AD-760 918

THE CONTROL OF ALCOHOLISM IN COMBAT ARMS UNITS

Eugene R. Cocke

Army War College
Carlisle Barracks, Pennsylvania

28 February 1973

DISTRIBUTED BY:

NTIS
National Technical Information Service
U. S. DEPARTMENT OF COMMERCE
5285 Port Royal Road, Springfield Va. 22151

AD 760918

MONOGRAPH

The views expressed in this publication are the author's and do not necessarily reflect the views of the Department of Defense or any of its agencies. This document may not be released for open publication until it has been cleared by the Department of Defense.

28 FEBRUARY 1973

THE CONTROL OF ALCOHOLISM IN COMBAT ARMS UNITS

BY

LIEUTENANT COLONEL EUGENE A. COCKE
INFANTRY

Reproduced by
NATIONAL TECHNICAL INFORMATION SERVICE
U S Department of Commerce
Springfield VA 22151

D D C
RECEIVED
JUN 8 1973
B

US ARMY WAR COLLEGE, CARLISLE BARRACKS, PENNSYLVANIA

DISTRIBUTION STATEMENT A
Approved for public release;
Distribution Unlimited

Copy 1 of 9 copies.

59

USAWC RESEARCH PAPER

THE CONTROL OF ALCOHOLISM IN COMBAT ARMS UNITS

A MONOGRAPH

by

Lieutenant Colonel Eugene R. Cocke
Infantry

US Army War College
Carlisle Barracks, Pennsylvania
28 February 1973

ABSTRACT

AUTHOR: Eugene R. Cocke, IN
FORMAT: A Monograph
DATE: 28 February 1973 PAGES: 55 CLASSIFICATION: Unclassified
TITLE: The Control of Alcoholism in Combat Arms Units

This paper addresses military alcoholism and what it portends for the Army. Data was gathered using a literature search, querries to established sources, and consultation with personnel knowledgeable in the field of alcohol abuse. Alcohol abuse presents an intolerable drain on the Army's most precious asset--its people. The major effort in addressing alcohol abuse must be made at Division and lower unit level using the many personnel management tools and services that are normal and available to that level or organization. It is concluded that the Army has a serious problem with alcohol abuse in its ranks. Leader action to establish an effective program of identification, counseling and treatment will produce substantial results in terms of recovered personnel. The Army should take the following action: integrate an Army wide effort of education on alcohol abuse into its information and training programs; prepare a leaders' guide to alcohol abuse; establish a system for training and placing alcohol counselors down to battalion level; revise separation procedures to allow for treatment in VA hospitals for individuals released from service due to alcohol abuse.

TABLE OF CONTENTS

		Page
ABSTRACT		ii
TABLE OF CONTENTS		iii
CHAPTER I.	INTRODUCTION	1
	Background	1
	Purpose	3
	Organization of the Paper	3
II.	THE IMPACT OF ALCOHOL	6
	Nature and magnitude of the problem on society	6
	Alcohol abuse and the military	7
	Past attitudes and policies	9
	Revised attitudes and current policies	10
III.	DISCUSSION OF SPECIFIC PROBLEMS	17
	Acceptance of the problem	17
	Alcohol problem identification	19
	Counseling	22
	Treatment and rehabilitation	24
IV.	A TACTICAL UNIT APPROACH	33
	Attitudes and education	33
	The tools available	35
	Division and lower level organization	41
V.	CONCLUSIONS AND RECOMMENDATIONS	47
SELECTED BIBLIOGRAPHY		50
APPENDIX I.	DEFINITIONS	54

CHAPTER I

INTRODUCTION

In July 1971, Senator Alan Cranston of California said, "Alcoholism continues to be the most prevalent, largely untreated disease in this country."[1] The next year, Brigadier General Robert G. Gard Jr., reflecting the Army's concern, stated that alcohol abuse continues to be the Army's most serious drug problem.[2] These two comments set the stage for what has recently become a serious concern of our society and of the Army.

BACKGROUND

Alcoholism has been rated, along with cancer, heart disease and mental illness, as one of the four most serious health problems in our country.[3] Yet at the time when large amounts of money and well organized efforts were being directed toward the control and elimination of such cripplers and killers as cancer, polio, tuberculosis and heart disease, alcoholism with its problems and effects was being ignored or was being regarded as an issue of morality rather than the treatable disease which it is. Physicians were not trained to treat it; hospitals rarely provided their services to alcoholics; and the "public drunk" was treated like a criminal and ostracized by society.

This research paper will focus on alcoholism and related problem drinking, particularly in the Army. Although a series of

useful definitions are to be found in Appendix I of this paper, several key definitions are to be emphasized as they are fundamental to the views, conclusions and recommendations presented. Numerous definitions of the following terms may be found; however, those presented are believed to be the most definitive and realistic regarding the Army's approach to alcohol and its problems.

Alcohol Abuse. Any irresponsible use of an alcoholic beverage which leads to misconduct, unacceptable social behavior, or impairment of an individual's performance of duty, physical or mental health, financial responsibility or personal relationships. It may also lead to alcoholism.

Alcoholic. A person who cannot control the desire or need for alcohol and whose repeated and uncontrolled use of alcoholic beverages impairs his health, personal relations, social conduct, or job performance. An alcoholic is physically or psychologically dependent on alcohol.

Alcoholism. Psychological or physical dependency on alcohol or both. It is a chronic, relapsing, progressive illness characterized by the loss of control over the drinking of alcoholic beverages to the point of interfering with health, personal relationships and the ability to work effectively. Alcoholism is both preventable and treatable.

Problem Drinker. An individual whose repeated or continued excessive use of alcohol interferes with normal job performance, health, personal relationships and family life.

PURPOSE

The purpose of this research project is to analyze the Army's current problems with alcohol abuse in order to define suggested methods for effective control and reduction of alcohol related problems. It is not the intention, through material presented or measures outlined herein, to be concerned with casual or normal social drinking, nor to intrude in any way upon the private lives of service members whose use of alcohol causes no trouble. However, any soldier or officer whose drinking habits are interfering with his performance of duty or his personal relationships impacts adversely on the Army and needs to be addressed and treated with the same concern which would be shown over his having any other serious health problem.

ORGANIZATION OF THE PAPER

Chapter II of this paper addresses the influence of alcohol on society and the military. The nature and magnitude of the problem are briefly reviewed as are the past attitudes and policies towards alcoholism. Current policies and trends are then analyzed to show the recent awakening to the problem and the machinery being put into motion to combat alcoholism. Highlights of selected programs which have been effectively used by industry and other civilian agencies are also described. Chapter III contains a discussion of specific problems relating to attitudes, problem identification, counseling, treatment and rehabilitation.

In Chapter IV, alcoholism and related problems are viewed from the Division level where a practical approach to the problem, utilizing various tools available at this level, is presented. Chapter V contains the conclusions and recommendations of this research project. It should be noted at the outset that alcoholism is a complex and difficult issue. In the last year or two various elements of society and the military have taken great steps towards combating the problems related to alcohol. The recent success that has been realized in industry, government, and the uniformed services provides a glimmer, hopefully, of what is to happen in the future as practical and realistic measures are adopted in addressing this treatable disease of alcoholism. The Army, along with the other services, has taken major steps in the past twelve months to address the problems of alcohol and to devise ways of handling them. The findings and recommendations of this study may duplicate or be contrary to actions either implemented or under study. This research project provides no panacea but is intended to provide additional rationale and suggested techniques which will assist the Army in harnessing and reducing a problem of major proportions.

CHAPTER I

FOOTNOTES

1. US Congress, Senate, Committee on Veterans' Affairs, Subcommittee on Health and Hospitals, _S2108, HR 9265 and Related Veterans' Addiction Treatment and Rehabilitation Bills_, Hearings, 92d Congress, 1st Session, p. 333.

2. Robert G. Gard, Jr., "The 'Other War' on Drugs, Alcohol," _Army_, October 1972, p. 108.

3. General Motors Corporation, _Some Facts About the GM Employee Alcoholism Recovery Program_, p. 4.

CHAPTER II

THE IMPACT OF ALCOHOL

Alcohol is not all bad nor is everyone who drinks a problem drinker, and there is little doubt that drinking is here to stay. Alcohol, if used sensibly, can be a pleasant ingredient towards relaxation and the enjoyment of social occasions. Taxes from the sale of alcoholic beverages provide substantial income for public use. Of the 18 billion dollars spent by the American people each year on alcohol, the Federal, state and local governments receive about 7 billion dollars in taxes.[1] The majority of people in this country who drink do so with little or no harmful effect to themselves or those around them. The harm lies with the drinker who has lost his control over alcohol.

NATURE AND MAGNITUDE OF THE PROBLEM ON SOCIETY

In the last several decades, alcohol related problems have become increasingly evident and have taken an unacceptable toll on our society. In the last ten years there has been a 20 percent rise in the consumption of alcohol in this country.[2] Let's look at the significance of this increase. Of the 95 million Americans who drink, 9 million do so to excess.[3] This means that one out of ten persons who drinks is having serious problems with alcohol, and these problems are not limited to just the individual concerned. Alcohol is a factor in 28,000 auto deaths per year in

this country--more than half of the total US deaths in the entire 10 year Vietnam conflict.[4] It has been estimated that abusive drinking costs this country 15 billion dollars per year with lost work alone accounting for 10 billion dollars.[5] One out of every three suicides involves an alcoholic.[6] Every third arrest involves drunkeness.[7] In time lost, major industrial firms estimate that the alcoholic employee loses 22 more days each year and can be expected to die 12 years sooner than the nonalcoholic.[8] And so the statistics run on and on--each one impressive in the fact that alcohol creates a multitude of problems when used improperly. These problems are social, economic and medical in nature and exist in all walks of life affecting the individual, his family, friends, fellow workers and the society of which the Army is a reflected part.

ALCOHOL ABUSE AND THE MILITARY

Translating the problems of alcohol abuse from how they appear in society into how they affect the military is not an easy task. It is obvious that these problems have been with the Army for many years. There are few career soldiers with more than several years service who cannot vividly remember the red faced non-com, or officer for that matter, fighting a hangover a couple of mornings each week or coming up with that invariable absence from the job due to overindulgence. Service efforts have only recently been initiated to size up, with any accuracy, the

results of alcohol abuse in the military. A 1971 Department of Defense survey revealed that 88 percent of the military population used alcoholic beverages where only 33 percent were using or had used illegal drugs.[9] This same survey indicated that 5.3 percent of the military were identified as needing help with a drinking problem as compared to 1.7 percent with a drug problem. In the past, the Armed Forces have lost more time from duty and more lives from alcohol abuse than from the abuse of heroin.[10] The General Accounting Office says that the military could save 120 million dollars yearly by the treatment and rehabilitation of alcoholics.[11] For a clearer view of the problem, let's apply some figures to a combat unit. Here we will assume that the 5 percent alcoholic figure is fairly accurate and that an additional 5 percent are problem drinkers. This equates to the size of the problem and its two categories as found in industry.[12] In an 800 man infantry battalion you would find approximately 40 alcoholics and 40 problem drinkers not yet to the alcoholic stage or a total of 80 soldiers with alcohol related problems. In an 800,000 man army, the figures total at some 80,000 men with alcohol problems--think of that in the numbers of Army divisions represented and the size of the problem focuses more clearly.

Is the problem that great? Does the Army reflect societies ills that closely? I believe it does--even to a greater degree--because of the additional factors, stresses and strains found in the military. The following factors are believed to have an increasing effect on the incidence of alcoholism in the military.

a. Family separation.

b. Low cost of alcoholic beverages.

c. Easy availability of alcoholic beverages.

d. Boredom/hyperactivity.

e. Lack of a good education program concerning alcohol.

f. Lack of an effective identification and treatment program.

g. A social climate which encourages drinking.

h. Tolerance of intoxication.

i. Failure to admit the presence of the problem Army wide.

PAST ATTITUDES AND POLICIES

In the past the attitude of the military, in viewing the problem of alcohol, has closely paralleled that of society. Look at the alcoholic, the symbol of the problem. The church accused him of being totally immoral; society was embarrassed by the skid row image he presented; business rejected him as a waste and too great a risk; and to his friends and family he was just making a fool of himself. Yet the alcoholic is just as sick as the man with diabetes or tuberculosis or cancer except that he is more misunderstood than any of these. He has long been looked on with a mixture of amusement, scorn and disinterested curiosity. Prior to 1970, two-thirds of the general hospitals in this country did not admit patients for alcoholism.[13]

The Army has been reluctant to admit that its ranks harbored alcoholics. Identification of the alcoholic problems did not

take place until he had reached an advanced stage. The system just waited until the individual involved had become ineffective or had committed a couple of punishable offenses because of his drinking. Treatment was neither offered nor was it readily available. More often than not the alcoholic was treated in this priority:

- he was left alone
- he was transferred
- he was punished
- he was discharged
- he was counseled or treated

REVISED ATTITUDES AND CURRENT POLICIES

In the past quarter century, the pendulum has begun to swing ever so slowly towards a realistic approach to alcohol related problems. Alcoholism was designated a disease by the World Health Organization in 1951 and by the American Medical Association in 1956.[14] A National Council on Alcoholism has been established. Government Agencies, in particular, have taken great strides in their approach to alcohol problems. Alcohol related disorders treated in VA hospitals have doubled between 1965-1969, to the point that in 1971 one out of eight VA patients suffered from alcohol related disabilities.[15] Appropriations for federal grants to States to assist them in the development of programs to deal with alcoholism and alcohol abuse have increased as shown:

FY 71 - 40 Million Dollars

FY 72 - 60 Million Dollars

FY 73 - 80 Million Dollars[16]

Industry no longer views the alcoholic as one who should be fired because of the problems in rehabilitating him. Instead, enlightened attitudes, techniques, and planned programs have begun to yield substantial benefits. Those previously viewed as hopeless drunks have recovered from their alcohol problems to become normal productive workers. Several randomly selected successful industrial and government programs are highlighted below:

> E. I. DuPont de Nemours - Beginning in 1943, this company made perhaps the first major effort to rehabilitate alcoholics in their organization by using techniques suggested by Alcoholics Anonymous. Since its beginning in 1935, Alcoholics Anonymous has been singularly successful in dealing with the problems of alcoholism. This organization has been very effectively relied on for assistance by industry and other elements of society in combating the problems of alcohol.[17]
>
> American Motors - This company established a six man national committee consisting of three union and three management representatives to address alcoholism in the ranks of American Motors. Similar organization is mirrored at the local level with two union and two management committee members.[18]
>
> Utah Copper - A division of Kennecott Copper, this organization has established a free counseling service for all employees and all family members on financial, family, legal, alcohol and drug problems. To receive help, the caller need only dial INSIGHT on the telephone. In fifteen months, a minimum of two calls per day were received. Of the 900 referrals, nearly 20 percent were alcohol related.[19]

FY 71 - 40 Million Dollars

FY 72 - 60 Million Dollars

FY 73 - 80 Million Dollars[16]

Industry no longer views the alcoholic as one who should be fired because of the problems in rehabilitating him. Instead, enlightened attitudes, techniques, and planned programs have begun to yield substantial benefits. Those previously viewed as hopeless drunks have recovered from their alcohol problems to become normal productive workers. Several randomly selected successful industrial and government programs are highlighted below:

> E. I. DuPont de Nemours - Beginning in 1943, this company made perhaps the first major effort to rehabilitate alcoholics in their organization by using techniques suggested by Alcoholics Anonymous. Since its beginning in 1935, Alcoholics Anonymous has been singularly successful in dealing with the problems of alcoholism. This organization has been very effectively relied on for assistance by industry and other elements of society in combating the problems of alcohol.[17]
>
> American Motors - This company established a six man national committee consisting of three union and three management representatives to address alcoholism in the ranks of American Motors. Similar organization is mirrored at the local level with two union and two management committee members.[18]
>
> Utah Copper - A division of Kennecott Copper, this organization has established a free counseling service for all employees and all family members on financial, family, legal, alcohol and drug problems. To receive help, the caller need only dial INSIGHT on the telephone. In fifteen months, a minimum of two calls per day were received. Of the 900 referrals, nearly 20 percent were alcohol related.[19]

New York City Police Department - Begun in 1966, an authoritarian approach system was established which has yielded a 66 percent recovery rate. Over a 6 year period, more than 1,000 policemen have been successfully treated and returned to full duty.[20]

General Motors - This program provides for medical treatment where necessary, sick leave and the retention of company benefit eligibility and seniority.[21]

There are many more examples of successful progressive programs. In all of those examined, however, two facts stood out:

1. Employees with alcohol problems were encouraged to seek help from Alcoholics Anonymous. In many cases, the in-house establishment of Alcoholics Anonymous chapters had been effected. In other cases, Alcoholics Anonymous had assisted significantly in the establishment of effective counselling, treatment and rehabilitation programs.

2. In every case, the company or agency involved approached the problem in this way. The employee was counseled, the problem was frankly identified; and the particular program of assistance established by the company was explained and offered. The employee was told that if he could not get other help or would not progress through the company's program, then his employment would be terminated.

The military has similarly begun to swing with the pendulum. Although each service was beginning to show an increased awareness and concern with the problems of alcohol, there appeared to be no consolidated position on how the problem was to be approached. Accordingly, on 1 March 1972, the Department of Defense issued a

directive establishing policies within the defense establishment for the prevention of alcohol abuse and for the treatment and rehabilitation of alcohol abusers and alcoholics.[22] With this directive as a base, the services have begun to study the problem in earnest and to establish appropriate policies and programs to deal with alcohol abuse.

Essentially, the services now view alcoholism as a condition which is preventable and treatable through the application of enlightened attitudes and techniques. Each of the services established pilot programs to gage the success of these new attitudes and approaches--the Army at Fort Benning, Georgia; the Navy at Long Beach, California; and the Air Force at Wright-Patterson Air Force Base in Ohio.

The Navy program, formalized under the 1972 directive, was begun in midsummer of 1967, at Long Beach in an initial attempt to deal with the many problems of alcohol noted at the medical facility there.[23] Since that time, a formal structured program has been established at Long Beach and has produced impressive results. Of the four hundred plus patients who have been treated and who have remained on active duty allowing followup evaluation, 60 to 70 percent are recovered from alcoholism.[24] It is believed that almost as high a proportion of the seven or eight hundred men who have left the service would show similar improvement if followup were possible.[25]

Current directives allow for hospital treatment up to 30 days for Army; and up to 60 days for Navy and Air Force personnel

diagnosed as alcoholics.[26] Bear in mind that under previous attitudes and practices, these same men would have received little attention, scorn, disciplinary punishment alone or perhaps release from the service--all with little or no attempt at treatment.

The following quote from DOD Directive 1010.2, Alcohol Abuse by Personnel of the Department of Defense, 1 March 1972, is key.[27] "Alcoholism, in itself, should not be considered as grounds for disciplinary action."

The revised attitudes of the service and the related programs concerning alcohol abuse are indeed encouraging. The major problem faced by commanders from the top down will be to insure that the magnitude of alcohol abuse problems in the service are recognized and that conscientious efforts are made to deal with these problems.

CHAPTER II

FOOTNOTES

1. National Association of Blue Shield Plans, The Alcoholic American, p. 38.

2. Department of Health, Education and Welfare, First Special Report to the US Congress on Alcohol and Health, p. 18.

3. Robert P. Hay, "Liquor Still Rated as Most Abused Drug," Christian Science Monitor (Eastern Edition), 23 February 1972, p. 2.

4. First Special Report to the US Congress on Alcohol and Health, p. viii.

5. Ibid.

6. International Lutheran Layman's League, I Am An Alcoholic, p. 10.

7. Ibid.

8. American Medical Association, The Illness Called Alcohol, p. 2.

9. Allen H. Fisher Sr., Preliminary Findings from the 1971 DOD Survey of Drug Use, p. 58.

10. US Department of Defense, Commanders Digest: Alcohol Abuse and Rehabilitation, p. 2.

11. "US Reconsiders Military Alcoholism," Christian Science Monitor (Eastern Edition), 22 March 1972, p. 22.

12. First Special Report to the US Congress on Alcohol and Health, p. viii.

13. The Alcoholic American, p. 38.

14. Comptroller General of the United States, Alcoholism Among Military Personnel, p. 11.

15. US Congress, Senate, Committee on Veterans' Affairs, Subcommittee on Health and Hospitals, S2108, HR 9265 and Related Veterans' Addiction Treatment and Rehabilitation Bills, Hearings, 92d Congress, 1st Session, p. 333.

16. US Laws, Statutes, etc., Public Law 91-616, p. 2.

17. Alcoholics Anonymous World Services, Inc., AA and the Alcoholic Employee, p. 5.

18. Marion Sadler and James F. Horst, "Company/Union Programs for Alcoholics," Harvard Business Review, September-October 1972, pp. 22-34.

19. Ibid.

20. City of New York, Police Department, Counseling Program for Problem Drinkers, p. 1.

21. General Motors Corporation, Some Facts About the GM Employee Alcoholism Recovery Program, p. 4.

22. Commanders Digest, p. 5.

23. Joseph J. Zuska, MC USN, Alcohol Education and Rehabilitation, p. 2.

24. Joseph J. Zuska, MC USN, Navy Regional Medical Center, letter to author, 8 November 1972.

25. Ibid.

26. Commanders Digest, p. 1.

27. US Department of Defense, Directive Number 1010.2, Alcohol Abuse by Personnel of the Department of Defense, p. 2.

CHAPTER III

DISCUSSION OF SPECIFIC PROBLEMS

There are many fences to be mended and barriers to be broken if the problems of alcohol in the service are to be reduced. Four specific problem areas are discussed in this chapter. These problems are fundamental to any meaningful and effective program for the reduction of alcohol abuse.

ACCEPTANCE OF THE PROBLEM

Captain J. J. Zuska, MC, USN, of the Long Beach Navy Regional Medical Center is one of the service pioneers in the field of alcohol abuse. On 8 November 1972, Dr. Zuska stated the following:

> As I gain experience in the field of alcoholism I am becoming more concerned with changing the attitudes of our society toward the alcoholic than I am concerned with the treatment of the individual alcoholic. I do not feel we can make a significant reduction in the number of alcoholics by treatment alone--we must prevent the illness by education, changing attitudes, overcoming prejudice and, of course, by those in leadership positions setting the example by their own sober behavior.[1]

The first step, therefore, is to have the problem recognized by the service--not just at the top, but by leaders at all echelons down to and including the company, platoon and even squad. This is tough because it requires a major change in attitudes of the supervisors all along the line. This supervisor is the same man who was raised in an Army where the consumption of alcohol has oftentimes

been tabbed the "mark of a man"; where it was not at all unusual to have the proverbial "27 day soldier" perform acceptably until payday, then be absent on a sanctioned three or four day spree.

In a short five year period, the services, particularly the Army, have awakened to and wrestled with the awesome and increasing problem of drugs. The country has made massive efforts to cut off supplies of drugs, educate the masses to the dangers, and establish elaborate detection and treatment facilities. There is scarcely a serving soldier who has not seen vivid filmstrips and numerous displays on drugs--their dangers and their characteristics; who has not taken a urine test for drug use; and who is not aware of the "Halfway House" or similar facilities on the road back to normalcy. In short, quick and effective action has been initiated to bridge this new cult of the youngster. But what about alcohol? The young soldier says that what hashish and heroin are for him and his buddies--so beer and liquor are for the sergeants and the officers. In the eyes of the troops the differences between alcoholism and drug use are very slight indeed. The unruly behavior, rowdiness and boisterous antics of the drunk is much less acceptable to the new breed of young soldier than the drowsiness and lethargy produced by heroin. The sight of the bleary eyed, beer-bellied lifer denouncing drugs as he tries to fight off his morning hangover is looked on as another hypocritical absurdity of Army life and of the attitude of the "Green Machine."

In informally discussing the problems of alcohol and its effect on the Army with career soldiers, I find a very obvious reluctance

on their part to accept the fact that alcohol abuse is seriously affecting the Army and needs to be addressed. This attitude is generally characteristic of the War College students despite convincing evidence that the problems are there. I would expect the noncommissioned officer ranks to be even more reluctant to admit that alcohol abuse is causing the Army serious problems. So acceptance of the problem is a major difficulty. Education is the initial answer--education as to the nature and extent of the problem in both society and the Army; education as to the Army's official attitude and policies regarding alcohol and alcohol abuse; and wide dissemination as to what tools are available to help soldiers with the problem. In the final analysis, positive action by all levels in the chain of command will determine the success of the program.

ALCOHOL PROBLEM IDENTIFICATION

In the case of most illnesses, once diagnosed, the patient is eager and willing to receive treatment. Free chest X-rays for tuberculosis or cancer check programs are enthusiastically received with little or no persuasion. Alcohol abuse is different. Alcoholism is a disease of denial and concealment. The alcoholic simply won't identify himself until he gets to the extreme stages. The problem drinker is even more difficult to identify. Early detection of a drinking problem is a good way to win the fight against alcoholism. The disease is less expensive to treat in its early stages, the recovery potential is greater; and there is less

chance that permanent health damage has occurred. Senator Harold Hughes of Iowa, chairman of the Senate Subcommittee on Alcoholism and Narcotics, believes that if problem drinking is left unchecked it will eventually destroy the family. The Senator says:

"In a great many cases, the abuse of alcohol almost always leads to family difficulties. It takes a high toll on the family unit through divorce and fracturing of the home."[2]

Since the individual, either alcoholic or problem drinker, is reluctant to admit that he has a problem, more often than not it will be the action of the supervisor which is most effective in identifying the problem. The chain of command is in good position to spot problems and potential problems. There are indicators which should key the immediate supervisor, and others in the chain of command, to the possible existence of a problem. It may not be an alcohol problem, but the chances are that if several indicators show up or are repititious, alcohol may be involved in some way. At any rate a problem will be identified which will need follow up. The indicators discussed will be, primarily, those in everyday work or training environment rather than professional medical indicators. Medical authorities have had little success in identifying personality structures that can predict alcoholism accurately. However, once addicted, all alcoholics show similar behavior patterns: they have a low tolerance for frustration; show feelings of inferiority combined with attitudes of superiority, fearfulness and dependency; and have a low tolerance for criticism

or failure.[3] These personality structures are manifested in a number of on-the-job signs which are particularly evident in the problem drinker's or alcoholic's performance and personal behavioior. These should be trouble lights to the supervisor.

Performance Indicators

Failure to complete work assignments on time

Morning hangovers

Late to work

Leaving work early

Drinking during duty hours

Drinking at lunch

Absenteeism--half day or for longer periods

Frequent sick call attendance

Unusual excuses for absences

Temporary unexcused absences from place of duty

Decline in or erratic duty performance

Personal Behavior Indicators

Family problems

Financial difficulties

Vehicle accidents or violations

Frequently edgy or irritable

Hand tremors

Frequent use of "breath purifiers"

Avoiding superiors

Increased nervousness

Decline in standards of personal appearance

Argumentative or sullen

Use of medication for nerves or tension

These indicators are not all encompassing nor are they sure signs that the soldier involved has an alcohol problem, but they are indicators which should be looked into. The alcoholic will show many of these signs, and frequently. The problem drinker, on the other hand, may overindulge on occasion but he does not permit alcohol to interfere with his work over long periods of time or to frequent great extent. He is much more difficult to identify but also easier to help.

COUNSELING

One of the most frustrating characteristics of alcoholism is the inability of the drinker, at any stage of his illness, to accept or recognize that he is in serious trouble despite overwhelming evidence that he is. When confronted by his superior, or by his peers, with the fact that indications point to a problem, the drinker will usually deny that a drinking problem exists. He will lay his problems to misfortune, poor working conditions, impossible tasks or even to an unhappy home life. He will usually state that he can handle alcohol perfectly well. To try to convince him that he does have a drinking problem will only increase his hostility. The truth is that he knows that he has a serious drinking problem and as soon as his confidence is obtained in the system and the

sincere desire of the chain of command to help him, he will tell you how unhappy, sick, confused and desperate he really is.

Confronting him with the problem, therefore, is the first step. This can best be done by the people who know him and are with him daily. There are some who say that, in the final analysis, a medical diagnosis is essential to confirm the existence of an alcohol problem. Certainly the medical system is an important part of the diagnosis, counseling and treatment process. Few physicians, however, possess either the skills or desire to make judgments based solely on criteria related to job performance or social pathology. With few exceptions, successful contemporary management programs are personnel management orietned.[4] Peers or close supervisors should make the first attempt or two to gain the problem soldier's confidence and to help him in voluntarily seeking further aid.

In the past military supervisors at the troop level, where the initial steps at identification and referral take place, were reluctant to confront the alcoholic or problem drinker. Additionally, the tools available to the leaders weren't used until the drinking situation had been tolerated to the point where major problems had developed. In today's Army the immediate chain of command is in the best position to handle the situation. The effectiveness of the chain of command will be determined by:

--Knowledge of Army and unit procedures and policies regarding alcoholism and problem drinking.

--Knowledge of the indicators of problem drinking.

--Willingness to accept and implement alcohol program policies.

--Willingness to understand and assist the problem drinker.

--Firmness in implementing the program.

--Genuine interest and follow-thru of each man's problem.

A few down to earth techniques are necessary to effective counseling on alcohol problems whether employed by the commander, doctor, chaplain or other counselor working with the individual. These techniques are:[5]

--Don't apologize; be straightforward.

--Don't discuss "the right to drink"--Alcoholism is not a moral problem, it's an illness.

--Comments such as "Slow down," "Stick to beer," or "Save it for the weekend" are useless.

--Scare techniques are equally futile, such as "You'll die sooner" or "you'll develop liver trouble." The drinker has invariably heard of someone who drank a quart of whiskey a day and lived to be a hundred.

--Advice to cut down on drinking or be punished is valueless unless treatment is concurrently offered.

In sum, discussing alcohol related problems with a soldier is an ego bruising experience for him. The counselor must avoid putting the soldier through a grinder process that will be either humiliating or demeaning. Honest concern and straight talk are the foundations for effective counseling.

TREATMENT AND REHABILITATION

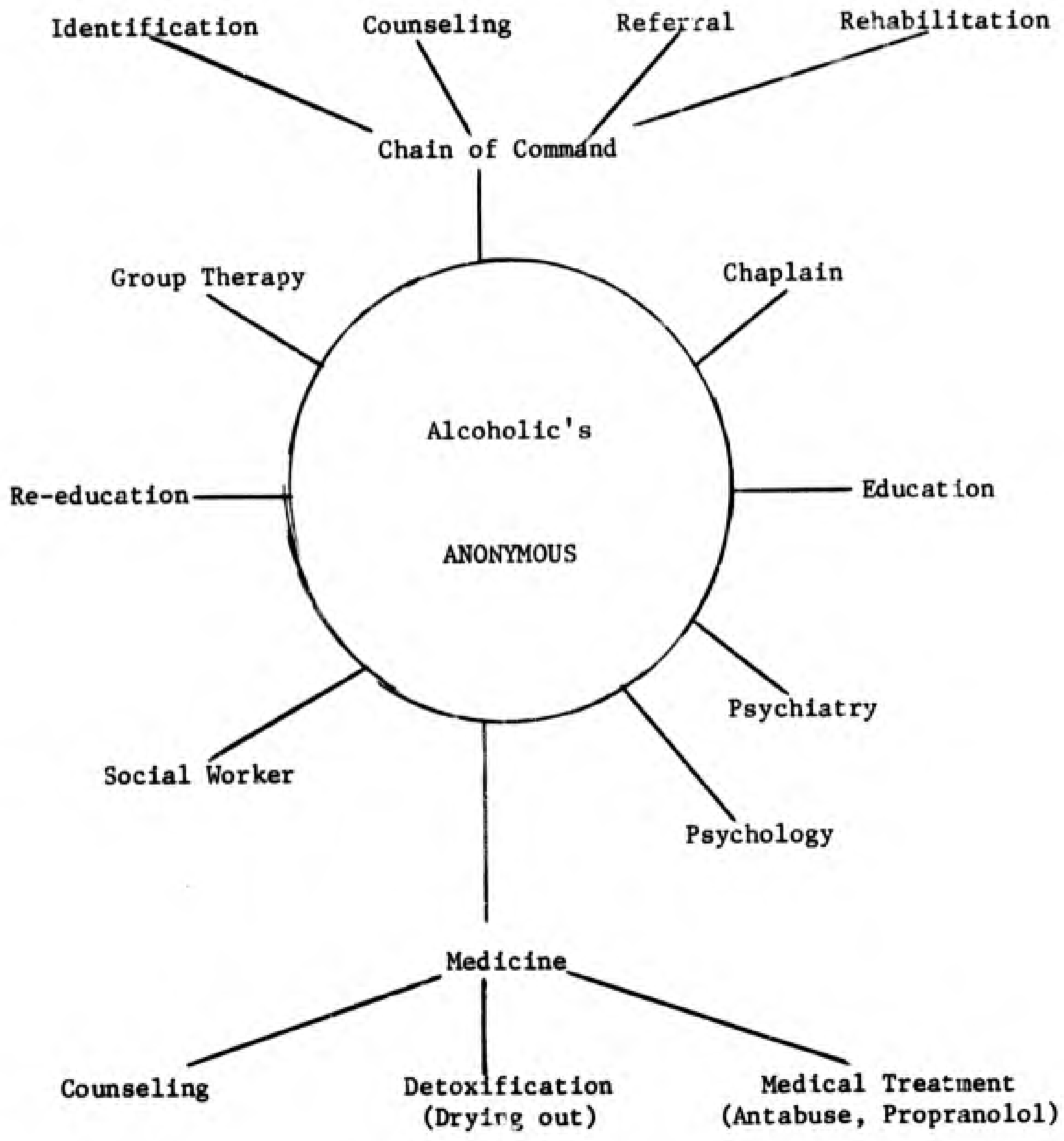
There is no known cure for alcoholism and no known way in which the alcoholic will ever be able to drink like he once did or as his friends drink. But the condition can be arrested, and provided he abstains from drinking, the alcoholic can recover and

be restored to a healthy life.[6] Most treatment programs in the past, both in and out of the service, have been geared to the chronic alcoholic--the public drunk--where the cure-all was to throw him in the "drunk tank," dry him out, and start him off again with no further effort to help him. The lack of knowledge about the causes of alcoholism is intensified by the previously discussed reluctance of the alcoholic or problem drinker to admit his difficulty and to voluntarily accept help in treating his disorder. Complete abstinence is, of course, the surest method for recovery; achieving it is another problem. Too frequently responsibility for alcoholism treatment is believed to lie primarily within medical channels. This belief may hold true for the small percentage of alcoholics in the extreme stages. However, most alcoholics and problem drinkers need a shotgun type approach to find the proper combination of social, medical and occupational adjustments best suited for the needs of each man. For that reason a variety of tools should be applied to find the most effective combination of controls.

Any treatment program, where possible, should cooperate with Alcoholics Anonymous. This organization has been responsible for more recoveries among alcoholics than medicine, psychiatry, and religion combined.[7] A varied or multidisciplinary treatment program addressing the many different aspects in the life of the alcoholic would have the greatest chance of success. Treatment for some people is most effective through use of drugs such as Antabuse; for some, a turn to religion may be the answer; for

others, down to earth peer assistance such as that offered by Alcoholics Anonymous may be the right method; still others may respond to psychiatry; or there are any number of other approaches which may provide the answers to control of an alcohol problem. The Army, or a particular unit, does not always have all of these tools, but most of them are available, and, where used properly, can form the basis for a very effective control program.

Displayed in diagram form, centered around Alcoholics Anonymous, are the main facets of an effective multidisciplinary treatment program. Mere reliance on Alcoholics Anonymous or any other single facet is not the answer, nor is the mere provision of medical attention and treatment.



The key to an effective alcohol control program is a joint effort at education, identification, referral, treatment and follow thru.

Soldiers identified as having alcohol problems can be placed in two categories regarding their acceptance of treatment.

Voluntary: This is the individual who appears to accept the fact that he has a problem and wants help. Treatment for him can be directed by counselors, leaders and by medical personnel based on his character and problem evaluation and on his own desires. He may, for example, agree to seek help from Alcoholics Anonymous; he may want to be helped by preventive medicine; or he may wish to work through the Chaplain, marriage counselor or other less formal modes of treatment. The stage of the alcohol problem he is experiencing and his own personal attitudes are the indicators dictating which element or combination of elements of treatment should be tried.

Involuntary: This soldier presents a different type situation entirely. His suspicion of the system and his reluctance to admit to an alcohol problem are the major roadblocks. Because of the nature of alcoholism, the involuntary patient is unfortunately in the majority. The approach to this soldier and his problem is one of employing the wide range of treatment options in an attempt to find the one which may unlock the problem door. From the beginning of the identification process, particularly in counseling at all levels, it is vitally important to try to convince the soldier that the effort to help him by the "establishment" is a sincere one; that he does have a problem; that submitting himself to its resolution will not adversely affect him; and finally, that if he does not participate in a program to arrest or to eliminate his alcohol

problem, his job and service career will be in serious jeapordy. In this regard many of the involuntary patients will identify themselves through an alcohol related incident or disciplinary problem such as family fights, accidents, or unexplained absences. Judicious use of suspended punishment by the commander to channel the alcoholic or problem drinker into a treatment program should be encouraged. Forced treatment is not the answer; however, subtle forms of coercion may prove successful. Senator Harold Hughes, a recovered alcoholic himself, said, "I have never known a successful program of force to be utilized in alcoholism."[8]

Several aspects of treatment for advanced drinking problems previously mentioned are more fully clarified below:

The Patient - Since alcoholism and advanced problem drinking usually take several years to develop, most alcoholics are found in the 30-55 year age bracket although recent signs indicate alcoholism is showing up at much earlier stages.[9] This means that the family will be greatly affected and involved by the drinking problem. The family can be equally involved in treatment assistance through the same means of education and understanding so necessary for the chain of command. A recent study in CONARC indicated that alcohol usage seemed to permeate all age groups equally. Frequency of habitual usage of alcohol varied only slightly (3%) by two year age groupings from 18 to over thirty.[10]

Medicine - Medication to arrest alcoholic consumption should be given only to soldiers who voluntarily submit for treatment.

Two types of drugs have come to the forefront in recent years which, when properly applied, have been very effective in the treatment of patients in all phases of alcoholism and problem drinking. These drugs are:

Disulfuram (Antabuse) - A drug which blocks the catabolism of alcohol in the liver. It has a purely physical effect, making the drinker violently ill after taking a drink. Taken regularly, Disulfuram affords protection for 10-14 days after the patient stops taking the drug.[11]

Propranalol - A drug which blocks the behavioral and psychic effects of alcohol. Since most drinkers drink to achieve an alteration in mood, anxiety plays a major role in the decision to drink. This drug blocks the effects sought by the drink.[12]

Treatment time - In advanced stages of problem drinking and in alcoholism, the supervisor must be prepared to lose men for the period of effective treatment. Total hospital time for advanced cases of alcoholism runs about four weeks.[13] Three to five days are required for initial evaluation and "drying out" while an additional three weeks is needed for the rehabilitation phase. The Alcoholic Treatment and Research Center at St. Louis finds that a patient who is allowed to leave the hospital in less than 10 days has a very high probability of returning to drink within a few days.[14]

The question of what to do with the continued failure must also be addressed. The Army cannot continue to keep those who refuse

help and who continue to decline in their affectiveness even after treatment. The most severe cases must be released from service. Yet the Army must make every effort to insure that these men have a chance of success in civilian life. In that regard, effective use could be made of the fine facilities of Veterans' Hospitals. As a condition of his release, the alcoholic would spend a 30 day period in the Veterans' Hospital nearest his home which has adequate treatment facilities. This effort would put more useful citizens back into society than the process of merely dumping them out of the service with no further attempts to help.

These problems discussed are by no means an all encompassing review of alcoholic and problem drinker difficulties. They highlight the reluctance to accept or to admit the problem by both the afflicted and by his leaders. Additionally, the review of these problems spells out the broad range of available treatment tools and the necessity for their wide use.

CHAPTER III

FOOTNOTES

1. Joseph J. Zuska, MC, USN, Navy Regional Medical Center, letter to author, 8 November 1972.

2. National Association of Blue Shield Plans, The Alcoholic American, p. 20.

3. Barney Halloran, "Juice," Soldiers, October 1972, p. 7.

4. National Institute on Alcohol Abuse and Alcoholism, Occupational Alcoholism, Some Problems and Solutions, p. 3.

5. Alcoholics Anonymous World Services, Inc., AA and the Alcoholic Employee, p. 19.

6. The Alcoholic American, p. 31.

7. Joseph J. Zuska, MC, USN, Alcoholic Education and Rehabilitation, p. 7.

8. The Alcoholic American, p. 37.

9. General Motors Corporation, Some Facts About the G M Employee Alcoholism Recovery Program, p. 7.

10. United States Continental Army Command, A Study on Drug Attitudes, p. 15.

11. S. J. Holmes, MD, "Treatment of Alcoholism," Canadian Family Physicain, January 1970, p. 48.

12. "Psyching the Alcoholic," Newsweek, 21 August 1972, p. 62.

13. Donald R. Seidel, Military Alcoholic Rehabilitation Program, p. 3.

14. Ibid.

CHAPTER IV

A TACTICAL UNIT APPROACH

In this chapter, an attempt is made to identify some procedures, areas of increased emphasis and organizational techniques which could be applied, primarily at division level and below, to the problem of alcohol abuse. Emphasis is placed on the procedures, organization and methods which are readily available rather than the more complex sophisticated approaches to the problem which may or may not be readily available to the combat unit commander.

ATTITUDES AND EDUCATION

Officials of the National Council on Alcoholism believe that the incidence of alcoholism in the military is no less than in industry.[1] The first task, therefore, is one of convincing the leaders of the Army at every level that a problem exists and to teach those leaders about its magnitude; how to recognize it; and what they can do about it. There is no doubt that alcohol and its use are here to stay. It is permissiveness toward abnormal drinking behavior, or alcohol abuse, which must be addressed; in the military society abstinence from alcohol must be as acceptable as its use. Accepting abstinence, however, sounds hollow against the clink of glasses and beer mugs at every social function and the never ending variety of Happy Hour enticements. The commander must set the tone and the example for positive action at every

must set the tone and the example for positive action at every echelon. Dr. Zuska very effectively summed up the leader's role when he said:[2]

> The combat officer like any supervisor should first of all set the example for his men by his own sober behavior at all times, deemphasize and deglamorize the use of alcohol at social and professional gatherings and promote the attitude of 'responsible drinking.' Next he must learn to recognize work problems and behavior problems that are the result of alcohol abuse and exert the necessary humane pressure by counseling, suspended sentence, etc. to force the individual who needs help into a treatment program.

No battle against a problem can be successful if it attends only to the casualties. Just as a comprehensive education program on drugs was promoted and made available Army wide, so must a similar program for alcohol be adopted. This education program should have as its goals:

a. To dispel myths about alcohol.

b. To identify the nature and magnitude of alcohol related problems.

c. To recognize alcohol problems as treatable.

d. To announce command policies concerning alcoholism and problem drinking.

e. To portray the Army's sincere interest in helping individuals with alcohol related problems.

In laying the ground rules, every soldier in the Army should know:

a. That the Army is not concerned with eliminating social drinking or infringement into the soldier's private lives; rather it is concerned about drinking to the extent that it causes job performance, personal or social problems.

b. That alcoholism is recognized as a health problem which can be treated and from which recovery is possible in the majority of cases.

c. That the Army's interest in alcoholism stems from the detrimental effects on job performance and interpersonal relations to include the family.

d. That every effort will be made to help those with problems who will accept assistance.

e. That continued alcohol abuse subjects the soldier to disciplinary action and may seriously jeapordize his continued service if misconduct or impaired job performance results from his drinking.

THE TOOLS AVAILABLE

The Army has taken great strides in recent years to provide a wide range of personal services for the soldier and his family. This help has been available through both professional and nonprofessional sources. Marriage counseling, expanded legal services, and the drug program, such as the Halfway House concept, are but a few examples of these services. The problems of alcohol can best be included in the framework of this broadly based policy of personal services now such an important part of the Army. In this

chapter are discussed some of the tools readily available to the combat unit leader which would strengthen the effectiveness of the unit alcohol control program. This chapter does not discuss the professional services, such as psychiatry, medicine, and others which are available to the commander on a referral basis and which form one of the conerstones of an effective program.

Records checks and interviews - All soldiers pass through three critical points where the identification of a possible alcohol problem could preclude the more difficult job of identification through job performance or behavior at a later time. These points are the Reception Center, Unit replacement processing and reenlistment processing. The technique advocated would be to screen carefully both the personnel records and the medical records for signs of a possible alcohol problem. This screening could be accomplished by a trained personnel clerk and by a medical specialist, officer or enlisted, with sufficient training to read the signs. Examples of indicators, not all inclusive, are listed below:

Personnel Records Indicators

Repetitive periods of AWOL--usually for short periods.

Accident record where alcohol was involved.

Disciplinary record where alcohol was involved.

Financial problems.

Family or marital difficulties.

Medical Records Indicators

Emergency room treatment

Nervous condition/use of tranquilizers

Excessive sick call attendance

Prescriptions for treatment (Antabuse/Propranolol)

Seizures/tremors

Chronic gastritis

Liver problems.

Blackouts.

Oftentimes information of a questionable or derogatory nature is removed from medical records by the individual if he feels discredited or shamed by it. This could be circumvented by the medical officer's analysis and notation in medical terms which would indicate the involvement of alcohol to the trained eye but not to the layman.[3]

It is important to note that these indicators do not necessarily confirm an alcohol problem--in some instances alcohol may not be at all involved. The indicators, however, do provide a basis for followup by personal interview. This interview would take place at reception, transfer or reassignment, and at time of reenlistment.

Counselor Training Program: Counseling should be available at all echelons by the chain of command and down to battalion level by trained peer counselors, recovered alcoholics or paraprofessionals. It is obvious that formally trained professional counselors are not going to be available at each unit. Trained counselors should be

available at all reception stations and at each Division or separate brigade and major installation where replacement reception and reenlistment functions are performed. The armed forces do not presently have in-house counselor training programs for alcohol abuse. Training is available, however, at many civilian institutions such as the 24 week course offered at the Baltimore City Alcoholic Center.[4] The Army takes advantage of this training now and could easily expand the program by additional quotas and by schooling at other institutions. Additionally, the Armed Forces could very profitably establish a Drug and Alcohol Counselor Program along the lines of the recently established Department of Defense Equal Opportunity Institute at Patrick Air Force Base in Florida.

Alcoholics Anonymous: Nonprofessionals constitute a potential for extensive and effective assistance. Recovered alcoholics form the most lucrative nucleus for nonprofessional counseling and assistance. The unique ability of the recovered alcoholic to identify himself with other problem drinkers has been notably successful as evidenced by the achievements of Alcoholics Anonymous in assisting alcoholics and problem drinkers on the road to recovery. Alcoholics Anonymous is a fellowship of compulsive adult drinkers who have joined together to abstain from the use of alcohol. The organization was formed by problem drinkers and does not involve professional therapists.[5] Alcoholics Anonymous is the single most effective form of therapy for the chronic drinker.[6] There are more than 16,000 local AA chapters in CONUS and abroad.[7]

These chapters are already active in the military community and provide a source of treatment and therapy invaluable to the military effort in its bout with alcohol problems.

Chain of Command Supervision and Counseling: Commanders and supervisors at all levels must be aware of alcohol problems, able to identify symptoms, and employ positive thinking in their counseling techniques. This is the location where the Army's program, however simple or complex, will succeed or fail. A ready assistance to leaders is the maintenance of informal notes on circumstances, observations, indicators and results of interview--not as a cover, but as an aid to him in further counseling and probing to find the path to recovery for soldiers of his unit.

Individual Tests: Along with an effective education program, tests can be given on a voluntary basis, the results of which will not be recorded. The test often will point out to the individual facts about himself he has been reluctant to admit. If the individual has confidence in the sincerity of the system and its program, the results of these tests may cause him to seek help voluntarily. These tests are many and varied. The most effective should be straightforward and simple. The 20 question test below, which relates to drinking patterns, was developed by medical researchers at John Hopkins Hospital and has been used, occasionally with modification, in a number of industrial alcoholism programs.[8]

The test:

		Yes	No
1.	Have you lost time from work due to drinking?	( )	( )
2.	Has drinking made your home life unhappy?	( )	( )
3.	Do you drink because you are shy with people?	( )	( )
4.	Has drinking affected your reputation?	( )	( )
5.	Have you gotten into financial difficulties because of your drinking?	( )	( )
6.	Do you turn to lower companions and an inferior environment when drinking?	( )	( )
7.	Does your drinking make you careless of your family's welfare?	( )	( )
8.	Has your drinking decreased your ambition?	( )	( )
9.	Do you want a drink "the morning after"?	( )	( )
10.	Does your drinking cause you to have difficulty sleeping?	( )	( )
11.	Has your efficiency decreased since drinking?	( )	( )
12.	Has your drinking ever jeopardized your job or career?	( )	( )
13.	Do you drink to escape from worries or troubles?	( )	( )
14.	Do you drink alone?	( )	( )
15.	Have you ever had a complete loss of memory as a result of drinking?	( )	( )
16.	Has your physician ever treated you for drinking?	( )	( )
17.	Do you drink to build up self-confidence?	( )	( )
18.	Have you ever been in an institution or hospital on account of your drinking?	( )	( )
19.	Have you ever felt remorse after drinking?	( )	( )
20.	Do you crave a drink at a definite time daily?	( )	( )

When he takes the test, the soldier is reminded that only he can determine whether or not he has an alcohol problem. However, if the soldier answers yes to as few as three questions, he can be reasonably certain that alcohol has become, or is becoming, a problem for him.

DIVISION AND LOWER LEVEL ORGANIZATION

For the past few years, particularly since the March 1972 DOD Directive on alcohol abuse, the services have begun to gear up to tackle the alcohol problem. A variety of techniques can be viewed across the Army in an effort by units, posts, camps and stations to find the best method for organizing and dealing with the problem. The alcohol abuse program must obviously be a command effort. Directives have established the DCSPER/G1 as the principal staff coordinator and have suggested the appointment of an Alcohol and Drug Control Officer (ADCO).[9] Additionally, the establishment of Alcohol and Drug Dependency Intervention Councils (ADDIC) have been directed at installation level to assess the alcohol and drug problem, to recommend policies and to coordinate the program.[10] A fifteen man Alcohol and Drug Prevention and Control Team consisting of a physician, chaplain, social worker, psychologist, ten paraprofessionals and a typist are discussed in the new regulation on alcohol abuse, although the level at which this team is to be found is not clearly defined.[11] The success of an alcohol abuse program will rise or fall at division level and below. Certainly there will be many times where the qualified fifteen man team will not be available. The combat unit leader must fill this gap and establish a program that will work with the resources he has available to him. A possible organization for division, brigade and battalion level units is discussed here.

Division - The division G1 is the principal staff coordinator. Working closely with him must be the Division Surgeon, for professional services, and the Adjutant General, for administrative support, particularly in-processing procedures. Special functions to be conducted at division are:

Screening and In-processing - Each new arrival in the division will have his personnel and medical records carefully screened by qualified personnel trained and instructed by the AG and Surgeon. The purpose of this detailed screening is to identify:

a. Alcoholics

b. Problem Drinkers

c. Recovered alcoholics

d. Individuals with counseling or social work background.

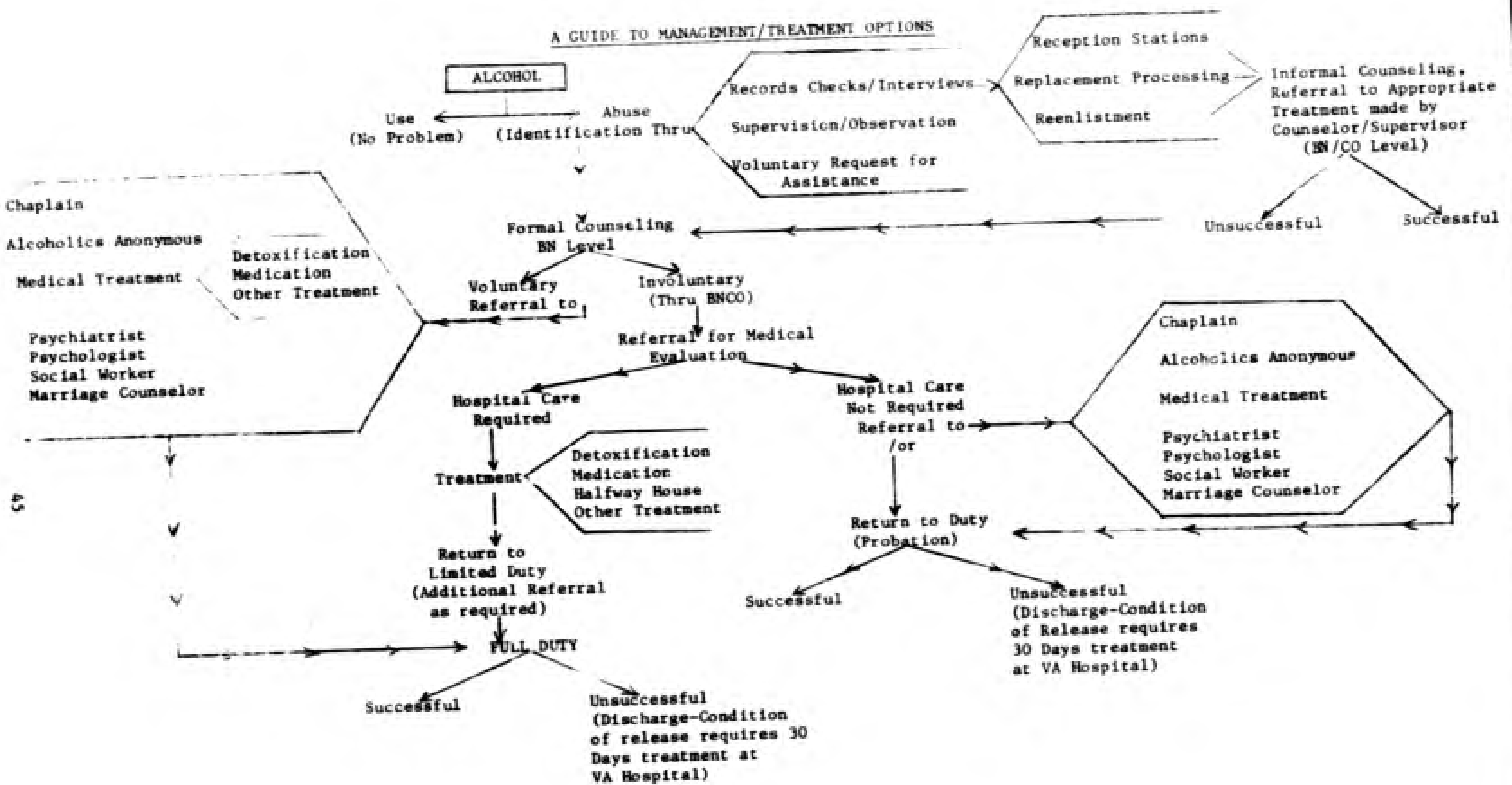
Identification of possible drug problems could also be incorporated into this program at this critical point. Once identified as either a possible problem or as a possible worker in the alcohol abuse program--such as a recovered alcoholic--an interview would be conducted at division level prior to unit assignment. Interview procedures and counseling at this initial stage are critical and must be handled by the most qualified person available, preferably an enlisted man. This initial identification and counseling procedure is the key to follow-on action and must be closely monitored by both the G1 and the Surgeon. The purpose of this interview is to get those needing help into a voluntary program. Those not voluntarily seeking help are then identified for observation and followup assistance after unit assignment. This determination is sensitive

and critical. The counseling unit at division level must exercise care and discretion in their evaluation. Information, observations and recommendations of the counseling process at division level would then be passed to the alcohol abuse counselor at brigade or battalion level. The chain of command would not be brought into the picture at this point. Information passed between counselors would not be made a matter of official record. The unit counselor would then make observations, conduct interviews and take such other action as he deemed necessary under the circumstances in an attempt to identify the problem and begin work towards its solution. The matter would be referred to command channels only after the second attempt is made at unit level to have the individual seek help voluntarily.

The organization at brigade and battalion level would consist of one counselor at each unit. This soldier would normally be assigned to the S1 section and could perform other duties as well. These counselors would most likely be nonprofessionals. The most effective would be recovered alcoholics or soldiers having counseling or social work experience. In any case they must want to do the job. Qualifications of these brigade and battalion personnel will undoubtedly vary. The functions of these lower level unit counselors is to monitor the unit program, provide peer counseling and referral services to soldiers with problems and to make recommendation to the commander. Interviews with soldiers having observed problems would be initially conducted by the unit counselor. Thereafter, interviews would be continued by the counselor or referred to the chain of command for additional assistance as deemed appropriate by

the counselor. The exchange of information among all members of the division counseling and treatment community would provide the basis for a progressive and productive program.

As a summary of the actions taken, the following chart could be used as a basis for management/treatment options relating to the alcohol abuse program at Division level and below. A similar guide could be effectively employed at any level where an organized program exists.


A GUIDE TO MANAGEMENT/TREATMENT OPTIONS
ALCOHOL
Use
(No Problem)
Abuse
(Identification Thru
Records Checks/Interviews
Supervision/Observation
Voluntary Request for Assistance
Reception Stations
Replacement Processing
Reenlistment
Informal Counseling, Referral to Appropriate Treatment made by Counselor/Supervisor (BN/CO Level)
Unsuccessful
Successful
Formal Counseling BN Level
Voluntary Referral to
Involuntary (Thru BNCO)
Chaplain
Alcoholics Anonymous
Medical Treatment
Detoxification
Medication
Other Treatment
Psychiatrist
Psychologist
Social Worker
Marriage Counselor
Referral for Medical Evaluation
Hospital Care Required
Hospital Care Not Required Referral to /or
Treatment
Detoxification
Medication
Halfway House
Other Treatment
Return to Limited Duty (Additional Referral as required)
FULL DUTY
Successful
Unsuccessful (Discharge-Condition of release requires 30 Days treatment at VA Hospital)
Chaplain
Alcoholics Anonymous
Medical Treatment
Psychiatrist
Psychologist
Social Worker
Marriage Counselor
Return to Duty (Probation)
Successful
Unsuccessful (Discharge-Condition of Release requires 30 Days treatment at VA Hospital)

CHAPTER IV

FOOTNOTES

1. Comptroller General of the United States, Report for the Subcommittee on Alcoholism and Narcotics, Committee on Labor and Public Welfare, United States Senate, *Alcoholism Among Military Personnel*, p. 6.

2. Joseph J. Zuska, MC, USN, Naval Regional Medical Center, letter to author, 8 November 1972.

3. Interview with James W. Ransone, Col, MC, Durham Army Hospital, Carlisle Barracks, 15 January 1973.

4. First United States Army, *Command Alcohol Workshop--After Action Report*, p. 5.

5. Harrison M. Trice and Paul M. Roman, *Spirits and Demons at Work: Alcohol and other Drugs on the Job*, p. 214.

6. *Ibid*., p. 213.

7. Alcoholics Anonymous World Services, Inc., *AA and the Alcoholic Employee*, p. 5.

8. *Ibid*., pp. 14-15.

9. US Department of the Army, *DA circular 600-85*, Alcohol and Drug Abuse Prevention and Control Program, p. c1.

10. *Ibid*., p. c2.

11. *Ibid*.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

There are a variety of factors affecting the control of alcoholism and problem drinking in the Army. Hopefully, this study has pointed up some of the more important ones. The intent was to bring about an awareness of this problem, its effect on the Army and some attitudes and techniques which need to be developed if the Army is to get the most from its most precious resource--its manpower. The comments in this study were not meant, in any way, to infer a lack of current action on the Army's part. Even since this study was begun there has been a rapid evolvement of events pointing up the Army's serious intent to reduce the problem of alcoholics in its ranks.

CONCLUSIONS

The major conclusions brought out and supported by the study are:

1. Alcohol abuse has a serious and substantial effect on the Army.

2. Career military men are reluctant to admit that alcohol abuse is a serious problem in the Army.

3. Necessary elements to establish an effective alcohol abuse program are currently present in the Army.

4. Identification, counseling and treatment of the alcoholic and problem drinker are sensitive. There are techniques and

procedures which, if used correctly, have proven to be very effective in combating the problems of alcohol.

5. The alcoholic is most receptive to a program when he knows it is offered and conducted in a sincere and effective manner to help him.

6. The key to an effective alcohol abuse program is the action taken by leaders and supervisors, particulary at the lower unit level.

7. The Army's efforts to reduce the problem of alcohol in its ranks will provide substantial results in terms of recovered personnel of continued future value to the Army.

RECOMMENDATIONS

On the basis of available information, it is recommended that:

1. The Army integrate into its information program an Army wide effort of education and alcohol abuse.

2. The Army design a training program to provide unit leaders with the requisite knowledge to effectively conduct an alcohol abuse program.

3. The Army require training centers and leader type school curriculum to contain instruction in alcohol abuse.

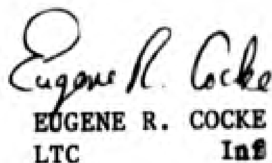
4. The Army prepare and provide leaders with a guide to alcohol control, emphasizing action and techniques to be employed at division, installation and lower level organizations.

5. The Army obtain and fund quotas for training alcohol counselors at established civilian centers and that the services

establish, in conjunction with the drug abuse program, an in-house training center for alcohol counselors.

6. The Army establish a goal of having a trained alcohol counselor at each battalion sized unit.

7. The Army seek change in appropriate laws and regulations regarding separation procedures to allow for additional treatment in VA hospitals for individuals released from service due to alcohol abuse.



EUGENE R. COCKE
LTC Inf

SELECTED BIBLIOGRAPHY

1. "Alcohol and Society." Journal of the American Medical Association. Vol. 216, No. 6, 10 May 1971, pp. 1011-1013.

2. Alcoholics Anonymous World Services, Inc. AA and the Alcoholic Employee. USA: 1971.

3. Alcoholics Anonymous World Services, Inc. Alcoholics Anonymous And the Medical Profession. USA: 1971.

4. Alcoholics Anonymous World Services, Inc. A Member's Eye View of Alcoholics Anonymous. USA: 1970.

5. Alcoholics Anonymous World Services, Inc. Alcoholism the Illness. New York: 1971.

6. Alcoholics Anonymous World Services, Inc. Alcoholism is a Management Problem. USA: 1971.

7. Alcoholics Anonymous World Services, Inc. 44 Questions and Answers about the AA Program of Recovery from Alcoholism. USA: 1971.

8. Alcoholics Anonymous World Services, Inc. Sedatives, Stimulants and the Alcoholic. USA: 1971.

9. Alcoholism Foundation of British Columbia. Motivating the Alcoholic in Industry to Seek Treatment. Vancouver: 1969.

10. American Medical Association. The Illness Called Alcoholism. Chicago: Undated.

11. "Criteria for the Diagnosis of Alcoholism." Annals of Internal Medicine, Vol. 77, 1972, pp. 249-258.

12. Baltimore City Health Department. Course Syllabus, Alcoholism Counselor. Baltimore: Undated.

13. Comptroller General of the United States. Report to the Subcommittee on Alcoholism and Narcotics, Committee on Labor and Public Welfare, United States Senate: Alcoholism Among Military Personnel. Washington: 1971. (HV 5292 A3).

14. Department of Health Education and Welfare. First Special Report to the US Congress on Alcohol and Health. Washington: US Government Printing Office. 1971.

15. Effron, H. S. "One Day at a Time." Soldiers, February 1972, pp. 41-42.

16. First United States Army. Command Alcohol Workshop - After Action Report. Fort Meade. 1972.

17. Fisher, Allen H. Sr. Preliminary Findings from the 1971 DOD Survey on Drug Use. Alexandria: Human Resources Research Organization. 1972.

18. Gard, Robert G. Jr. "The 'Other War' on Drugs, Alcohol." Army, October 1972, pp. 107-108.

19. General Motors Corporation. Some Facts About the GM Employee Alcoholism Recovery Program. USA: Undated.

20. Gorry, Michael, Sp5. Alcohol and Drug Control Office. Personal Interview. Carlisle Barracks: 10 January 1973.

21. Halloran, Barney. "Juice" Soldiers, Vol. 27, No. 10, October 1972, pp. 4-12.

22. Hey, Robert P. "Liquor Still Rated as Most Abused Drug." Christian Science Monitor (Eastern Edition), 23 February 1972, p. 22.

23. Holmes, S. J. "Treatment of Alcoholism." Canadian Family Physician, January 1970, pp. 46-49.

24. International Lutheran Layman's League. I Am An Alcoholic. St. Louis: 1972.

25. Kellerman, Joseph L. Guide For the Family of the Alcoholic. USA: 1972.

26. Kelley, James W. "Case of the Alcoholic Absentee." Harvard Business Review, May-June 1969, pp. 14-36.

27. Kemper Insurance Company. Detour-Alcoholism Ahead. USA: 1972.

28. Kimbula, Tendayi J. "Industry Finding Alcoholism as Treatable Disease." The Patriot (Harrisburg), 15 February 1973, p. 10.

29. McCormack, Patricia. "Alcoholic Assistance Available." Evening Sentinel (Carlisle), 20 December 1972, p. 22.

30. McCormack, Patricia. "Alcoholism: 'We'll Help You'." Evening Sentinel (Carlisle), 21 December 1972, p. 12.

31. McCormack, Patricia. "Federal Aid for Alcoholics Set." Evening Sentinel (Carlisle), 22 December 1972, p. 24.

32. National Association of Blue Shield Plans. The Alcoholic American. USA: 1970.

33. National Council on Alcoholism. 13 Steps to Alcoholism. New York: 1972.

34. National Institute on Alcohol abuse and Alcoholism. Occupational Alcoholism, Some Problems and Solutions. Rockville: 1972.

35. Police Department, City of New York. Counseling Program for Problem Drinkers. New York: 1972.

36. "Psyching the Alcoholic." Newsweek, Vol. 80, August 21, 1972, p. 62.

37. Ransone, James W. Col. MC. Commanding Officer, Dunham Army Hospital. Personal Interview. Carlisle Barracks: 15 January 1973.

38. Roman, Paul M. and Trice, H. M. The Sick Role, Labelling Theory, and the Deviant Drinker. Ithaca: New York State School of Industrial and Labor Relations. 1967.

39. Sadler, Marion and Horst, James F. "Company/Union Programs for Alcoholics." Harvard Business Review, Vol. 50, No. 5, Sep-Oct 1972, pp. 22-34.

40. Seidel, Donald R. Military Alcohol Rehabilitation Programs. Washington: 1966.

41. "Confessions of an Alcoholic Executive." Duns, Vol. 99, No. 6, June 1972, pp. 72-74.

42. Treasury Board Secretariat. Personnel Policy Branch, Canada. Alcoholism--A Guide for Public Service Managers. Ottawa: Information Canada. 1971.

43. Trice, Harrison M. and Belasco, James A. Supervisory Training About Alcoholics and Other Problem Employees: A Controlled Evaluation. Ithaca: New York State School of Industrial and Labor Relations. 1966.

44. Trice, Harrison M. and Roman, Paul M. Delabeling, Relabeling, and Alcoholics Anonymous. Ithaca: New York State School of Industrial and Labor Relations. 1970.

45. Trice, Harrison M. and Roman, Paul M. Spirits and Demons at Work: Alcohol and Other Drugs on the Job. United States: Hoffman, 1972.

46. US Congress, Senate. Committee on Veterans Affairs, Subcommittee on Health and Hospitals. S2108, H. R. 9265 and Related Veterans Addiction Treatment and Rehabilitation Bills. Hearings, 92d Congress, 1st Session. Washington: US Government Printing Office. 1971. (KF 72 S761-1 Pt.2 C.2).

47. United States Continental Army Command. A Study on Drug Attitudes. Ft. Bragg: 1972.

48. United States Continental Army Command. CON Circular 600-85, Personnel--General: Alcohol and Drug Abuse and Control Program. Fort Monroe: 10 August 1972.

49. US Continental Army Command. CON PAM 350-7-4: Project Assist. Fort Monroe: 1 September 1972.

50. US Department of Defense. Commanders Digest: Alcohol Abuse and Rehabilitation. 28 December 1972.

51. US Department of Defense. Directive Number 1010.2: Alcohol Abuse By Personnel of the Department of Defense. 1 March 1972.

52. US Department of Health Education and Welfare. Alcohol--Some Questions and Answers. Washington: 1971.

53. US Department of the Army. DA Circular 600-85: Alcohol and Drug Abuse Prevention and Control Program. Washington: 30 June 1972.

54. US Department of the Army. Army Regulations 600-300;: Alcoholism Program for Civilian Employees. Washington: 24 January 1972.

55. US Department of the Navy. SECNAV Instruction 5400.20: Alcohol Abuse and Alcoholism among Military and Civilian Personnel of the Department of the Navy. Washington: 18 May 1972.

56. US Laws, Statutes, etc. Public Law 91-616, 91st Congress., 31 December 1970. "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970."

57. "US Reconsiders Military Alcoholism." Christian Science Monitor (Eastern Edition). 22 March 1972, p. 22.

58. Vogel, A. J. Executive Drinking: Too Many Losers. Vancouver: Alcoholism Foundation of British Columbia. Undated.

59. Zuska, J. J. Alcoholic Education and Rehabilitation. Presented at the Surgeon Generals' Conference, 22 May 1970. (Cited with special permission of Dr. Zuska).

60. Zuska, J. J. Naval Regional Medical Center. Letter to author, 8 November 1972.

APPENDIX I

DEFINITIONS

<u>Alcohol abuse</u> - Any irresponsible use of an alcoholic beverage which leads to misconduct, unacceptable social behavior, or impairment of an individual's performance of duty, physical or mental health, financial responsibility or personal relationships. It may also lead to alcoholism.

<u>Alcoholic</u> - A person who cannot control the desire or need for alcohol and whose repeated and uncontrolled use of alcoholic beverages impairs his health, personal relations, social conduct, or job performance. An alcoholic is physically or psychologically dependent on alcohol.

<u>Alcoholism</u> - Psychological or physical dependency on alcohol or both. It is a chronic, relapsing, progressive illness characterized by the loss of control over the drinking of alcoholic beverages to the point of interfering with health, personal relationships and the ability to work effectively. Alcoholism is both preventable and treatable.

<u>Alcoholics Anonymous</u> - A worldwide fellowship of men and women who help each other to stay sober. They offer the same help to anyone who has a drinking problem and wants to do something about it. Since they are all alcoholics themselves, they have a special understanding of each other.

<u>Detoxification</u> - The process of establishing physiological equilibrium to include the elimination of alcohol from the body. It is often

referred to as "drying out" and normally occurs within six to twenty-four hours from cessation of drinking in otherwise healthy individuals. Detoxification is the first step in the treatment process for alcoholics.

Halfway House - A place where soldiers in the Army's drug program may stay, usually after leaving the hospital and before returning to full duty. They may either live in full time for a short while or perform regular duty in the unit and return to the halfway house at night.

Problem Drinker - An individual whose repeated or continued excessive use of alcohol interferes with normal job performance, health, personal relationships and family life.

Recovered Alcoholic - A person whose alcoholism has been arrested. Normally this is accomplished through abstinence and is maintained through a continuing program of personal recovery.