officer candidate schools, and reserve officer training corps schools. Professional military education at basic, advanced and senior levels also includes specific courses in drug abuse education. Drug education is provided to medical and legal officers and to chaplains as a portion of their overall general military instruction upon entry into the military and at their advanced courses. Specialized conferences and seminars are conducted by each service for command and supervisory personnel on a command-wide basis. These meetings establish a forum for the exchange of ideas and information among responsible officers and to improve support for imaginative and effective drug education programs.

One of the major methods of supplying commanders and their staffs with up-to-date information and advice in drug abuse prevention is through the use of drug education specialists on the commander's staff. In the Army, the personnel officer is the principal staff coordinator for drug

matters. However, it has proved useful to appoint an Alcohol and Drug Control Officer as the operational director of the drug and alcohol abuse program. He is responsible for implementing and conducting education, identification, and rehabilitation functions. The ADCO normally has operational control of, and provides administrative support for, installation halfway houses and rap centers, while a clinical director, usually a medical corps officer, serves as a consultant and assists the ADCO by supervising the professional aspects of the program. In Army brigades and battalions in Vietnam, Drug Abuse and Rehabilitation Teams were used to keep commanders informed of the local drug situation.

The Navy employs a large number of Drug Education Specialists to assist commanders in designing and implementing drug abuse programs in their command. All of these personnel are graduates of the Navy school in San Diego. The Marine Corps officers and noncommissioned officers are trained with the Navy and provide the same service to their commanders.

Air Force commanders and staff are advised by Air Force personnel who complete training at the Social Action School at Lackland Air Force Base and return to their home stations to develop and conduct drug education programs. They work directly for the commander at each level and provide him and his staff with up-to-date information concerning local drug problems. When major problems arise, the Mobile Assistance Branch of the Drug Education and Counseling Course can be called for assistance. This branch provides an assistance team which is available to Air Force bases throughout the world to provide technical assistance to field commanders and Social Action personnel. They are primarily education and training officers and technicians. The Air Force also provides a Social Action Traveling Team to help commanders identify problems. This team is composed of five interdisciplinary professionals -- a personnel officer, judge advocate, information officer, chaplain, and psychiatrist. They visit Air Force installations to conduct seminars, assist their counterparts, discuss policy and communicate identified problems to the local commander for his solution.

In addition to the drug specialized staff assistance provided to the commander, each military service established local councils and committees to help the local commander in preparing, coordinating, and implementing drug abuse control programs. These groups took many forms. The Army established Alcohol and Drug Dependency Intervention Councils in the major Army commands. This is an attempt to involve the total Army community in the drug problem and to improve communications on the subject at higher levels of command. Participants are the chaplains, preventive medicine officers, judge advocates, law enforcement officers, behavioral science specialists, and General Staff representatives of the commander.

In the Navy, major shore commands are establishing Drug Abuse Control Councils with senior line or command chairmanship. Membership of the Council is made up of chaplains, medical and legal officers, investigators, enlisted men, civilian employees of the Navy, dependents, and members of the surrounding civilian community.

The Marine Corps established a Drug Awareness Analysis Team in order to provide commanders with a means for evaluating the overall drug abuse situation in the Marine Corps.

The Air Force established Drug Abuse Control Committees at installation, major command, and headquarters levels. These function to coordinate and direct drug abuse prevention programs and coordinate drug abuse control efforts with the local civilian community agencies.

Command awareness of personnel and management problems in the drug abuse prevention area is now facilitated through a series of newsletter articles on current programs, policies and actions in the area of drug abuse. These include the design, preparation and dissemination of preventive drug abuse information; special management information; and educational articles directed to commanders.

A significant lesson learned in applying drug education/prevention emphasis to the command structure is that in the military system, command support behind a clearly defined objective and program is a must for any effort to be fruitful. The drug program is a command program, devised and promulgated in the name of the commander and it must be supported by him in all its aspects.

Another important lesson learned in manning drug abuse positions is that the staffer must be assigned on a full-time basis. Many individuals responsible for drug education had numerous other duties which the commander felt were important; consequently, the educators were unable to perform effectively as educators. It was soon learned that when an individual's efforts were directed solely to the drug problem, the program was more effective. The commander's problems in this area were lessened as qualified individuals became available for full-time assignment as drug abuse education specialists.

Educating the Potential Drug Abusers

As time went on and the awareness of the drug situation in the military services increased, studies and surveys were performed to determine the characteristics of the potential drug abuser. In Vietnam, as an example, he was found to be a young man in the lower enlisted grades, a draftee or enlistee in his first enlistment who, in the majority of cases, used drugs before entering the service. Many features of the potential user were thus isolated and this knowledge was used to shape the programs aimed at preventing the improper use of drugs. The target audience may vary by size, profession, age level, background, interests, and informational needs but these differences must all be considered when deciding upon an appropriate program. The programs which have evolved are as varied as the audience and its interests. The lesson learned is that no one approach is effective with all groups. On the other hand, a combination of many techniques has proved effective. These techniques include presentations from ex-addicts from therapeutic communities; hotline counseling and use of rap centers; workshops, lectures, films, brochures, news media, tapes, theatrical productions, panel discussions, variety shows, and rock festivals.

One example of a program model that provides factual information and discussion of facts and issues is the "decision search" oriented program. The objective is to insure that every man has the facts he needs to make an intelligent decision concerning use or abuse of drugs. It provides drug information kits in which audio and visual aids are utilized. Each kit contains an audiovisual projector with 14 films and eight tapes covering the spectrum of drugs and drug usage. Each kit also has seven to eight books which address drug areas in depth. Also, there is a series of "quick fact" handouts that can be read in a period of three to four minutes; each addresses a particular portion of the drug spectrum. The table model projector throws an image on a small viewing screen and has the added capability of projecting onto a larger screen for use with audiences of up to 30 people. Of the 14 films, six are brief film episodes which bring out the need for further knowledge. Utilizing this vehicle, the educator can address the issues raised by showing one of several five-minute, single-concept films.

Another example of a useful program model which provides a resource trained in rehabilitation methods as well as reliable information concerning drugs and their effects is the training program for selected, highly motivated, young enlisted men in drug abuse education. Part of this training includes "live-in" experience at a therapeutic community. Upon completion of training, the individual returns to his unit to serve as an informational source in support of drug abuse prevention efforts. His experience in the therapeutic community provides him with valuable information concerning drug abuse problems and also establishes credibility for him in the drug abuse field. His contemporaries look to him as an expert in this field.

A well-received program that provided information and assistance to both supervisors and potential abusers was the Drug Education Field Teams. These teams were organized in Vietnam with two civilian ex-addicts, two military educational specialists (an officer and an enlisted man), and a Vietnamese national. They traveled to company-size units in the field. There they provided guidance and assistance to the unit drug education specialists and commanders and carried out extended discussions with the target audience of potential abusers. The team also provided information to the commanders and supervisors concerning the size and type of drug problem in his unit as well as advice on ways to approach the problem. The technique used divided the unit into one group of officers and non-commissioned officers (the "establishment"), one group of younger enlisted men, and the group of local Vietnamese. The team officer and one ex-addict talked to the first group while the enlisted team member and the other ex-addict talked to the enlisted group. The Vietnamese national talked to the Vietnamese group. The goal was to dispense credible information and to establish rapport with a resulting meaningful exchange of ideas.

Educating the Medical Personnel

DoD early recognized the need for additional special training for medical and legal officers and chaplains and provided for such training in the various service schools. The advent of the military drug problem quickly highlighted a need for additional training for medical personnel.

In many cases, the physician was not knowledgeable of the manipulative skill of those seasoned in the drug culture and was easily controlled by the drug abuser. Medical personnel had to be trained to recognize that the drug abuser is not the best source of information about himself and his habits, and the the more addicted he is, the more devious he is likely to be in his attempts to avoid abstinence or unpleasant realities concerning his own responsibility in the negative results of drug abuse.

Crisis situations involving drug overdoses often created problems for medical personnel due to a lack of standard information concerning drug effects, cultural patterns and methods of abusing specific drugs. This led to a recognized need for standard crisis management guidelines and special training in their use for the medical population. Medical support programs did not provide adequate education for physicians who were not familiar with the identifying symptoms in drug abuse cases, particularly those involving multi-drug use.

Another problem was the tendency among some younger physicians to avoid stigmatizing an individual by identifying him as a drug abuser if there was no evidence of physical deterioration due to drug abuse. This caused hardships for individuals attempting to cope with their own drug abuse problem in its early, more easily curable stage.

Solutions to the medical problems involve further in-depth training in recognition of drug problems, crisis intervention, and diagnosis and training. Training must be given to physicians, nurses, emergency room technicians, pharmacists, and similar medical professionals. The training should develop a set of guidelines to be followed in drug abuse crises just as there are guidelines for heart attack cases, strokes, etc. The benefits of early identification and treatment must be stressed to overcome any hesitancy on the part of medical authorities to identify individuals with drug abuse problems.

As a result of the need for drug abuse guidelines for medical personnel, the DoD initiated the preparation of a tri-service publication which provided guidance for medical officers concerned with the identification, evaluation and treatment of drug abusers, including management of intoxication and withdrawal syndromes, and clinical identification and treatment of diseases often associated with drug abuse. The publication is entitled Drug Abuse (Clinical Recognition and Treatment Including the Diseases Often Associated), is dated 15 January 1973, and is distributed as Army Technical Bulletin MED No. 290, Navy Publication No. P-5116 and Air Force Pamphlet No. 160-33.

Another problem noted was that medical administrators also need additional training. It was found that all too often no official means existed to provide information about or to motivate an individual toward continuing treatment as he moved from one place (and program) to another, e.g., from his unit in Vietnam to a treatment center and then to the United States. In addition, those methods of treatment which had a higher rate of success with certain groups were not known to all treatment personnel. This same lack of continuity appeared when an individual was transferred to the Veterans Administration. When a man was transferred

to the VA for treatment, he 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. These examples point out a clear need for efficient handling of medical and personnel records and for truthful, knowledgeable counseling of the drug abuser on what he can expect from each phase of his treatment. Stated otherwise, here is another credibility gap which has been identified and which can be closed given special training and efficient administration.

Educating the Dependents

The same DoD directive which prescribed special training for medical and legal officers and chaplains recognized that drug abuse among dependents can also be a problem. Consequently, the instructions for attacking the drug problem in the military included provisions for program extension to civilian employees and dependents. Included were the development and procurement of drug abuse materials such as films, pamphlets, posters, and radio and television programs. Further, the opportunity for drug abuse education and training was made available to the total military community.

Within the United States, with rare exception, dependents receive drug abuse education in the local public schools. Overseas, they also receive instruction. In the European area, for example, the school system reports that all junior and senior high schools teach drug education units and 86% of all schools teach drug education. Peer programs have been inaugurated in the majority of overseas dependent schools. One peer education program called Teen Involvement, utilizes volunteer high school teen counselors to provide effective drug abuse information to dependent students in the elementary and junior high school grades. Such programs were established in 1971 in the Marine Corps school at Quantico, Virginia; in the Air Force schools in the Philippines; and in the Army and Air Force schools in Germany. They have since been expanded throughout the rest of the United States, Pacific and European areas.

The DoD strongly encourages its members and dependents to participate in civilian community programs in order to both learn and share their knowledge and experience. For example, the Teen Involvement program came to the military through the teachings and experience of a nonmilitary group. This effort had its beginning in Phoenix, Arizona where carefully selected military dependents were sent for training. They then returned and implemented the approach in military-operated dependent schools. It is also offered to local public schools servicing military families.

Teen Involvement utilizes the concept of youth teaching youth. It provides a valuable lesson learned. Carefully selected and trained high school teenagers from the community can be used to guide elementary students to make effective rational decisions concerning the use and abuse of drugs. This approach is not wholly devoted to drug abuse. It may include decision making in any fundamental area. The program devotes itself to the basic concept that an elementary student will be approached some time in the near future and that a personal decision concerning drug abuse will be required. The teen counselor, through positive alternatives, role playing, etc., helps the elementary student form his personal decision about illegal drug abuse in the future.

From the Teen Involvement program it was learned that intelligent, mature, active counselors with reasonably high classroom grades are required for a successful program. A motivated faculty sponsor is also required as well as a firmly established counselor-teacher relationship based on mutual knowledge and understanding of each other's problems and goals. Parental involvement is desirable, but normally it is difficult to obtain.

At Appendix A is an account of four Teen Involvement counselors who spent a year traveling throughout the United States and introducing the Teen Involvement concept to interested military and civilian communities. This account describes the program, its evolution, the techniques used, the lessons learned and concludes with the young counselors' recommendations.

Adult education is being provided to wives' clubs and parents' organizations. The objective is to understand drugs and their abuse better so they may understand and cope with the younger generation.

At the command level, councils and committees have been formed to afford interaction with the civilian sector of society. The Military Departments encourage maximum participation with the civilian community as part of their drive against drug abuse as well as an exercise in good public relations. Programs have been instituted whereby the neighboring civilian community utilizes military facilities and vice versa. The net effect is an awareness of each other's problems and capabilities and an amalgamation of the effort against drug abuse.

In summary, the present thrust of the service educstion programs encompasses the many lessons learned in recent yesrs about drug education and prevention. These education programs strive to help the individual realize that he, and only he, is responsible for his decision to use drugs, while at the same time they provide him with the facts about the consequences if he does choose to abuse drugs. These efforts are not restricted to the military alone. Many programs are designed to include the entire military community as well as those segments of civilian society with which they interact.

SECTION 3

Identification of Drug Abusers

General

Although much was learned about drug education and prevention in the armed services, no program proved to be 100% effective and so identification of those who, in spite of all, elected to abuse drugs became a situation of concern. It was readily apparent that if subsequent treatment and rehabilitation were to prove effective and timely enough to allow return of the detected drug user to full duty, identification of the drug abuser would have to be accomplished while he was still an experimenter or occasional user and before he became firmly addicted. How this identification problem was attacked is described below, as are the various means by which identification is accomplished, the associated problems, and their solutions.

Preliminary Screening

Clearly, if drug abusers are detected at the time they appear for induction or enlistment and are refused entry into the armed services, the drug abuse problem within the services will be abated to that extent. Therefore, procedures were established at the Armed Forces Examining and Entrance Stations to identify drug dependent individuals by evaluating the results of the initial physical examination (which does not include urine testing for drugs) and through psychiatric consultations. Detection of drug abusing prospective recruits was stressed, and those measures which are used to identify them were given special attention, such as needle marks, thrombosed veins, or bizarre behavior. When drug use is detected the physician discusses the report of medical history with the processee to determine the history of drug use and its extent. If applicable, the processee is requested to provide additional documentation from medical sources to assist in an accurate diagnosis of his drug situation. Finally, the medical evaluation is used to make a judgment of whether or not to accept the individual for duty in the Military Establishment.

Upon leaving the AFEES, the new recruit proceeds to his initial duty station for his introductory or basic military training. Within 48 hours of his arrival at that station, he is subjected to a urinalysis test for drug abuse. Those found with a positive urinalysis are considered for separation on a case by case basis.

With the physical examination at the AFEES and the more detailed examination at the initial receiving station, a number of those individuals who abused drugs in civilian life are identified and refused entry into the armed services. This has two salutary effects: first, drug abusers who would almost certainly emerge as problems to themselves and their service

are denied entrance into a service; and second, a drug-contaminating influence on the susceptible younger population of the service is kept from that population.

Diagnosis of drug dependency when entering a service was and is particularly difficult because of the lack of complete and reliable medical information. It was found necessary to effect extensive coordination between the medical and moral waiver sections of the AFEES to insure that all available corroborative information was screened to assist in the identification of drug dependent individuals. It was also found necessary to promulgate extensive guidelines for the examining medical officers at the AFEES and to stress to recruiters the necessity for identifying the drug dependent applicant.

Urinalysis

The most effective means devised to date for detecting users of opiates, amphetamines, and barbiturates are three urinalysis tests: the Free Radical Assay Technique, the Thin Layer Chromatography system, and the Gas Liquid Chomotography system. Unfortunately, no such operational systems exist at present for the detection of users of hallucinogenic agents and cannibis sativa derivatives. Because of their demonstrated potential, these systems were selected for world-wide use in the Department of Defense campaign against drug abuse in the military services. However, many problems arose with their use, and the solutions thereto constitute a compendium of experience which should be noted and weighed by any agency contemplating or engaged in a similar program. One problem, that of quality control of the urinalysis testing effort, is so complex and so important that it is treated separately in a later portion of this report.

The urinalysis testing program provides several advantages which were not initially recognized and which can accrue to any agency involved in a similar program. First, a reliable indicator of the overall magnitude of the drug abuse problem is generated. Second, urine testing permits the early identification of drug abusers prior to the point at which physiological and psychological dependence occurs. This in turn increases the chances of success in treatment. Third, testing and identifying drug abusers permit the removal of sources of infection in units and prevents reinfection by identifying drug abusing replacements before they reach their units of assignment. Finally, random urinalysis testing on an unannounced basis serves as a deterrent to would-be drug abusers.

One of the early issues which arose when the urinalysis program was initiated in mid-1971 centered around the legality of requiring a serviceman to submit to a urine sample for test. This situation was resolved by referrence to a Court of Military Appeals ruling that it was permissable in the armed services to require an individual to submit a sample of his body fluids for health examination.

In general, urinalysis screening is done for two purposes: identification of drug abusers and laboratory support in treatment and rehabilitation programs. With regard to the latter use, it has been learned that the urinalysis test is a meaningful measure of an individual's progress in

rehabilitation as long as all the cautions which pertain to a successful urinalysis program are followed. It has also been learned that it is imperative that the rehabilitation facility staff be tested as well as the patients; such testing serves as a deterrent to drug use by the staff and permits early detection of those who are inclined or encouraged to experiment.

Experience has shown that the time and frequency of testing play a significant part in the success of the screening program. The most sensitive time requirement, of course, is the random screen, tests conducted so that the target unit or individuals have no advance warning. The random screen not only identifies those who have ingested drugs in the preceding two or three days, but it also acts as a deterrent for the experimenter or one who can not otherwise withstand peer pressure. Certain precautions must be taken, however. In order to be truly random and to be effective, the test must be administered with absolutely no prior indications to the population being tested. In the past, the randomness has sometimes been destroyed by events such as open stockpiling of urine test materials; by tests being announced in advance at large formations; and by some personnel - those living off-post for example - being excused. The selection of those to be tested must be made by a bona fide random process; each individual must understand that he may be subjected to a urinalysis test at any time - with absolutely no hint of an advance warning. Only then will a random program work as it should.

Another category of the urinalysis program is event testing, i.e., tests given at particular times during a serviceman's tour of duty. It was found useful to screen those returning to the United States from Vietnam. Normally, the experimenter would refrain from drug use in order to pass this screen but the drug dependent individual should have been detected at this time and referred for treatment. Other event tests have been used to good advantage: the urinalysis test administered upon entry into a service bars many drug abusers from entry; tests administered to men ordered overseas identifies many drug dependent servicemen who are seeking transfer to areas of high drug availability; and tests administered at reenlistment single out those who wish to remain in a situation where drugs are available and affordable.

The differing ease and price with which drugs are obtained in various parts of the world influenced the DoD to divide the world areas into high risk, moderate risk, and minimum risk areas, and to vary the frequency of random urinalysis testing according to the risk area in which a serviceman is serving. In the high risk areas (Vietnam, Thailand, Philippines, Okinawa and Taiwan) the average test frequency was set as 3.0 per person per year. In the moderate risk areas (Korea, Panama, Europe, the Middle East, and the West and Northeast coasts of the United States) the average frequency is 1.6 tests per person per year, and in the minimum risk areas (all other geographic areas) the test frequency is 1.2 tests per person per year.

It was decided at the beginning of the urinalysis test program that the level of detection of ten micrograms of morphine per milliliter which was required of civilian laboratories was not sensitive enough for the

military program. Therefore, the laboratories doing drug urinalysis for the services were required to operate at sensitivity levels 1/20th of that of the civilian laboratories. The reasoning behind this decision stems from the fact that in civilian life one deals with addicts who have seldom gone more than a few hours, or at most a day, since their last drug use. In the military experience it was found that the greatest percentage of users were experimenters and casual beginners. It was highly desirable that the military be able to detect this type of person, one who had used a relatively small quantity of drugs two or three days before. If this non-addict can be detected before he is hopelessly dependent, he is a less difficult treatment and rehabilitation problem.

A very real problem with the urinalysis program is that an individual might be falsely accused of being a drug abuser due to laboratory error. This, of course, could have serious consequences for him, both in and out of the service. Therefore, a confirmatory procedure was prescribed which reduces the possibility of an unjust drug abuse accusation to near zero. When the urine sample arrives in the laboratory it is subjected to the FRAT (for opiate detection) and TLC (for other drug detection) tests. If both produce negative results, the testing of the urine sample is concluded. If either test is positive, the urine is subjected to a confirmatory test with the GLC system. If the GLC test is negative, the urine sample is judged to be drug free; if positive, action is undertaken to determine whether or not the donor is a confirmed drug abuser.

Originally, if an individual had a laboratory confirmed positive urine specimen, that fact was reported to his unit commander, whereupon medical personnel began a period of observation and clinical evaluation to confirm the individual's drug use. Only at the conclusion of that medical evaluation could the suspected drug abuser be clinically confirmed as a bona fide drug abuser. He was reported as such and detoxification and treatment began.

The military drug abuser was seldom completely drug dependent. Consequently, he exhibited few of the symptoms that mark the civilian addict. This lesser dependency on the part of the serviceman created diagnosis problems for the military physicians because they seldom had the necessary training to diagnose a drug abuser of the type found in the service. As a result, many drug abusers with laboratory confirmed positive urinalysis were not clinically confirmed as drug abusers because the examining physician was either hesitant or unable to make the diagnosis.

Two approaches were taken to rectify this situation. First, efforts were made to include more training in drug diagnosis and drug-related problems in service medical schools; second, the confirmation decision-making procedure was broadened to include a social evaluation and a commander's decision. When a urine specimen is laboratory confirmed as positive, the individual is referred to a physician for an interview and physical examination. In the course of the examination the medical officer takes one of the following actions:

- If he determines that the use of the drug identified in the service member's urine was authorized, he may dismiss the member from any further evaluation.

- If medical treatment is required for drug dependency or abuse or drug related illness, he immediately enters the service member into detoxification or treatment.

- If he confirms drug abuse, but the service member does not require medical treatment, the service member is referred for social evaluation.

- If he is unable to medically confirm drug abuse or verify the authorized use of the identified drug(s), the service member is referred for social evaluation.

A person experienced in the evaluation of drug abuse (social action officer, psychologist, sociologist, rehabilitation counselor, etc.) is designated by the commanding officer to conduct a social investigation of those members referred to him by the medical officer. The social evaluator prepares a recommendation for use in the final determination utilizing all available information such as command or supervisory comments related to performance of duty and conduct; the service member's personnel record; and any other demographic or investigative data available.

The physician and the social evaluator then confer regarding their separate findings and prepare recommendations for a future course of action for the use of the commander in making his final determination. In the event clinical evidence of drug abuse has been found by the medical officer, the joint consultation results in a recommendation for a specific course of treatment and rehabilitation for the service member.

Based upon the medical officer's report of clinical evaluation or the joint consultation, the commander makes one of the following determinations:

- The service member who has been medically diagnosed as a drug abuser or drug dependent is entered into the appropriate course of treatment and rehabilitation following the advice of the evaluators and in accordance with Military Department directives.

- The service member who has a positive urine test but who cannot be medically confirmed as a drug abuser/drug dependent and has not provided satisfactory evidence of authorized drug useage is placed in a urine surveillance program.

- If additional evidence, either medical or social, is completely lacking to support confirmation of drug abuse, the commander may assume an administrative error was made in the testing process and release the service member from any further consideration.

The serviceman who denies the abuse of drugs despite a positive test result and the absence of a convincing explanation is placed in a urine surveillance program wherein he submits three urine samples a week for eight weeks for examination. If a subsequent urine speciman is reported positive, the serviceman is reevaluated. If all surveillance tests are negative, the man is released from the program.

Figure 1 is a graphic presentation of the evaluation procedures. The use of the exact procedure to be followed may vary somewhat between the military services and commands due to the availability of qualified and experienced personnel, but the principles of the evaluation process apply throughout.

Another problem associated with the urinalysis program is that of the individuals who simply fail to appear for a urinalysis when notified to do so. Obviously, these men are highly suspect as drug abusers. The solution to this problem lies squarely in the commander's realm. As soon as senior commanders learn of a unit with this problem, corrective action is demanded and the so-called "no-show" rate drops dramatically.

The drug testing laboratories were originally established to aid in the DoD drug abuser identification program wherein any individual identified solely by involuntary urinalysis was automatically sheltered under the exemption policies of the services. However, on some occasions the capabilities of the laboratories were utilized for forensic purposes, that is, for law enforcement or disciplinary purposes. It soon became apparent that the credibility of the health aspects of the testing program would suffer from too close an association between laboratory analysis of samples generated by the drug abuse testing program, and the testing of samples for law enforcement purposes, i.e., for disciplinary action under the Uniform Code of Military Justice or for the purpose of supporting board action that could result in an administrative discharge under other than honorable conditions. Accordingly, urine specimens in the forensic category are not accepted for testing in the DoD urinalysis testing system. Other laboratories, apart from the DoD drug testing laboratories, are assigned the forensic testing responsibilities.

The problems noted above and their solutions deal mainly with policy and administration of the urinalysis program. Another area with many problems to tax the ingenuity of the program administrators is that of the actual collection of the urine samples and the physical handling of them after collection. Also included in this category are the series of problems encountered in the installation and use of the urinalysis laboratory equipment.

The Armed Forces Vietnam experience is rich in problems unique to the laboratory and to the collection and handling of urine samples. These problems and their solutions provide a myriad of lessons learned. Consequently, the majority of the remaining discussions in this Urinalysis portion of Section 3 relates directly to the problems encountered by the military services in Vietnam.

The first problem encountered in establishing the first urinalysis program in Vietnam was that no precedent existed - there was no text to follow, no experience to fall back on. Thus, each situation had to be forecast as well as possible and a solution prepared. Unforeseen problems had to be solved as they arose. The solution in this situation was to assign experienced, professional individuals who had the capabilities of foresight, ingenuity, initiative, and the energy and will to do the job quickly and correctly.

EVALUATION PROCEDURES

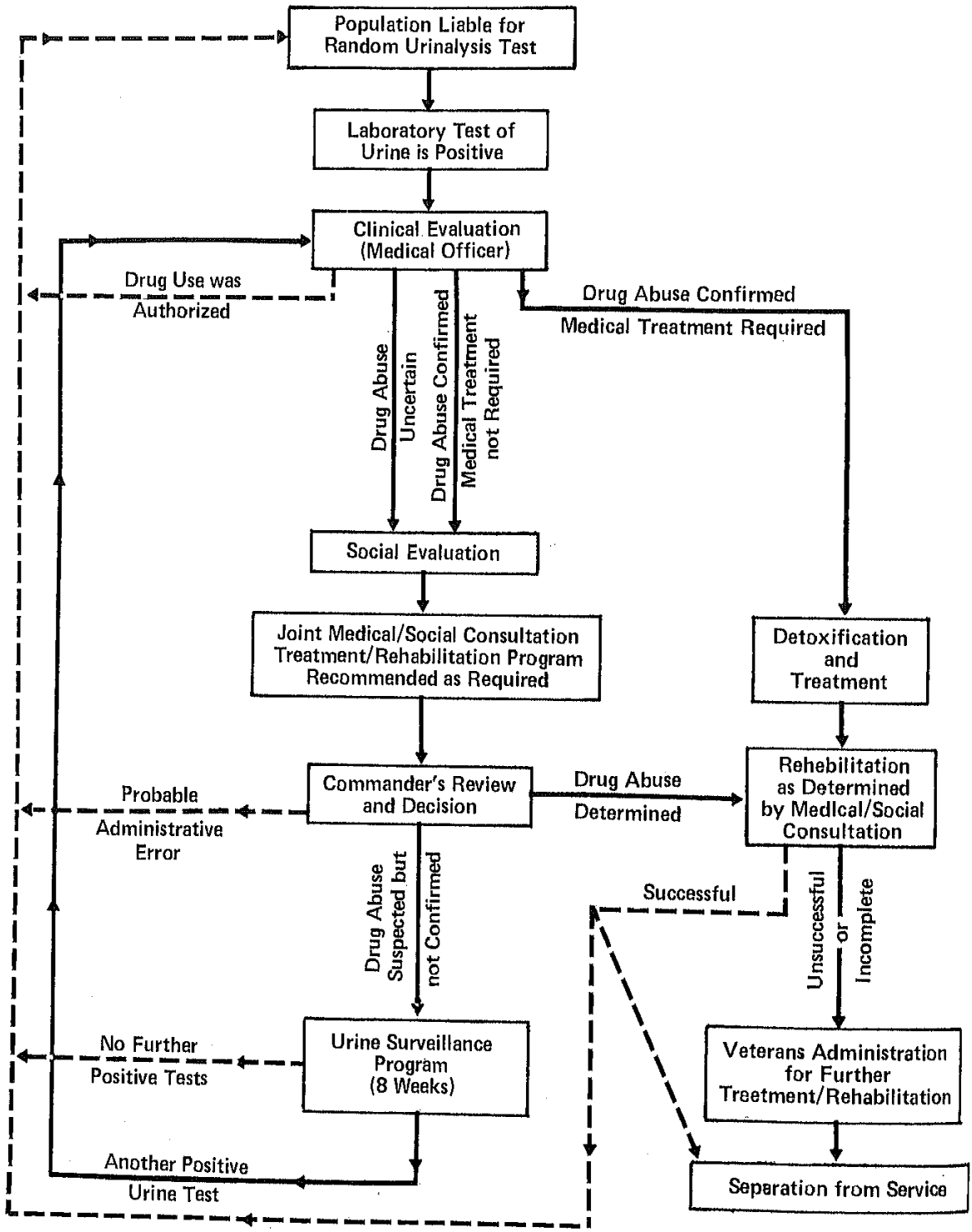

Figure 1

Other problems arose in learning the sensitivities of the new urinalysis equipment. For example, the Chloroquine tablets which are taken once a week in Vietnam as a malaria suppressant caused positive readings on the TLC equipment similar to those of morphine. Using laboratory personnel who were known not to be using drugs as a sample population, a urinalysis experiment was conducted to determine the proper negative level of the equipment so as to be able to differentiate between Choloroquine and morphine.

Another problem was that of obtaining a valid urine sample from the donor. Where the donor had no drug involvement, there was no problem. However, a confirmed drug abuser is wary and may employ deceptive means to escape detection in the urinalysis screen. Bribing medical corpsmen was a means used to avoid detection; the solution demanded honesty on the part of the corpsmen and close supervision by their supervisors. Next, the supervisors learned that it was essential to observe the donor directly when he was giving his sample; otherwise, he might substitute a drug-free urine - which he could buy - for his own. Urine containers were found secreted on the persons of the donors so that a physical search was required before the urine sample was taken. Donors added water to their urine sample thus diluting it to the point where the laboratory equipment could not detect a positive. Thereafter, all water was removed from the specimen collection area. Men would drink enough fluids before the test to produce a diluted sample; this ploy was successfully countered by measuring and requiring a urine specific gravity of 1.010 or greater. If the specific gravity is too low, the donor is required to submit another sample.

Some learned that drinking fruit juices before the test reduced oxidation in the system and caused inaccurate FRAT readings. The medical technicians met this challenge by adding dichromate which oxidizes the reducing fruit juices.

Vinegar was tried. If there is a wait between the time the dichromate is added and the time the FRAT test is performed, the vinegar overwhelms the dichromate oxidizer and the FRAT morphine signal disappears. This situation is readily apparent to the medical technician. He has only to prepare another sample of the same urine for test and to place it in the FRAT machine immediately. The vinegar does not have time to react with the dichromate and the true FRAT signal is obtained.

Collecting urine samples from women proved a problem because the women objected strenuously to the direct observation provisions of the early testing directives. This requirement was later eased to permit alternate procedures for collection of urine samples from women as long as the procedures insured that the speciman obtained was a valid sample.

After collection of the urine samples, the next problem of magnitude which arose in Vietnam was the physical handling and securing of the samples and the related records. Great care had to be taken to properly identify each sample and to physically secure it throughout its entire travel from the sample collection point through the testing laboratory. Experience proved that the devious drug abuser will employ all possible means to destroy or exchange his sample. The same care had to be taken with the urinalysis records; they too were physically secured so that they could not be altered by unscrupulous individuals.

Within the laboratory, the supervisory personnel learned that they must, in addition to securing all samples and records, insure that all collected samples are tested. Not to do so destroys any randomness of the collection scheme. They learned that all laboratory work must be done promptly; backup equipment should be on hand to prevent backlogs in the event the primary equipment is inoperative due to malfunction or maintenance. To keep equipment downtime at a minimum in Vietnam required a controlled laboratory environment. The excessive heat and humidity caused equipment breakdowns and necessitated an air-conditioned, controlled humidity laboratory facility. Finally, reports must be dispatched promptly from the laboratory after the urinalyses are completed. In summary, all laboratory operations must be conducted in an efficient, organized, timely manner. If they are not, the laboratory credibility will be reduced, which in turn destroys the credibility of the urinalysis program, not only in the eyes of the men being tested but also in the eyes of the professional staff administering the program.

It was learned that the maximum possible communication between the laboratory and physicians handling actual or suspected drug abusing individuals is desirable. Where this has been done, it has improved the physician's understanding of the capabilities and limitations of the laboratory procedures and has reduced his suspicion of laboratory error when he receives unexpected positive or negative results. Among physicians and others assisting in the treatment and rehabilitation of drug abusers maximum publicity must be given to the existence of a centralized quality control program, explaining how this, and other special measures such as use of special supervisory personnel in laboratories, assist in maintaining laboratory performance at the highest level of proficiency. Communication with the physician benefits the laboratory in another way, by alerting the laboratory to hitherto unrecognized technical problems such as commonly prescribed drugs mimicking closely the characteristics of drugs of abuse in detection procedures. Examples are Darvon confused with methadone and Valium confused with opiates.

After the urine testing program was under way, subsidiary areas of interest and bits of knowledge came to light. For example, it became obvious that the dispensing of drugs for legal use required a close scrutiny. With the multitude of common ailments in Vietnam many drugs were dispensed on a routine basis without a doctor's prescription. Paregoric is such a drug, dispensed in many instances by medical aid men for common diarrhea. Of course, paregoric is tincture of opium which produces a positive urinalysis reading. Consequently, in order to reduce the number of positive urinalysis reactions which detected legally used drugs, a program was initiated to identify the drugs which caused positive readings and the drugs which could be substituted for them. After this was done, the effort turned to convincing the medical community to dispense the substitutes for the positive producing drugs.

Another aspect of the urinalysis program which proved to be contributory to the success of the program was the fact that detection of the drug abuser did not lead to punitive measures. That is, if detected through urinalysis the drug abuser could expect nothing worse at the moment than detoxification followed by treatment and rehabilitation; he knew he would

not be turned over to the police authorities. This manner of handling the situation is credited with averting many problems.

Another move to eliminate a source of trouble before it began was the separation of those maximally involved with drugs from those who were experimenters or beginners. It was felt that the latter group had a much better chance for rehabilitation if they were divorced from the debilitating influence of the hard-core addict.

The implementation of the urinalysis program for drug abuse detection throughout the DoD served to isolate two principles of management, which although known for years, have now been thoroughly highlighted again. The first of these is the need for unwavering command support for the program. Where the commander provided his wholehearted backing, the program succeeded and the drug abuse situation subsided. Where command support was lacking, resolution of the drug problem required more work. Similarly, the layer of middle managers was surfaced as extremely important in the detection of drug abusers by urinalysis detection. There are innumerable opportunities for the urinalysis scheme to be rendered invalid in the steps from specimen collection to clinical confirmation, reporting and treatment. Honest, professionally qualified technicians and supervisors are an absolute necessity if the program is to succeed. This was visibly demonstrated in Vietnam where heroin was the primary drug of abuse, and was liable for detection by urinalysis screening. Some of the means by which drug abusers sought to escape the screen have been described above. In situations of this nature, and situations like these must be expected where drug abusers are involved, a quality layer of well-trained, motivated middle management is one of the essentials to success.

In addition to the obvious lessons which can be derived from the episodes described above, the DoD experience in establishing a urinalysis program in Vietnam produced several other recommendations which should be considered by any agency embarking on a similar program. First of these is the recommendation that a movable urinalysis laboratory be established, manned and equipped at the national level. Such a laboratory would be ready to move to any site in the country where an onset of drug abuse similar to that which occurred in Vietnam might break out. An advantage of such a laboratory is that it provides a quick detection capability which has been proved invaluable in combatting drug abuse. Another advantage is the deterrent effect. It has been found that the threat of a urinalysis screening with the attendant high probability of detection is a high order deterrent.

Another recommendation centers around the need for continued research to expand, improve and refine the drug abuse detection technology. A means of positive detection for hallucinogenic agents and marijuana is urgently required. As this research progresses toward the final goal of 100% detection of all drug abuse, it should be accompanied by credible factual publicity. Reliable laboratory results coupled with widespread, understandable knowledge of the accuracy of this drug detection capability will add another measure of worth to the deterrent effect of the detection process.

Finally, there is a need seen for tighter control in the production of commercially produced drugs. This recommendation is best illustrated by the following example: an individual's urinalysis indicated a barbiturate had been ingested. Through investigation it was found that the only medication taken by that individual was a vitamin. Analysis of the vitamin tablets revealed traces of a barbiturate leading to the speculation that the barbiturate trace came from using the same pill press for both the vitamins and the barbiturates. The barbiturate found was not sufficient to cause a problem to the person, but the detection of the barbiturate in his urine could possibly lead to problems with his present and future employers.

Quality Control of Laboratory Urinalysis

Many times when a new program is instituted the personnel who work with it do not understand it in all its aspects and therefore tend to disregard or discredit it. The urinalysis program was no exception. One of the means used to increase the credibility of the urinalysis program was the establishment of a visible, believable quality control program for the urinalysis laboratories.

The need for quality control is underlined by the fact that laboratories experienced in support of methadone maintenance programs are not necessarily proficient in detection of new drug users. Methadone maintenance programs yield large numbers of positive urines containing high concentrations of methadone which are easily detected. In this population a negative urine is unexpected, and, if found, can be checked easily because the individual usually can be contacted quickly for another urine specimen. In the DoD program the great majority of urines are genuinely negative for drugs and positives, when found, usually contain very low concentrations of drugs. Considerable effort is required to reorient a laboratory from the relaxed atmosphere which surrounds largely positive urine identification to the tense atmosphere which should underlie the search for infrequent, low concentration positives in a sea of negatives.

Quality control of the urinalysis laboratories output was recognized from the outset as a prerequisite to a successful urinalysis program. During the first three weeks of testing in Vietnam quality control testing was exercised by the periodic insertion into each laboratory of urine samples containing known added amounts of morphine. The FRAT was used for screening, with TLC and ultraviolet spectroscopy used for confirmation. Later, when two screening laboratories arrived from the United States, GLC was used for confirmation and the quality control procedures were expended to include the following:

- Daily standards were applied to FRAT, TLC and GLC procedures for all detectable categories of drugs.

- Pooled morphine samples were inserted in the system by the laboratory officer in charge or noncommissioned officer in charge. These were coded by number to appear exactly as a urine sample would when it arrived at the laboratory. At least one such sample was inserted during each operating shift.

- Amphetamine and barbiturate specimens were prepared by spiking a drug-free urine with known quantities of the compound.

- In order to evaluate performance among laboratories, at least 50 samples were shipped from laboratory to laboratory biweekly for examination by all technology. Results of this interlaboratory comparison were evaluated by the drug laboratory consultant and a summary of the performance reported to Headquarters, United States Army, Vietnam.

Quality control of the contract laboratories in the United States was initially done by the area medical laboratories of the area in which the contract laboratory was located. In the next step, a Tri-Departmental Subcommittee on Laboratory Methodology (a subcommittee of the DoD Tri-Departmental Coordinating Committee) was formed and chartered to accomplish the following tasks:

- Examine all current drug detecting methodologies and establish standards.

- Establish quality control procedures and practices, and prepare and implement a worldwide quality control plan.

- Establish drug detection sensitivity levels for all classes of compounds of interest.

- Prevent unnecessary duplication of effort.

The Armed Forces Institute of Pathology was designated as the DoD quality control laboratory and resources were allocated to it. The remarks that follow pertain to the knowledge gained by the AFIP in instituting the worldwide quality control program and operating it at an acceptable level; however, before proceeding further, it is best to describe briefly the current quality control procedures.

As the first step, the quality control laboratory prepares stocks of urine containing varying quantities of the drugs of interest according to prescribed formulas. From these stocks, sample sets are made up for each laboratory in the program. Further, one set of samples is chosen at random for analysis by the quality control laboratory and a set is put aside in storage for reference and backup purposes. The analysis or standard set is analyzed by the quality control laboratory. The sample sets being dispatched are coded so that the quality control laboratory knows the quantity and type of drug present in each sample. The sample sets are then dispatched to collecting stations, points at which bona fide urine specimens are collected and sent to the participating laboratories. At the collecting station, the quality control samples are repackaged and recorded so that they are indistinguishable from the bona fide samples emanating from that station and they are then forwarded with other samples to the drug testing laboratory. At the laboratories the samples are analyzed and the results reported to the collecting station. There the quality control sample reports are extracted and forwarded to the quality control laboratory, and weekly and quarterly reports are then prepared of the results obtained from each participating laboratory. These results are furnished to the participating laboratories and to the

military service laboratory control officers for whatever corrective action may be required.

Initiation and operation of the quality control program has been of inestimable value in demonstrating once more the absolute need for quality management. This need first became apparent during the establishment of the program when space, equipment and personnel had to be located and worked into an efficient team in a minimum of time. Professional, dedicated middle management personnel at the collecting stations also proved to be a necessity. The lack of such dedicated personnel caused many growing pains in the program. Many operations are performed at the collecting stations: urine samples must be repackaged, they must be coded, the code numbers must be recorded, the laboratory reports of urinalysis must be scrutinized for the quality control specimens, and the report to the quality control laboratory must be prepared. All of these operations are hand operations, tedious and tending toward routine and boredom, but all must be done without error for program success.

The report form and a set of instructions are included with each shipment of urine samples to the collecting station; they are simple and easy to follow but oftentimes the work is not done properly which makes it difficult to correlate the reported results with the sample and other requested information. Without the proper care at the collecting station an unfair error rate may be attributed to a laboratory. The situation demands managers who can set up a routine at the collecting station complete with the requisite checks, and then exercise the necessary degree of supervision to make the system work without error.

Another location which requires first class management is the participating urinalysis laboratory. In those laboratories where the management has been forceful, knowledgeable, enterprising, interested in producing a good job and willing to spend the time to insure a good output the quality has been high and vice versa.

In the physical arrangement of the quality control laboratory it was found essential to house the facility in its own work area, to physically separate the people, laboratory equipment and operations from other elements in the same location, and then to physically secure the laboratory area from outside intrusion. A walk-in, refrigerated cold room for sample and chemical storage is also necessary. Supplies proved they could become a unique problem, e.g., large quantities of drug-free urine are required. A suitable container for shipping urine samples is required, one that does not leak, spill or react with reagents -- the AFIP settled on a glass bottle with a crimped top.

Handling of data became a major pursuit in the program. Many different data items are involved such as schedules for dispatch of sample sets, concentration levels of drugs in samples, randomization of samples in a set, code numbers for bottles, labels for bottles -- all of these come up for preparation each week for each participating laboratory. With the tremendous amount of data handling it was decided that the situation was best handled by digital computer. A program was prepared and the required data inserted so that when the time comes to begin the cycle of dispatching a

sample set to the field, one input card identifying the laboratory to be tested and its work load is inserted into the computer. The machine then prints out the samples required and the concentrations of drugs to be used; it performs the required randomization and preprints the labels.

Handling of incoming reports of quality control results was also found best handled by the use of automatic data processing procedures. The results returned by the participating laboratories are placed in a computer system, and weekly action and quarterly summary reports are generated for distribution to the laboratories and the service program directors.

A feature which enhances the fairness and reliability of the quality control system is the so-called "double blind" system. This system was briefly described above; it is the process whereby the sample sets are sent from the quality control laboratory to the collecting station. The collecting station knows the samples are quality control samples but does not know what drugs and what concentrations are used. This is the first step in establishing the anonymity of the sample set. At the collection station the samples are repackaged and recoded to appear as normal bona fide specimens and are then sent on to the analyzing laboratory. That laboratory cannot identify the quality control samples among the bona fide specimens. This is the second step in the anonymity establishment procedure which completes the double blind method of providing sample sets to the laboratory.

A final 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 tested laboratories and the service representatives; changes and improvements must come from them. Serving as an impartial referee without any stake in the outcome removes the stigma of possible bias from the quality control laboratory and its director.

Exemption Policy

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. In October 1970, the DoD authorized the Military Departments to establish amnesty programs on a trial basis. Under these programs individuals were told that if they had a drug problem and sincerely wanted help with it, medical assistance would be made available to them, action under the Uniform Code of Military Justice may be suspended for the unauthorized use of drugs and a discharge under honorable conditions may be considered. As the extent of the drug problem in the armed services became more and more apparent, the DoD policy was changed from that of a trial basis to implementation service-wide. In so doing, the word "amnesty" was supplanted by the word "exemption" since use of the word "amnesty" connoted total exoneration which was not the intent. Under the exemption policy, evidence of drug usage or possession 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 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 violations of other applicable laws and regulations. These include those laws and regulations relating to the sale of drugs or the possession of significant quantities of drugs for sale to others. However, the information gained through use of the exemption policy may, if deemed advisable, be used in other administrative actions such as removal from flying status, reassignment, denial of security access, and administrative discharge under honorable conditions.

A problem with the exemption policy was that of credibility. Initially, the policy with all of its ramifications was not understood in detail by the officers, noncommissioned officers and the target group of drug abusers. Lacking knowledge, the credibility gap was large. Some exemption participants were undoubtedly subjected to harrassment. Some felt that there were no incentives or rewards to apply under the exemption policy and no true guarantee; others had pressures applied by drug users and distributors not to apply; and still others felt there was nothing physically or morally wrong in using drugs. The task then became one of defining the legalities of the exemption policy, translating them into operational criteria and then mounting a program of education and publicity first of all to inform all concerned of the exemption policy details and then to convince the drug abuser that it was to his benefit to volunteer for treatment. To succeed in the latter the drug abuser must believe that the exemption policy benefits are greater and its liabilities less than continued drug abuse. Further discussion of the education problems, procedures and techniques is contained in Section 2, Drug Education and Prevention.

The solution to the credibility situation was found in the personal or human approach. Drug abusers need counseling to convince them that the "establishment" is sincere in its efforts to help them, that they are worth helping, and that they have something to contribute to their unit and to society. Moreover, they have to be convinced that they can enter treatment under the exemption policy through officials other than their commander -- a physician or chaplain, for example; the point to be made was that the official acted as a liaison element to get the drug abuser into treatment and not as an exemption approving authority.

Posters, radio and television announcements, lectures, and conferences can explain the points of the exemption policy to the target audience, but, for real effectiveness, it is necessary to employ a personal, man-to-man approach. Further, there must be close coordination and cooperation among the leaders, counselors, medical personnel, criminal investigative personnel, and chaplains so that they all present the same exemption policy and establish it as a credible program.

At first it was thought that anyone entering treatment under the exemption policy was probably sincere in wishing rehabilitation. As experience was accumulated it was learned that many who availed themselves of the exemption policy volunteered rather than take the risk of being detected

and were merely biding their time with no serious intent of committing themselves to rehabilitation. That some of those volunteering under the exemption policy are devious manipulators is borne out by a recent study of drug abusers in Vietnam where the men in the exemption group were found to have higher incidence rates of school suspensions for drug abuse and courts-martial than those drug abusers who were detected by other means. The insincere individuals applying under the exemption policy dwindle in number as tougher and more exacting surveillance procedures are used in treatment and rehabilitation.

Apart from the credibility problem was one of the lack of real concern for the drug problem by many officers and noncommissioned officers. They often felt that a problem of any magnitude did not exist and so they did not direct their best efforts toward it. In such an atmosphere the chances of success of the exemption policy can only suffer. The solution to an apathy situation of this type is education to present the drug problem and the exemption policy in their true light and imposition of command emphasis from more senior leaders so as to focus the attention of the junior supervisors on the problem and the part they are expected to play in its solution.

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 use were to be reviewed for recharacterization upon the application of the affected individual. If his discharge is recharacterized the individual becomes eligible for VA aid. 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.

Other Means of Identifying Drug Abusers

The urinalysis screen and the exemption policy are the primary means whereby drug abusers in the military services are identified. However, there are other ways. One of these is through the medium of criminal investigation. Many drug abusers are identified in the course of the investigations conducted by the military investigative agencies.

Another method uses dogs trained to detect cannibis sativa derivatives. A pilot program was initiated in the Army in 1969 and proved successful. Since then dog teams have been employed by the Air Force and Marine Corps, and the Navy is in the process of implementing a dog program. The use of dogs not only serves to locate marijuana and hashish but also serves as a deterrent. The sight of the dog and handler often is sufficient to cause users to dispose of their drug stocks, and, as was pointed out by one former division commander, the dog need not always be trained to detect cannibis to function in the deterrent role -- the drug abuser cannot tell the difference between a trained and an untrained dog, and he cannot afford to take a chance on making a mistake.

There are problems, however, with cannibis detecting dogs and their use which should be considered before embarking on a detector dog program.

Dog handler training involves the matching of a dog and a man, who will thereafter work as an inseparable team. A well-conceived plan for dog use should exist. A dog which after training is not worked or is overworked because of inadequate planning will soon lose his effectiveness.

Adequate kenneling is necessary for success of a detector dog program. Without proper kennels a dog's desire to work will diminish. Experience has shown that dogs maintained in kennels away from the handler's quarters have a better attitude toward work each day. Proper kenneling security is also necessary to protect dogs from injury or mishandling by drug traffickers or others.

A very critical element in a detector dog program is the follow-up proficiency training. No matter how thorough the initial training, a dog will become unreliable if the handler is not faithful to proficiency training requirements. This must take place every day to assure that the dog continues to associate with the odor of the drug and not begin looking for something else, such as the odor of plastic wrapping material. If this problem is not dealt with adequately, the dog's initial level of proficiency may never be regained.

Although the urinalysis program has proved effective in identifying the abusers of opiates, amphetamines and barbiturates, and dogs have had some success in detecting cannibis derivatives, research must continue to find methods whereby the abusers of other drugs can be identified. When these methods are established the DoD will be in a position to take another significant step toward eradicating the drug problem in the Armed Forces.

SECTION 4

Treatment and Rehabilitation

General

Implementation of the DoD control programs regarding drug abuse was accelerated following the President's mid-1971 announcement of a national drug abuse counteroffensive. Prior to the President's announcement, the policy was largely oriented toward law enforcement. Then, in his memorandum to the Secretary of Defense of 11 June 1971, the President emphasized his desire that the military services not discharge addicted servicemen into society without treatment and efforts at rehabilitation. Thereafter, the DoD policy turned toward rehabilitation.

The DoD 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 for the Department of Defense to assume responsibility for long-term, in-service rehabilitation of servicemen whose potential for continued useful service is doubtful. 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 service. Others are phased into Vetersns 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 thirty days of treatment. In implementing this program, it was learned that several factors interrelated and so amplifying instructions were issued.

First, it was stated by the Aasistant Secretary of Defense for Health and Environment that the drug dependent service member would go into either a military service treatment program or a VA facility via the Armed Services Medical Regulating Office. Further, he would not be separated from his service until he had completed a minimum of thirty days of treatment for his condition subject to the following:

- The thirty-dsy period may start with detoxification but the services have the prerogative to select the treatment starting date.

- The objective of the thirty-day period is to attain thirty days of treatment free of drug use by the individual prior to his release to civilian life to asaure that the services are not releasing drug dependent personnel into society without a aignificant effort to eliminate the drug dependency.

- A aerviceman may remain beyond his normal term of service in order to complete thirty days of treatment if he voluntarily extends his active

service or if he is required to make up time lost under applicable service regulations. In the event that neither of these conditions apply, he is released to meet his original expiration of term of service date.

- The VA is responsible for the completion of the thirty 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 whether a drug dependent serviceman is assigned to a VA facility or to a military facility for treatment depends upon the circumstances in each case. Following are the general policies for assignment:

- The drug dependent serviceman who has sufficient time remaining in the service for short-term rehabilitation is provided treatment in service facilities. During or at completion of the service rehabilitation, an evaluation is made regarding retention in the service and extent of rehabilitation required. If it is determined that long-term rehabilitation is necessary or the serviceman will not be retained in service for a period adequate to complete his short-term rehabilitation, he is processed for administrative discharge and transferred to the VA for treatment with separation effective fifteen days or more subsequent to arrival.

- The drug dependent serviceman who fails to respond to service rehabilitation efforts is processed for administrative discharge and transferred to the VA for treatment with separation effective fifteen days or more subsequent to arrival.

- The drug dependent serviceman who is approaching his expiration of term of service date and has insufficient time for service rehabilitation is processed for discharge and transferred to the VA for treatment with separation effective fifteen days or more subsequent to arrival. This fifteen-day minimum requirement may be waived when it is determined to be in the best interest of the patient and is agreeable with the receiving VA facility.

- Personnel not in any of the three categories above are treated by the services until completion of the minimum thirty days of treatment or expiration of term of service is reached.

- Any serviceman who is transferred to the VA for treatment and after admission becomes recalcitrant to such an extent that his presence is disruptive to the operation of the hospital, and VA personnel determine that he would not be receptive to further treatment, is returned to service control. Military Departments are responsible for the immediate movement of such serviceman from the VA to service facilities.

Existing procedures for providing the separation date and other pertinent data to the VA on ASMRO transfers are carefully observed. In addition, the number of days of completed treatment free of drug use is provided to the VA for each individual at the time of transfer.

A problem which arose with the DoD policy of treatment and rehabilitation dealt with the status of service members while they were assigned to facilities designed to evaluate, treat or rehabilitate drug abusers. At first, individuals who were assigned to such facilities under identical circumstances were being treated differently with respect to the application of 37 U.S.C. §802. Section 802 of Title 37 provides that a member of the Armed Forces who ". . . is absent from his regular duties for a continuous period of more than one day because of disease that is directly caused by and immediately follows his intemporate use of alcoholic liquor or habit-forming drugs is not entitled to pay for the period of that absence. . . ."

Policy requires that individuals identified as drug users either as a result of urine testing or because they admitted their use under the exemption policy be provided appropriate evaluation, treatment, and rehabilitation. In some cases, this policy may require that the individual be absent from his normal duties. Such absence does not necessarily have any relationship to the presence of a disease, the direct cause of any disease that may be present, the length of time subsequent to use of any substance, the habit-forming aspects of any substance used, or the ability of the individual to continue to perform the duties that were assigned to him prior to his identification as a drug user. Because of this policy, the fact that a member is in a drug treatment or rehabilitation facility does not mean that the law requires a forfeiture of his pay.

For the reasons stated above, it was determined that a member of the Armed Forces who is assigned to a drug treatment or rehabilitation facility as a result of the exemption policy or the urine testing program is absent from his assigned duties because of administrative policies and that the forfeiture provisions of 37 U.S.C. §802 do not apply to the period of time he spends in a treatment or rehabilitation program. In other situations, the determination is made on a case-by-case basis.

This interpretation of the time forfeiture provisions of Section 802 was provided to all the Military Departments to standardize the manner of handling "bad time" situations throughout the DoD.

Experience quickly established the fact that treatment and rehabilitation programs are not simply a medical problem. To produce a truly rehabilitated individual requires the efforts of spiritual, community, command, and medical personnel. Further, in some cases it was found that the better treatment was being provided by para-medical or para-professional personnel. Thus, it appears that the success of a treatment or rehabilitation program is less a function of the degree of medical knowledge brought to bear and more a function of the degree of energy and enthusiasm of the treatment personnel coupled with a knowledge and understanding of the drug culture, why people enter it, and why they succumb to its abuses. By attacking the attitude and behavior problems of the drug abuser as well as his medical problems, the success rate of rehabilitation turned upward.

Military Service Programs

The manner in which treatment and rehabilitation programs are operated varies from service to service. Each administers its own programs within the guidelines and policies established by the DoD.

The rehabilitation plans developed by the military services during mid-1971 had a number of points in common as well as one major difference in approach. 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 his involvement and on the basis of that decision an assignment to an appropriate treatment or rehabilitation center was made.

The one major difference in service approach was the degree of centralization of the rehabilitation efforts for those personnel who were found to have a more serious dependency on drugs. The Army chose to rely on a decentralized model for rehabilitation, whereas the other services developed plans on a centralized model.

Regardless of the agreement or differences in the rehabilitation plan and approaches, the problems experienced in developing drug abuse programs were common to all the services. Before proceeding to the problems and their solutions, a brief description of each service program is presented so as to provide a base for the comments to follow.

The Army treatment and rehabilitation program is operated on a decentralized basis at installations throughout the United States and overseas locations. Thirty-three hospitals in the United States have been designated to receive drug abuse patients returning from overseas.

Following the identification of a drug abuser, detoxification, if required, is accomplished in an Army medical treatment facility. The time spent in detoxification varies with the individual, his degree of drug dependency and the drug or combination of drugs involved.

During the process of detoxification and initial treatment, a medical evaluation is made to determine the drug abuser's individual rehabilitation needs. Rehabilitation is accomplished in a unit environment with halfwsy houses and rap centers used for transitional and supportive assistance as required. Rehabilitation is a command responsibility and involves all elements of the community to provide support to the soldier to restore him to effective military duty. For success, the soldier, his commander, and the medical and nonprofessional personnel in the rehabilitation program work together as a team.

Halfway house facilities provide a more structured environment for the individual who does not require inpatient care but who is not ready to assume his full duties. Such facilities provide for a man to live-in either full-time for a short while, or part-time while performing duty in his unit. Although treatment is conducted under medical supervision, the halfwsy program is a command responsibility.

Rap center activities add to the outpatient rehabilitation program. Many soldiers do not need contact with a halfway house and others respond better to s less structured program.

Those drug abusers who cannot be rehabilitated in a reasonable period of time are transferred to VA hospitals as described earlier or are referred to other established civilian programs for long-term care.

The Navy offers basically two levels of rehabilitation for the identified drug abuser. Naval personnel determined to be drug dependent are referred for inpatient treatment at one of the two Naval Drug Rehabilitation Centers at Miramar, California, or Jacksonville, Florida. The Miramar facility utilizes a five-track (multi-modality) approach to rehabilitation. Track determination is based on the demonstrated interest of the patient and the professional staff's evaluation of the level and intensity of treatment required. A detailed discussion of the Navy experience in establishing the NDRC at Miramar with a complete description of the five modalities is found at Appendix B. The Jacksonville facility utilizes a one-track, two-phase program of treatment. Rehabilitation commences with Phase I (group therapy, didactic teaching and behavior modification techniques) and progresses into Phase II (self-governing responsibilities and continued rehabilitation counseling in a halfway house atmosphere).

Those Navy members who evidence other than serious dependency or who are labeled experimenters and are capable of maintaining command directed job responsibilities are rehabilitated locally at one of the many Navy Counseling and Assistance Centers or are counseled within the individual unit. The CAAC provides a resource through which an integrated program of education, prevention and counseling service is made available to local commands in a coordinated effort to combat drug abuse and to return the drug abuser to productive service. Specific services offered include the screening, counseling and evaluation of identified drug abusers, drop-in crisis intervention and referral, exemption representative training, follow-up counseling for personnel returned to duty from an NDRC, and drug information dissemination.

If an identified drug abuser in the Marine Corps is found not to be drug dependent, he is retained in his parent command and undergoes treatment and rehabilitation at the local level. Local rehabilitation programs vary among commands depending on their resources, personnel and operational commitments. While participating in the local program, the serviceman is evaluated as to whether or not he has further service potential warranting retention on active duty.

If the Marine drug abuser is determined to be drug dependent, he is medically evacuated to one of the NDRCs at Miramar or Jacksonville. Upon completion of his treatment, the NDRC makes a recommendation on the service potential of the individual; the Marine Corps then determines whether to retain or separate him.

The Air Force treatment and rehabilitation program is considered to be a centralized system of sequential activities into which each known drug user is introduced. Drug abuse rehabilitation is offered to all servicemen and is limited only by the member's willingness, capacity for rehabilitation, and time remaining in service. The Air Force concept of drug abuse rehabilitation includes five basic phases: Phase I - identification; Phase II - detoxification; Phase III - phychia-evaluation; Phase IV - behavior reorientation; and Phase V - follow-on support.

Phase I identification is accomplished through urinalysis testing, apprehension or investigation, the Limited Privileged Communication Program (exemption policy) and identification incident to normal medical care.

Phase II of the rehabilitation process is physiological detoxification. It involves placing the drug dependent individual in a patient status at the nearest medical facility. The time required for detoxification is dependent on the individual circumstances. Average time at present is five to seven days. During detoxification the decision is made on further treatment or evaluation needed. The most severe cases are referred to the USAF Special Treatment Center, Lackland Air Force Base, Texas. Those that require further evaluation then enter Phase III.

Phase III is psychiatric evaluation. When further psychiatric or neurological evaluation is needed and is not practical at the local installation, individuals are referred to the Special Treatment Center. Initial psychiatric and neurological evaluation, treatment, and disposition requires an average of seven to ten days but may be extended to as many as twenty-one days. The evaluation results determine the next step. If no further medical treatment or behavioral reorientation is needed the individual is returned to normal duty. If appropriate he is entered into the behavioral reorientation phase either at the local installation or the STC. If in-service rehabilitation is precluded he is referred to a VA facility for rehabilitation prior to separation from the service.

Phase IV is the behavioral reorientation process and is a nonmedical approach to rehabilitation. At the Special Treatment Center, the team concept is used. At base level, Phase IV is primarily educational in nature and will usually not require the intensiveness applied at the STC. Upon completion of this phase, the individual may be evaluated and returned to duty, discharged upon completion of service, administratively discharged or transferred to a VA facility or other civilian agency. In all cases successful rehabilitees who are returned to duty are entered into the final follow-on support phase.

Phase V, follow-on support is the process by which rehabilitees return to normal duty. Duration of this phase is one year from date of entry. Its function is to monitor and facilitate the reentry of rehabilitees into normal military life and help them avoid a return to drug use. This phase always takes place at base level under the guidance of the base Social Action Office.

Medical Screening

Drug abusers are identified primarily through urinalysis screening and the exemption policy. Once detected, they enter a drug detoxification or treatment program where they are processed through some form of medical screening. Several problems arose at this stage which required correction and which should be borne in mind by anyone directing a drug abuse program. The more important screening problems are listed below.

- There were failures to diagnose drug abuse for fear of stigmatizing an individual or through lack of professional knowledge -- these situations are discussed more at length in Section 2, Drug Education and Prevention.

- There were failures to clinically evaluate the extent of an individual's use of drugs or his drug dependency; sometimes positive urinalysis results were accepted without further examination.

- There were failures to attempt to determine what drugs were being abused.

- There were failures to diagnose pathology which was directly or indirectly secondary to the drug abuse, e.g., a failure to examine the patient for hepatitis in drug abuse cases.

- There were failures to diagnose drug abuse as a secondary diagnosis to other pathology.

The screening done when a suspected drug abuser enters a medical facility must be thorough, accurate, and not dependent upon the testimony of the individual being examined. The part played by medical personnel in the screening process must be clear; their instructions must be specific and detailed, and all concerned must be adequately trained in the part they play in the screening process. Finally, all must be motivated with the understanding that drug abuse is a serious problem, and it is their responsibility to fight that problem regardless of their personal convictions.

Detoxification and Treatment

Within the military services, several modalities of treatment have been used. One, that of methadone maintenance has been rejected by the DoD as being inappropriate for the type of drug abuser found in the active Military Establishment. Most servicemen who are drug abusers are young and few of them have an extensive history of heroin use. It is the policy of the DoD that these men will be given the opportunity for rehabilitation in a drug free program.

It was learned early in the drug abuse control program that detoxification procedures were not always sufficient because only a limited clinical evaluation was made after a urinalysis test was judged positive. Consequently, the drug or drugs with which involved and the degree of involvement were not completely determined. This led to later problems through use of improper detoxifying agents or improper use of detoxifying agents.

Further, there was a failure sometimes to combine therapeutic treatment with detoxification; the therapeutic treatment was begun after detoxification resulting in loss of time and opportunity. In other instances, patients did not receive treatment for the medical problems they might have because those problems were not detected or diagnosed properly, or standard medical follow-up procedures were not observed. From this it was learned that a complete medical examination is required on all drug abuse patients.

The comments above illustrate the point that although the planning may be sound, the execution in all cases may not be adequate, possibly because it is not completely understood. Sometimes, programs become so enmeshed in day-to-day problems that the prime goals relative to drug abuse are not realized. The solution to the situation centers around the structuring of realizable goals and the definition of the medical responsibility and relationship for the drug treatment program. Following this, guidelines for the medical support of the program have to be established and published. Service medical schools can perform this function admirably. The final steps in the

solution are full and complete command support for the drug program and dynamic execution by the individuals in charge of specific areas. Where dynamism, energy and enthusiasm are lacking, the programs are seldom adequate.

At Appendix C is an account of the problems, with their solutions, arising from the establishment and operation of treatment centers in Vietnam. This account grew out of a DoD workshop held in March 1973 which brought together many of the Army officers and enlisted men who were associated with drug abuse control programs in Vietnam in 1971 and 1972. Their comments and recollections were enriched by the drug experiences of knowledgeable officers from the Navy and Air Force.

Rehabilitation

The rehabilitation of detoxified drug abusers took many forms, proving that there is no single modality route to success. In Vietnam, for example, where different units tried different approaches, the success of the program seemed to depend mainly upon the enthusiastic work of dedicated volunteers, most of whom were nonprofessionals, with the encouragement and support of their commanders. Their programs cannot always be institutionalized. Some mistakes were made, of course, but the experience provided much knowledge of value to any rehabilitation program.

One rehabilitation facility in Vietnam used a number of ex-addicts as counselors, and they were considered to be the key to the program's success. After a number of bad experiences, however, most of them were removed. The ex-addicts tended to be weak and dependent personalities themselves, as evidenced by their having become addicts in the first place. Often they lacked leadership qualities and refused to conform to Army rules. They did not get along with the "straight" counselors and showed little sense of responsibility. They still needed to receive a good deal of support themselves. Some reverted to heroin use. One after doing so recanted all the bad things he had said about heroin with considerable impact on those who listened. Presence of ex-addicts as counselors also discouraged a number of well-trained and educated enlisted men from serving as counselors themselves, since they did not wish to become identified with former users. Those in charge of the facility agreed, however, that it was essential to have some ex-addicts participating in the program, but these had to be given close supervision. There was a consensus also that ex-addicts can work effectively in information campaigns, where the strains are less and they have good credibility with soldiers.

Another Vietnam facility operated on the theory that changing the environment helps to drop the drug habit. The atmosphere was somewhat sterile and ascetic, as contrasted with the more psychedelic tone of other installations. The counselors here noted that heroin addicts often had little capacity to cope with frustration. They tried to provide a supportive environment, with medical, physical, psychological, and spiritual help. Residents of the house were encouraged to participate in athletics such as volleyball. An effort was made to give them mental rehabilitation -- the assurance that they could face their everyday problems. A unique feature of the program was the strong religious emphasis. The men were encouraged but not required to engage in religious discussions and Bible study.

One division handled its program differently. Because of limited resources, only one-fourth of the drug abusers received the full rehabilitation program after detoxification. The others were followed up by unit drug teams which had been established in each battalion. The drug teams, which also give drug abuse instruction to their units, were enlisted men trained by the surgeon. Most had background in psychology, social work, and similar disciplines. Very few were ex-addicts.

An aviation group had the most structured of the programs and the longest in duration. It involved counseling and evaluation before a man was permitted to enter the program, a withdrawal phase, and then physical rebuilding combined with group therapy. A man was not allowed to begin the program unless he was believed to be strongly motivated to stop abusing drugs. A staff of thirteen men handled a maximum of eleven new drug abusers who entered the program each week. The first week of the three-week program consisted of withdrawal. In the second week the man entered the "rebuild platoon " where he received a good deal of physical exercise, and an effort was made to give him goals and to build up his self-esteem. The final week concentrated on work therapy -- painting a building, for example -- and classes on military subjects and matters of interest to soldiers such as VA benefits. Following the three-week program the man returned to his unit where he received counseling on a weekly basis for five more weeks.

The men in the aviation group program were not harassed, but they were required to maintain a neat appearance and to keep their belongings in order. There was discipline as well as sympathy and understanding. Any who refused to conform were dropped from the program. The rehabilitees moved through the three stages as a group; the counselors considered this group identity to be important. A nurse also participated in the program. It was noted that she was often able to elicit information from the men that doctors and counselors could not.

Appendices D and E are two accounts of drug rehabilitation efforts in Vietnam. Appendix D is a summary compiled from the experiences of several individuals associated with the Army Drug Rehabilitation Centers, and Appendix E is a condensation of the after-action report of the Commander of the U.S. Army Drug Rehabilitation Center in Danang.

As described earlier under Military Service Programs all services conduct rehabilitation in hospitals or special drug centers for those who are more deeply involved than those treated at base and unit level facilities. Experience has produced some items of interest here also. The Navy, for example, has demonstrated conclusively that rehabilitation can be accomplished in a military environment, e.g., the Naval Drug Rehabilitation Centers at Miramar, California and Jacksonville, Florida. (It has been held by some that the military atmosphere was distasteful to the drug abuser to the point where attempts to rehabilitate him in a military environment were not feasible.) The Navy's experience is that the rehabilitation efforts can be profitable using a staff which includes physicians, line officers and civilians.

The Air Force has exhibited success with their five-phase program and concentration of the most heavily involved drug abusers in the Special

Treatment Center at Lackland Air Force Base. The Air Force program and the STC provide a viaible, structured model for conaideration by any community embarking on a drug treatment and rehabilitation program.

In some instances programa did not succeed; the knowledge gained in these situationa is likewise applicable to military and civilian programs alike. First, it was learned that it is necessary to define specifically the goals of the rehabilitation process and then to structure the program to accomplish these goals. Specific taboos which were unearthed are:

- No individual was designated aa the person in charge of the program.

- Drug abusera were running some programs themselvea.

- Drug abuse patients were permitted to diagnoae their own illnesses.

- No program was planned for those acheduled to be in treatment for a short period.

- Clinicians were not permitted to counsel individuals during detoxification.

- There were failures to shift treatment from one modality to another when the first did not succeed, and failurea to use multi-modality approaches.

- There were failurea to define the roles of the counselor, therapist, and group leader, and to train them adequately for their taska.

- There were failures to provide outpatient and outreach services.

- There were failures to establish a proper follow-up system so that the rehabilitation of an individual could be evaluated on a continuing basia.

The solutions to the deficiencies noted above lie in proper program preparation and training. Organizera and leaders are required to lay the ground work, to do the planning, and then to supervise the execution; the miatakes of othera should be observed and avoided, and their lessons used in structuring new programa.

Coordination with Veterans Administration Facilities

The proceedings whereby servicemen may be transferred to VA hospitals for further drug treatment was described in the opening paragraphs of thia aection. As this program got under way problems and misunderstandings, primarily administrative, arose with respect to the DoD policy associated with the transfer of active duty aervicemen to the VA. Some of these were:

- Patients arrived at VA hospitala without proper recorda.

- Patient records did not contain adequate data to assure continuity of treatment, i.e., the records lacked information on the type of drugs involved, the modalities of previous treatment and the amount of treatment completed.

- Patients arrived at VA hospitals without prior notification to the hospital staff.

- Patients arrived at VA hoapitals without adequate clothing or with an excess of clothing; the latter situation caused storage problems at the hospitals.

- Patienta stated upon arrival at VA hospitals that they were to be placed on leave or to be discharged which was uaually false. In some cases these statements were not verified by the hospital staff.

- Patients arrived at VA hospitals during off duty hours or during weekends without advance notification to the hospital staff.

- Patients were not adequately briefed by the military servicea on the assistance which would be provided at the VA hospitals.

In evaluating the causes of these difficulties, it was clear that a closer working relationship between the staffs at the military installations transferring patienta and the VA facilities receiving these patients would minimize the problems. Accordingly, the Assistant Secretary of Defense for Health and Environment established the following policies:

- Esch service would establish direct communication between the installation sending a drug abuaer serviceman and the VA facility receiving the patient. Prefersbly, communication ia accomplished through the medium of service staff viaita to the VA facility. When circumstances limit staff visits, telephone contacts with the VA authorities are established as a minimum. These contacts and staff visits are maintained on a continuing basis.

- The person to be contacted at the military installation when problems or unresolved administrative procedures arise would be identified to the VA authoritiea as part of the direct communicstion procedure. Alternate contacts are also provided.

- The services would encourage staff visits by members of the VA facility to the military installation and would provide appropriate orientationa on the service drug problems and the handling of personnel being transferred to the VA.

In a similar fashion the VA hesdquarters directed the VA subelements who were receiving drug sbuse servicemen to initiate s similar program of staff visits to the military installations.

The prescribed personal contacts and liaison viaits significantly eased the problema attendant to sending active duty servicemen to Veterans Administrstion hospitals.

SECTION 5

Records and Information Handling

General

In any program with the scope and breadth of the DoD drug abuse control program, it is mandatory that records and statistics be kept in order to be able to judge the degree of success or failure of the program. In a drug abuse program it is doubly important to devote considerable attention to records keeping; the typical drug abuser is not necessarily interested in being identified as such and having his drug habit curtailed. It requires an extensive effort to identify him and to detoxify, treat and rehabilitate him. Accurate, up-to-date records are necessary to keep him from escaping the identification screen and to keep track of him once he has been identified. Similarly, much effort must be expended in acquiring accurate statistics of drugs of abuse, degrees of involvement, treatment modalities provided, and the success of rehabilitation efforts. These statistics should not be considered as absolute measures of success or failure; because of the many variables involved, they can only be accepted as relative indicators of trends. This in itself is valuable.

A paradox which arises in the records area is that there is a situation where it is advantageous not to keep too many records. In rap centers and similar installations, servicemen often come in for counseling and help but wish to preserve their anonymity. Delving into their past and personal data too deeply can be counterproductive by frightening off those who require help. Some records probably will always be required, such as attendance figures and the type of drugs used, but recording too much personal data in an anonymous type of situation is self-defeating.

Recognizing that semantics alone could cause unnecessary problems in drug discussions, the DoD promulgated a set of common drug terms in 1970. Other lists of definitions were published, usually by memorandum, as the need arose. By so doing, a common drug abuse language was created for use among the DoD and the Armed Forces. When one speaks of an addict, an experimenter, or casual supplier, his audience knows exactly to what category of person he is referring.

Drug Abuse Data Collection and Recording

Any program with the complexities and variables of the services drug abuse programs requires a maximum planning effort during the initial stages. Early, successful planning saves time and money and helps to ease the detected drug abuser into and through the several programs efficiently, thereby assisting in the establishment of program credibility in the minds of patients and staff alike. A properly planned program anticipates problems which may emerge as time goes on and provides for them in advance -

changing a program after it is under way typically is more difficult than preparing for the same contingency beforehand.

It was learned that the composition of planning groups should include representation from each of the significant categories of the effort being planned. Where drug abuse programs are concerned, medical personnel and counselors should join the administrators in planning the program. Each group represented has different interests and possibly different goals so each viewpoint must be considered in arriving at an efficient, workable, integrated program plan.

As masses of data accumulate it becomes more and more difficult to sift and extract specific items by hand. With digital computers available it has proved much more rapid to handle the reduction of data by machine. Therefore, planning a data collection and recording effort should take into account general machine requirements and formats from the outset.

Another element of data collection and recording is patient follow-up. It is easy to predict that any situation with the ramifications of the drug abuse problem will see studies and surveys conducted in order to dissect the problem and search for solutions. An enterprising planning group will keep the follow-up eventuality in mind and will plan to collect that personal and medical data which will facilitate follow-up studies.

Medical data is a category of information which is required from all drug abusers who enter some form of detoxification or treatment program. The armed services medical records and formats are, for the most part, prescribed by regulation. The difficulty lies in having the documents prepared properly and accurately. In the military, sick or wounded servicemen may enter one medical facility, be processed or stabilized there, and then moved on to one or more subsequent facilities. Sometimes this movement is quite rapid so preliminary planning is necessary to provide for quick and efficient, but accurate recording of all necessary data. Because of this movement, a requirement also exists for complete, factual, accurate documentation of diagnoses and treatment at each facility which handles the servicemen, and for forwarding that information to the gaining facility at the same time or before the serviceman arrives there.

Accuracy of data plays an important part in the several studies and surveys which have been conducted to examine specific aspects of the drug problem in the Military Estsblishment. Often the studies use existing medical records as sources for their base data thus emphasizing once more the need for accuracy in recording information. The physician who is concerned about stigmatizing an individual as a drug abuser will create problems if he fails to factually report his findings and disposition. He must be convinced that he will do his patient and the effort against drug abuse more good by recording complete, factual and accurate data.

Although information must be made available for authorized research projects, the medical records of patients must be protected from deliberate or inadvertent unauthorized disclosure. There are laws and service directives to regulate this problem; all must be rigorously observed and enforced. It was learned early that the confidentiality of the health record had to be

guaranteed to the drug abuser as one element in establishing the credibility of the drug program in his mind.

In October 1971 the Army initiated a survey of drug abusers in Vietnam using an 84-question questionnaire as the instrument of data collection. This illustrates another common type of information collecting and recording which has produced some problems and solutions worthy of consideration by those responsible for drug programs.

The Army questionnaire is long and requires some care for proper preparation. Imposition of a work load which the questionnaire represents will encounter resistance unless adequate preventive measures are taken. These measures include advance explanations to establish credibility and need for the questionnaire and the data it will gather so that commanders, staff and workers, understanding the importance, will be motivated to do the job well. The support of commanders and supervisors is particularly important since they must oversee the continued high level of data collection performance after the task has been reduced to tedious routine.

It was learned that interviews need not be conducted by physicians or psychiatrists. Social workers and counselors are well qualified to handle interviews of drug abusers. The patient should not be permitted to fill out questionnaires by himself. He will not understand all questions and will make mistakes - an interviewer can explain questions and elicit more accurate answers. Further, the typical drug abuser probably has little if any motivation to extend himself to complete a questionnaire correctly, and accuracy in collected data is essential for a bias free study.

Another reason for the use of an interviewer experienced in the ways of drug abusers is to detect and counter obliqueness in the answers given by the drug abusing patient. For example, it was found in Vietnam that some drug users exaggerated their drug use in the hope that they would be returned to the United States early whereas others minimized their use hoping to stay in Vietnam where drugs were plentiful.

In addition to collecting and recording data, certain information must be disseminated. Each management level must be furnished with the program information required to measure progress and to make decisions. However, report requirements must be realistic. If the report period is too short, the report data will have little statistical validity. If the report is required too soon after the end of the report period there will be insufficient time to examine the data, investigate suspected mistakes and have questions answered. This contributes to incorrect reports and an inaccurate data base upon which to base decisions.

Further, for efficiency, the number of different reports should be kept to a minimum. Where different requirements must be met, e.g., from command, medical and police agencies, the reports content and format should be examined with the goal of combining as many requirements as possible into a single report.

Finally, the report planning should be as thorough and foreseeing as it can possibly be. Report changes after the original instructions have

been promulgated create turmoil beyond belief throughout the entire reporting system.

Experience has shown that sophisticated automated data collection and processing equipment can be used to good advantage in drug programs. When one begins to collect data on individual drug abusers, the quantity of data collected quickly outstrips the capability for manual reduction of the data to meaningful results in a reasonable time. The use of automated data processing permits the application of sophisticated statistical techniques to masses of data and provides results which are credible from a statistical point of view. The resulting output can then be used with assurance as a basis for policy and program decisions.

The need for accurate statistics and the use of automated data processing equipment has been touched on above. However, as studies go deeper into the drug abuse situation, more and more data are required; this in turn leads toward the use of automated data processing equipment to store, retrieve and manipulate vast quantities of information. One military service, the Army, has prepared and is implementing a plan for a computerized drug abuse collection system, a system which has considerable potential for civilian drug abuse program use.

The objective of the Army system is to provide a confidential, centralized method of collecting data on identified drug users to meet research and medical management requirements of the Army drug programs. In concept it establishes a comprehensive data base on identified drug users. This data base will have information on each drug abuser pertaining to his:

- Past medical and drug history.
- Physical examination.
- Withdrawal and treatment.
- Demography.

A standardized questionnaire data form is structured to meet the requirements. Information sought on the form is obtained during a personal interview by a counselor or medical technician familiar to the user, and after the early phase of any abstinence syndrome. As a credibility check similar questions concerning the user's abuse of drugs are placed in different formats on other medical records used in recording the evaluation and treatment of the individual. The data collected is sufficient to facilitate the following analyses and evaluation of users on an individual and collective basis.

- Personal profile.
- Drug abuse history.
- Physical findings.
- Abstinence syndrome.

- Medical complications of drug abuse.
- Psychological assessment.
- EEG and EMG during withdrawal.
- Hematological assessment.
- Biochemical studies, i.e., glucose, bun and creatinine, calcium and phosphate, liver function, serum proteins, and immuno electrophoretic pattern of serum proteins.
- Endocrinological studies, i.e., catecholamines before and during withdrawal, and 17-keto-steroids before and during withdrawal.

Categories of information to meet local requirements can be analyzed according to the type of drug facility where the data is originally collected. A complete summary of any category of information can be furnished on collected data for any layer of management desired. Further, the problem of observing rehabilitation results on a long term basis can be facilitated by programming to isolate recidivists.

Urinalysis Program Quality Control

After the urinalysis program was under way, a quality control system was instituted to police it. It quickly became apparent that with the masses of data required for the samples going to laboratories and the masses of replies coming back to the Armed Forces Institute of Pathology, some automated means of information handling had to be devised. Such a system was devised and activated in the AFIP early in 1972. A description of the entire quality control program and the part automated data processing plays in it may be found in Section 3, Identification of Drug Abusers.

Information Materials

Many drug abuse education and prevention programs prepare their own informational materials; however, the DoD operates an Office of Information for the Armed Forces, a central facility for all of the Armed Forces which prepares and provides informational materials to support service drug education programs. This support includes films, pamphlets, brochures, and posters as well as tapes and records of radio and television programs, all dedicated to drug abuse material. In addition, subscriptions to publications such as Grass Roots and Addiction and Drug Abuse Report are provided to interested drug education offices. The advantages of the OIAF stem from the centralized organizational location where it can deal on a DoD-wide basis with outside agencies, e.g., artists and entertainers, and can handle the coordination and administrative functions of providing materials. This relieves the services from that burden, reduces costs, and assures a coordinated service-wide approach in the story which the informational materials present.

A great amount of drug abuse material is presently available in the National Institute of Mental Health Clearinghouse for Drug Abuse Information

and the Buresu of Narcotics and Dangerous Drugs. The Clesringhouse for Drug Abuse Information hss inserted the drug information into an automated data bank and st least one service, the Air Force, has found that source of information so valuable that they have installed a computer terminal at Lacklsnd Air Force Base, Texss (home of the Air Force Special Treatment Center) connected to a data link to the Clearinghouse data pool.

In summary, records keeping to evaluate progrsm progress is an sbsolute necessity. Automation can assist this process to s marked degree but the first, and most important requirement is the complete, sccurate recording of the data bits at the source.

Once again, the need for csre snd accuracy in first hand dealings with the drug abuser highlights the requirement for detailed planning, quality personnel assigned to drug abuse programs, and supervision by dedicsted, professionally competent managers.

SECTION 6

Concluaion

This report has examined the various components of an overall drug abuse program. It has also examined the experiences of the Armed Forces in coping with the drug abuse situation as they found it and the problems which arose as they went along. And, it attempts to document the military experience for the benefit of others who have an interest in drug programs. Some of the experiences which have been recorded here are unique to the military -- most are not. In any event, it is the desire of the Department of Defense to provide the general public with the lessons learned in the drug program education process which the Military Eatsblishment has undergone in the hope that this knowledge may be applied to good advantage in the nationwide fight against drug abuse in all its forms.

APPENDIX A

Report of Department of Defense Teen Involvement Activities

In the summer of 1972 the Department of Defense employed four recent graduates of the Quantico High School (Quantico, Virginia) to introduce an education program for school children to interested communities throughout the United States. This effort operated for about one year. Following is an account of the Teen Involvement program, its history, concepts and techniques, lessons learned and certain recommendations. This account was written by the four teenaged counselors at the completion of their work.

Program Outline

In February of 1971, four juniors (three of whom are military dependents) at Quantico High School on the Marine Base at Quantico, Virginia, were approached by the administration of that school and asked to examine a drug education program in Phoenix, Arizona, for possible implementation in their community. The basic concept of this program was youth reaching youth. Specially selected high school students were being trained to help educate elementary school students in subjects including drug abuse. The four students agreed and were sent to Phoenix, where they underwent training in a program then called "Dope Stop." At the end of the training the four returned to Quantico and, being impressed with the program's concepts, adapted it to their community, changed the name to "Teen Involvement," and implemented a pilot program which included only sixth grade elementary students.

The pilot program at Quantico was begun on March 17, 1971, and continued until the school year ended. The following spring, thirty other high school age counselors were trained in the Quantico school system. These students were chosen from some fifty who had volunteered during the previous May and June. The four original counselors, with these students, were then able to expand the program to reach all fourth, fifth, and sixth grades in the Quantico elementary school system.

Upon graduation from high school, the original team was offered a position with the Department of Defense introducing the Teen Involvement approach to interested military/civilian communities throughout the United States. The team accepted and has been introducing their program to interested communities since July 1972.

During the summer months, the team traveled throughout the United States briefing commanders and school administrators at major military headquarters about the program. With the beginning of the 1972/1973 school year, the team began a series of two-week visits to school systems which had invited them to help in establishing Teen Involvement programs. There have been more requests for their services than time available

within the school year. Their travels have taken them to schools from coast to coast. By the end of the school year, they have helped establish Teen Involvement programs in more than fifteen communities, and introduced program concepts and classroom techniques to over two hundred new teen counselors.

Factual Information

During the period from July 4, 1972 to September 4, 1972, the DoD Teen Involvement team traveled to military command headquarters at Patuxent Naval Base, Maryland; the Presidio of San Francisco, California; Fort Campbell, Kentucky; Military District of Washington Headquarters, Washington, D. C.; Fort Belvoir, Virginia; Fort Meade, Maryland; and El Toro Marine Corps Base, California. These headquarters had representatives from the bases under their command liaten to the team's presentations, and then go back to their posts and decide whether the Teen Involvement program was needed in their community. If they were interested, they submitted their request for the team to help them establish a program in their community, including their choice of dates. Priorities were then established for scheduling.

From September 4, 1972 until May 11, 1973 the DoD team visited fourteen military installations for the purpose of establishing Teen Involvement programs in each community. Excluding El Toro, every installation visited was an Army post. The programs at this time are centered in twenty high schools which have enlisted the services of over four hundred teen counselors. The team itself taught 115 example classrooms in sixty-seven elementary and junior high schools. Ninety-four elementary and junior high schools are presently enjoying the services of these established Teen Involvement programs.

Two teams were formed for follow-up technical assistance visits. From May 21 to June 3rd, these teams revisited seven different communities that had requested assistance in areas including the selection of teen counselors and formulation of expanded programs for the following year. For further information on expansion of programs see Enclosure 1.

Concepts and Techniques

In order to establish a Teen Involvement program, the community must involve and enlist the support of several fundamental groups. If involvement or approval of these sources is not gained then the chances of the program's success are drastically reduced.

The first and primary group is the administrators involved in the decisions concerning the program's initial existence. These administrators may be either military or civilian. It is essential that every effort be made to explain the program in detail to the school district officials who are interested in establishing a pilot program.

Following clearance from these higher echelons and having received permission to enter a high school, one must concentrate on gaining full approval from the second group -- the interested school. It is evident that there must be some genuine interest or desire from within that community before the program has a worthwhile opportunity for success.

The quality of any program of this nature depends directly upon the third group, the teen counselors. These are the personnel with the largest influence on the quality of the program. In the crucial and most important task of selection one must remember that only a very highly motivated and capable person will become an effective teen counselor. For suggested criteria in selection of a teen counselor see Enclosure 2.

Best results in the classroom itself have been achieved by forming teams of two counselors, consisting of one boy and one girl. This provides an elementary student of either sex with a counselor with whom he can confide. These teams should be trained extensively prior to entering their first classrooms for the simple reason that the responsibility of teaching lower grade levels is enormous. The training should provide the individual with ample factual information on topics which may be of interest to the age groups in these classrooms. Drug abuse information is only one of these varied topics. Group techniques and training for the counselors in recognizing small group interaction may prove to be most beneficial in working with younger children. See Enclosure 3 for a list of suggested training sources.

In making visits to classrooms, the frequency suggested is once every three weeks for approximately an hour. If each team took a class load of two to three classes, that would mean the counselors would be missing at least four hours per month of school. This of course does not include the time a counselor must sacrifice for training and classroom planning. This in itself suggests the need for a person with great desire and ability.

Administratively, a program like this requires a great deal of coordination and diplomatic action. To provide this a sponsor must be appointed, preferably from within the school itself. The role of a sponsor is multifaceted. He must coordinate all classroom visits with the counselors and the teachers. He must also provide training for the counselors and continue this training during the year. In the case of teacher, parent, or administrative difficulties, the sponsor must be available and capable of handling them. This job is sometimes very time consuming and therefore someone willing and able to fulfill the time requirement should be selected.

The most effective way of dealing with the teachers and their classrooms is to inform them of the existence of the program and allow them to decide if they would desire a team for their classroom. Teams are then used only in classrooms where they have been invited, and not forced upon the uncertain or unwilling teacher. The suggested grade levels best suited for the program are grades four to eight. It is in this age group that the students are not quite firm in their basic foundations and can still be led to or shown other paths or alternatives. It is a must that the counselors and their teacher meet prior to the start of their sessions to make sure that their goals and ideas coincide. To insure that this relationship remains positive it is further suggested that the counselor discuss his or her class with the teacher both before and after class. A question that arises often is whether the teacher stays in the classroom or not. If the counselors operate under the policy that they are invited into the teacher's classroom it will have to be left up to the teacher as to whether

or not she wishes to leave her class for any of the sessions. It is hoped that the counselor and teacher will have achieved a relationship that will allow free discussion concerning this topic.

Parents are notorious for being totally uninterested in any parent meeting other than those in which their children are performing. Still it is the responsibility of those involved in any program of this sort to make every effort to inform and enlist support from the parents and other adults in their community. The ideal situation would be to involve the parents as much as their own children by holding regular meetings to answer any questions they might have and also to inform them of what was done during the most recent classroom meetings.

Lessons Learned

In revisiting some of the installations where Teen Involvement programs were established by the DoD team, certain observations were made that might be applicable to Teen Involvement programs in general.

During the revisits, it became obvious that programs with more active, intelligent, and mature counselors were doing much better than programs where students were not so outstanding. Therefore, it follows that in the selection and screening of the teen counselors, standards should be set as high as possible. It was also observed that teen counselors were more secure in the classroom when their training had been extensive in all areas. A solid basis of training is necessary.

The faculty sponsor showed possibilities of being the weak link in the program. Overwork and lack of time for all necessary duties were the problems. Proper selection of a motivated faculty member is a great asset to the program.

It must be remembered that the teen counselor could not function at all if not invited into the elementary classroom by the teacher. Therefore excellent counselor-teacher relations are a must.

In some communities the military establishment was weak in making its willingness to support the program clear through personal visits and through administrative channels to the school administration. Continued contact and clear communication is a necessity for a successful program.

Parental involvement in this program has been consistently poor. We have only observed two instances in which parents have turned out in large numbers to be informed about the programs. At one Army post a commanding general requested all parents to attend a meeting and then took the roll. In another situation information on Teen Involvement was presented as a prelude to a song and dance extravaganza performed by the audience's children. Different methods will be successful in different communities, but a continual effort to involve the parents is necessary.

Recommendations

In accordance with the need for above average teen counselors, we would recommend primary consideration be given to students who have

already demonstrated their abilities in high school work and extracurricular activities.

The training of teen counselors should contain sufficient factual information so as to make them at least conversationally knowledgeable in subjects common to their student's age level. More important than this, however, is the need for training in group understanding and leadership. This enables the counselors to accomplish their goals with a minimum of chaos.

To strengthen the role of the faculty several alternatives are available. Selection of a person with more free time than the average teacher is a workable solution. A sharing of responsibilities between two or more teachers is another satisfactory arrangement. A teen coordinator could act as a go-between between the sponsor(s) and counselors. This would eliminate a great deal of legwork for the sponsor. The sponsor should also be sure that his counselors receive sufficient in-service training to keep them up-to-date and refreshed on all topics and techniques.

In order to prevent unnecessary complications in teacher-counselor rapport, the counselor should make every effort to consult the teacher before and after each class. Suggestions from the teacher should be incorporated into the teen counselors presentations whenever possible.

In order to provide the civilian community with a constant and reliable resource, the military should state its willingness to support the program and make clear to exactly what extent. It is also necessary that the counselors make clear to the administration and the teachers their definite plans and goals for the class.

Parental involvement is of such importance that in some cases it may be necessary to employ unusual tactics to receive sufficient response. Every effort should be made in this endeavor; close cooperation between the school administration and the military command structure is very helpful in fulfilling this objective.

Proposed Future Actions

There are two recommendations that we have for the future of the Teen Involvement program. The first of these is that more teenagers not be hired to fill the job we will be leaving. Because the programs that we have started this year are scattered geographically throughout the United States, we feel that it would be more economical for any place that desires this program to send their teen counselors to a program already established in their local area rather than have another team fly from Washington, D. C. In this way, the instruction they receive will deal more closely with topics and problems in their own area. A team from the Pentagon would not know the social and cultural topics and problems unique to each area. On this same subject, we suggest the DoD Drug and Alcohol Abuse office continue to play a part in the coordination of the programs throughout the United States as well as giving full support to any base interested in Teen Involvement.

The second recommendation that we have is that a national or international Teen Involvement convention be held annually, inviting representatives from all programs throughout the United States.

Expanded Teen Involvement Programs
(To Begin September 1973)

Fort Campbell

Fort Campbell High - 25 counselors
4 grade schools - 30 classes

Fort Hood

Copperas Cove and Killeen High - 162 counselors
21 grade schools
52 classes

Fort Sam Houston

Macarthen, Cole, Roosevelt High - 150 counselors
2 grade schools - 15 classes

Fort Riley

Xavier, Junction City High - 9 counselors
2 grade schools - 4 classrooms

Fort Leavenworth

Leavenworth, Immaculata High - 50 counselors
4 grade schools - 22 classes

Fort Sill

Lawton High - 18 counselors
2 grade schools - classes

Presidio of San Francisco

Washington, Rafael High - 25 counselors
2 grade schools - 12 classes

Fort Knox

Fort Knox High - 25 counselors
3 grade schools - 50 classes

Enclosure 1 to
Appendix A

Fort Dix

Pemberton Township High - 12 counselors
1 grade school - 5 classes

Fort Carson

Fountain High - 40 counselors
4 grade schools - 24 classes

Fort Ord

1 counselor
statistics not applicable

Fort Lewis

Lakes - 25 counselors
10 grade schools - 40 classes

Fort McClellan

Jacksonville, Aniston Academy, Aniston High,
one other - 44 counselors
4 grade schools - 16 classes

Fort Jackson

Dent Junior High, Spring Valley High - 30 counselors
35 grade schools - 120 classes

Fort Devens

5 high schools - 120 counselors
no number of elementary schools - 63 classes

Criteria for Selection of a Teen Counselor

A. A Teen Counselor must be a volunteer to insure that his motives are based on his own personal convictions and vitality.

B. A Teen Counselor must be able to relate with poise and confidence to both adults and young people.

C. A Teen Counselor must be willing and able to handle the responsibilities imposed by the role he takes on in his assigned classes. This includes the distribution of objective information and a genuine personal interest in kids.

D. A Teen Counselor should be a natural leader from within his high school's social population.

E. The grade level suggested for counselors has ranged from 9th through the 12th grades. It must be remembered, however, that the upper classmen being more mature will, most likely, be more confident in the classroom.

F. A Teen Counselor should have an open attitude which will aid him not only in the classroom but also in discussions about his classroom.

G. To be a Teen Counselor one must be able to miss time from school and therefore must be able to keep up with his work. A steady grade point average is essential.

Enclosure 2 to
Appendix A

Local Personnel Useful in Training Teen Counselors

Psychologist and/or psychiatrist

Elementary school teacher

Elementary school counselor

Drug "experts" - pharmacists, researchers, etc.

Lawyers - laws concerning drug abuse

Doctors involved in field

Group therapists or professionals

Sex education teacher and/or planned parenthood

Persons involved in values clarification

Experts in group interaction methods

Experts in role playing - problem solving

Community organizations that might be needed for referral

Experienced teen counselors

Persons involved in supplying recreational facilities - positive alternatives

Enclosure 3 to
Appendix A

APPENDIX B

Experiences Establishing a Drug Rehabilitation Center in the Navy

CDR A.M. Drake, MC, USN*
and
Douglas Kolb, MSW**

The Naval Service has shared with the other uniformed services and the civilian community of the United States a growing concern with the problem of drug abuse among its members. It was therefore a natural evolution of this growing concern that planning for the establishment of the first permanent Naval Drug Rehabilitation Center was begun in response to Presidential directive on 12 June 1971. The site selected for this pioneering venture was the Naval Air Station, Miramar, California.

Previously, drug abuse in the military had been considered primarily a disciplinary problem and for the most part, individuals with a history of significant drug utilization were separated from the service through administrative channels. However, the generally widespread utilization of drugs by the youth subculture of the late 60's and early 70's, as well as mounting concern over the prospect of Vietnam veterans who had ostensibly become addicted to cheap, high-purity heroin while overseas and who might continue their drug use patterns upon return to CONUS, led to the realization that forceful and innovative approaches to the problem were mandatory and urgent.

The Naval Drug Rehabilitation Center, Miramar was formally established as a line command, manned by a staff of Navy line officers, physicians, psychologists, chaplains, Navy and Marine Corps enlisted men, civilian counselors, social workers, and several ex-addicts who were themselves graduates of civilian treatment programs. This mixture of staff, altogether unorthodox by traditional Navy standards, was to provide the basis for a multi-disciplinary approach to the treatment of drug-related problems, allowing much greater scope for the program than would have been possible had a more monolithic orientation been proposed. While the staff was being assembled, two large triple-deck barracks were undergoing conversion to house offices for staff and quarters for over two hundred patients.

The patient population which soon began arriving at the center -- too soon for comfort for the staff was still in the process of being ordered in and the barracks were still undergoing renovation -- was an heterogeneous

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collection. Heuristically, they could be separated into six major categories. First were those patients considered to be drug-addicted. Many of the early arrivals from Vietnam had been sniffing cheap, easily-obtained heroin which was 95-98% pure. They had not developed the criminal life-style of the street addict, nor did they manifest any severe degree of withdrawal symptoms. As the Navy's engagement in Vietnam diminished, this population of addicts receded in importance to be replaced by addicts with more established drug-taking patterns, who were using the impure heroin available in the United States, usually were mainlining, and had developed the manipulative, sociopathic life-style associated with the street addict.

The second and more numerous classification were those men considered poly-drug abusers, and who had included in their spectrum of drug use experiences with psychedelics, glue, amphetamines, barbiturates, marijuana, alcohol, and a variety of other substances sometimes identified with only the haziest of accuracy. The scope of poly-drug abuse extended from casual experimentation to daily use of multiple doses of whatever happened to be available.

The third major classification comprised the military malcontents, disciplinary problems, and manipulators. These were young men with histories of repeated, although often relatively trivial, military offenses. They were anti-establishment in orientation, dress, and grooming, unhappy with the military, and anxious to press for early discharge into civilian life. They manifested a tendency to blame society in general, and the military in particular, for their drug usage and offered the glowing anticipation that all would be well once they had shucked the uniform and relocated themselves in a milieu which would permit them to "do their thing." Their histories of drug abuse sometimes were fabricated or grossly exaggerated, and there was often a pronounced element of machismo in their stories of four and five hundred "acid trips" and voluminous consumption of psilocybin, cocaine, THC, STP, etc.

Fourth was a large segment of patients who were simply struggling through the normal rebelliousness, experimentation, and identity diffusion of adolescence. They had become involved in drug abuse because of boredom, peer pressure, curiosity, job dissatisfaction, or the pursuit of altered and more ecstatic states of consciousness. Their backgrounds revealed poor social relations with family and peers, poor work and vocational orientation, and a tendency to avoid personal problem areas, but did not otherwise support a diagnosis of specific psychiatric disorder.

Fifth was a contingent of character and behavior disorders, with well-established patterns of maladaptive social relations, self-defeating behaviors, poor impulse control, and failure to recognize personal responsibility for the course of their lives. Drug abuse came easily to them as a manifestation of other, ongoing difficulties in adapting to society and formulating self-satisfying goals.

Last was a small number of patients considered to be bordering on more severe psychiatric illness, who were using drugs in an attempt at self-medication for long-term problems with depression, anxiety, low self-esteem, and social alienation.

An analysis of background information obtained from the first 458 Navy men to enter the Miramar program supports the clinical impressions of many of the patients. Although most had ostensibly "volunteered" for service, many did so on the spur of the moment or for negative reasons, e.g., to break home control or because they were unemployed. Their average length of time in service was two years and more than two-thirds had attended at least one service school. Approximately three-fourths of them, however, had never achieved a pay grade above E-3. The majority reported strong negative feelings about the service in general and expressed dissatisfaction with their Navy duties, with half believing that their abilities were not employed and with almost nine-tenths expressing boredom with service responsibilities. While quarterly marks were in the 3.2-3.4 range, more than half admitted to at least one disciplinary offense, chiefly nonjudicial punishment.

Pre-service histories would indicate marginal school adjustment for many with over half having been expelled or suspended and as many "playing hooky" more than six times. Forty-four percent of them did not graduate from high school. At least a third had been arrested and almost as many had spent time in jail. A quarter of them admitted to emotional problems prior to entering the service; more acknowledged having trouble with their temper and moodiness.

Detailed drug abuse histories of these men will be reported elsewhere. Suffice it to say, this population reported heavy use of a variety of drugs: heroin - 58%, barbiturates - 46%, amphetamines - 61%, LSD - 81%. Daily use of heroin was admitted by a third of the total group. Marijuana was used by 96% of the men with 64% claiming daily use.

In order to provide the flexibility necessary to provide a therapeutic range broad enough to encompass such a heterogeneous population, five separate therapeutic programs, called therapy tracks, were developed over the first three months of the center's existence. Each program tended to focus upon particular problem constellations which had become evident among the patients. The tracks were designated the Project, the Community, the SHARE Program, the SALT Company, and Our Family.

The Project is a therapeutic community headed by a medical officer with the assistance of a line officer, a psychologist, and civilian counselors as well as Navy enlisted men, both corpsmen and nonmedical rates drawn from the fleet. The program stresses individual responsibility in dealing with a man's life, and utilizes small and large groups as well as individual sessions to assist in effecting a change. Members of the therapeutic community have the opportunity to move through four graduated levels of responsibility which carry with them different obligations to the group and rewards for the individual. The basic thrust is toward encouraging increased maturity through self-awareness and discipline as it related to group interaction and the mutual obligations engendered by life within a structured society.

The staff mix of line officers, mental health professionals, and military and civilian counselors has been found to be extremely useful. The line officer in the therapy tracks has administrative responsibilities

and handles discipline. His presence maintains the reality of the military situation, a reality which may become obscured if the patient is confronted by mental health professionals only. The civilians, primarily individuals holding masters degrees in social work, counseling, and psychology are thus able to deal with therapeutic matters, unencumbered by the necessity for fulfilling a double role of therapist and disciplinarian. This seems to reduce opportunities for patient manipulation. One additional benefit of this staff mix is that social reentry appears to be facilitated. The patient has an opportunity to observe and relate to a variety of individuals from a variety of disciplines and backgrounds, some of whom are admittedly "square." It is our impression that this contributes a wider scope of life experience than is possible in programs which are run entirely by and for individuals who are themselves immersed in the drug subculture and who cannot provide a broader spectrum of alternative life styles.

The Community is also a therapeutic community under medical direction, utilizing a similar mixture of civilian counselors and line staff. The primary emphasis is directed toward self-understanding through the use of group and individual therapy. Self-understanding is facilitated by a video tape system used to study the interpersonal reactions and dynamics of the group. The patients clearly become quite interested in reviewing their own tapes, and the confrontation with their own provocative behavior provides a rare opportunity to "see ourselves as others see us." The track modus operandi is predicated on the observation that many of the patients have long histories of extremely poor interpersonal relations with family, peers, school authorities, and employers, and also that one of the almost universal characteristics of our population is low self-esteem. Vocational counseling and educational opportunities are encouraged on an individual basis. Initially the time scheduling within this program permitted considerable flexibility so that patients would have time for introspection and reflection. It was discovered that the time so allocated was poorly used, often producing boredom. A revision of the program schedule has now provided structured activities throughout the entire day, which appears to be working more satisfactorily. Our patients do not tend to be very highly self-motivating, resulting in inability to utilize unstructured time. The dilemma for the therapist is that free time is dismissed as boring while scheduled activities are denounced as hassling.

The SHARE Track is an acronym for Self-Help, Assistance, Rehabilitation, and Exploration. This track is led by Navy line personnel and stresses personal motivation, role modeling, and military leadership. Instruction concerning drug education and communication is offered along with motivational courses, field trips, and lectures by guest speakers. The patients, referred to as Shareholders, are encouraged to take maximum advantage of the educational and vocational resources available at the NDRC, such as General Education Development completion, Project Step-up, Project Transition, and various on-base construction projects. The rationale for the SHARE Track approach is that not all individuals involved in drug use will require therapy within a standard medical model. Not all men are amenable to standard psychotherapy in the first place, and for some, the simple act of associating with more mature and successful men may help to form useful identifications. As the track evolved, however, it was learned that a simple line approach emphasizing leadership and good example did not appear

to provide a completely rounded approach. The patients expressed a desire for a more active psychotherapeutic experience, which the line staff did not feel qualified to provide. As a consequence, two civilian counselors holding masters degrees in mental health professions have been added to the SHARE program, and provide the men with group and individual counseling.

As one of the center's major problems is trying to obtain a commitment to therapy from the patient, the SHARE Track emphasizes this aspect of commitment by requiring formal signature of a contract between the individual patient and the therapy program, emphasizing his responsibilities, outlining the restrictions to which he must commit himself, and specifying the discipline which may incur if track policies are broken. Active participation by Shareholders is encouraged via a patient government organization which permits the men to contribute to track policy and athletic committees, and exercise peer control over minor disciplinary infractions. The discretionary limits of the member government are established by the track administrator, a Navy Lieutenant.

Discipline within SHARE is confrontive and prompt, and limit-setting is firmly established and exercised. In accordance with the patient's emphasis upon the development of self-motivation, all members of the track are required to publicly announce and discuss in a group setting a formulation of prospective life goals, and delineate possible ways of attaining them.

The SALT Track is a chaplain-directed community utilizing a staff including a clinical psychologist, civilian counselors, and enlisted men. It is based upon the premise that values and ethical problems are important aspects of today's world, often overlooked in the conventional psychotherapeutic program. SALT is an acronym for Self-respect, Acceptance, and Trust. The program is predicated upon the consideration that an existential approach is of benefit to many troubled adolescents who find themselves adrift in a society undergoing upheaval, widespread questioning of formerly accepted values and institutions, and the much publicized "Future Shock." A reflection upon some of the opinions widely voiced around the nation over the past five to ten years reveals a preoccupation with social alienation and fragmentation; i.e., God is dead and religion is no longer viable or relevant; government and industry are characterized as corrupt, irresponsible, and self-aggrandizing; the so-called "generation gap" proposed that a youngster trust no one over thirty, etc. Without becoming embroiled in a diatribe over the validity of any of these attacks upon the current state of society, it nonetheless becomes apparent that a total and unquestioning acceptance of these positions may ultimately end up cutting off a young person from any of the customary supports and structures which our culture provides. The void so created, perhaps more often than not, is filled by boredom, depression, and heavy drug utilization. The SALT Company, then, works toward an understanding of the problems of existence and the development of more positive alternative life styles. Both the chaplains assigned as track leader and assistant track leader have extensive backgrounds in counseling, and theological dogma does not enter prominently into the formulation of their program. Evidence for the desirability of providing a quasi-spiritual approach to rehabilitation is afforded by the interest which the young themselves currently display in seeking out a variety of religious and cultist experiences as substitutes for drug usage.

The prevailing philosophy in SALT is that one's existence is at stake. Accordingly, all aspects of the program are designed to challenge the individual to look at his life style. Through group and individual sessions, opportunities to exchange ideas with staff, educational classes, and exposure to successful persons in the broader community, the individual learns how others approach and deal with life's problems.

The Family Track is under the direction of a Navy clinical psychologist and employs a staff of three ex-addicts as counselors in addition to two military enlisted men. The three counselors are themselves graduates of similar programs in the California state hospital system which are philosophical outgrowths of the Synanon approach. The Family functions in a very highly structured and disciplined milieu in which unsuccessful and undesirable modes of behavior and thinking are confronted in a group setting. Creative discipline is conducted with an eye to emphasizing the nature of a man's problems, rather than following standard military types of discipline. Thus, a patient in the Family may wear a placard for one week proclaiming that he is "a big-mouth and a wise-ass," thus maintaining continuous attention to the type of maladaptive behavior which must be discouraged. Because of the rigorous therapeutic approach, the Family is an entirely voluntary program and is the most selective of all the tracks. As a consequence, the Family is numerically the smallest of the programs, and its continuing operation requires the presence of the remaining therapeutic programs to absorb the less highly motivated patients who leave the track. The very rigorousness of the program, although highly beneficial to those who complete the entire four-month course, discourages those individuals whose motivation for self-inspection and change is low.

Prior to placement in one of the therapeutic programs, patients entering the Miramar Naval Drug Rehabilitation Center are placed in the Evaluation Unit where they undergo approximately five days of screening. During this period, psychological testing, biographical questionnaires, and personality inventories are administered under the guidance of the Navy Medical Neuropsychiatric Research Unit. Medical and service records are examined, and standardized interviews are conducted; some of this information is utilized for clinical purposes, and the remainder is recorded for later research analyses. During this evaluation, the patients are assigned to small groups at which time staff members meet with them to discuss their problems, orient them to the center, and ultimately assign the man to a therapeutic program.

The program extends for a maximum of 120 days. Cross-transfer between tracks is effected if it is thought that a man may benefit more from a different approach.

After successful completion of the program, patients may either be returned to duty or discharged to civilian life, depending upon the subject's demonstrated capacity and the needs of the Navy. A high return-to-duty rate is not regarded as the sine qua non of therapeutic success. All recommendations for return to duty or for discharge from the service are evaluated by a special board consisting of two line officers and one medical officer and by the Commanding Officer. The qualifications of those men returning to duty must conform to high and stringent standards; thus, at the present time most patients completing treatment are discharged to civilian life.

If there is evidence that treatment has not been successful and that a drug problem continues to exist, pstients are transferred directly to the VA.

Both Marines and Navy men are treated at NDRC, Miramar. The Center received the majority of its clientele through the so-called Exemption Policy which provides for the withholding of punishment for those men who voluntarily seek treatment for the use of drugs. The program is not set up for drug detoxification, and all personnel requiring medically supervised withdrawal will do so at a Naval hospital. Patients wear uniforms of their respective services, and adhere to all Naval and base regulations. Staff also are in appropriate uniform. The question is often raised as to whether the flavor of s military setting imparted by uniforms and the hierarchy designated by rank is antithetical to therapy. It has been our impression that such is not the case, and in fact, if a realistic confrontation and resolution of problems with rank, authority, and military structure is to occur, the wearing of the uniform is essential. In any event, once s therapeutic relationship has been established, uniforms tend to become irrelevant.

In addition to the therapeutic programs, the rehabilitation center contains educational and vocational training services. A man's service record is reviewed shortly after his arrival, his educational and vocational deficiencies are noted, and an appointment is scheduled with the Educstional Services Office which can offer him high school equivalency training, college level courses, and a wide variety of occupational placements. The object here is that whether a man remains or leaves the service, his chances of maintaining his self-esteem and realizing life goals are enhanced if he has acquired some education and/or vocational skills which he can turn to useful purposes. As with many other areas of the total program, consideration is directed toward the needs of the whole person, rather than focusing exclusively upon his extent of drug involvement.

Perhaps the greatest single problem encountered by the staff of the rehabilitation center is the fact that most of the patients arrived without motivation for either rehabilitation or for continued military service. Young, healthy, and receiving regular pay checks, most of the men are still involved in drug sbuse at a stage where it appears to be fun. Almost none have had the degrading personal experiences which become the lot of the addict whose luck has run out. As a result, many of the men sre initially loath to take their drug usage seriously. Many claim that their drug abuse is primarily situational and will resolve itself if they are separated from the Navy/Marine Corps. A few claim that drugs might possibly constitute a source of future trouble, but they express a desire for follow-up care at civilian agencies of their own choosing. Many patients are initially hostile to the idea of rehabilitation, expecially rehabilitation in a military setting. Administrative difficulties with the trial Amnesty Program instituted in Vietnam in May 1971, and the Exemption Policy which subsequently replaced it, resulted in a majority of the early patients arriving at NDRC with the intention of obtaining separation from the military. They had the expectation that claiming exemption from prosecution for their confessed -- real or fabricated -- drug abuse would guarantee them s discharge under honorable conditions regardless of their participation in a rehabilitation program. The drug abuse program, by being associated

with the possibility for premature separation, thus became an avenue of attempted escape for those young men disenchanted with the military and desirous of finding a quick and easy way out of an unhappy situation. It has been discovered, however, that if even the most verbally abusive and uncooperative patients are retained at the center beyond the first one or two weeks, their initial apprehension, hostility, and uncertainty begin to dissipate and they begin to explore in a more realistic light the internal problems existing within their own personalities instead of issuing blanket denunciations of society and the world at large. When capable of lowering their defensive barriers, the patients then expose feelings of low self-esteem, identity problems, inability to handle intimacy, and frustrated strivings for acceptance and recognition in a world which appears too complex and indifferent. Once these basic conflict areas have been confronted, it is then possible to deal with the patients in the spirit of mutual respect and confidence which is necessary for therapy to exist. The fact that this has occurred is a tribute to the sincerity and obvious concern and dedication of the staff of the entire center.

A second major problem was the dramatic influx of patients during the first hectic weeks of operation. By the end of September 1971, more than 500 men had been admitted to the center and approximately 348 were still in residence. This number exceeded the capacity of the original facility by 75%. Admission to the Miramar Drug Center was limited in October, and an accelerated and intensive screening of the men in residence took place so that the poorly motivated men could be released from the program. Because of these circumstances, any effort to assign men to the various therapy tracks on any systematic basis at that time was impossible. Currently, with the patient population reduced to a more manageable level, assignments are made more in accordance with the patient's specific needs and problem areas.

Control of drug traffic is an ongoing problem. Drugs can become available wherever the demand exists, even in prisons and on locked psychiatric wards, and it was inevitable that they should also become available at Miramar. The center is not a security area; there are no fences, spotlights, or guards. There are 16 outside doors in the barracks, and none of the windows are locked. Despite periodic urine screens which occur randomly twice weekly and inspections of the living spaces, drugs continue to appear from time to time, depending primarily upon the complexion of the patient population and the extent to which peer pressure in the therapy tracks can be mobilized against their importation. In a rehabilitation setting some back-sliding is to be expected normally, and when this occurs it is dealt with initially within the therapeutic community, ultimately by the Commanding Officer if the extent of drug use has become flagrant or a question of dealing is involved. Excessive positive urines and/or continued drug trafficking is considered to be indicative of poor motivation and may become grounds for disciplinary action and/or dismissal from the program.

Another significant problem area, faced by any drug treatment center of whatever type and wheresoever located, is the matter of gaining acceptance by the local community, in this case the military population stationed at the Naval Air Station. There was an initial tendency to project many

fears and worries upon the rehabilitees, and there was slso s tendency to resent the renovsted barracks in which they lived snd the imagined pampered quality of their life style, to ssy nothing of the multiple misconceptions regsrding "therapy," s term which is often subject to the broadest of interpretations even in professional circles. To the Center staff, a group of patients sitting with their primary counselor under s tree constituted a valid discussion group; to a psssing sailor putting in a 12-hour day at work, they were "goofing off." The situstion wss not aided by the fact thst on occasion, especially during the esrly months of the program, the rehabilitees drew sttention to their own presence, thereby proclaiming to the air station at lsrge that they were the "Druggies" from "Rehab." These problems, wholly understandsble, are not unusual in any progrsm which establishes a facility to care for persons regsrded with suspicion by the local community. This unique situation hss been hsndled by maintsining good relations with the other facilities on the base snd by ensuring that the rehsbilitees obey the same rules and standsrds of appesrance, behavior, and conduct as do the other residents of the air station.

Considering the unique character of the center and the diversity of the Center staff, some considersble emphasis hsd to be placed upon maintsining internal communications. A line command in which a physician administers the major operational department, which employs civilisns rsnging in background from Social Workers to ex-addicts, and which is tasked with the job of providing s rehsbilitation effort to a group of angry snd rebellious young men who aren't altogether certain they wish to be rehsbilitated, is by its very nature an unusual beast and requires great flexibility, patience, snd forbearance on the part of sll staff members. As professional groups, neither military officers nor physicians are especially noted for their humility, and sdjustments had to be made and many staff meetings called in order to establish the atmosphere of mutual trust and respect which now exists. That this has occurred is, agsin, a tribute to the staff who weathered the initial throes of uncertainty and confusion.

In view of the considersble effort which the nation has lately msde in promulgating drug education, our patients, as a whole, manifest a general lsck of realistic information about drugs they have been using, despite their claims of expertise gained from extensive self-administrstion. Most are ignorant of significsnt medical side effects of the drugs, or took comfort in the belief that "it can't happen to me." Many sre critical of the customsry forced didactic lecture sessions to which they have been exposed, both in the military and in civilian schools, and they indicste they got much more from informal drug discussion groups. One of the frequently raised srguments is the claim by the young enlisted man thst he csn not trust the establishment suthority figure who has been assigned the task of disseminsting information snd lecturing, often times inaccurately, on drugs snd drug abuse.

The success of a program such as this is hard to quantify, although one of the stock questions invarisbly asked by visitors is "How much success are you having?" Evaluation of success is at least partly s function of time -- how long has the pstient remained off drugs -- snd this is, of course, impossible to ssy st the present. Follow-up questionnaires sre planned for those pstients who hsve returned to civilian life snd will be

mailed at intervals of six months, one and two years. Over thirteen hundred patients have come through the Center since its inception, snd the process of follow-up has just begun. Determinations of the status of patients returning to the military is more easily derived, and so far only three csses of unsucceasful adjustment to the military are known, although the time factor is so short that this figure is scant cauae for exultation. It must ultimately be admitted that many, perhaps most, of our accomplishments will turn out to be relatively intangible -- a msn who feels better, who has a better relationship with himself and hia aociety, whose pattern of drug use has shifted from harmful drugs to more innocuous substances, or who has simply grown up a bit because someone was willing to spend aome time with him. These results are difficult, if not sometimes impossible, to measure. Recognizing this, the Center is now embarking upon an extensive program evaluation which hopefully will provide new insights to the drug abuse problem.

APPENDIX C

Observations and Impressions Gathered in a Drug Treatment Center

In June and September of 1971 the U.S. Army, Vietnam established Drug Treatment Centers at Cam Ranh Bay and Long Binh, Vietnam, respectively. These centers operated through the worst of the drug situation in Vietnam; the Cam Ranh Bay DTC closed in April 1972 and the Long Binh DTC finally closed in October 1972. In March 1973, the Department of Defense convened a workshop, one segment of which addressed the problem of drug treatment. The attendees at the treatment sessions of the workshop were for the most part involved in the Army's drug treatment programs at the DTCs during 1971 and 1972. These men and women prepared an outline of the observations and impressions which they gained during their Vietnam experience, an outline which later was filled out by one of their number. That paper is reproduced below; it offers an excellent summary of the views of the professional men and women who were charged with the day-to-day business of establiahing and operating a center to treat drug abuse patients in a far from ideal environment.

The Patient

When one is confronted with a mass of confusing, somewhat impressionistic data it becomes an imperative task to classify and categorize the problem. The problem of the drug abuser in Vietnam aroused in most participant observers a curious ambivalent mixture of fear, hate, envy and disguat which further complicated the quest for clarity. Attempts to stereotype him according to demographic variables or personality characteristics proved to be a frustrating challenge. In time, however, a general picture began to emerge which allowed us to begin to think of treatment approaches. This outline served as a working hypothesis in understanding the etiology of this behavioral disease and the implications it held for us in our efforts to interrupt the progression of the disease.

Broadly speaking, we knew we were dealing with a young enlisted man who may or may not have been thinking of the Army as a future career. He was Mr. Hometown USA when considering his geographic origin, religious preference, and level of education. There was a tendency toward a larger representation of minority groups, primarily black, than might have been anticipated by their percentage within the Armed Forces. There seemed to be a trend toward a family background history of disruption by divorce or death of important family members. The history of adjustment in other social apheres such as work, school, and community leaned toward inconsistent completion. These expected findings, however, were not significant to a degree that would suggest a basic characterological pattern disturbance. Other pieces of information began to give form to the puzzle.

A rather large percentage of those soldiers detected as heroin users admitted to prior drug experimentation or abuse in the United States. In contrast to its use within the U.S., heroin in Vietnam was used in a group setting rather than as an individual preoccupation. The primary modes of ingestion were nasopulmonary rather than the intravenous route. There were strong hints that a social subsystem was developing complete with its own language, dress style, free time pursuits, myths, mores, and taboos. The peer pressure that it placed on incoming personnel was evident in the discovery that most were introduced to heroin use within their first few months in Vietnam.

Individually, most of those identified as users seemed to be in varying stages of intrapsychic regression. The stress of separation from family and friends, familiar surroundings, and the usual avenues of dealing with frustration were common to all those who rotated through Vietnam. The exposure to death or injury in a combat zone was an unpredictable factor depending on one's military occupational specialty, in-country location, and time of rotation. The gnawing pressure of boredom engendered by a static defense became a subtle undermining force. Depression based both on loss of external ego support and internalized rage was a universal response. Evidence of regression was more prominent in those who had not yet matured developmentally to a degree that their response could be a persistent, yet flexible one. Earlier, more primitive forms of adaptation to stress were reintroduced into their life styles.

The clinical state of depression is a physiological conservation of energy allowing the individual to withdraw to a less anxiety prone state. Other forms of withdrawal or retreat were present in our patient population. A pervading attitude of challenging the limits of authority more in keeping with an early adolescent rebellion was noted. They attempted to split authority figures collaboration by manipulating one against the other. The groups they formed tended more toward a loosely defined gang or informal family rather than an organized team. Their individual relationships had a superficial, transient, uncommitted quality to them. Their demand for immediate solutions to complicated questions suggested a conceptual reorganization to a concrete, black or white simple answer level. Comics were the preferred form of literature. Fantasies, rumors, and myth formation were considered superior to reality interpretations. As in a child the control over aggressive impulses was related more to the situation rather than to internal control.

Fortunately, as a group they retained many of the redeeming qualities which permits adolescence to be a tolerable phase for those who must deal with it. The energy behind the basic developmental drive was awesome once it could be released. The search for an older person, a model to identify with, was prevalent. The need to band together with a definable, cohesive group or organization in a hierarchal pattern was present. The strong sense of imagination and drama and the groping for idealism were evident. A longing to develop a close relationship with another human being had not been lost in most.

We all strongly felt that this was not one mass problem or stereotype but rather a continuum where the use of heroin as a symptom and the

interpersonal/intrapsychic development of the individual were cross valencea in a matrix. At one end of the spectrum was the primary, antecedent, physiologically addicted individual who used the drug heavily (intravenously) to meet a basic recurring flaw in his character structure. At the other terminus we found the reactive, accidental, social user who smoked periodically in response to peer pressure or transient emotional needs. Somewhere in between fell the majority of our patients in a roughly shaped Gaussian curve combining many of the developmental arrests or regressions mentioned before with a moderate degree of heroin usage. Along these lines we developed a system for diagnosis which is represented thus:

DEGREE OF INVOLVEMENT

PROGNOSIS	MILD	MODERATE	SEVERE
GOOD			
FAIR			
POOR			

It is a roughly correct and appropriate schema to use in categorizing this diagnostic dilemma but in practice it suffered from its generalization. It was fairly easy to establish definitive guidelines concerning the degree of involvement with heroin based on level of reported use, severity of the withdrawal syndrome, and the presence or absence of objective physical findings. The problem we found was in judging the prognosis on the data we had available to use. There was no reliable way to check on an individual's prior mode of functioning under stress. Judging the degree of social and intrapsychic regression or arrest requires a measure of clinical psychiatric sophistication and time investment that was not generally available or realistic.

Additionally, the judgement of motivation is a risky business whatever the field of human endesvor. Even so, attempts were made to resolve this point. Check lists and question and answer forms were administered to broaden our knowledge of the individual patients. We reviewed their personnel records to evaluate their general aptitude scores, schools attended, awards and decotions, and history of judicial and nonjudicial punishment. Informal tests were administered to check for level of commitment to change. At one installation patients were allowed an overnight pass to determine their readiness for further progression in a realistic manner. Although difficult, we found this diagnostic exercise to be an important one as a constant reminder that we were dealing with an infinitely variable group of individuals whom we had arbitrarily placed under one diagnostic classification - heroin abuse.

The Staff

The selection of a staff may become the crucial variable in determining the eventual success or failure of a drug treatment program. Early in the

history of the program large numbers of people with little training and negative motivation were pushed into positions to fill out the personnel roster. Through this ordeal we began to realize that individuals with specific personality traits were necessary to accomplish the mission. For those dealing directly with the patients these assets were necessary ingredients for therapeutic effectiveness.

Positive motivation can overcome a host of personality inadequacies and training deficits. Those replacing our original staff were volunteers fully aware of the hazards and responsibilities they faced. Their persistence in the face of considerable frustration was a tribute to this characteristic. The ability to delay immediate gratification for a more distant abstract goal was a necessary trait in order to maintain oneself through the various stages of staff development. A strong sense of loyalty to group goals with a suppression of absolute individuality eased strains within the treatment team.

In dealing with the patient, clinical training is an absolute must. Its great advantage to the staff member was that it provided a necessary sense of confidence in dealing with ego threatening patients. In spite of prior experience, specific in-service training is advisable to further supply a fund of objective knowledge and a subjective feeling of competence. With the use of training techniques to focus on group process and therapeutic strategies it will enable the potential therapist to gain timing and balance in the delivery of ideas of change. A degree of objectivity is helpful in order to distance oneself from many emotionally laden situations. Equally, self-discipline is provoked by those testing the outer limits of control. When one is challenged by the "mind game," hopefully he is mentally alert to the point that he is able to respond quickly with a twist of humor. In order to do this he must feel reasonably comfortable with verbal aggression, both giving and taking. A quality of empathically "tuning in" to a patient's feeling and thoughts hidden behind his surface veneer will allow the staff member a therapeutic patience to persist. Lastly, a broad tolerance of different life styles and solutions to life's problems is essential to survive the culture shock of trying to understand the drug user's view of the world.

Staff Development

A new staff embarking on an uncharted course of developing a treatment program for drug abuse patients will pass through many phases. Some staffs may become fixated at a particular stage and may be unable to move forward unless outside pressure and leadership is exerted.

One will find certain elements of the treatment team lagging behind the others with a section or informal leader being stuck at a certain point. Then a pointed effort must be made in education, persuasion, or coercion to help them catch up so the staff as a whole mutually supports one another. On rare occasions a staff member may become so intransigent that reassignment may be the desired course.

Whatever, the steps are progressive, well defined ones and may appear as stumbling blocks or transient episodes in the staff's developmental march.

A thorough working through of each phaae ia the preferred pace; the completion of one phaae will atimulate movement to the next.

Twelve Phases of Staff Development

1. Naive - Helpful

The ahock of entering a field where the balance of feelinga ia weighed negatively toward the patient arouaes in moat an intereated, protective responae. The deaire to help ia usually tempered with a realiatic asaessment that the staff haa little knowledge or training in thia clinical area. They approach the problem with an air of optimistic miagivings. Soon they are enthralled with the experience of viewing another peraon'a breaking of a aocial taboo, the uae of heroin. The hiatoriea are detailed and explicit but they aoon find that there exiata a language barrier which preventa them from really getting into the aubject. Soon one hesra akag, amack, downers, capa, heavy habit, shooting up, etc., bsndied about aa if they are really "rapping" and "getting down" with the patienta and begin to aak the inevitable question, "Why?" The patient'a reaponse ia a mixture of curiosity and mirth, "Becauae I like it, man." "But don't you know it will hurt you?" The patient leana back with a look of knowing diadain for thia riciduloua neophyte and laugha. This aymbolic interchange aeta the ataga for the moat difficult and longeat phaae of ataff development.

2. Anger - Rejection

"If the patient doean't need me, I certainly don't need him." What follows runa the gamut from aubtle sarcaatic cuta to brutal aadiatic handling of the problem. "They're juat animala ao what did you expect." "I locked him up in a Conex container for a week." "Put them out to aea for a week and bring back one peraon - the guy who pulled the plug." The supply of fantaaies and black humor will be endleaa. It is important to allcw the staff to vent thia rage without allowing them to act it out at the patient'a expenae. Jokea, humor, aonga, and akita are healthy waya to hsndle this reaction to diaappointment. The danger with this atep ia that it msy become rationalized and institutionalized if allowed to peraist. The staff will be frightened by their anger and try to run. The ataff may even encourage the patienta to run. Requesta for reaasignment will inundate the superviaor.

3. Control of Anger

Slowly, with encouragement and understanding reaaon will prevail and the ataff will begin to take ateps to control their unwilling patienta. It will be a time when outaide control forcea will make themaelves known snd actively available. They are neceaaary but care ahould be taken that they do not become the eaay aolution and the treatment center assume the trappinga of a penal colony. Phyaical methoda including fences, guarda, locka and aeparation areas will aeem reaaonable alternativea. Rules and regulationa will be more clearly drawn. The levels of medication for withdrawal symptoma will begin to riae. Ideaa concerning organizing the patient groupa in a more controllable fashion will begin to emerge. Thia stage, even with hard work may take up to two months for complete reaolution.

4. Exploration of Anger

The staff will begin to wonder why their own reaction was ao intenae and what it is in the nature of the patient that provoked such a response. Their intellectual curiosity will show itself - a handy supply of good literature would be helpful at this time. The creation of in-service training programs and discussion groups is encouraged to enhance this educational process. Those with a more active interest will initiate research projects with surveys, psychological tests and laboratory tests of physiologic responses leading the way. They will want to know what can be done.

5. Goal Formation

This phase is an interesting one in that it runs concurrently with the following one of role formation; both seem interdependent on one another. As the staff begins to speculate on the realistic possibilities for their program the goals they set are very simple and concrete. An example is 1) detoxification, 2) research, 3) rehabilitation. It is important that these initial goals be very clear and well within the reach of the group's talents. Small successes are a necessary ingredient for an optimistic push toward a group's ultimate aim.

6. Role Formation

The discussion of the team's goals becomes the form but a battle for territory becomes the content as everyone tries to carve out as large a role as he can for his section. Care must be taken that everyone who has a potential role is included at this stage and has a fair chance to participate. They may drop out later but it is easier to allow that than to make room for a newcomer. Once the pushing and shoving has subsided a test case, usually trivial, will arise.

7. Cohesion - Problem Resolution

Should the patients be allowed to write letters home while on the intensive care ward? A discussion will ensue that will tempt one to cut it short with an arbitrary decision. Everyone will become involved and every ramification of the problem will be explored. Compromises will be offered and rejected. No solution seems possible but one must insist on a resolution. One by one, minor points will be solved and the staff will exhaustively agree that the patient should be allowed to write home on the third day, late evening shift, with the Red Cross supplying the pencil and paper, and supply and services the stamp. The staff has just taken their first step, shaky, but without a doubt a step. The ensuing battles will be spirited but will share one overriding characteristic. Compromises will be found and will occur more and more easily. Formal and informal channels of communication will appear. A nursing report can become a common line for interdisciplinary contact. The coffee lounge, officers mess, or a particular enlisted man's quarters become meeting places that buzz with the exchange of ideas. Problems that would have seemed to be a crisis in the past are handled routinely. A strange calm settles in.

8. Group Ego Ideal

Calm becomes boredom and it in turn leads to restlessness. Vague noises of disaatisfaction begin to be heard. A slow distinct rumble is heard, "Why can't we do more for the patient?" The staff has found they can work together and now they want to reach for the limits of their capabilities. It is an exciting period for them because they have committed themselves to extend themselves. This extension may simply be shifting emphasis from detoxification to treatment but in their eyes it is important. Careful thought is given to restructuring the therapeutic approach. Familiar and unfamiliar terms with creative modes of presentation are heard -- group therapy, psychotherapy, behavior modification, confrontation, occupational therapy, tranaactional analysis, implosion therapy, transcendental meditation, psychodrama, yoga, and so on. What emerges is a carefully structured, highly integrated plan with the staff utilizing their individual backgrounds and skills to the utmost.

9. Implementation

A difficulty arises in having the plan approved relatively unchanged and having it coordinated with all the supporting elements. Eventually it is accepted with some resistance and considerable doubts. As the day for implementation approaches, tension runs high. There is minor confusion as staff members check and recheck their schedules to make sure they are following their part of the plan. Woe be to the staff member who doesn't appear at the right time or who takes too long.

10. Success

The plan is workable. The staff can't believe it at first but the mounting evidence becomes undeniable. Depending on the degree of diagnostic research and the accuracy of the treatment response the relative success runs from acceptable to fantastic. Sullen, resentful patients are suddenly cheerful, laughing young men. The use of methadone and tranquilizers for withdrawal falls to a minimum. The separation area becomes an uninhabited shell. The staff and patients begin working together as if they are in a common venture and not caught in an adversary system. The control element begins to wonder what their purpose is in life. It is a euphoric moment that should be allowed to linger. Soon enough the staff will be hatching fantastic unrealistic schemes that must be considered while maintaining both feet firmly on earth. A correction back to reality will ensue and a feeling of realistic satisfaction begins to show. An occasional staff member is discovered in his office after hours and unrequested projects come forth. What happened? The patients are the same people who were treated months before.

11. Evaluation

The staff knows the patients are doing well in the treatment program but how long does it last and what happens to them after they leave the center? Forms are developed to pass on information to the succeeding rehabilitation unit or to the patient's line commander. Questionnaires sent to the commander will probe the follow-up success

or failure of the individual. The authorities will demand to know what the success ratio is and how it can be improved.

Subtle adjustments are made in the program structure. The staff wants to know if other follow-on treatment and rehabilitation are successful and may wish to keep the patients longer if they think they are not.

12. Termination

The end of the treatment program will at first be denied and then resisted. Eventually, the staff will accept the inevitable dissolution of the team. Parties, going away gifts, skits, and awards help to soften the blow and send them on their way hopefully better prepared to participate in or form new treatment teams should the need arise.

A Model Program

If a treatment program is well integrated into an overall plan for rehabilitation it must have a time frame. It has been commonly reported that the fifth or sixth day is a period of irritability, insomnia, and of wavering resolution in the withdrawal syndrome. It may be due to the cellular surrender of bound morphine or to a dawning awareness that one is truly drug free. In any event, this reason plus the need to give the individual an opportunity to begin to take the realistic long view of life's problems and to develop habits makes it advisable to allow at least ten days for the initial stage of treatment. What follows is a detailed description of the therapeutic philosophies, techniques and interdigitating roles of a treatment model.

1. In Processing

Invariably, this routine but essential task is best performed by the control element in the form of military police, customs inspectors, or narcotic control officers. Their search must be thorough without demeaning the patient. The patient's belongings must be carefully accounted for so that his initial contact with the institution is one that reflects careful concern for his problem. At this point it is important to separate the individual from his prior symbols of identification to include beads, medals, crosses, combs and probably hair. A new set of fatigues without unit insignia or a pair of patient's pajamas is another neutralizing move. The admitting paperwork is usually the next step; it should be done as rapidly as possible so that those in severe withdrawal or with complicating medical problems are not denied proper medical care. The next stop is the physician's examining room and here a drug use and medical history is obtained. Although they are essentially healthy young men, care should be taken in the physical examination to check for obvious complications of drug use such as hepatitis, endocarditis, and abscesses, plus the many minor ailments overlooked in personal care by a person enmeshed in drug abuse. A check list is a helpful reminder and time saver. Those with serious medical complications or fevers of unknown origin and those requiring nursing care should be separated at this point and sent to the acute ward. Judgement of the withdrawal state should not be made at this moment unless the person is markedly dehydrated, vomiting, or has signs of diarrhea. A calm supportive

attitude should be used in response to questions about medication for their pains. This is not the time to administer long questionnaires or psychological tests. This is the time to consider the character of the patient group with an attempt to form a mildly heterogeneous mixture of ages, ranks, educational level, ethnic groups, and marital status. A number of factors should be considered to achieve a positive therapeutic blend.

2. Orientation

This is an important task which should continue throughout the patient's stay in the program. It may open with an introductory welcome and comment by the team leader, doctor, or nurse. A clear outline of the drug program and therapeutic intent written in normal English, not drug jargon, is helpful. Anticipating a seemingly endless barrage of questions one is advised to preempt them by a presentation from the various sections that are best able to explain and answer the questions. Signs, charts, posted questions and anawers all reinforce the initial orientation. All the members of the treatment team, its structure, and their roles should be introduced. Rules, regulations and expectations should be made absolutely clear and should be provided in written form. The time required for this orientation may last from one hour to one day depending on the amount of confusion preaent in the patient.

3. Treatment Team Structure

Remembering the patient's manipulative resourcefulness and his recurrent challenge to symbols of authority it is wise for lines of responsibility and communication to be made crystal clear. There should be no interference and no compromise with competing outside chains of command. These will only invite administrative confusion.

The control element is an external, symbolic member of the treatment team whose contribution can be supportive or disruptive depending on the success of the in-service clinical training. The control element is responsible for controlling entrance and exit to the treatment compound; this may require badges, name tags, and staff rosters. Control members must be quickly available to handle any loss of individual impulse control to avoid larger group involvement. Most infractions can be treated with a simple time out in the separation area and recycling to the next time frame. The program should reward cooperation, completion and success adequately so that little time or motivation is left for disruptive purposes. Finally, the control element has the unenviable responsibility of controlling the entrance and abuse of contraband. Periodic searches should be held to a minimum.

The leader of the therapeutic team must have sufficient rank and position so that there is no question of his authority. In the military structure the Medical Corps officer or physician is the logical choice for this position. He sets the tenor of the therapeutic thrust through his direction of the team meetings, supervision of the group therapy, and active participation in daily activities. The more traditional areas of diagnosis and prescription, medical management and drug abuse education will be his daily calling. A general medical officer or partially trained specialist

is better utilized in this post than is a fully trained specialist, even a psychiatrist.

The nurse's usual role of attentive observation can supply an enormous amount of information if she is properly trained. Her very presence has a calming, tension reducing effect in helping the patients establish a more normal male/female relationship. This can be used to dramatic effect in therapy where role playing and psychodrama may be used. A young energetic nurse with a flexible sense of humor best fills this role. She can be a great help in filling in on activities that need an extra push at times.

The ward master must be an experienced handler of men. He provides a sense of continuity with the Regular Army structure and coordinates the daily formations and work details to maintain the living areas. Forceful encouragement of the patients to complete activities will also fall to him as does the supervision and coordination of the corpsmen under his immediate control.

There is a need for someone to be responsible for directing and supplying the sports activities program. He must be an organizer, coach, referee, and enthusiastic participant who will show patients who think they are having withdrawal cramps that they are simply pangs of boredom and lassitude.

A person skilled in working with simple but imaginative crafts plays an important role for evening activities and rainy days. The American Red Cross is often available for this task. It is vitally important that these crafts be the type that can be used constructively in the patient's unit as hobbies and not just time fillers. Music, study groups, art, gardening, and fishing, for example, can all provide tangible alternative pursuits to the patient.

The leadership of therapeutic groups is best handled by a psychiatrist, chaplain, or social work officer. Unfortunately, they are in scarce supply and it is necessary to look to others to train for a wider application of these skills. The doctor, nurse, and ward master are the second line of trained personnel, but these require special courses as most of them probably have not had training in group techniques. It is a mistake to turn to the enlisted social work technician whose basic and advanced training hardly qualify him to control and direct the complex interactions of a group therapy experience. Further, by using him, one places a peer in the position of advising another peer and the inevitable response is a counter-attempt to expose and humiliate the technician. He can be trained to lead a very structured group with the support of written materials; simple techniques, such as role playing; music therapy; didactic sessions; and to administer and discuss forms and questionnaires. To ask him to be a group therapist is making improper use of available resources. Another error common in early programs is to turn over the heavy group therapy responsibility to an ex-drug abuser. He supposedly knows "from where they're coming" but unfortunately he rarely knows where they should be going. He often sounds articulate and committed, but that usually represents a reaction formation whereby the individual is trying to convince himself to stay off drugs by helping others to do so. It is an unpredictable defense

mechanism and often falters leaving everyone embarrassed including the "ex" drug abuser.

A number of consultants should be readily available to the treatment team. Specialists should include an internist and a psychiatrist to advise and teach in their related areas. A clinically trained psychologist is helpful in developing clinical and research questionnaires. The social work officer and chaplain are strong supports in the group work. Finally, an administrative officer or noncommissioned officer can advise and forestall many administrative problems.

4. Goals of Treatment

One of the great and surprising lessons learned in Vietnam was that the withdrawal syndrome from heroin was a myth of exaggerated proportions. The return of the autonomic system after its prolonged inhibition by this depressant was usually akin to nothing more than a bad cold and rarely as bad as a case of the flu. Approximately six percent of the patients required fluid and methadone support. Even then it took only two or three doses of 20 mg of methadone at six-hour intervals, a day of intravenous fluids, and bed rest in an air-conditioned ward. The remainder of the patients did quite well with symptomatic relief in the form of Valium for cramps and insomnia, Tigan for vomiting and kaopectate or Lomotil for diarrhea. It was found after a number of episodes of tonguing the Valium tablets that a liquid preparation with the addition of a slight taste of quinine for a bitter taste discouraged the abusers. Barbiturates for sleep are contraindicated and dangerous to have around a ward. Phenothiazines showed no superiority to Valium and one had to watch for the hypotensive and extrapyramidal reactions. In short, the less mention made of withdrawal, the better, and everybody out on the baseball field. If a patient complained of severe withdrawal symptoms he was simply checked for objective clinical signs such as tachcardia, hyperperistalsis, goose flesh, dilated pupils, hyperpyrexia, vomiting and diarrhea. The muscle cramps were real but they did not prevent one from spiking a well set up volleyball.

A conceptual approach to treatment of the heroin abuser must be presented at a level that is understandable to staff and patients alike. This is not the time or place for therapeutic mystery or aloof theorizing. One might view drug abuse from an intrapsychic, interpersonal, or cultural viewpoint or even a mixture of the three. Each plays its role in the process and a strategy to interrupt it at each level increases the possibility of success. An example of examining drug abuse from an intrapsychic point of view might be to compare it to something everyone has had some experience with, breaking a habit. If one thinks about the emotional and attitudinal shifts one must make to give up cigarettes, for example, he must:

- Become aware of the destructive aspects of the habit.

- Accept the habit as an integral part of his learning process - a part of him.

- Begin to experience a sense of guilt for the danger he is placing himself, and reflectively those who are concerned about him, in.

- Develop an internalized rage at his inability to control or reverse his habit spontaneously.

- Consolidate his rage to a directed, workable anger.

- Make a decision or resolution to direct one's energies to control and redirect this habit.

- Establish a plan to support that part of him that wants to relinquish the habit.

- Carry through with the plan.

One might object that comparing a heroin addict to a cigarette habit is akin to the difference between a hornet and a mosquito sting. The answer is that if the heroin habituation is not caught when it is an inadequately reinforced learned response one can forego attempting to reverse the dependency in a three-week or even a three-month treatment program. A similar approach can be worked out for the interpersonal choice one makes for friends or why he chooses to join the "head" subculture and what he can do to look for another.

If a therapist looks to helping effect an internalized shift in another's attitude and wishes to bring it to his awareness he may be subtle or direct. If time is short or denial is strong a direct exposure of contradictions may be necessary. Various forms of confrontations are used ranging from an objective delivery of the facts to calling one a liar in the presence of his peers. Secondly, the therapist must help the patient assume personal responsibility for the fix in which he has placed himself. Again, pointing out his personal actions and choices leading to his involvement is superior to emphasizing guilt but with some the latter is necessary. Explaining cause and effect relationships is a revelation to most. A refusal to accept a rationalization or a displacement of the blame to others brings the cause back home. A careful, reasoned delineation of the full impact of the effect (detention, withdrawal, medical dangers, personal and family shame, future job compromise) help bring closure to the thought process. A further push in this direction helps him to see that he is capable of change and that it is expected of him. The patient may be angry now because he has been shown a bit of truth and has been challenged to deal with it. The therapist accepts his fury and allows the new idea to sink in. Then he goes back to his task pressing home the concept of accountability and showing the patient through focusing his anger and aggressive push on small challenges that success is a possibility and a euphoric fruit in its own right. This can be done in an endless variety of ways from speaking up for the first time in a group meeting to finishing building a small mobile for his living area to getting a base hit for his team on the field. What these small accomplishments share in common is that they must be recognized as significant and good by the therapeutic team members and reflected back to the patient as realistic praise. As one might suspect this takes sensitive attention and much giving on the part of the staff. This occurs at about the same time the patient begins to emerge from the withdrawal state and a combination of relative hypoglycemia and emotional dependency needs place large demands on the food service. It was found that the patients required almost twice

the amount of food that is supplied to a normal hospital population. This total kind of support tends to drain the staff's energies and predictable, recurrent periods of time off duty are imperative.

Hopefully, the patient is now beginning to wonder what can be done about his problem. It is the therapist's job to show him in detail what problem solving, goal oriented behavior is all about. This can be done by setting up plans for athletic teams, developing competitive strategies, organizing craft projects from materials to the finished product, teaching him how cohesion can be built into a group interaction, and indicating to him the steps of internal change he has achieved in getting to his present point. He is gently chided and pushed when he gets irritable or discouraged. At times, this may take an evangelic zeal to maintain the forward momentum. Using his naturally acquired goal oriented skills helps him to see that other goals may be more rewarding than the pursuit of hard drugs, and to broaden his spectrum of choices to reveal to him the myriad pathways from which one has to choose in life. He is left with this cultural overload long enough to stimulate him but not to the point of confusion. He must be forced to commit himself to a reasonable number of physical, social, emotional, and recreational avenues that share nothing with drug use or its culture. The rest depends on the enthusiasm and quality of the teachers. Hopefully, the staff and the program have gained the cooperation, trust, and respect of the patient, and his innate drive for health and self fulfillment will propel him forward, possibly with an occasional boost.

The Patient Group

One of the strongest weapons at one's disposal is the intense need of the young men to band together in a defined group. An associative need to this is the desire to have at the head of the group a somewhat idealized leader as a model for identification. These two naturally occurring phenomenon give one a tremendous leverage in fashioning forces to introduce healthy, more natural solutions to life's conflicts. Ideally, therapy is a recapitulation of the individual's normal course of maturational development. A one-to-one relationship merges with a family numbered group or setting. With a natural evolution one then sees externalized family or friends, adolescent gangs, teams, clubs or fraternities, organizations, political movements, nation states. A roughly similar pattern can be seen within the military structure minus the formalized family and individualized grouping. Recalling that a significant proportion of our population comes from a disrupted family background one can speculate that his experience with groups other than a one-to-one relationship is limited or disordered. A family group of six to eight with a "parent" at the head, available to give individual attention would hopefully include ninety-five percent of the patients. At the very least one should organize a gang of ten to fifteen and help them develop into a team. Now that your family or gang is going, it is necessary to give it a group identity. Team colors, a gang cheer, family traditions, a secret code or "dap," are all tools of the trade in building the system. They should eat, sleep, work, plan, play, and pray together. A commonly shared experience, either traumatic or successful, builds ties that are extremely resistant to external forces. If the ego ideal is the kind of man one hopes he is, a tradition of trial and error, success and failure, flexibility, patience, persistence, creativity,

and humor will slowly develop as the group's response to their common fate. One's strength will compensate for another's weakness and will act as a stimulant for further individual growth. Soon the family or gang are pulling together and finding that by modifying their individual differences their success as a group is increased. Each success feeds the desire for another and the system becomes self-perpetuating.

The problem is not whether one can successfully build a tight group, but how it can be translated into the more complex organizational strata of the military system. One has the choice of either extending the original group and developing it as in basic military or advanced training, gradually easing out the ego ideal as a natural leader emerges, or training the individual to the point where his instinctive response is to enter an advanced group system. Rehabilitation is built on these premises.

Proposal for Prevention

When subsystems begin to develop within an organization, and they were rampant in Vietnam, one can either treat the results of it or give the system the tools and flexibility within the structure to deal with it. The family group (with a military name) could be a fairly easy shift led by an ego ideal senior noncommissioned officer for a period of training when symptoms of a system breakdown are evident. The noncommissioned officer would have to be cross trained in group dynamics and development as in the treatment model. Preferably, he would be with his group day and night structuring their lives in a fashion similar to the treatment model. The problems one would face in a venture of this sort lie in the resistance of the system to the increased personal investment required. However, the additional training supplied to the noncommissioned officer should lessen the resistance. It would make an interesting experiment in relieving disparate stresses on the system. If it was found through the follow-up that no treatment system, however sophisticated, can cure a person once he is addicted to heroin, a preventive approach becomes the only approach.

APPENDIX D

Lessons Learned from the Operation of Drug Rehabilitation Centers in Vietnam

In addition to two Drug Treatment Centers, standardized Drug Rehabilitation Centers were established throughout Vietnam in the latter part of 1971. Some of the officer and enlisted members of the staffs of these DRCs were gathered together at a March 1973 Department of Defense workshop. Their collective experiences and observations are recorded below.

From June 1971 to June 1972 those individuals who were engaged in the task of rehabilitating heroin abusers gained invaluable experience from the standardized program of the U.S. Army, Vietnam, Drug Rehabilitation Centers. The organizational structure provided staffing of one combat arms major as the commanding officer of the rehabilitation center and one medical officer as the center physician. Also provided were a noncommissioned officer in charge, administrative personnel, thirteen branch immaterial counselors and two noncommissioned officer field representatives. These enlisted men were recruited from units in the area supported by the rehabilitation center. As augmentation, the Medical Command provided four corpsmen and four enlisted social work specialists. It should be emphasized that the Drug Rehabilitation Center was a nonmedical facility under the command and control of the area commander. While the responsibility of operating the center rested with the commander of the area in which the center was located, professional medical consultation and supervision were provided by professional medical officers from the Medical Command and other medical facilities near by. The normal period of rehabilitation lasted fourteen days, during which time extensive medical evaluation was done and physical and psychological rehabilitation attempted.

It was found that an experienced combat arms officer had the prerequisites to inaugurate and operate a program which was judged to be successful in all aspects. He provided the experienced leadership which was so necessary to establish and maintain a constructive and stable military milieu within the center. At rehabilitation centers where strong, experienced leadership was present, staff morale was high, and intrastaff communication was facilitated. At these centers it was made explicitly clear to the patients that mature and soldierly conduct was expected of them. It was found that unit commanders who found high military standards in their local center used that Drug Rehabilitation Center and supported the rehabilitation activities. On the other hand, centers where military courtesy and conduct were substandard and where strong leadership was absent suffered a lack of credibility and outside support which were so essential to the operation of a rehabilitation center.

The majority of centers in Vietnam found the assignment of a medical officer essential to treat secondary medical problems in addition to

performing the initial medical evaluation of the patients. Doctors also played a key therapeutic role by providing technical and psychological support to other aspects of the rehabilitation program. They provided advice on physical reconditioning, group activities, counseling, and drug pharmacology. It was rare to find a doctor who had received specialized training in the rehabilitation of drug abusers. Further, in Vietnam many physicians lacked knowledge of simple military subjects such as Army organization, Army sociology and established operating procedures; this at times discouraged otherwise willing medical officers and reduced their effectiveness. At centers commanded by experienced officers, however, this particular problem was reduced.

In spite of the command emphasis and publicity airing the drug abuse problem as a serious social problem in the Army, commanders at all echelons continued to view the Drug Rehabilitation Center as a medical facility and expected that the drug abuse patient would be cured by its doctors. Medical officers assigned to drug rehabilitation centers experienced a great deal of frustration at this unrealistic expectation. The commanders' expectation that the medical officer would cure the immaturity which was often found to be the core of the drug abuser's problem was the result of inadequate dissemination of information to the commanders in the field. The societal or cultural myth that the doctor is the healer of all sickness to include the social problem of drug abuse also contributed to the commanders' expectation.

The physicians found their traditional medical methods were minimally productive in dealing with drug abusers. They learned that the routine use of psychiatric diagnostic classification of character and behavior disorder created anti-therapeutic nihilism which only served to dispel the enthusiasm and motivation of physicians and counselors alike. The traditional medical approach placed the drug abuser in a dependent role, implying that he was dependent upon the doctor to cure him. The Vietnam experience reversed this view when it adopted as a treatment modality the constant reminding of the drug abuser that he was responsible for his behavior and the choices that he makes in dealing with life situations. When this adult-like expectation was made clear to him, he often responded constructively and positively, provided a strong emotional support was provided by counselors and the abuser's peers.

Another lesson learned deals with the criterion for selection of counselors for the Drug Rehabilitation Centers. It was found that civilian and military occupational specialties in such fields as social work, neuropsychiatry and occupational therapy were not necessarily the most important requirements for an effective counselor. While previous experience in social work, psychology and other human relations fields merits some consideration in the selection of prospective workers, certain personal qualities contribute more to a good counselor. These qualities are the ability to experience and express human feelings, the ability to relate to people -- seniors, subordinates and peers alike, realistic but optimistic attitudes, verbal articulateness, correct military bearing and courtesy, and most of all, emotional maturity. All of these qualities contributed to increased credibility with drug abusers who sought help. While enlisted social work specialists who had previous experience as social workers or counselors

contributed to the program by assuming leadership roles, they at times had obvious feelings of inadequacy and disappointment. Only the innate personal qualities cited above seemed to sustain these enlisted paraprofessionals through the long hours of labor. On the other hand, the thirteen branch immaterial counselors who were recruited locally and screened by the center commander, medical officer and social work specialist proved themselves to be more capable than originally expected. These individuals showed enormous enthusiasm, compassion and endurance. The college-educated counselor sometimes created a barrier between himself and the drug abuser, who may be a high school dropout with an apathetic attitude toward the future. On the other hand, a former infantry soldier counselor with a high school or general education development diploma seemed to provide a realistic relationship with the drug abuser with the absence of professional jargon. With constant psychological support from the center commander and his staff, the branch immaterial counselors were quite productive when working in a team approach with the enlisted social work specialists. Each complimented the other.

Each Drug Rehabilitation Center had its own distinctive style and emotional overtone, in spite of the basic standardization directed by the U.S. Army, Vietnam. The rehabilitation center was tailored by the personalities and attitudes of the commander and his staff members. It had its own center insignia, and cultivated its own unique language and mode of expression. Counselors who were able to fit into the style of a particular Drug Rehabilitation Center tended to be successful.

The use of ex-drug abusers in rehabilitation work was tried in Vietnam and failed. This was due in large part to the fact that with few exceptions ex-drug abusers lacked many of the essential counselor qualities already listed. Further, the civilian counselors sent from the United States were generally not productive. The majority of them had little knowledge of the Army, its organization and procedures; consequently, their credibility with commanders was weak.

Among the counselors there was the occasional manifestation of what came to be called the "burned-out syndrome." The "burned-out syndrome" was not necessarily a reflection of poor personality traits of the counselor. It was the result of a series of disappointments over the low success rate of rehabilitation when a counselor had unrealistically high expectations of himself and of other counselors, or when he had his savior fantasy shattered by his experiences. When the "burned-out syndrome" was seen in a counselor or staff member it was found best to remove him from the program. This type of staff breakdown was contagious and spread to other staff members as well as to the patients.

In the Army one finds many young soldiers who can relate comfortably to his peers; however, among these young soldiers there are a number who have a considerable difficulty in relating to individuals in positions of authority. As long as the rehabilitation program is going to be operated within the Army structure, a counselor who has difficulty relating to authority figures is basically noneffective no matter how well he relates to his peers. This type of counselor found himself lacking credibility with the commanders who were the providers of the all-important command support.

An important activity of counselors charged with the responsibility of day-to-day rehabilitating of drug abusers was found to be the maintenance of open communications with other staff members on the progress of each patient. At centers where the program was considered successful, the staff consistently held daily meetings of considerable length to share the events of the day and to exchange viewpoints and observations with others. This daily meeting not only served the purpose of disseminating administrative information, but it also provided the therapeutic opportunity to air frustrations and to solicit tangible and intangible intrastaff support to strengthen the cohesiveness among staff members. This was believed to be the essence of the therapeutic community principle under which the program was conducted in Vietnam.

When the drug abuser was admitted to the DRC he was immediately assigned to a group led by a social work specialist and one or two counselors. Successful rehabilitation was seen when the social work specialist and counselors alike joined the patients in all aspects of the center activities including the individual and group counseling sessions, physical reconditioning, work details and meals. Where the center commander, medical personnel and noncommissioned officers participated in center activities with patients, morale was high among all participants. Further, the psychological games of manipulation by patients seemed to diminish.

Counseling activities at the DRCs were mainly group oriented. Individual counseling, when it was done, was by and large ineffective because many patients used it as a means of avoiding involvement in group activities. The group encounter experience was found to be much more effective. It focused on the expression of feelings related to here-and-now situations. Self-awareness was encouraged. The technique of role playing was found to be extremely useful. It was not only realistic and applicable to immediate situations with which drug abusers had to learn to cope, but it also appealed to the dramatic qualities of young soldiers who otherwise were incapable of using theory or abstract ideas in their dealings with people and everyday living. Since military organization and its unique culture traditionally values adult behavior and individual responsibility, strong emphasis was placed upon the patient to assume responsibility in his decision making.

All rehabilitation centers also used activity oriented group programs, such as carpentry, drawing and other goal-oriented work details. When patients labored and produced a finished product, their self-esteem was heightened.

Regression and passive dependency was not tolerated, but the backsliding individual was not harassed. Increased support was given to such an individual in the form of constant encouragement in the expectation that he could grow up if he so desired.

The unit counselor program deserves mention because it is believed to be a major contribution to the drug rehabilitation effort in Vietnam, and has potential for application throughout the Armed Forces as well as the civilian community. The unit counselor concept was conceived to create an effective counter drug abuse resource within the unit. The program

provided drug education orientation, preventive programs, and much needed rehabilitation follow-up services for rehabilitated drug abusers who had returned to their home units after a stay in a rehabilitation or treatment center. The program operated through interpersonal communication among the men at all echelons of the unit.

Prior to the summer of 1971, DRCs were operated by various units and organizations in Vietnam; these units reported a high recidivist rate among soldiers who were returned to duty from rehabilitation centers. The causative factors were numerous. There was a marked lack of drug education for men of all grades. As heroin abuse became a social group phenomenon among abusers, a former abuser returning from a rehabilitation center was faced with drug-using peer pressure in the absence of an organized and functioning drug-free peer group to help him maintain abstinence. Ideological and attitudinal conflicts between noncommissioned officers and lower grade enlisted men existed. Troops were not fully informed of drug abuse, rehabilitation programs, and the policies of the commander. The traditional modality of outpatient clinic follow-up was attempted by centers and was unsuccessful in the face of the problems which existed in the combat zone, namely great geographical distances, unpredictable mission demands, long working hours, and lack of transportation.

On the other hand, it became clear that a soldier's successful abstinence from drugs during his tour in Vietnam depended on an effective counter-drug abuse program within his unit. All soldiers needed credible information about drug pharmacology and the command policy and program. Just as important, he needed effective, personal support to initiate and maintain his membership in a drug-free peer group throughout his tour. Some organizations attempted to deliver constructive services to meet the educational and interpersonal needs of their men through the use of battalion surgeons, chaplains, battalion drug coordinating teams and coffee houses. Their approaches had varying degrees of success depending largely on the personal interest of the designated workers and the commander. Sometimes, these attempts failed to reach the critical target audience of drug abusers in the small unit who had already psychologically alienated themselves from communication outside their drug-oriented life style.

The foremost advantage of having the helping resource within the unit was the unit counselor's ready availability. The unit counselor was readily available to assist the commander in taking care of his mens' human needs because he belonged to and lived in the unit of his assignment. He was the compassionate peer counselor to individual soldiers and an influence for desirable social action and change for the unit's welfare. Next he had the requisite knowledge to qualify him to act as a catalyst in influencing the psychological climate within the unit.

In addition to maturity, genuine interest in human beings and compassion for them, which are essential prerequisites, the unit counselor had to be capable of effective interpersonal communications and relationships. He had to have an ability to reach out to the impressionable target clientele of lower enlisted ranks and relate effectively to his seniors. He had to be a resourceful individual to bring to bear the available resources of the organization to assist his fellow soldiers. Furthermore, he was

expected to seek and create human interpersonal realtionships as dynamic helping resources to meet the paychological needs of the soldiers.

Upon selection, the unit counselor was trained at the local DRC in the subjects related to his assigned mission. Thereafter, he assisted the unit commander and his subordinate leaders in gaining an understanding of the whole drug abuse problem in the unit. He briefed each newly assigned man on the drug scene in Vietnam, the hazards and consequences of drug abuse, and the urinalysis and rehabilitation programs, and he encouraged drug abusers in the unit to seek help.

A basic lesson learned in the unit counselor program centered on the selection of the prospective unit counselor. That selection reflected the commander's attitude and interest toward drug abusers and the command program. When the commander was interested, he selected good men to be trained as unit counselors. Unfortunately, the commander was not always interested and the program in his unit suffered. Some selected counselors were nonvolunteers who had little interest in assuming the counseling duty. Since the positive and constructive use of interpersonal relationships in counseling and consultation is an important tool of the unit counselor, the employment of nonvolunteers as counselors was found to be counter-productive.

Some commanders selected former drug abusers as their unit counselors; generally, these made inappropriate candidates for the part.

The depth of involvement of the unit counselor in carrying out the unit drug education, prevention, and follow-up services depended on the degree of commitment of the individual unit counselor, his skills and ingenuity, and most important, the support of his unit commander. Unit counselors faced human problems other than drug abuse. Soldiers who were in psychological shock after receiving bad news from home needed emotional support and ventilation. Some voiced concern over a marriage or engagement after a long break in correspondence. Soldiers planning on a post Army future were interested in discussing college plans and veterans benefits. Still others simply needed someone to listen to their stories of loneliness and anxiety after being away from home. Many unit counselors met these human needs of fellow soldiers, thus expanding their role from drug-related counseling and related activities to a wider sphere encompassing the whole spectrum of human relations problems. Some full time unit counselors had duty hours which began at 2 o'clock in the afternoon and lasted until midnight; they found that soldiers predominantly sought counseling and rap sessions during the late afternoon and evening hours.

An invaluable lesson learned was that the unit counselor should be trained to be a sensitive listener and skilled referral agent who can make maximum use of his knowledge of available resources to assist with his unit's human problems. To set the goal of teaching him to be skillful in counseling techniques in the time available is unrealistic.

Finally, just as the counselors and staff members of the Drug Rehabilitation Centers needed emotional support and professional supervision, so also did the unit counselors, but to a greater extent. No other factor was more demoralizing to a unit counselor than his feeling of isolation, his needs for supervision and consultation unmet.

APPENDIX E

After Action Report
United States Army Rehabilitation Center - Danang

In March 1972 the officer who established, organized and commanded the U.S. Army Drug Rehabilitation Center in Danang, Vietnam submitted a report of his experiences to the Corps Commander. That report has much of value in it for anyone concerned with drug abuse programs and so it is reproduced below. It has been edited slightly, primarily to remove irrelevant material.

History

Personnel - The decision was made that a combat arms officer would establish and command the Drug Rehabilitation Center, and on 30 September 1971, I was informed (on a remote firebase southwest of Duc Pho) that I was to report to G-1, XXIV Corps on 1 October. I did so and in an interview with the Commanding General, XXIV Corps the next day I was directed to open the Center on 11 October. Notwithstanding the formidable administrative and logistical tasks to be accomplished, including approving a facility, relocating its tenants and renovating it to be suitable for a Drug Rehabilitation Center, the first priority was selecting and training a staff. On 2 October two Army Private First Class social workers especially trained in drug rehabilitation reported for interviews and were selected. Major subordinate commands in the Danang area were required to submit nominees for counselors for the Center for interviews, and the interviews began in earnest. On 4 October the Medical Director was finally selected. As he and I traveled to other rehabilitation centers in operation and to Headquarters, U.S. Army, Vietnam for guidance, a program began to take shape. The small staff now moved to the new facility to begin the long hours of hard work necessary to clean the facility and to renovate it. By 11 October, one ward had been constructed, the staff numbered twelve of twenty-eight authorized, and three patients were admitted. Eight more patients were admitted on Thursday, 14 October, but because of insufficient staff, no patients were admitted the following Monday. Standards for selecting the staff were high, and even when an enlisted man was found acceptable for the staff, an inordinate amount of time was required for coordination between USARV and the unit before the individual reported for duty, if he ever did. Admissions dates on 9 December and 31 January 1972 were also missed because of insufficient staff. The staff was organized into three operational sections: social workers, counselors, and wardmaster (see Inclosure 1). The social workers consisted of a noncommissioned officer-in-charge and four enlisted men, one for each of the four patient groups which would be in the Center at once. The counselors consisted of a noncommissioned officer-in-charge and four teams of counselors, one team for each of the four patient groups. The Wardmaster Section attended to patient care and such minor medical care for the staff as was required.

Program - USARV Manual No. 600-10 directed that the Drug Rehabilitation Center "provide billeting, messing, group psychotherapy, minor medical treatment, administration, modest recreational activities and a program of rehabilitation" in the fourteen days authorized for the program. From the beginning, this Center used the first three days of each group's stay for detoxification. This simply involved putting the patient in hospital pajamas and leaving him in a special detoxification ward under medical supervision for three days. All his meals were served him in the ward. Some medication was available for alleviating symptoms of withdrawal but was used sparingly. Placebos were found to work almost as well as tranquilizers. Should the patient need to leave the ward to go to the latrine, he was escorted there and back individually. After three days in the detoxification ward, the patient was anxious to get outside and start his rehabilitation. Each of the eleven days devoted to rehabilitation included activities for physical as well as psychological rehabilitation (see Inclosure 2). Physical rehabilitation was thought to be a very important part of the program, and was approached through one ninety-minute organized athletics period daily, and two ninety-minute periods of "work therapy" or work details daily. This was designed not so much to keep the patient occupied or to tire him out as to rehabilitate him physically, and they all needed physical rehabilitation. The most important aspect of the program, however, was psychological rehabilitation, and the basic tool was the group psychotherapy session. Using any one of a number of proven themes and techniques developed for the group session (see Inclosure 3), the social worker guided his group, the individuals working on each other, towards the goal of providing each patient an objective look at himself and an understanding of his true relationship with drugs. The social worker, through the group sessions and also through daily individual counseling of each of his charges attempted to reinforce the patient's resolve to stay off drugs. Nightly rap sessions and the arts and crafts program were also part of the psychotherapy. Two nights a week each group participated in a group session directed by a chaplain. The religious approach, which has some value in some cases, was tried, but only on a voluntary basis on the part of the patients. Other features of the Center's program were:

- The Team Approach - patient group integrity was found to be important. An amorphous group with constantly changing identity may function well in a long term effort, but with just fourteen days with which to work, group identity and integrity were thought to be critical factors. Consequently, the social worker assigned to each group received it into the Center and stayed with it to the end of the fourteen-day program as did the three staff counselors. These four staff members constituted a team with the patient group which makes attaining the psychological objectives possible and facilitates the resocialization efforts as well.

- Comprehensive Records - patient records were carefully kept. Each patient's personnel file and health records were scrutinized upon entry and extracts made for the Center's records. The social worker's intake interviews, his daily counseling records, comments by medical personnel and a daily comment by each counselor on the team became part of the patient's records at the Center. Finally, a lengthy interview with each patient was conducted by the senior social worker as the patient neared the end of the program; this completed the patient's file. A detailed profile of each patient could be obtained at any time by referring to his file.

- Follow-up - from the very first day of operation, we realized the importance of follow-up on graduates. Our goal was to see each graduate at least twice monthly, counsel him, help him with any problems he may have and give him the opportunity to prove that he is atill on the program through urinalysis tests. If trends current then continued, well over 50% of the Center's graduates would return to the United States without returning to heroin. In addition to follow-up, the liaison noncommisaioned officers alao effected continuing liaison with the units served by the Center.

- Unit Counselor Training - rehabilitation muat continue in the unit if it is to have a good chance of auccess. USARV Manual 600-10 directed each company-size unit to have two unit counselors and directed the Drug Rehabilitation Center to train them. Unit counselors enhance a unit's ability to approach the drug abuse problem and permit a continuation of rehabilitation started in the Drug Treatment Center as well as in the Drug Rehabilitation Center. More than 300 men were sent to the Center for this training, and each of the 120 who completed the course received a letter attesting to this completion for inclusion in his personnel file.

- Facility - an area with excellent potential was made available for the DRC. It was surrounded by a barbed wire fence which served to keep visitors out and also functioned aa a psychological barrier to the patients. The location was isolated from the great majority of units served by the Center. It provided ample space for wards, and adequate space for billeting the entire staff. It also featured an outside patient patio, and space for weight lifting, horseshoes, touch football, volleyball, and basketball. It proved to be an eminently satisfactory facility.

- Support - peraonnel services support was provided by Headquarters, XXIV Corps and was adequate. Logistical support (property, mess and transportation) was initially provided by 1st Battalion, 44th Artillery and then by 58th Transportation Battalion and was alao adequate. Additional support was provided by 45th Engineer Group and Headquarters, XXIV Corps (supply and special services). Particularly helpful was the support volunteered by U.S. Army Support Command which provided 16,000 sand bags and two vehicles, among many other items.

Problems

A modeat request for Engineer assistance, involving about $4,500 was turned down by USARV. As a result the small staff had to undertake the monumental task of rebuilding the facility without the requisite skills, tools, or materials, and at the same time conduct a drug rehabilitation program. Often working thirty-six hours at a stretch, the staff persisted. The facility was completely renovated, and represents a tremendous accomplishment.

Selection of staff, especially military occupational specialty immaterial counselors, was most difficult. Those nominated should be intelligent, mature, and have an interest in helping the drug abuser. Those interviewed and selected should be immediately made available, but most often were not. Coordination between USARV and the unit was lugubrious and ineffective. The

Center Commander must have virtual carte blanche for selecting his staff, and those he has selected must be made immediately available.

A potentially serious problem were "drop-outs," those who entered the program professing motivation, but left soon after detoxification. These individuals contributed nothing to the program and in fact seriously detracted from the rehabilitation effort made on the others in the program who may have been sincerely motivated. This problem was identified early and the command emphasis placed on it by the Commanding General of XXIV Corps virtually eliminated the problem.

A major concern at any drug center is maintenance of a drug-free environment. Every effort must be made to stop the flow of drugs into the area. No Vietnamese were allowed to enter. No visitors were allowed the patient, except officers, senior noncommissioned officers and unit counselors (who should regularly submit to urinalysis). All mail was suspect, and opened in the presence of a staff counselor. No packages or in-country letter mail were allowed the patients. Absolutely no contact was allowed the patient with personnel outside the Center and as little as possible with other patients not in the group. Upon admission, a new patient was stripped of all his belongings which were returned to him when he completed the program. These included cigarettes, watches, bracelets, cigarette lighters, and toilet articles (except razor), to reduce the chance of his smuggling anything in. Notwithstanding this, patients and staff submitted to a urinalysis at least twice a week (and the days were varied from time to time), and the staff was constantly on the alert to changes in the mood of the patients, as well as to guard against ourside contacts.

Unit counselor training was a very important aspect of the Center's operation, yet it is only as good as the men selected from the unit to receive the training. Of more than 300 men sent to the Center to receive the training, only 120 completed the course and less than one-fourth of them, or thirty could be said to have good potential for unit counselors.

Lessons Learned

The purely professional approach works. No catchy name was given the Center (The U.S. Army Rehabilitation Center - Danang), no evocative slogans were used, nor psychedelic posters displayed. We were all business from the start leaving no doubt in the patient's mind that our mission was to return him to his unit as a functioning soldier. From all reports this approach worked well.

Once the tone of the Center was set, changes in key personnel such as Center Director, Medical Director, or Senior Social Worker were carefully approached. Unless all key personnel can generally agree on the direction of the rehabilitation effort, chaos will result.

Former drug abusers are not necessary nor even desirable as staff members. They enjoy no advantage over the nonuser in showing the "junkie" that he need not resort to drugs. The character and behavior disorders that invariably characterize the drug abuser are often still present although he may not be on drugs presently. Three former users selected for the staff

were released, not because they reverted to drugs, but because they were unstable.

Withdrawal syndrome was found to be minor. Fewer than five percent of the patients exhibited significant withdrawal symptoms.

Placebos work almost as well to relieve discomfort during withdrawal as do potent medication.

So sorely tested is the resolve of even the most sincerely motivated of patients during the first few days of the program that not more than one man from any one company should be admitted with each group. If two men knew each other, invariably they would both drop out.

Everything is suspect - glue, paint thinner, toothpaste, spray deodorant. If it is possible to get a "high"on it, they will try it.

Visual deprivation is an important feature for the group session room. The room should be plain and the walls unadorned so there will be no distractions from participation in psychotherapy sessions.

The patient will have a voracious appetite after detoxification and in the fourteen days will gain back from fifteen to twenty-five of the pounds he lost while on heroin. Extra rations should be requested and approved.

The patient's bowels will move and with a vengeance, often for the first time in weeks. More than the normal number of accommodations must be made available.

The patient profile is not representative of the American soldier in Vietnam or anyplace else.

The drug abuser problem is not substantially a heroin problem - it is a personnel problem; sixty-five percent of the Center's patients abused drugs (not counting marijuana) prior to coming into the Army. Most of them had sociopathic personalities.

Fifty percent of the problem, as we saw it, could be eliminated in basic and advanced training; for example, more than half of our patients received nonjudicial punishment in their first sixteen weeks. Procedures should be implemented to void the enlistment contracts of such individuals at that time.

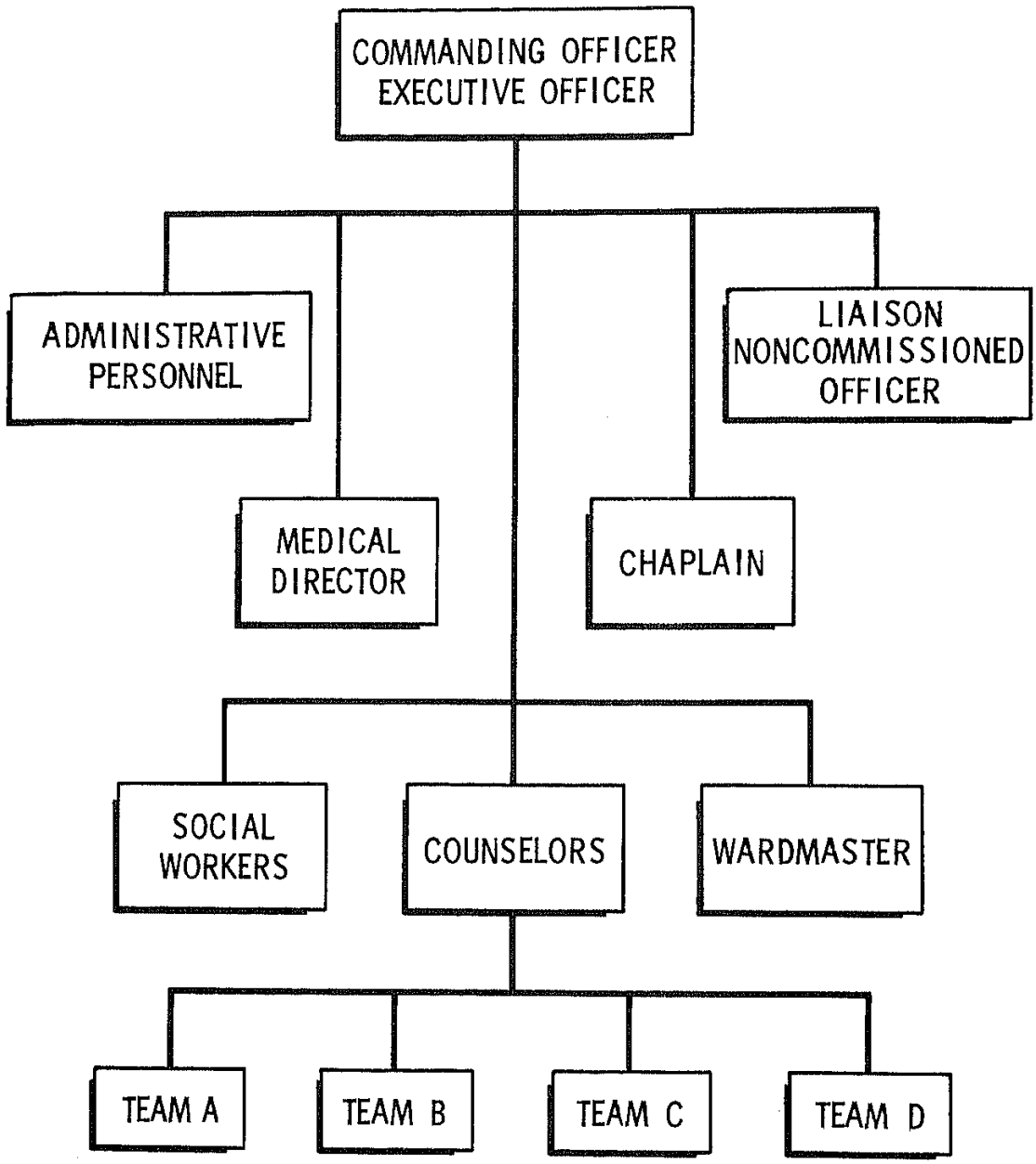
Seventy percent of the problem, as we saw it, could be eliminated by selective recruiting (sixty-one percent of the patients were high school drop-outs and sixty-nine percent had civilian police records).

Probably ninety percent of the problem, as was presented to us, could be eliminated by using a test to identify the sociopathic personality, coupled with selective recruiting.

Major, Infantry
Commanding

3 Inclosures
Incl 1 - Organizational Chart
Incl 2 - Schedule
Incl 3 - Group Counseling and Therapy
Isaues, Themes and Techniques

UNITED STATES ARMY REHABILITATION CENTER
– DANANG –



ACTIVITIES SCHEDULE

Thursday 17 February 1972

	0730-0900	0900-1030	1030-1200	1200-1230	1230-1400
GROUP 30	Work Details	Group Session	Arts snd Crafts	L U N C H	Work Details
GROUP 31	Group Session	Arts and Crafts	Work Details		Group Session
GROUP 32	Move to Rehabili-tation Ward	Work Details	Group Session		Athletics
GROUP 33	I N P R O C E S S I N G				

	1400-1530	1530-1700	1700-1800	1800-1900	1930-2100
GROUP 30*	Group Session	Athletics	S H O W E R S	D I N N E R	Chaplain's Session
GROUP 31	Athletics	Work Details			Day Room
GROUP 32	Work Details	Group Session			Chsplain's Session
GROUP 33	D E T O X I F I C A T I O N				

* Group 30 will clean the Dining Room and Day Room

Inclosure 2 to
Appendix E

Group Counseling and Therapy
Issues, Themes and Techniques

1. Group discussions with the patients about themselves and their lives without mention of drugs or the war in Vietnam.

2. "Loser syndrome: the constant need to get high." Explore reasons why some individuals need a synthetic high (whether heroin, barbiturates or alcohol) and how their lives are wasted by the constant drive to obtain and use the drug.

3. Compare care, compassion and love -- search for the definitions of each term and how these emotions apply to everyday living. Discuss the role each has played in their lives (both present and past) and what they could do to improve their relationships with others.

4. "Trust" -- who do they trust and why? What actually is trust and how can a person earn another's trust? Does a person have to trust himself and how much should a person trust another if he wants help? (Some physical trust exercises are applicable -- for example, the outstretched hand waiting response from the other person.)

5. "Rebirth" -- how an individual must change his ways and life pattern if he hopes to lead a constructive life. Discuss how a person must be "reborn" to the straight world from the drug oriented life.

6. "Dope fiend attitudes and ways" -- how drug culture ways have affected life styles and ways of thought, and why such habits should be broken and amended to live a drug free existence.

7. Put an individual in a circle, and (a) have each member discuss how he feels about the person and what he likes and dislikes about him; (b) describe the person as an animal, mineral or vegetable -- best fitting his personality and actions; and (c) attack him for his inadequate performance and attitude and have him try to defend it in front of every one.

8. "Blow your image" -- have different individuals do or say something that they are unaccustomed to doing or which is foreign to their personality. The goal is to break down the person's inhibitions.

9. "When you're looking good, you're looking bad -- and when you're looking bad you're looking good" -- examine this statement and how it applies to their activities and their "image."

Inclosure 3 to
Appendix E

10. Role playing -- have the individual take the part of the social worker, a parent, his wife, his commander, an employer, a "straight," or a friend. In this role, he attempts to determine how the other person thinks and acts and what his responsibilities are.

11. Have those present name three persons (living or dead, famous or perhaps just a relative) that he would like his son to be like and why -- explore his reasoning and the characteristics he admires most in a person.

12. "Where I came from -- where I am going" -- goal discussion and planning take into consideration how a person must strive daily for a certain ultimate goal or ideal. Put into perspective how a person can build on his past and present experiences to create a productive future.

13. "What goes around, comes around" -- discuss how a person can be swept up into a movement or thought without really accepting it. Have the patient interpret the saying in the way he thinks best as it pertains to heroin use and abuse.

14. "Today is the first day of the rest of my life" -- aim for the patient to think about his future and to construct his everyday life for a profitable future.

15. "Friendship" -- who is a friend? How does a person become a friend to another? What are the basic rules of friendship and when are they violated?

16. Discuss projects completed in arts and crafts sessions. The purpose is to help the patient gain a better insight of himself through nonverbal communication. Topics that apply well are the completed projects exhibited to the group during discussion: (a) "The Me Nobody Knows," (b) finger painting exercise, (c) "The Year 2000", (d) self-portrait.

18. "With what can you replace drugs?" -- examine ways a person can lead his life without using drugs by interacting with people, taking pride in one's work, hobbies, concern for family, and self-awareness.

19. Presentation of photographic art (subjects may vary but should deal with a central figure in an unnatural or threatening situation) -- give each person a picture, have him decide on an interpretation and then defend it in front of the others. Have the individual put himself into the picture and explain how he would act or think and then have him put another group member into the picture and describe how he thinks he would act.

20. "You've got to give it away to keep it" -- a look at selfishness and how a person must interact and share himself with others before he can become a "complete" individual.

21. "Individuality" -- what comprises an individual and what makes him different from others? What is expected of him from others? Can people be alike and yet still be an individual?

22. "If you could be anyone or anything in the world, what would it be and why?" -- this inveatigates the ideals the patient had and what he perceives himself of being.

23. What does the patient like the most about himself and what does he like the least?

24. "If . . . " -- explore the patient's sttitudes and ideas on different situations if he was confronted with them. (Example: Where would you go if . . ., What would you do if . . . .)

25. "The most important thing is . . ." -- examine the priorities the patient has in his life.

26. "Success" -- what does it mean and who is one?

27. Work within a system (Army, school, law, and even society) -- have the discussion center on the need of system, what is enough to get by, responsibility of a person to the system, and making the system work for you.

28. "Family" -- what has the patient done for and to them, and what has the family done for and to him.

29. "Love" -- how does it feel to give and receive it? Also, look at the patient's concept of it and what role it played in his life a year ago, a month ago, and now.

30. "Why he" -- knock down the "picked-on-attitude" and discuss the point that the only one the patient is really hurting or depriving is himself and not the world. Try to focus on how most of their problems evolved out of something that they had done previously.

31. "What are you doing for the rest of your life" -- goal construction; have the patient look at his life if it would continue in the same way. Also, confront the patient with the fact of how soon he would be dead if he continued drug use; or how long he would have to spend in jail if he continued his criminal way.

32. Have each of the patients (after about a week of group experience) take the responsibility of the group upon himself and lead it in a worthwhile discussion/interaction. (Time limit -- not less than ten minutes.)

33. "Changes that I've gone through" -- discuss the changes a person goes through in life, since he has been in the Army, since Vietnam, since drug or heroin use, and since he has been in the rehabilitation program.

34. "What would I do with a million dollars?" -- let the patient use his imagination and see what he would do or buy with such an amount. A daydream exercise that can check the patient's wants and desires, interests and priorities in life.

35. "I've been down so long, it looks like up" -- ask for the patient's interpretation and how it applies to himself - especially when he was on heroin, and before he began any type of drug abuse.

36. Have each of the patients compare and contrast their backgrounds, life styles, and habits with the other members.

37. Have the patients look at how they have coped with their problems in the past -- and see how they would like to have coped with them.

38. "Running away" -- when does a person finally catch up with himself? From what or whom is he running?

39. Have a member of the group sit outside of the group and let the group discuss the individual in any manner they wish; the topic person can not interrupt the inner group's discussion. (Checks on how others perceive an individual and what they would say about him "as if he was not there." Can be tried on a single individual on a rotation basis or when the need arises or to several if a clique has arisen within the group to have them see and hear what they are doing.)

40. "How does it feel to be drug free and can it last?" -- usually done after being in the Center for over a week; it examines the feelings of being straight to the memory of being on drugs -- and the future of it.

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