AD NUMBER

AD920042

NEW LIMITATION CHANGE

TO

Approved for public release, distribution unlimited

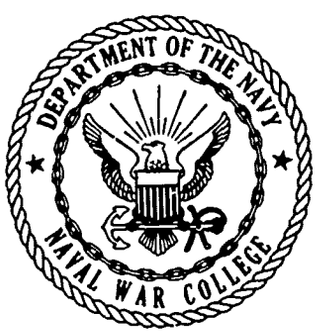
FROM

Distribution authorized to U.S. Gov't. agencies only; Administrative/Operational Use; 20 JUN 1974. Other requests shall be referred to Naval War College, Newport, RI 02840.

AUTHORITY

USNWC ltr, 26 Sep 1074

THE UNITED STATES NAVAL WAR COLLEGE



PUBLISHED BY

THE NAVAL WAR COLLEGE

ADVANCED RESEARCH PROGRAM

PREVENTION OF ALCOHOLISM AND OTHER DRINKING PROBLEMS IN THE U.S. NAVY

by

Commander J. R. TAPPAN, U.S. Navy

This document is a Completed Study, the product of Naval War College Advanced Research Project No. 007, and is circulated under the provisions of NAVWARCOL-INST 3920.2.

FOREWORD

Commande: Jeremy R. Tappan, USN, was a member of the Ninetieth Class of the Naval War College, College of Naval Warfare, 1972-1973. He completed the first two-thirds of the regular curriculum and then, on his application and on the recommendation of the Advanced Research Council and with the approval of the President, transferred to the Advanced Research Program for the undertaking of which this paper was the product.

The time available to Commander Tappan for completing the research and writing that his product called for was approximately four months. His faculty advisor was Captain James E. Wilson, Jr., USN, holder of the Military Chair of Human Resource Management.

The subject of Commander Tappan's research, on which this paper is the final report, is one of great importance that requires careful and discriminating handling. It is the opinion of all members of the staff and faculty of the Naval War College who have examined this paper that Commander Tappan completed his project with thoroughness, with objectivity, and with remarkable dispatch. It is a professional product in which the author and all who advised and assisted him may take pride.

James E. King

Director of Advanced Research

Abstract of

PREVENTION OF ALCOHOLISM AND OTHER

DRINKING PROBLEMS IN THE U.S. NAVY

A study of the concept of prevention of alcohol problems and the program for the reduction of the U.S. Navy's high incidence of problem drinking. The extent of the Navy's alcohol problem, current theories of prevention, and the Navy's solution to the problem are examined in an effort toward significant reduction of personnel casualties due to the misuse of alcohol. There is a serious alcohol problem in the Navy, and it will not be overcome solely by treatment and rehabilitation of problem drinkers. The long-range solution is a comprehensive, widely-supported and multi-faceted program of prevention. The U.S. Navy has established a viable and extensive prevention program as a vital element in its relatively young alcohol abuse control program. However, an early and serious obstacle in preventive efforts is the skepticism and lack of involvement of command managers. No significant reduction in the high incidence of problem drinking in the Navy will be made unless middle- and upper-level command managers believe in and are directly involved in this long-range prevention concept. Recommendations are made to involve management more directly, to further enhance existing Navy preventive measures, and to maximize the effectiveness of the Navy's present and future prevention programs.

TABLE OF CONTENTS

PREVENTION OF ALCOHOLISM AND OTHER DRINKING PROBLEMS IN THE U.S. NAVY

CHAPTER I

INTRODUCTION

The Problem

The proportion of "problem drinkers" in the U.S. Navy may be as high as 38 percent. This estimate is projected on the basis of a recent survey[1] of the extent of alcohol problems conducted at four different locations (two in the United States and two overseas) in the U.S. Navy. This alarming statistic would also indicate a dramatic change if a 1944 study on the alcohol problem in the Navy was accurate. The study reported by F.M. Harrison concluded that, "Alcohol, in short, is not a serious problem in the Navy."[2]

The authors of the 1972 Navy survey, Drs. Cisin and Cahalan, have been involved in similar surveys of the nation as a whole and of the U.S. Army. They are careful to include a qualification in their report that the statistics should not be taken as an indication of the overall Navy problem. However, the four Navy sample installations surveyed bear no significantly different characteristics from other Navy bases. Also, the percentages found for different categories of drinking problems and for the overall extent of the

problems differ by only ±.5 percent from the statistics found in a much larger sample in the U.S. Army survey. If the findings in the sample are representative of the entire active duty U.S. Navy, Marine Corps, and Coast Guard population, the above 38 percent equates to about 317,600 members who may have alcohol-related problems. The U.S. Navy uses a conservative figure estimate, however, of 15 percent or 125,000 individuals in the three service branches above who have serious problems because of alcohol.[3] The higher percentage, if it were accurate, would mean an annual loss to the Navy Department of about $475 million; the more conservative estimate equates to an annual loss of $188 million. The monetary loss estimates are based solely on poor job performance using loss rates equivalent to that of industry. The losses do not include related costs such as medical and psychiatric care, replacement costs, or the unmeasureable costs to the family and the individual himself.

Even if the Navy's "addictive" alcoholic population were as low as the nation's or industry's that would mean that 7.2 percent of its force is afflicted with the disease of alcoholism[4] and at least 10 percent have other serious problems due to the misuse of alcohol. These figures, however, reveal only a cold and incomplete picture of the overall problem. The real and personal tragedies are obscured by the workforce statistics. For example, four or five others are

usually adversely affected by each alcoholic; 52 percent of alcoholics are children of alcoholics[5] and, if big changes are not made, what does this tell us of the children dependents of Navy alcoholics? It means that as many as half of these children who elect to serve in the Navy when eligible will become alcoholics. Indeed, half of them will become alcoholic whether or not they choose to serve in the Navy or any other service. In addition, if a Navy alcoholic is able to ride his disease to retirement, he can look forward to becoming a Veterans Administration (VA) statistic and a VA hospital resident--not a pleasant retirement life-style.

The sample Navy statistics in the Bureau of Social Science Research, Inc., (BSSR) report, which will be examined in Chapter II, indicate a higher rate of alcohol problems than is usually advertised for the nation as a whole. The published figures on the national scale are usually for the whole adult population. Of the estimated 9,000,000 alcoholics in the United States, 97 percent are employed with an incidence in business and industry of five to eight percent. The nation's population, including women and all ethnic and religious groups, has an abstinence rate of 32 percent with 68 percent drinking to varying degrees. The Navy is primarily an adult male population with less than three percent abstainers. Nevertheless, alarming as the comparisons to national statistics may be, placing the sample Navy group in a proper perspective does little to ease the seriousness of the Navy's problem.

The author feels that the BSSR survey probably gives a fairly accurate picture of the Navy's alcohol problem and that alcohol may be the Navy's number one health problem. This feeling is based on his close observations during the past 21 years in the Navy of serious alcohol abuse both ashore and afloat, overseas and at home, and at private as well as semi-official social functions. Even if the Navy's rate of problem drinking and alcoholism is as great as the nation's, it is still a very serious health problem. The Navy has an obligation to reduce personnel casualties, whatever the cause, and a further obligation to the taxpayer to maximize cost-effectiveness.

The Purpose

The basic purpose of this paper is to examine the U.S. Navy's program for the prevention of alcohol abuse and alcoholism. Previous research and other existing prevention programs will be examined in order, hopefully, to suggest additional or alternative measures and policies which may significantly reduce the U.S. Navy's high casualty rate due to the misuse of alcohol. The word "prevention" may immediately conjure up negative thoughts and prejudices on this subject. However, this effort is not a move backwards toward prohibition nor an attempt to revive the temperance crusade, although a small percentage of those who have, but as yet will not admit having, a problem with alcohol may

disagree. The author recognizes the legality of the drug alcohol and the fact that the majority of people who drink, do so responsibly and without problems or the danger of developing alcoholism. Rather, this paper is an effort toward sound management of a very high cost problem in the Navy and toward the reduction of casualties due to the misuse of alcohol to its most valuable resource--its men and women and their families.

Problem Elements

Myths and Misunderstandings. Perhaps the biggest problem about alcohol is the confusion, ambivalence, and general lack of understanding surrounding the whole subject. Alcohol, alcohol problems, and alcoholism are highly controversial and sensitive topics. This is due, in part, because central to issues of alcohol use and abuse are individual freedoms and rights, past American experiences with Prohibition and temperance movements, today's differing laws and regulations, the complexity of American society, American culture, traditions and images, and the lack of a clear-cut societal attitude toward what is acceptable or unacceptable behavior as a result of drinking.

Recent Action. Today, America--shocked by the drug abuse and addiction of our youth--has realized that alcohol is really the number one drug problem in the nation.[6] With increasing

public awareness of the problem, Public Law 91-616, the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970," was passed setting a precedent and the stage for a major public health campaign. This Act of 1970 was followed by Public Law 92-129, the "Armed Forces Drug Abuse and Drug Dependence Prevention, Treatment, and Rehabilitation Act of 1971," Title V to the Selective Service Act, which directed that preventive, treatment, and rehabilitative measures be taken by the Department of Defense (DoD).

Obstacles. However, many obstacles and problems stand in the way of this campaign. Long-established customs, traditions, attitudes and values which are alcohol-oriented and encourage abuse of alcohol for various reasons will be difficult to change. The style of the reckless frontier drinker hangs on even today. The "cocktail hour" is a firmly implanted American custom. The U.S. Navy, in particular, is heavily tradition-bound and has strong images which tend to hinder progress in the control of alcohol abuse. In addition, the nationwide disagreement about what is acceptable and what is not acceptable drinking behavior is evidence of a basic cultural conflict.

These disagreements and ambivalent attitudes regarding drinking behavior and misunderstandings about alcohol problems

have resulted in widespread neglect of problem drinking. There has also been confusion and reluctance in approaching the important issue of prevention of alcohol problems.[7] This is due, in part, to the fact that the cause or causes of alcoholism have not been established.

Theoretical Causes. Alcohol is a necessary condition for the development of problem drinking, yet the great majority of alcohol users do not become problem drinkers. Therefore, other factors must be involved in the development of the disorder. The search for a single cause of alcoholism has thus far been fruitless, and many theorists now suggest a multifaceted approach which incorporates elements from each of the broad areas of physiology, psychology, and sociology. Yet, even without knowing the underlying causes of alcoholism, a wide variety of treatment methods and preventive measures can and have been applied in efforts to overcome alcohol problems.[8]

In general, although causes have not been proved, alcoholism involves: (1) a multiplicity of causal factors; (2) the probable existence of many different courses of development (rather than a single course of development); and (3) the need for a variety of treatment and preventive approaches.[9]

Definitions. Confusion and controversy reign also when experts in the field of alcoholism try to come to terms with

definitions of vital elements of the alcohol problem. Nevertheless, the World Health Organization and the American Medical Association (AMA) designated alcoholism a disease in 1951 and 1956, respectively. The Act of 1970 recognized and designated alcoholism as a disease, and the U.S. Navy was able to adopt the disease concept in early 1973. This concept and other operative definitions in the Navy's Alcohol Abuse Control Program (AACP) pertinent to this paper are:

1. Alcoholism. A nonratable disease characterized by psychological and/or physical dependency on alcohol.

2. Alcoholic (Alcohol Dependent). A general reference to an individual who suffers from alcoholism, as defined above.

3. 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.

4. Alcohol Addiction. A physiological condition in which there usually is a marked change in tolerance to alcohol, and consumption of alcohol is necessary for the prevention of withdrawal symptoms.

5. Intoxication. A state of impaired mental and/or physical functioning, resulting from the presence of alcohol in a person's body. This condition does not necessarily indicate alcoholism as defined herein, nor does the absence of observable intoxication necessarily exclude the possibility of alcoholism.

6. Problem Drinker (Habitual Alcohol Abuser). A person who may or may not be an alcoholic, but whose use of alcohol conforms to the definition of alcohol abuse herein.

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

8. Effective Restoration to Duty. An objective evaluation after treatment wherein the alcoholic or alcohol abuser is found to have demonstrated overall work performance and conduct equal to, or better than, the minimum standards required of all members of equivalent rank or rate for retention in the naval service. Primary indicators are the commanding officer's recommendation for retention, reenlistment or promotion; satisfactory fitness reports or performance evaluations; and the absence of serious disciplinary or medical problems.[10]

Preventive Elements in the Problem. Since identification and treatment of problem drinkers are preventive measures, although generally considered as late-stage prevention, these elements of the problem will be examined in detail. Early-phase preventive efforts are just beginning in this country and in the Navy as well. These early preventive measures and programs are the prime concern of this paper.

Recommendations. The proposals offered in Chapter VI are made to enhance the U.S. Navy's prevention program. The recommendations are tailored to categories found in most preventive theories:

1. Identification and early case finding,
2. Attitudinal, behavioral and value changes,
3. Social control and changes to the environment, and
4. Evaluation and experimentation.

These recommendations deal with:

1. Methods to involve middle- and upper-level command management in the prevention program,

2. Medical and other methods of early identification of problem drinkers,

3. Changes to the OPNAV AACP Instruction and the Navy film "One Day at a Time" (CNO SITREP No. 6),

4. Promotion boards,

5. Teen-age children of Navy alcoholics and other "high-risk" groups,

6. Involvement with the local community.

7. Base club manager and employee alcohol education and responsibilities,

8. Advertising of base clubs, base package stores, and the Navy Times magazine,

9. Transcendental meditation,

10. Alternative activities, such as recreation and other special services functions,

11. Overseas commands,

12. Experimental Navy control groups or installations and evaluation of prevention programs.

Organization of the Study

If we are to prevent the abuse of alcohol and the disease of alcoholism, we must have a broad understanding of

the subject of alcohol and alcohol problems. Therefore, readers who are not working in the field or are not familiar with the alcohol problem should review Appendices I through VI to gain a sufficient understanding of the subject. These appendices summarize much-repeated general information in the literature on alcohol, such as history, effects of alcohol, causal theories, defining the problem, and identification, treatment and rehabilitation of problem drinkers. Readers familiar with this type of information may wish to review the summarization in these appendices. With a foundation of background information on alcohol and problem drinking in mind the main body of the text, which deals with prevention, will be more meaningful.

In the main body of the text we will examine the extent of the Navy's alcohol problem more closely, along with a brief look at the AACP's treatment and rehabilitation program. Next, we will examine the concept of early prevention of alcohol problems. The Navy's prevention program will then be reviewed as well as other programs--business, industrial, and governmental--in the United States and other countries. Previous research will be highlighted as well, and many of the existing and proposed preventive measures not already operative in the Navy, but considered worthy of incorporation in the Navy's prevention program, will be recommended for application to the Navy's problem. Other preventive measures will also become apparent upon examination of the above.

Summary

Problems stemming from the misuse of alcohol are extensive both in the Navy and in the nation as a whole. The Navy's casualty rate due to the alcohol problem may be substantially greater than the general population's and it is a very costly problem.

Humanitarian considerations, as well as the essential requirement of better management of scarce resources, dictate an obligation for the Navy to reduce significantly its personnel casualty rate due to the misuse of alcohol and the resultant cost to the taxpayer. Treatment and rehabilitation alone will not significantly reduce the incidence of alcohol problems. Only through a realistic preventive program will the numbers requiring treatment begin to decline.

This paper's purpose is an effort toward meeting the Navy's obligation with an in-depth study of prevention of alcohol problems.

CHAPTER II

SCOPE OF THE NAVY PROBLEM

The GAO Estimates the Problem

The General Accounting Office (GAO) found in its review[1] of alcoholism among military personnel for a Senate Subcommittee on Alcoholism and Narcotics that the DoD had no complete, reliable data to show the extent of alcoholism in the Armed Forces. The GAO report contained a National Council on Alcoholism (NCA) minimum estimate of the incidence of alcoholism of five percent, which is comparable to the civilian work force. The GAO also concluded that alcoholism in the military could be a more serious problem than in the civilian population because of the frequently dangerous and critical duties involved.[2]

The five percent estimate above, however, is a lower estimate of the civilian incidence rate than is made by several other surveys[3] conducted between 1964 and 1969 by George Washington University. One of these nationwide studies found that 43 percent of the men and 21 percent of the women had one or more problems related to their drinking, and 15 percent of the men and four percent of the women had severe alcohol-related problems.[4] The main problems involved were psychological dependence, frequent intoxication, and problems with spouse or relatives.

Another recent national survey[5] of civilian men, age 21 to 59, revealed that 19 percent had experienced similar adverse consequences of excessive drinking in the last three years, and another 13 percent drank heavily enough to be at considerable risk of such consequences. This would indicate that it is likely that the incidence of drinking problems in the Navy would be rather high since the greater percentage of military personnel are men and in the younger age groups which civilian studies have shown to have the highest problem rates.[6]

Of course, the percentages and categories all depend upon how one defines "alcoholism" and other "drinking problems." This area of the subject is difficult to agree upon. It appears, however, that the GAO or NCA estimates of at least five percent incidence of alcoholism in the military is comprised of the hard-core, addictive alcoholic such as Jellinek's gamma-type.[7] (See Appendix III)

A Navy-sponsored Survey of the Problem

Nevertheless, the results of the nationwide surveys compare more closely to the results of the initial study[8] sponsored by the Bureau of Naval Personnel in 1972. It must be remembered that this Navy-sponsored survey was only a sample of the Navy population (1600) and the results are based on these samples from four Navy installations. However, as

previously mentioned, the statistics vary less than one percent from a similar survey conducted on a much larger sampling (11,000) of the U.S. Army.

The Navy-sponsored survey revealed that as many as 38 percent (officer and enlisted combined) may have a serious problem with alcohol. (See Table I) This category includes, on the least serious end of the scale, those individuals who had a "very heavy intake" or who were "binge" drinkers in the three years preceeding the study. "Very heavy intake" was defined as drinking twelve or more drinks during one occasion at least weekly or eight or more daily. "Binge" drinking was staying intoxicated for several days or going on a "binge" three or more times. It should be noted that throughout the survey report problem drinking refers to self-reported consequences of drinking, rather than to drinking behavior.

The most serious end of the scale in the 38 percent category includes four to five percent rated in the "critical" category. This typology included individuals who had at least two very serious problems, such as with the police, health or injury, job, wife, etc.[9] Another 21 percent of those surveyed, in addition to the above 38 percent showed indications of potential problems with alcohol.

According to the Navy's definition of "alcoholism" it could be interpreted that all individuals in the 38 percent

TABLE I

CURRENT DRINKING PRACTICES AND THEIR CONSEQUENCES OF SAMPLE FROM FOUR NAVAL INSTALLATIONS (OFFICER AND ENLISTED MEN COMBINED)[a]

Serious Consequences Typology (In last three years)	Results from Questionnaires (in percentages)	
	By mail (N=845)	On-site (N=758)
Critical Conditions (2 or more very serious problems with wife, friends, job, police, health, injuries)	4	5
Very serious Consequences (A very high score in one of problem areas above)	10	13
Serious Consequences (numerous unfavorable consequences--problems with wife, friends, job, police, health, finances)	18	14
Very Heavy Intake or Binge (the higher side of Heavy Intake below or staying intoxicated for several days or on binge 3 or more times)	6	6
Subtotal	38%	38%
Heavy Intake (5 or more drinks at least 4 days a week; or 8 or more at least once a week; or 12 or more at least once a month)	14	13
Potential Problems Only (Psychological dependence, loss of control, belligerence)	20	22
Drank, No problems	26	24
Non-drinkers	3	3
(May vary due to rounding off) Total	101	100

[a] Data obtained from Memorandum to Director, Alcohol Abuse Control Program from Ira H. Cisin and Dr. Don Cahalan, Bureau of Social Science Research, Inc., subject: Supplementary Analysis of Drinking Problems, Navy Pilot Study, dated 28 February 1973.

category above would be classified as "alcoholics," as would many of those in the "potential problems" category above. This interpretation is justified because of the "psychological dependence" proviso in the definition. However, in view of the great controversies over definitions and classifications of "alcoholics" or "problem drinkers" one should avoid such an interpretation. It is evident also that the Navy intends to avoid such categorizations. The Navy definitions are necessary for administration and management of the problem and are not for clinical purposes. Indeed, such an interpretation is not necessary to show the extent of the Navy's problem. When it is realized that the Navy personnel surveyed voluntarily answered, or did not answer, the questionnaire and that very few, if any, individuals would over-admit to alcohol-related problems, it should be reasonable to project that at least one-third of the active duty Navy population abuse alcohol and have had serious problems because of it. A Navy AACP status report[10] uses a very conservative 15 percent, which converts to 125,000 Navy, Marine and Coast Guard personnel with a serious alcohol problem. Other studies would support at least doubling or tripling the GAO estimate of five percent incidence of alcoholism since previous studies have shown that 40 percent of heavy alcohol abusers eventually become "alcoholics," i.e., dependent upon the drug.[11] In other words, 40 percent of 38 percent equals

15.2 percent. But, whether it be 15 percent or 38 percent of a force seriously handicapped by problem drinking, that is an extensive health problem for any organization.

A significant difference appears in the BSSR statistics between officer and enlisted personnel. For example, the 38 percent figure above reflects combined officer and enlisted results. However, 47 percent of this category were enlisted and 26 percent officer. This enlisted-officer ratio is interesting because 1 1/2 to 2 times this many officer personnel as enlisted were categorized in the "potential problems only" typology. This is just the opposite of the foregoing ratio.[12] In addition, the statistics show that the greatest number of alcohol abusers are the younger, more junior enlisted personnel. (See Table 2) 21 percent of the junior (below E-6) enlisted men who admitted job-related drinking problems within the last three years also admitted having been high or tight on duty one or more times during that period.[13]

Further, regarding performance of duties, a relatively high proportion of both enlisted men (27 percent) and officers (22 percent) reported alcohol-related inefficiencies such as putting in only part of a days work or substandard performance.[14] Businesses and industries which are aware of employee alcohol problems are also familiar with the "high-priced half-man" -- a highly paid executive or manager with alcohol problems.

TABLE

CURRENT DRINKING PRACTICES AND CONSEQUENCES BY PAY GRADE CATEGORY[a,b]

Serious Consequences Typology (Last three years)	Enlisted Men			Officers		
	Total (N=895)	Junior (N=559)	Senior (N=334)	Total (N=708)	Junior (N=455)	Senior (N=251)
Critical Conditions	7	7	7	2	2	2
Very Serious Consequences	14	16	12	7	9	6
Serious Consequences	17	20	13	14	13	15
Very Heavy Intake or Binge	9	8	1[illegible]	3	3	3
Heavy Intake	13	12	15	13	13	12
Potential Problems Only	16	16	15	27	28	24
Drank, No Problems	20	17	26	32	30	37
Nondrinkers	3	4	3	2	2	2
Total[c]	99	100	101	100	100	101

[a]Data obtained from Memorandum to Director, Alcohol Abuse Control Program from Ira H. Cisin and Don Cahalan, Bureau of Social Science Research, Inc., subject: Supplementary Analysis of Drinking Problems, Navy Pilot Study, dated 28 February 1973.

[b]Data on pay grades were unavailable for two enlisted men and two officers.

[c]Totals may vary because of rounding of components.

Estimates of annual monetary losses due to poor job performance were provided in Chapter I.

Stigma and Tradition

A statistic to show the extent of the problem cannot be attached to the following example of the effect of some of the Navy's traditions. This excerpt is quoted from a letter written in April 1973, by the commanding officer of a Naval Hospital to the Director of the Navy's AACP:

> I felt compelled to write you concerning the recent Chief's Initiation which I mentioned to you when you were here.
>
> Further investigation of the episode reveals the following facts:
>
> Unbeknownst to me one of my new chiefs is an alcoholic who has made an excellent recovery. He was on Antabuse but stopped it ten days before the affair because he was afraid alcohol would be forced on him which it was. He developed an atrial fibrillation and was hospitalized. Fortunately, no great harm was done but I think this demonstrates how compelling any new chief feels this ceremony is.

The stigma associated with seeking help and thereby possibly being identified as "alcoholic" or "problem drinker" is still a big part of the overall problem. In late 1972, the survey showed that 69 percent of enlisted men and 77 percent of the officers surveyed agreed that Naval personnel with drinking problems usually do not seek help through Navy sources for fear of damaging their careers.[15] There are positive indications, however, that by mid-1973 this barrier

is not as strong as it was prior to the AACP's initial educational efforts. The reduction in the stigmatic force can be attributed also to the Navy's early, but highly effective, treatment and rehabilitation program. A brief look at this program will further indicate the extent of the Navy's overall alcohol problem, especially in regard to the numbers seeking help and certain replacement and retraining costs.

The U.S. Navy Treatment and Rehabilitation Program

It is often said that the military service is but a cross section of American society and, as such, manifests most of its ills. This is true of illegal drug usage and of alcoholism, too; but after examination of many of the model alcoholism programs in industry and government, it is apparent to this author that the U.S. Navy's Alcohol Abuse Control Program is not just a cross-section or an example of other programs in the country. It is one of the largest and best in the world in terms of resources, organization and overall effectiveness. In the relatively short period since its official inception in August 1971, the Navy's treatment and rehabilitation program has resulted in an approximate 70 percent effectiveness rate. It should be noted that business and industrial programs also claim 60 to 80 percent effectiveness; however, the Navy's criteria for rating effectiveness include somewhat

more stringent requirements than those of civilian companies. Navy criteria are specified under definitions in Appendix VII and include, for example, the requirement that the recovering individual be recommended by his or her commanding officer for retention, reenlistment, or promotion after restoration to duty and a suitable observation period.

Although the Navy AACP was not established until mid-1971, an alcohol rehabilitation center (ARC) at Long Beach, California, has treated over 1500 patients since 1967. In 1972 alone, ARC Long Beach treated 339 patients with alcohol problems and realized an 82 percent effectiveness rate. As of the end of February 1973, 2125 enlisted men and women inpatients at ARCs and alcoholic rehabilitation units (ARUs) had completed rehabilitation. Effectiveness rates have ranged between 65 and 75 percent depending on age, rank or rate, and location.[16] A high compliment was paid to the Navy recently by Dr. Richard S. Wilbur, M.D., Assistant Secretary of Defense (Health and Environment). He described the Navy's Alcohol Rehabilitation Program as "nine miles ahead of everyone else," at a meeting with the Chief of Naval Personnel on 25 May 1973.

The Navy AACP managers realized early that one of the first important actions in the battle against alcoholism would be to establish credibility[17] by doing what they said they would do. This credibility was necessary in order to begin to break down the stigma which had long helped to hide

the Navy's many alcoholics. Therefore, in conjunction with a broad-sweeping, all-media educational awareness effort aimed at all hands, other ARCs and ARUs were established throughout the United States and overseas for the purposes of treating and rehabilitating Navy personnel and restoring them to duty. The high Navy-wide improvement rate and early educational efforts have established and reinforced the credibility of the AACP so quickly that the Navy now has an increasing backlog of individuals with alcohol problems awaiting treatment at ARCs and ARUs, despite the expansion of the treatment program which now includes four ARCs and 14 ARUs in operation.

It is encouraging that several recovered alcoholic pilots are back in their cockpits again. The cost savings alone of effectively rehabilitating three pilots at ARC Norfolk, Virginia, was $1.5 million. As of March 1973, seven of the nine officer patients at ARC Norfolk were pilots.[18] In addition, some of the patients reported in the statistics are high-ranking officers. These officers' recovery and restoration to duty will be helpful in the Navy's AACP anti-stigma campaign.

Unfortunately, however, the problem of promotion of recovered alcoholics has not as yet been overcome. Once labelled an alcoholic, recovered or not, the individual still carries a negative mark before a selection board.[19] This is

ironic, in a way, since the statistics would indicate that possibly 10 or 15 percent of those sitting on selection boards themselves have an alcohol problem of some kind.

Other Aspects of the Navy's AACP

Appendix VII contains the Navy's alcohol abuse control instruction, outlines the entire AACP, and gives a detailed explanation of Navy policy and procedures regarding other aspects of the program, such as discipline, promotion, retention, security clearances, standards of behavior, stigma, education, and prevention--some of which are not pertinent to this paper. Those that are will be examined in Chapter IV.

Summary and Conclusions

In dealing with statistics from studies of alcohol problems, it is important to define carefully the specific categories of results. In addition, the sample population needs to be kept in mind.

The well-publicized statistics on alcoholism for the nation as a whole usually include a figure related to an incidence of alcoholism of five percent. A Navy-sponsored survey of 1600 officers and men at four naval installations concluded that 38 percent of those surveyed may have a serious alcohol problem. Although there is no justification for projecting a Navy-wide estimate from this survey, a similar

survey of a much larger sample (11,000) of the U.S. Army revealed similar statistics in problem categories which varied less than ±.5 percent from the Navy survey. Nevertheless, these two percentages--five percent and 38 percent--cannot be compared unless definitions of categories are made explicitly clear. There are varying opinions by different experts as to just what the nation's "alcoholics" are who supposedly comprise five percent of the population. It is assumed that these five percent are addictive alcoholics or alcohol-dependent persons.

The Navy-sponsored survey does not use a category labelled "alcoholic." Instead it uses "problem drinkers" and typology related to problems as a result of drinking. When this type of categorization is utilized, the Navy statistics appear not to differ significantly from other broad-based surveys of the nation's adult population and adult male population. Nevertheless, the Navy's AACP is semi-officially using a very conservative estimate of 15 percent of active duty Navy members who have serious alcohol-related problems.

However, whether the 15 percent or 38 percent estimate of Navy members with serious alcohol problems is correct, each individual's problem and the Navy's larger alcohol problem need solving. The U.S. Navy has rapidly established a highly effective and resourceful treatment and

rehabilitation program to meet that need. But treatment and rehabilitation alone will not solve the problem. Prevention is the key to keeping more and more problem drinkers from appearing on the scene. Let us next examine this vital concept.

CHAPTER III

THE CONCEPT OF PREVENTION OF PROBLEM DRINKING

Concept and Commitment

Although the subject of alcohol is highly controversial, there is almost universal agreement that treatment alone of persons afflicted with the disease of alcoholism will not prevent further casualties; nor will treatment alone significantly reduce the incidence of problem drinking. The Department of Health, Education, and Welfare (DHEW) Task Force in its report to the Congress on alcohol abuse found that:

> No battle against a public health problem can gain a significant victory if it attends only to the casualties. Appropriate treatment of persons who are abusing alcohol--the primary condition that may lead to alcoholism--can intercept the development of many cases of alcoholism. Yet much of the work in the field of alcoholism has been focused on treating late-stage victims of the disorder. Programs that are exclusively therapeutic or rehabilitative will not result in long-term conquest of the problem unless ways of preventing new cases of alcoholism are developed.[1]

With abuse of alcohol being the primary condition that may lead to problem drinking, one obvious answer to prevention is to take away the causative agent. However, legislative attempts to prohibit the sale and use of alcohol have failed in this country, and they have failed in many other countries

as well. Ever since Prohibition, "prevention" has been a sensitive topic, carrying with it negative or futile overtones--a subject generally avoided. According to Mark Keller, of the Rutgers University Center of Alcohol Studies and perhaps the most knowledgeable man in the field in this country, "We (in the United States) have been paying lip-service to prevention for 30 years with little other than token educational programs offered."[2] He believes that the main thrust of studies and research in the field of alcoholism should now be shifted to this essential area.

The question is: can problem drinking really ever be "prevented" -- in the U.S. Navy, or in the country as a whole? Also, how can a disease ever be prevented if its cause has not been established? Many authorities believe that as long as there is alcohol, alcoholism cannot be prevented, and this may be true. Yet, the DHEW Task Force concluded in its study that even though the specific causes of alcoholism have not been scientifically proven, enough is known to begin a commitment to preventive programs.[3] Also, Public Laws 91-616 and 92-129 and the Department of Defence (DoD), Secretary of the Navy (SECNAV), and Chief of Naval Operations (CNO) directives all address "prevention" of alcohol problems. It is these Laws and directives which fully commit the Navy to attempt to prevent alcohol abuse and alcoholism among its members, even though the original question will probably remain unanswered perhaps for decades.

The Three Phases of Prevention

Before examining how the Navy is meeting or planning to meet its objectives in the prevention of problem drinking, "prevention" needs to be examined. Medical authorities refer to three phases of prevention. Primary prevention is directed toward preventing a disease from ever getting started. Secondary prevention is directed toward the early recognition of the disease to prohibit full development and the identification of individuals for whom there is increased risk in developing the disease. Tertiary prevention is directed toward treatment of persons already afflicted with the disease. Until recently medical endeavors to prevent the disease of alcoholism have been concerned almost entirely with the tertiary phase.[4]

Indeed, the Navy's Alcohol Abuse Control Program (AACP) initial efforts in prevention were also necessarily tertiary. In an earlier discussion, the necessity was demonstrated of establishing AACP credibility and a reasonable effectiveness rate for recovered problem drinkers. This is being accomplished now, and tertiary preventive measure will continue as long as there are Navy personnel suffering from problem drinking.

Unlike most successful civilian alcoholism programs, the Navy has also quickly moved into secondary prevention and even in some ways into primary preventive measures. It is

these earlier phases of prevention--primary and very early secondary--with which this paper is concerned. In addition, it is assumed that what is meant by "prevention" and what is really desired by the Navy at this stage in its program is a very significant lowering of the incidence of problem drinking, including alcoholism. It would be naive to think that total prevention of these problems in the foreseeable future is possible. Most experts are thinking in terms of several generations before scientific prevention becomes a reality.

Prevention in the Business World

In some leading business programs, prevention to any significant degree is thought to be a hopeless cause. This feeling was expressed by the medical director of a company which is a model for business and industrial alcoholism programs and has had an alcoholism program for 25 years. Early identification (secondary prevention) in the business world is difficult and few, if any, preventive measures other than general "shotgun"-type education are evident in most company programs. In fairness to the business community, however, it must be recognized that a company's control over its employees is not nearly as extensive as it is in the military services. Also, there are probably some companies, like Winchester-Western Division of the Olin Corporation, which have become "inner city" companies. (See Appendices V and VI) Dr. R.E.

Brubaker, Winchester's medical director, tells of extensive company involvement in community social actions to the point where the role of its medical department has also changed. As a result of this community involvement the company has a "quite effective, broad program in primary and secondary prevention of socio-psychological problems"[5] Winchester's alcoholism program is relatively new (1968) and the effect of primary and secondary measures to prevent alcoholism is not as yet known. Dr. Brubaker believes, however, that a total community setting and involvement is needed for maximum effectiveness of an alcoholism program.

A Multidisciplinary Approach to Prevention

Most experts in the field seem to agree that a comprehensive, broad-based, multidisciplinary approach to prevention of problem drinking is needed rather than the piecemeal, fragmented efforts in the past.[6] It is thought that any major attempt to prevent drinking problems must include efforts to influence the whole climate of drinking in a society.[7] This would include big changes in social attitudes, values and behavior with respect to alcohol and its use. Thus, most proposals for preventive programs include:

1. Incorporation of features of ethnic groups or cultures which have a notably low prevalence of alcoholism, such as the Jewish and Italian groups. This grafting process

from one culture to another and over a period of generations would be difficult indeed. Even then, changes would probably vary from one group or sub-culture to another if changes were possible at all.

2. Substitution of activities, such as sports, cultural interest and recreation. This assumes that the needs and values satisfied by drinking can be met by other social activities.

3. Improvement of socioeconomic conditions and mental hygiene measures. This would include improvement of family conditions and life and other measures to diminish the need of insecure personalities to escape through use of alcohol (or any other drug).

4. Early identification and control of the disease.

5. Broad training and education programs to alter attitudes about alcohol. This should be education <u>on</u> alcohol rather than <u>against</u> alcohol and should also attempt to remove the emotionalism and stigma attached to the subject.

6. Social control to establish sanctions which will clearly define unacceptable drinking behavior at all levels and enforce group opinion on the deviant. This would allow intervention into the alcohol abuser's private life and would exert preventive pressures in his or her job as well as in his social and other leisure activities.[8]

No one can say with certainty whether programs incorporating these proposals would work. But what are the alternative suggestions--more research, more discussion, more casualties? If proposals such as the above were implemented only in the U.S. Navy and not in the society as a whole or by the NIAAA on the national level and not in the U.S. Navy, the drinking problem in the Navy certainly would not be reduced significantly. However, most of the preventive approaches above are also incorporated in the NIAAA's goals in its prevention program. Moreover, the Navy's alcohol abuse control instruction, OPNAV Instruction 6330.1 of 29 May 1973, (Appendix VII) appears to encompass just the sort of comprehensive, broad-based, multifaceted approach to prevention as outlined above.

On the pessimistic side of the prevention controversy are some high-level officials working in alcoholism programs both in the well-known voluntary organizations and in the Navy, as well. One such Navy authority believes that prevention is not possible in the Navy until the attitudes and values of the entire American society are changed. Nevertheless, it appears that the Navy's AACP and policies include a viable prevention program, and some suggestions to measure its effectiveness are included in Chapter VI.

Summary and Conclusions

We have seen that treatment alone of problem drinkers will not prevent further casualties and that long-range conquest of the alcohol problem will require a comprehensive prevention program which can influence the whole climate of drinking in society. The three phases of prevention have been examined, noting that the primary and early secondary phases are the concern of this paper, and are the phases of prevention which have long been neglected.

Several proposals for a comprehensive prevention program have been reviewed as have some ideas on prevention in successful civilian alcoholism programs. We have seen also, despite the controversy over whether prevention will ever be possible in the Navy, that with the passage of Public Laws 91-616 and 92-129 and guidance from the DoD and SECNAV, the U.S. Navy is fully committed to attempt to prevent problem drinking among its members and their dependents. The Navy's prevention program is outlined in its alcohol abuse control instruction, OPNAV Instruction 6330.1 of 29 May 1973. Therefore, let us next examine the important preventive measures therein.

CHAPTER IV

PREVENTION OF PROBLEM DRINKING IN THE U.S. NAVY

There is considerable interest among the experts in focusing preventive measures on high-risk groups, that is, groups with high rates of problem drinking.[1] The Navy's instruction on alcohol abuse control, OPNAV Instruction 6330.1 of 29 May 1973 (Appendix VII), is directed at just such a population. The policy guidance therein is of vital importance in the prevention program, and the directive nature of the instruction makes the implementation of AACP preventive policies mandatory at all levels of command. Moreover, it appears to be the only significant force, other than passive educational efforts, which attempts to involve middle- and upper-command management in the AACP's preventive efforts.

Policies, Responsibilities, and Guidance

The basic instruction contains some strong preventive language. For example, on the first page, "Alcohol abuse and alcoholism to any degree constitutes an unacceptable loss to the Navy. . . ." (underscore is authors). Under the Action paragraph, responsibility is placed upon command

and supervisory personnel at all levels to adhere to the policies and guidance provided in appropriate enclosures to the instruction. The Department of the Navy's policies on alcohol abuse control are contained in enclosure (2). Detailed guidance for the establishment of a simple but effective program for the control of alcohol abuse by all ships and stations is outlined in enclosure (3) to the instruction. In addition, the Action paragraph and enclosure (4) assign specific responsibilities to the Chiefs and Commanders of many supporting bureaus, agencies and branches in the Naval establishment. This, in effect, is designed to muster extensive and direct involvement of many key Navy resources including personnel, medical, legal, public information, investigative, recruiting, religious, training, and safety.

The policy in the directive (enclosure (2)) with regard to prevention is that "the disease, illness, or condition known as alcoholism is preventable...and requires the application of enlightened attitudes and techniques by command, supervisory, and health service personnel." The basic responsibility for prevention is placed upon the individual and that of identifying alcoholics upon command. Another key policy statement deals with the Navy Department's standards of behavior, performance, and discipline and their application to an individual's conduct rather than to his use or abuse of alcohol. However, it is also the Navy Department's

task to promote attitudes of responsibility in those who choose to drink and to promote the social acceptability of those who choose not to drink alcoholic beverages. Thus, these policies establish the foundation for preventive approaches dealing with the host, emphasizing the individual's personal responsibility and fostering healthy attitudes regarding alcohol. The next enclosure involves extensive preventive measures affecting both the host and the environment. Enclosure (3) contains very direct and specific tasks and responsibilities for each command with regard to prevention. For example, each command has a particular responsibility for "counseling and protecting" its members against alcohol abuse and for "preventing and deterring" alcohol abuse. The words "protecting" and "deterring" almost open the prohibition door again, but the guidance offered clearly does not imply the renewal of such a movement.

Information and Education

Information Program. In a section entitled Education and Prevention, guidance regarding informational and educational programs and the resources available for their implementation is given. To implement an effective alcohol information program, it is suggested that publicity be directed to changing attitudes toward drinking through the use of all media available at the local level. The plan of the day,

ship's paper, local news media, and posters are suggested in order to reach all hands and their dependents to present true facts about alcohol and reasons behind policies of the alcohol abuse control program. In addition, the role of the referral network in preventive education and alcohol counseling is described. This referral network and the education package are, at present, two of the three key elements in the Navy's approach to prevention of alcohol abuse.

The Referral Network. The referral network, comprised of over 900 volunteer recovered Navy alcoholics, is in part a result of the Navy's early successes in tertiary prevention--treatment, rehabilitation, and initial educational awareness efforts. Many of the volunteers have recovered from alcoholism or other problem drinking through the Navy's prototype treatment and rehabilitation program. Others who have recovered on their own or through organizations such as AA have come out of the woodwork as the stigma is slowly being broken down. The objective of the network is to aid commands in connection with preventive education, identification, and alcohol consulting requirements. After special training, qualified recovered alcoholics are designated as collateral duty alcohol counselors (CODACs). CODACs have educational and other resources available to them and are working in coordination with the Navy's Human Resources Development Centers, the Naval Safety Center (driving safety program), medical

officers, local shore patrol, military and civilian police, chaplains, social workers, AA, and other local organizations as a means to maximize their effectiveness in the AACP. Since early identification of alcohol abusers is a major difficulty, the referral network is essential to the identification process as well as to the education program. It is significant to note that in the first half of calendar year 1973 the number of recovered alcoholics--not all of whom have overcome their problem with alcohol through the help of the Navy's program--who have volunteered their services has increased over 50 percent. This in itself is an indicator of the effectiveness of the anti-stigma campaign through early general and informational education efforts.

The great majority of these volunteers, however, are enlisted personnel. This is probably due, in part, to the lack of progress so far with officer promotion boards referred to in Chapter II. But also one of the early educational efforts, which is still in use, may tend to reinforce rather than reduce the stigma associated with alcoholism in the officer ranks of the Navy. The Navy's film "One Day at a Time," CNO SITREP Number 6, intimates by the relative absence of officers in the film that officers may not have alcohol problems. All but one of the recovering problem drinkers who are in the film talking about themselves and the rehabilitation program are enlisted personnel. The only

officer with a problem is a lieutenant commander and a medical officer. The film may well have portrayed the existing situation with regard to stigma when the film was made. But a revised edition, to include a larger percentage of recovering or recovered officers (the higher the rank the better) to address their particular problems in that segment of the Navy, would convey the true fact that a large percentage of officers, too, have alcohol problems. Nevertheless, the film has been highly and rightfully praised as the best film on alcoholism in this country today, and the NIAAA wants 1,000 copies of it for nationwide distribution.[2]

Alcohol Education. A half-day alcohol education package includes CNO SITREP Number 6, as well as other films and materials, and is being presented to all commands by CODACs and drug abuse education specialists (DAESs). This type of education is general and informational in nature. Other countries have had some success in their alcoholism programs with general educational approaches. For example, France has had a very high incidence of alcoholism; but, as a result of a modest educational and informational campaign directed especially at the young, alcohol consumption among the young is reported to be practically nil compared to the previous generation at the same age. A major theme of France's campaign has been

that of the importance of sound nutrition. It is reported, also that the peak mortality due to cirrhosis and alcoholism has been pushed back from the 7th to the 8th decade.[3] After her fourteen year fight against alcoholism, France now seems to be the only country in which alcoholism is declining. This fact makes a major point: that both publicity and the continuing education of the young can be effective weapons against alcoholism.[4] It should be noted, however, that typical education programs on alcohol in many school systems in this country have traditionally come under criticism. Scare tactics, late introduction (usually 12th grade), non-involvement of figures of authority, and emphasis only on abstention are some of the criticisms which add to the general ineffectiveness of these programs.[5] Dr. Seldon Bacon, Director of the Rutgers Center of Alcohol Studies, has little faith in "childish educational schemes which not even grade schoolers will buy." He cautions that military men and women cannot be expected to buy such programs either. He was unfamiliar at that time, however, with the Navy's prototype educational package, which has been externally evaluated as effective in changing attitudes and behavior.[6] In fact, the Navy's alcohol abuse education program is one of very few alcohol education programs which is evaluated by an external organization.[7] The conclusion of an early evaluation of the AACP pilot education seminars is quoted below:

> This report is the last in a series of evaluations of the seminars in the U.S. Navy Alcohol Abuse Control Program. . . The seminars appeared to increase positive attitudes toward the problems of alcohol and the alcoholic. Behavior seems to be changed after attending these programs.[8]

The pilot education seminars had seven objectives:

1. To achieve general acceptance of alcoholism as a disease that is preventable and treatable.
2. To identify alcoholics and alcohol abusers.
3. To remove stigmatic effects associated with alcoholism.
4. To promote attitudes of responsibility with respect to alcohol in those persons who choose to drink and the social acceptability of an individual's decision not to drink.
5. To acquaint supervisory personnel with the Navy policy toward and treatment facilities available for alcoholics/alcohol abusers.
6. To teach supervisory personnel how to detect alcoholism in its early stages and how to induce the alcoholic to seek treatment.
7. To promote the acceptance of the recovered alcoholic into the military community.[9]

The pilot alcohol education program was refined and has been incorporated in the Navy's Drug and Alcohol Education Program, which is described in Bureau of Naval Personnel (BUPERS) Instruction 6710.1A of 4 April 1973. The program's primary

goal is to provide command management with methodologies and educational and personnel resources to assist each command in establishing effective drug education and action programs. According to Commander Al Kelley, Director of the Navy's Drug and Alcohol Education project, the Navy has "the resources, the mandates, the goals, and management by objectives for the Drug and Alcohol Education Program. The biggest problem to date is convincing management--top and middle management in the Navy--that drug and alcohol abuse is a manageable problem."[10] Like other professional areas of management the command manager must know the facts, the resources and the system for the control of alcohol abuse. Education is a vital part of this system.[11]

It should be noted that an alcohol education program, such as has been described, is required by both the Secretary of the Navy and the Chief of Naval Operations in their directives on the subject to be implemented at the Navy's senior service schools. It is discouraging that a compulsory program on alcohol abuse has not as yet been integrated in the Naval War College curriculum for the next academic year. Referring to the difficult problem with middle- and upper-level management, it would seem an exciting challenge to the War College to incorporate the alcohol problem in its Management curriculum, possibly as a major case study. To be sure, a month after the War College's middle- and

upper-level managers graduate, regardless of where they go, they are more-than-likely going to have to manage alcohol problems. If they do not have a basic foundation of knowledge about this serious and extensive problem, they will manage not with sound management techniques but with emotions.[12]

General David Jones, Commander of United States Air Forces, Europe, has instituted a strong drug and alcohol abuse control program throughout his command. A Congressional staff report has cited Ramstein Air Force Base as an outstanding example of a community-wide program with enthusiastic and highly personal support of the base commander and vice commander.[13] A handbook for supervisors and commanders has been issued to Air Force European commands. Similar handbooks are used in the better business and industrial alcoholism programs, primarily for the purpose of identifying and approaching problem drinkers. Of course, the Navy's AACP education program materials will reach its supervisors and managers, but a special handbook for them might enhance managerial involvement and awareness, as well as identification measures. This is not in conflict with earlier comments on some business programs in which responsibility for identification of problem drinkers is laid solely on the supervisor. The Navy's identification measures apply to officers and enlisted personnel, junior and senior alike. Such a handbook hopefully would emphasize the added responsibilities of middle- and

upper-level management in the AACP for the purpose of deeper involvement in the problem.

Apart from the general and informational education requirements in the OPNAV Instruction are the remedial education requirements. Commands are tasked with implementing remedial education programs to help those members identified as alcohol abusers. This is an early secondary preventive measure which may result in correcting excessive drinking habits of possible early stage or potential alcoholics. The referral network is involved in this effort as are local resources such as the doctor, the chaplain, or the nearest Human Resource Development Center (HRDC).

The on-going educational endeavors have also included hundreds of briefings and talks provided to various types of audiences--military, dependents, professional groups, and civilian organizations--as well as alcohol symposiums, seminars, and workshops. A small example is the recent scheduling of eight regional alcoholism workshops throughout the United States by the Chaplain Corps.[14]

By 30 July 1973, all active duty units, both afloat and ashore, will have received their educational resource and implementation training--reservists and dependent overseas Navy Schools by 30 December 1973. By March 1974, the entire Drug and Alcohol Education Program will be transitioned to the Chief of Naval Training.

Attitudinal and Behavioral Changes Desired. The broad extent of the Navy's alcohol education program is essential in its prevention program, the main thrust of which is aimed at attitudinal and behavioral changes regarding the use and abuse of alcohol. In addition, the Navy's education program spans all three categories of prevention, although focused mainly on the secondary phase of early identification of problem drinkers.

Even though the causes of alcohol problems are not firmly established, there is general agreement among most experts in the field that eventual prevention of alcohol problems cannot be accomplished without this change in attitudes and behavior. The concern of some authorities over the attitudes and values of society as a whole as they might affect the Navy's incidence rate are well taken. Nevertheless, there is every indication that the type of education the Navy is providing does change attitudes and behavior in adults.[15] Moreover, although most young people have their first experience with alcohol at an average age of 14,[16] many begin drinking late in the teens or even early twenties. In fact, the highest rates of almost all types of problem drinking are found among people in their early twenties rather than late thirties or forties, as commonly believed.[17] Statistics also show that many people who drink at a given time either stop drinking or reduce their drinking. Even one-third of the abstainers

used to drink. These statistics reveal an encouraging amount of change in the drinking behavior of many individuals over a relatively short time.[18] They highlight the importance of early intervention measures by the Navy.

In fact, since the Navy places the responsibility for prevention of alcohol problems on the individual, AACP educators would be remiss if they did not intervene with educational advice to individuals on different non-alcoholic methods of coping with stress and tension. Many young people find "way out" things like meditation, for example, an acceptable personal experience. Transcendental meditation appears to be a possible non-chemical method of changing an individual's attitudes, behavior and means of coping. Two Harvard researchers, medical professor Dr. Herbert Benson and physiologist Dr. R. Keith Wallace, claim they may have found transcendental meditation a quiet and safe weapon with which to fight drug abuse. Observations of 1,800 persons who attended a meditation training course showed a continual decrease in drug use over time. After 21 months of meditation practice, the proportion of marijuana smokers had decreased from 78 percent to 12 percent, LSD users from 48 percent to 3 percent, amphetamine users from 30 percent to one percent, barbituate and narcotics users from 17 percent to one percent. Hard-liquor drinkers dropped from 60 percent to 25 percent. Even cigarette smokers dropped from 48 percent to 16 percent.

Benson believes meditation might be acceptable to young drug abusers as a non-chemical alternative to at least fulfill some of the needs behind drug abuse.[19]

It will be difficult to change Navy life to reduce significantly the tensions and stresses with which many individuals cope by abusing alcohol. Indeed, it will be difficult to change a vulnerable Navy man's or woman's attitudes and values to the point where he or she will seek less destructive ways of coping with these tensions. Both of these difficult changes are included as objectives in the Navy's Alcohol Abuse Control and Drug and Alcohol Education Programs. As an aid to meeting these objectives, transcendental meditation may be a valuable tool in early-phase prevention of alcohol and drug abuse for individuals.

Social Control and Changes to the Environment

Education alone, however, probably would not bring about th significant reduction of alcohol problems desired by the Navy. Therefore, to supplement its education programs in its multifaceted approach to prevention, the Navy's instruction details additional guidance to all commands to help in changing not only social attitudes and values but the environment as well. Recall that three elements are necessary before a disease can develop: the causative agent, the host, and the environment. The Navy's AACP directive concentrates hard on

the latter two, yet avoids regulatory measures regarding the agent alcohol, its sale, availability, or even use. It is the results or consequences of its use and the environment or climate surrounding its use upon which the Navy is focusing. This approach is the third key element in the Navy's prevention program.

To Change Traditions, Customs and Images. The next section of the OPNAV Instruction deals with this element, but avoids the word "shall" and uses instead the word "should" in providing guidance for commands. This section deals with "the elimination of institutional practices which may subliminally encourage personnel to drink through peer pressure or outmoded customs." Commands are encouraged to attempt in innovative ways to change the images of Navy men; images like, for example, "drunk as a sailor," "drink like a Navy man," the "officer and gentleman" who holds his liquor (no matter how much he puts away) or the adventuresome pilot returning to his revelry after a mission--destructive images which render alcohol abuse acceptable. Moderation is to be emphasized at social functions, such as ship's parties and picnics, happy hours, advancement celebrations, initiations, and "wetting-downs." If these policies are in fact carried out, incidents such as that which occurred after the chief's initiation described in Chapter II would be avoided. The instruction suggests that non-alcoholic beverages should be

easily available and offered at social functions and those who choose not to drink should be encouraged to participate in these functions.

The guidance summarized in the preceeding paragraph probably will be the most difficult for commands to implement in the entire program (other than perhaps that involving elimination of stigma). The education package and personnel resources to present it are or will be available to commands. The time resource is another matter. Until the Naval Training Command's master plan is totally implemented, the fleet unfortunately will continue to bear the burden of some education and training programs such as alcohol abuse control. Nevertheless, the alcohol education program should be relatively easy to implement. Also, the guidelines in the OPNAV Instruction regarding encouragement of activities as a substitute to the liquor bar at base clubs or off-base bars should be easily followed. In fact, many naval bases have been advertising such activities regularly.[20] This section of the instruction dealing with promoting alternative activities to those of clubs will be discussed below, as will the identification and referral process described in the instruction. This process utilizes an extensive organizational structure and wide-ranging resources which are established and available to commands; identification and referral of alcohol-troubled Navy members and dependents is being and

will be accomplished without too much difficulty. The main forces inhibiting this process are the stigma, which is being attacked through educational programs, and the individual alcoholic characteristic of denial of an alcohol problem.

But the task for command to attempt to eliminate the long-standing Navy traditions and customs which encourage excessive drinking may be a difficult one indeed. The GAO and other agencies have found that these are major contributing factors in the abuse of alcohol in the military service. The BSSR Navy survey found that both officers and enlisted personnel emphasized social reasons and encouragement to drink, such as frequent "happy hours" and semi-official parties, as reasons for drinking more at their present duty stations.[21] How should a command "eliminate" such institutional practices and "emphasize moderation" at the many Navy social functions where drinking has long been the central activity? Already there are cries of "witch-hunt" as a result of early AACP educational and organizational measures (which were the beginnings of a force to change the existing climate and attitudes)--even before the OPNAV directive was promulgated.

Of course, those who make this cry of protest probably have some kind of alcohol problem themselves. Although there has not been anything like a "witch-hunt" in the Navy, according to Captain Baxter "there has not been a case of mistaken identity yet." This refers to the normal identification and

referral process. Nevertheless, the question has been seriously raised, by some working in the field, "why not have a witch hunt?" The rationale offered for this approach is that those who are worried about having to curb their "habit" of abuse could be alcoholic or potential alcoholics and should be identified, counseled, and referred for treatment if necessary. Opponents to witch-hunting are concerned that this approach would reverse the anti-stigma efforts and inhibit troubled individuals from seeking help. Thus, these individuals might progress into more serious stages of problem drinking which may be more costly and harder to treat later. On the other hand, those who would cover-up or hide their problem during such a "hunt" would more-than-likely hide it regardless of what approach is taken. Nevertheless, the Navy at this time appears reluctant to specify a hard-line approach in areas other than job performance and law infractions, such as drunk driving and drunk and disorderly offenses.

The Lack of a Clear-Cut Definition of Unacceptable Social Drinking Behavior. This reluctance to date to specify strong policies and guidelines regarding drinking and social behavior in a way demonstrates the inconsistent and ambivalent attitudes with respect to alcohol. For example, alcohol is defined as a drug and it is a dangerous drug if misused, which it is by a large percentage of Navy members. A hard-line approach is used in the fight against illegal drug use with surprise

urinalyses, searches, and other means of identification. Yet a soft-pedal approach is being taken in certain areas (mainly social) with the abuse of the drug alcohol, which is at least twenty times the problem of illegal drug dependence.[22] The preceeding is an example of one argument for stronger guidelines regarding moderation and elimination of destructive institutional practices which encourage excessive drinking. However, most research which addresses this area of prevention--social control in changing customs, traditions, images, and cultures or sub-cultures, such as the U.S. Navy--indicates that regulatory measures or other forms of restriction have not been successful in the past in this and other countries; rather, that a gradual change in social attitudes, standards of behavior, and values should be attempted. Yet a gradual, subtle approach to get from a point where there is no clear-cut national or Navy standard as to what is acceptable and what is unacceptable drinking behavior to the point where drunkenness <u>anywhere</u> at <u>any time</u> would be looked upon as unacceptable behavior--as a sign of probable alcoholism--may take many decades. The soft-pedal approach in the social aspects of Navy life at this time may be in agreement with the thoughts of some leading experts in the field of alcohol, but the lack of <u>at least</u> a clear-cut definition of unacceptable social drinking behavior is not in agreement with most recommended prevention programs.

Experimental Control Groups. It should be remembered that this theory on early prevention is just that--a theory. No one knows as yet whether its application will help to reduce the incidence of problem drinking significantly. Establishing several control groups or control installations in the Navy for the purpose of experimentation in order to measure the effectiveness of using different levels or measures of enforcement of AACP preventive policies could prove valuable in the long run. The effectiveness of the AACP's treatment and rehabilitation program is relatively easy to measure. But unless control groups in the Navy are established, it is difficult to see how the effectiveness of its prevention program could ever be evaluated, if in fact evaluation is desired. The Navy has established a relatively long lead in all phases of alcohol abuse control in comparison to other organizations in the country. However, the permanent effects of its early prevention program will probably not be seen for perhaps five to ten years or more. Everyone working in the prevention of alcohol problems is proceeding with efforts based on theories. What will happen in five or ten years if the incidence of problem drinking in the Navy has remained at or near its initial high level? It would seem appropriate then to try different preventive approaches; but much time, money and lives may have been wasted during that period. It seems logical to the author that now is the time to

experiment with, and measure the effectiveness of, different preventive approaches which are bound to be taken anyway in the implementation of AACP policies by commands.

As with many Navy policies, interpretation and implementation are left strictly up to the commanding officer (CO). To be sure, because of the widely differing attitudes about alcohol, different interpretations and methods of implementation of AACP policies and guidelines will be made. Also, statistics would indicate that a certain percentage of commanding officers themselves have an alcohol problem. It would seem that the Navy's AACP would be very difficult for those individuals to accept and implement unless they themselves admitted to having a problem and took steps to correct it. But regardless of whether or not some COs are problem drinkers, there will still be different approaches taken in the prevention program, especially in the social area. What comes to mind is a possible parallel to the Navy's implementation of policies with regard to hair styles in recent years. Although it was claimed that standards had always been in effect, the hair lengths and appearances became intolerable because the standards were not clear-cut and because of differing attitudes toward the styles. And although it may be claimed that a clear-cut standard of social behavior with regard to drinking is specified in the OPNAV Instruction, no where in the instruction is it clearly

stated that drunkenness is not acceptable social behavior any where or at any time. It should be recalled that a clear definition of unacceptable social drinking behavior is a key element in most preventive programs recommended by experts in the field.

This deficiency in the OPNAV Instruction will no doubt result in different approaches in implementing AACP policies; to designate a few locations as control groups and evaluate them over a period of years would seem worthwhile in the long run. Some of the theories upon which the Navy is basing its prevention program may be proven or at least given more validity for future and wider application. Until then, however, one may hear "witch-hunt" cries at some locations and sounds of drunken revelry at others. And, the question of how commands "should emphasize moderation," "prevent and deter" alcohol abuse, or "protect its members against alcohol abuse" at Navy social functions will remain a very sticky one indeed. The author would like to believe, however, it is the Navy's intent that excessive drinking and drunken behavior at Navy social functions and elsewhere will be handled by commanders and supervisors discreetly and skillfully, but handled at any rate.

General Jones' strong alcohol abuse control program in Europe was mentioned in the discussion on educational programs. His program also includes measures which affect

social functions and the environment as well and which may be worthy of implementation by the Navy at least to study their impact on prevention. The hours of operation of base bars were reduced. Some were opening at 0700! Two-for-one drink nights were either eliminated or reduced in frequency. The length of "happy hours" was reduced. The prices of alcoholic beverages in base clubs were raised to bring them closer to off-base prices and the profits funneled into alternative activities, such as recreation.

Along with these strong command actions was an educational effort to convey every evidence, physical and otherwise, that these policies were not intended to drive people elsewhere for their drinking; that they were not part of a temperance movement (except in the literal sense of moderation); that drinking itself was not being discouraged; and that only abuse of alcohol was being discouraged.[23]

This type of program is an example of strong command action from the top and affecting a large geographical area. As of this writing, the impact of this program on prevention of alcohol problems or any other alcohol abuse control measures is unknown; nor is it known if it has even been evaluated as yet. Nevertheless, all or any of the features of General Jones' program in conjunction with others discussed herein could be incorporated in any naval installation's AACP at the discretion of the commanding officer. It would be beneficial,

however, to take the pulse of an installation or unit which plans to institute a similarly strong prevention program by surveying its personnel before the plan is implemented and at appropriate time intervals during the operation of the program.

To Change the Environment. The next section of the OPNAV directive under Education and Prevention addresses alternative activities to those which center primarily around the liquor bar. This effort is directed at primary and secondary prevention and is part of the campaign to change the Navy's leisure environment. Commands are directed to encourage non-alcohol oriented social and recreational activities, especially at overseas and isolated bases. Commands are encouraged to use innovation and salesmanship in promoting hobby shops, game rooms, libraries, educational courses, day and night time sporting events, and clubs, etc., which are not alcohol-oriented.

When one compares the advertisements of some of the Navy's base clubs with information about other non-alcohol oriented activities, it reveals where we are in the Navy. Enticing advertisements by many Navy clubs no doubt increase club business, but they encourage excessive drinking, too. For example, an entertainment package which includes "free drinks from 1930 to 2400," but no dinner served the same evening, and another with "cocktails before dinner, wine and

beer with dinner, after-dinner cordials, and drinks for the evening"[24] certainly do not encourage moderation or a healthy approach to drinking. The last advertisement, for the 3rd of July, also included a reminder, "Remember, you can sleep late on the 4th!"

Base commanding officers could have a significant role in control of the advertising of base package stores and clubs. Much of that advertising makes it appear that those base facilities are in business competition with off-base liquor stores and clubs. There is no justification for this nor is there for club advertisements such as those above which encourage drinking before, during, and long after dinner, whether one can sleep late the next day or not.

The advertising of all base package stores and clubs needs examination in order to give a healthier direction to this aspect of the Navy environment. Advertising which promotes beer and table wine, thus taking advantage of the cultural trend away from harder liquors to these beverages,[25] may be an influential preventive effort. Also, advertisements of alcoholic beverages emphasizing men only and manly images[26] detract from overall preventive measures.

Other beneficial controls commanding officers might easily apply are requiring base package stores to display booklets on the serving of food with alcoholic beverages and requiring ample food or snacks to be easily available at base

club bars. Just as social hosts, hostesses and friends have a responsibility not to contribute to another person's sickness regarding irresponsible, excessive drinking, so should bartenders, waiters and waitresses, and club managers share this responsibility also. Club employees need to become aware of the importance of food in a drinking environment, for example, and of their responsibility not to continue serving an obviously intoxicated person. Base club managers and other club employees who serve alcoholic beverages would benefit from the AACP educational presentation in this regard. The purpose of this indoctrination should not be for identification and involuntary referral of alcohol abusers, but for an increased awareness of the alcohol problem. Also, a lonely, isolated problem drinker will often confide in a bartender of his need for help. With the proper knowledge and the individual's consent, a bartender will be able to contact someone for help, such as a CODAC.

Apart from controls commanding officers might apply to educate club employees and influence advertising, service magazines and newspapers need examination. For some time now the Navy Times weekly magazine has carried few, if any, cigarette advertisements, no doubt because cigarettes have been adjudged as harmful to the health (if used excessively). The drug alcohol, if abused, has proven to be many times more dangerous to the health, indeed to survival itself,

than cigarettes. Yet, a recent issue of Navy Times carried 12 hard-liquor advertisements in its 50 some-odd pages, which was way out of proportion to other types carried.[27] Advertisements from the alcoholic beverage industry which promote moderate, safe, and healthy drinking patterns--including respect for the abstainer--would be beneficial if displayed or used in place of those which emphasize manly images or the harder liquors in the base clubs, package stores and in service magazines or newspapers.

But one need not compare club advertisements or promotional gimmicks to see where we are in the Navy. It is obvious we have first class base clubs and second class recreational and other leisure-time facilities.[28] The importance of non-alcohol oriented substitute or alternative activities, such as recreation, sporting events, libraries, hobby shops, etc., in the prevention program has been highlighted. However, many special services activities at various installations are not open on Saturday or Sunday nights, and most of them can be classified as second rate in comparison to most base clubs. Salesmanship and promotion of non-alcohol oriented alternative activities are required of commands by the OPNAV AACP Instruction. But along with this promotional campaign, the hours of operation of these activities may need extending during non-working hours--weekend nights included. In addition, regarding alternative

activities, General Jones has taken a forceful step in his program by raising prices of drinks in base clubs and using the profits to upgrade recreation and other facilities. When these types of facilities in the Navy can be upgraded to a level at least on a par with Navy clubs, then real progress will have been made in changing the environmental element involved in the disease of alcoholism. This is one of the long-range goals of the Director of the Navy's AACP.[29]

Identification and Referral

Under the section entitled Identification and Referral are procedures for commands to follow to facilitate secondary and tertiary prevention. Instruction is suggested for supervisory personnel in order that they may recognize an alcohol-troubled individual for referral to medical authorities, and familiarization with diagnosis criteria by medical officers is required. Cooperation with other organizations, such as the Naval Safety Center with its Alcohol Safety Action Program (ASAP), the local shore patrol, and the military and civilian police, for the purpose of identification of members involved in alcohol-related accidents and infractions of the law. Members identified should be counseled by those qualified to do so in the referral network and, if necessary, referred for diagnosis by a medical officer. Alcohol abusers not diagnosed as alcoholic should be required to attend remedial preventive education classes.

The guidelines above are mainly secondary preventive measures. Discretion is suggested in these identification methods, since "many abusers are not alcoholics." Yet it is not only the alcoholics the Navy wants to identify, treat, and rehabilitate; repetitive or habitual alcohol abusers, by Navy definition, are "problem drinkers" and need varying degrees of help as well. Recall the heavy policy burden placed upon commands to counsel and protect against, and to prevent and deter, alcohol abuse. These identification procedures are some of the tools which will enable commands to meet their responsibilities. Also, this type of identification enters the areas of performance of duty, misconduct, traffic accidents, and infractions of law which may involve line of duty matters. The Navy has every justification, including humanitarian reasons, to intervene in such matters and if alcohol abuse is involved to use the referral procedures outlined.

Intervention Methods. The research for this paper was purposely not extended to the medical aspects of identification and treatment to any significant degree. However, the search for preventive intervention measures has led to other countries which have had some degree of success. A medical method of early identification of alcohol abusers in France which is reported to be highly effective is the use of the "Le Gô Grid." The grid contains 12 spaces for data on intensity of signs of abnormalities in the face, conjunctivas, tongue,

mouth, fingertips, size of liver, blood pressure, weight, color and tremor. A steady increase of intensity of these signs leads to further demographic, psychological and biological examination. Analysis of over 1,000,000 Le GÔ Grids is reported to have shown that the combination of face and tongue abnormalities with tremor was found in 36 percent of early alcoholics. In advanced alcoholics the conjunctival and facial aspect are irreversible. The grid is inexpensive, objective, and easy for physicians to apply.[30]

In Yugoslavia, the use of psychiatric screening in its alcoholism program has been successful in early-phase prevention. Questionnaires are administered to certain population groups including those of high risks in regard to alcoholism, such as persons sentenced for misdemeanors, job applicants, those being treated for any disease that could have been caused by alcohol abuse, etc. A first screening selects those respondents who might be in trouble with alcohol. The second screening consists of a social-psychiatric questionnaire and examination. The psychiatric screening is reported to be fruitful in early detection of alcoholism.[31]

Because of the considerable interest in focusing preventive measures on high-risk groups, i.e., groups with known or potential high rates of problem drinking, this Yugoslavian or a similar technique might prove useful to the Navy. In addition, initial screening of those young Navy members who

are having difficulty in adjusting to Navy life, such as minor UCMJ offenders, might prove successful. A primary preventive measure would be the use of a similar screening method with delinquent or other "problem" children of Navy members who may come to the attention of Navy psychologists, psychiatrists, and chaplains.

We have entered here the domain of predisposition in the identification of potential problem drinkers, which was another avenue searched for possible measures the Navy might adopt. It is understood that Navy AACP authorities hope to build a statistical base to provide leads for the possible prognosis of vulnerable individuals[32] who might require special counseling on alcohol and their particular vulnerability. However, a good statistical base has already been established regarding the children of alcoholics. This group, other known high-risk groups, and those individuals who might be identified through psychological screening methods as possibly vulnerable to alcohol are in need of a special counseling and educational effort. This counseling and education would be most appropriately offered by CODACs or others with specialized training in alcohol and alcoholism.

It can be concluded that an extensive system has been devised for identification of troubled Navy members utilizing existing agencies and organizations in conjunction with the AACP's referral network. In addition, many excellent methods

of identification and intervention are specified in the OPNAV Instruction a. ' others have been discussed herein. With the required enlightened attitudes and proper education and training of all hands, early secondary prevention through identification and referral can be a reality.

CHAPTER V

SUMMARY AND CONCLUSIONS

It can be concluded that there is a serious alcohol problem in the U.S. Navy, as there is in the nation as a whole. Alcohol abuse is the nation's and the Navy's number one drug problem. Estimates of the incidence of problem drinking in the Navy range from five percent to 38 percent, with the Navy unofficially using a conservative estimate of 15 percent of its force having serious drinking problems.

As with other diseases, treatment alone of alcoholic persons will not prevent further casualties; nor will education or control measures by themselves significantly reduce the incidence of problem drinking. It is generally agreed upon by the experts in the field that a comprehensive, multidisciplinary approach to the prevention of problem drinking is needed to keep more and more problem drinkers from appearing on the scene. The main thrust of this type of approach is aimed at changing the whole climate of drinking in American society, including social attitudes, values, and behavior with respect to the use of alcohol. Most suggested programs in prevention include the following measures:

1. Cultural changes and adaptions,

2. Changes to the environment--substitute activities and improvement in socioeconomic conditions,

3. Broad-based education and training programs,

4. Early identification of problem drinkers, and

5. Social control to clearly define unacceptable drinking behavior.

It has been shown that the NIAAA has incorporated most of the above in its long-range prevention program on the national level. The Navy also has included most aspects of these proposals in its multifaceted prevention program.

The OPNAV Instruction, outlining the Navy's fight against alcohol abuse and alcoholism, includes measures in all three phases of prevention. The tertiary phase program--the arrestment of the disease through treatment and rehabilitation--is one of the largest, and most resourceful in the world today. The Navy's secondary prevention program--early case detection of problem drinkers and identification of high-risk individuals through education, identification, and referral--is well structured and organized.

Whether primary prevention is possible in the Navy or not, many of the AACP policies and educational guidelines do fall into this category. Namely, those policies dealing with changing the whole climate of the Navy's leisure activities and social functions are primary preventive measures. The objective is a change in this environment from that which encourages excessive drinking to that which encourages participation in a myriad of activities not centered around the club or drinking

and which encourages moderation at social functions where alcoholic beverages are served. Primary preventive efforts--any measures which will prevent an individual from ever abusing alcohol in the first place--are also included in the AACP's information and education programs. Although most young people have their first experience with alcohol at an early age, many begin late in the teens or even early twenties. If, through education and implementation of policies which eventually change attitudes and values in the Navy with regard to what is acceptable and what is not acceptable drinking behavior, many more Navy members choose not to begin abusing alcohol, then a beginning in primary prevention in the Navy will have become a reality. Indeed, it has been shown that the AACP's all-media educational awareness measures and the educational programs have been able to change attitudes toward this extensive problem. In addition, it is intended that the Navy's alcohol education program will extend to dependent wives and children as well as to Navy school children overseas. These are noble primary preventive efforts.

When the idea for this study was formulated in December of 1972, prevention of alcohol problems seemed to be the area needing the most attention in the U.S. Navy and in the country as well. During the course of the research period, the Navy rapidly expanded its entire Alcohol Abuse Control Program--education, training, its referral network, and its treatment

facilities--and it has issued its much-needed policy directive. The combination of these efforts appears to cover, at least in principle and in writing, many of the experts' key proposals and generally agreed-upon measures for prevention.

It can be concluded that a most extensive and well-organized system has been established to manage, control, and possibly eventually prevent the alcohol problem in the U.S. Navy. The inputs, such as policies, education materials, the referral network, facilities, command structure, and other resources which are not readily available to non-military organizations, are there for the prevention model to operate. Indeed, other elements of the system, notably tertiary preventive measures through treatment and rehabilitation, are operating highly effectively today.

The major conclusion of this study, however, is that getting middle- and upper-level command management in the Navy to realize that the alcohol problem is manageable and preventable is an early and serious stumbling-block. The many excellent preventive measures outlined in the OPNAV directive will never be implemented to any worthwhile degree unless command management believes in the prevention effort. Although the Navy is just getting started in the prevention area, the only methods in evidence of involving management are the once-issued OPNAV Instruction and the once-a-year-or-so

general, all-hands education package. Command managers at all levels must become directly involved in the prevention program if any significant progress is to be made in reducing the incidence of problem drinking in the Navy.

It can be concluded that the Navy has taken important beginning steps in the vital area of prevention. At this point, however, the effectiveness of the Navy's early prevention program cannot be determined, and it is difficult to forecast how it will affect the high incidence of problem drinking.

Yet, alcohol abuse and alcoholism in the U.S. Navy may not be as intractable as is commonly believed. The measured change, however small it may be, in attitudes, values and behavior of Navy personnel who undergo the drug and alcohol education program is one thing. But this change, in conjunction with other extensive and healthy changes and influences--environmental, social, peer-group, and other individual influences--will have tilled the soil of the Navy sub-culture. The seeds for a healthier, more constructive, life-style in the Navy will have been planted. And although the desired life-style may not be realized for decades and prevention of alcohol problems for perhaps several generations, implementation of these coordinated changes and influences in Navy life may result in significant reductions in the

incidence of problem drinking sooner than expected. However, these seeds and goals will need constant cultivation and attention. The Navy may have just seen the tip of the iceberg at its ARCs and ARUs to date. Should efforts in the prevention of alcohol abuse go the way of some of the formal Navy programs of the past decade or so, such as the John F. Kennedy-inspired Physical Fitness Program, the Navy's treatment and rehabilitation facilities will probably remain flooded and backlogged with deeply troubled Navy men and women.

It is recognized that there are time, personnel, and monetary limitations as to how far the Navy can go in preventive efforts. However, the author believes that a widely-supported, intensive prevention program is the key to the long-range solution of the Navy's alcohol problem, and that there are additional measures in the early phases of prevention which are worthy of consideration by the Navy. Most of the suggestions in the next chapter could be easily incorporated into Navy prevention programs.

CHAPTER VI

RECOMMENDATIONS

The proposed additions or changes to the U.S. Navy's Alcohol Abuse Control Program discussed in this chapter deal with measures to reduce the incidence of problem drinking, that is, early prevention of alcohol problems. The recommendations are tailored to three categories found in most prevention programs:

1. Identification and early case finding,
2. Attitudinal, behavioral and value changes, and
3. Social control and changes to the environment.

In addition, some proposals are made for experimentation, evaluation, and future directions in prevention.

General. The difficulty referred to in Chapter IV in convincing top and middle management that the Navy's alcohol problem is manageable and preventable is one of the major obstacles in the prevention program. It is considered essential that some type of follow-through or more positive and forceful steps, other than the OPNAV Instruction and the general, all-hands education package, are needed to convince and involve command managers. It is strongly recommended that a separate package from that of general education be prepared by the Navy's AACP

project office and presented to managers at all levels in each command, including the Naval War College and all other appropriate schools, on the subject of prevention of problem drinking. This package should include the specific preventive policies and guidance outlined in the OPNAV Instruction, any measures recommended herein which are considered worthy of implementation or experimentation, and any others which would enhance the prevention of problem drinking. Also, included in this prevention package could be: guidance for commands on how to evaluate their prevention programs; methods of obtaining feedback; questionnaires to survey changes in attitudes and behavior; and reporting requirements, if deemed appropriate. Such a package would involve command managers in prevention of the Navy's alcohol problem more directly and positively than the passive, once-a-year-or-so general education program, and the once-issued OPNAV Instruction.

Identification and Early Case Finding. These proposals are made with the following in mind: that the purpose of identification and early case detection of alcohol abusers is to prohibit full development of alcoholism, as well as to reduce the incidence of other types of alcohol problems; and that high-risk groups and individuals who may be prone to alcoholism have been established and may be defined by various methods in order that preventive measures may be applied.

The Le Gô Grid used in France by physicians for the early detection of problem drinkers appears to be highly

effective. It is recommended that the Le Gô Grid be investigated by the Chief, Bureau of Medicine and Surgery for possible adaptation by the U.S. Navy.

In Yugoslavia, the use of psychiatric screening in its alcoholism program is reported to be successful in early-phase prevention. It is recommended that the Chief, Bureau of Medicine and Surgery also investigate this or a similar screening technique for possible use by the Navy. Initial screening is recommended of those young Navy members who are having difficulty in adjusting to Navy Life, such as minor UCMJ offenders. A primary preventive measure would be the use of a similar screening method with delinquent or other "problem" children of Navy members who may come to the attention of Navy psychologists, psychiatrists, and chaplains. A special counseling and educational effort is recommended for groups or individuals already identified as high risks with regard to alcohol, such as children of alcoholics, or those who might be identified through psychological screening methods.

One last comment is offered regarding the medical profession and its responsibility in the prevention of alcohol problems. Evidence cannot be disregarded which relates alcoholism to biochemical factors and nutritional deficiencies, and the neglect of the nutritional approach cannot be justified.[1] Physicians should be conscious of the possible effects that

good nutrition may have in preventing the onset of alcohol problems in high-risk individuals.

To aid in identification of problem drinkers in job performance, a handbook for supervisors and commanders has been issued to Air Force European commands. A special handbook for Navy supervisors and command managers may enhance managerial involvement and awareness, as well as identification measures. Such a handbook is recommended for middle- and upper-level management.

Attitudinal, Behavioral and Value Changes. These proposals are made to enhance the Navy's efforts to change the climate in the Navy with respect to drinking.

Individual command policies and instructions will be promulgated below the headquarters level all the way down to the local and individual unit level now that the OPNAV Instruction on alcohol abuse control has been issued. However, the OPNAV Instruction, although inferring what is not socially acceptable drinking behavior, avoids a clear-cut definition of this important concept. Thus, this issue is left open to interpretation by subordinate commands in their implementing directives. It has been shown, however, that central to the issue of prevention is the question of what is and is not acceptable social behavior with regard to drinking. It is recommended that a standard of acceptable drinking behavior and what

is not acceptable drinking behavior in social situations be clearly stated in the OPNAV Instruction in order to preclude further confusion and ambivalence regarding this aspect of Navy life.

The Navy's film "One Day at a Time" (CNO SITREP Number 6) may tend to reinforce rather than reduce the stigma associated with alcoholism in the officer ranks of the Navy. It intimates by the relative absence of officers in the film that officers may not have alcohol problems. It is recommended that the film be revised to include a larger percentage of recovering or recovered officers (the higher the rank the better) to address their particular problems in that segment of the Navy.

As has been reported, a seemingly unchanging attitude toward recovered alcoholics has been that of promotion boards. A step in the right direction would be for the Secretary of the Navy to include in his general instructions to promotion boards the policy stated in his directive regarding promotion of recovered problem drinkers. Another helpful step would be to arrange for a recovered alcoholic to sit as a member on some key promotion boards.

The BUPERS Instruction 6710.1A of 4 April 1973, on drug and alcohol education and action programs, briefly addresses liaison and cooperation with the local community. This type of educational cooperation and involvement with the community is an important extension of primary and secondary preventive

efforts outside the gate. Involvement and cooperation should be accomplished with local community organizations, agencies, city and county governments, clubs, church groups, wives' groups, PTAs, JCs and other youth groups, and schools, if possible.

In addition to the special counseling the children of Navy alcoholics should receive because of their possible vulnerability to alcoholism, teen-age children in such high-risk groups might be recruited to work during the summer as ward aides in alcoholism facilities.[2] This would help increase their understanding of alcoholism, while meeting in therapeutic groups to aid them in coming to terms with their feelings about their alcoholic parent and reduce conflict about alcohol use.

Bartenders, waiters and waitresses, and base club managers have a share of the responsibility in solving the alcohol problem. Club employees need to become aware of the importance of food in a drinking environment, for example, and of their responsibility not to continue serving an obviously intoxicated person. It is recommended that commanding officers make it a mandatory requirement for base club managers and other club employees who serve alcoholic beverages to receive the AACP educational presentation. The purposes of this indoctrination should not be for identification and involuntary referral of alcohol abusers, but for an increased

awareness in these employees of the alcohol problem and of their responsibilities in its solution.

Anyone who is serious about reducing the rate of problem drinking in the Navy cannot disregard transcendental meditation as a possible non-chemical method of changing an individual's attitude, behavior and/or means of coping. It is recommended that transcendental meditation be investigated further to evaluate its potential in all phases of prevention of alcohol problems.

Social Control and Changes to the Environment. These proposals are made for the purpose of aiding primarily local commands in regard to social control and environmental changes which, if effected, may contribute significantly to the early prevention of alcohol problems. Some of the suggestions, however, might be more effectively and appropriately coordinated and directed from the headquarters level.

A clear definition of acceptable and unacceptable social behavior with regard to drinking was recommended in the previous section. However, this proposal falls within the purview of social control also. In addition, until the SECNAV and/or OPNAV Instructions are revised to include such a definition, it remains the prerogative of subordinate commands to interpret this aspect of those directives as they deem it appropriate. Therefore, it is recommended that subordinate

commanders include a clear-cut standard of drinking behavior in social situations as discussed in the previous section in their implementing policy directives.

Base commanding officers should exercise more control of the advertising of base package stores and clubs. Some alcoholic beverage advertising encourages unhealthy drinking practices. It is recommended that commanding officers examine the advertising of all of their base package stores and clubs in order to give a healthier direction to this aspect of the environment under their control. Advertising should promote beer and table wine thus taking advantage of the cultural trend away from harder liquors to these beverages. Advertisements of alcoholic beverages emphasizing men only and manly images should not be accepted for display on naval installations. In fact, where possible, commanding officers should display only advertisements from the liquor industry which promote moderate, safe, and healthy drinking patterns--including respect for the abstainer. In addition, it is recommended that commanding officers require base package stores to display booklets on the serving of food with alcoholic beverages and require ample food or snacks to be easily available and encouraged at base club bars.

The Navy Times weekly magazine carries a disproportionate number of hard-liquor advertisements in comparison to other types of advertisements. It is recommended that the Navy Times

staff be strongly encouraged by Navy or DoD authorities to accept only those liquor advertisements which were recommended previously to base commanding officers.

The importance of non-alcohol oriented substitute or alternative activities, such as recreation, sporting events, libraries, hobby shops, etc., in the prevention program has been established. Along with the required promotional campaign regarding these activities, it is recommended that the hours of operation of these activities be examined and extended where necessary during non-working hours--weekend nights included. In addition, serious steps should be taken by commands at all levels to upgrade these alternative activities and facilities to bring them at least up to a par with the Navy's base clubs.

Many of the recommendations in this chapter apply to the shore establishment. However, extensive abuse of alcohol is apparent among Navy personnel on liberty in overseas ports, such as in the Mediterranean or the Philippines. The pressures and tensions built up by lengthy family separations, shipboard duties, and the routine of shipboard life are vented by most men when on liberty. The valiant efforts of overseas fleet commands and units to provide recreational and alternative activities influence many individuals to take advantage of the large number of tours, inter-cultural events, and intramural sports programs. But the many clubs and bars also attract a

great number of Navy men despite these efforts. Measures to change the environment during visits to overseas ports would be difficult to implement. However, it is recommended that, in conjunction with an especially strong educational and informational AACP, extra efforts should be made in promoting alternative activities. In addition, the complete understanding of what is acceptable and unacceptable drinking behavior on the beach should be ensured. These standards should be attained and maintained by the example and the authority of those in positions of leadership and by the authority of the Shore Patrol.

General Jones' strong alcohol abuse control program in Europe includes measures which affect social functions and the environment as well. It is recommended that each commanding officer consider those measures in conjunction with others recommended herein for incorporation in the AACP for his base, ship or unit, and that innovative and comprehensive prevention programs be evaluated for effectiveness, before and during their implementation. This leads to a final set of recommendations regarding experimentation, evaluation, and future directions.

Experimentation, Evaluation, and Future Directions. Evaluation is essential to sound management practices. Therefore, these recommendations are made for the purposes of maximizing the effectiveness of the Navy's present and future prevention programs.

The Navy-sponsored survey (BSSR) recommended that a Navy-wide survey be made to determine more accurately the extent of the alcohol problem. The author agrees with this recommendation; but such a survey should be conducted as soon as possible--before preventive programs are thoroughly implemented. Thus, follow-on surveys of smaller samples in the Navy will better reflect the effects of the prevention program.

A serious attempt to normalize Navy life by changing the environment is being made presently on the U.S.S. SANCTUARY with the introduction of women as part of her crew. Assuming that the impact of women as part of the crew is being thoroughly evaluated, it is recommended that a special evaluation of the U.S.S. SANCTUARY be included with respect to the alcohol problem.

If General Jones' alcohol abuse control program in Europe is evaluated by the USAF for the effectiveness of preventive measures he has instituted, it is recommended that the Navy obtain this evaluation. Further investigation of his program may be warranted. As yet, because of the newness of the AACP prevention policies, there are few, if any, figure estimates regarding the effectiveness of preventive measures taken other than in general education. Treatment, rehabilitation and "effective" restoration to duty are tangibles, but the amount the incidence of problem drinking has been reduced

or will be reduced by preventive endeavors may never be determined unless the concept is properly evaluated. Therefore, it is recommended that various approaches to prevention be pursued and their effectiveness evaluated:

1. Even though there is continual turnover of personnel at naval installations which might adversely affect evaluation techniques, such is the real-life situation in the Navy. Although afflicted or potential hosts (problem drinkers) may move in and out of the particular group or location under study, the other two variables in the problem--the agent and the environment could be held relatively constant. The effects of an environment with an intensive prevention program in force on varying hosts (personnel moving into and out of the location) should be measured.

2. Four naval installations have already been surveyed--before AACP education programs and overall preventive policies were implemented. A follow-on survey at these four sites would be in order periodically after significant prevention programs are implemented. One or several of these installations should be designated a control group for purposes of continuing evaluation.

3. These and other special control groups, installations or units should be experimented with using different levels or measures of enforcement of AACP preventive policies and standards. As previously discussed, Mark Keller, of the

Rutgers Center of Alcohol Studies, is anxious to begin such studies in the prevention area,[3] and liaison with the Center is recommended.

APPENDIX I

BACKGROUND AND HISTORY

In one beverage form or another, alcohol is and always has been a matter of almost universal use and concern. Literature reflects that intoxicating beverages of wine and stronger drinks were used by the ancient Egyptians, Hebrews, Greeks, and Romans. They have been widely used and misued through the ages as an adjunct to religious rituals, sometimes mistakenly as a stimulant, often as a source of relaxation and conviviality, and unintentionally as a contributing factor to serious illness.[1]

Alcohol was probably the first tranquilizer known to man, and even today it remains the most widely used.[2] Alcohol is also a food--a source of calories, but lacking in nourishing vitamins. It is also a drug which acts upon the central nervous system. As such, it is prescribed in a variety of ways in medicine, for example, in diabetic diets and as a sedative.

The other facet of alcohol is more apparent. It is manifested in anguish and tragedy. History has amply documented the destruction of individual lives and families through abusive and irresponsible drinking. Drunkenness has been reported as a serious problem in classical literature, with moderation being the usually suggested remedy.

Temperance efforts are on record from 3000 years ago in Egypt, and similar writings in Greek, Roman, Indian, Japanese, and Chinese, as well as the Old and New Testaments denounce excessive drinking.[3]

The Temperance Movement in this country began in the early 1800's with a goal of moderation, but time altered that goal from moderation to total abstinence. In 1919, the 18th Amendment to the U.S Constitution was a triumph for the prohibitionists, but it was repealed as a failure in 1933. Yet, forty years later, Prohibition and Temperance are still controversial subjects. Arguments that Prohibition decreased drunkenness are opposed by those claiming it reduced only the incidence of moderate drinking and actually glamorized drinking and intoxication.[4]

Today it is generally accepted that those adults who wish to drink have the right to do so. It must be remembered that many more people enjoy the effects of alcohol in a healthy way than in a sick way.[5] However, when this country became horrified by the abuse of such drugs as heroin, the halucinogens and stimulants by our youth, we were finally forced to recognize that the abuse of alcohol is actually the major drug problem in the nation. It was reported early in 1973 by the National Commission on Marijuana and Drug Abuse that "compulsive use of alcohol is the most destructive drug-use pattern in this nation." Alcoholism has been

declared the most widely untreated treatable disease in the country, the third largest cause of death, and the fourth most serious health problem after heart disease, cancer and mental illness.[6] It could very well be the U.S. Navy's number one health problem.

The recent increases in public awareness of the alcohol problem, although renewed by the illegal drug abuse scares, were nurtured by men like Senator Harold Hughes of Iowa. He, others like him, and the long-standing voluntary helping organizations like Alcoholics Anonymous (AA) and the National Council on Alcoholism (NCA) helped the nation to emerge from an era when alcohol abuse and alcoholism were looked upon as moral degeneration to when the landmark Public Law 91-616, the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970," set a precedent and the stage for major public health efforts. Other laws, such as the "Armed Forces Drug Abuse and Drug Dependence Prevention, Treatment, and Rehabilitation Act of 1971," Title V to the Selective Service Act, were passed and directed that preventive, treatment and rehabilitation measures be taken by various segments of the Federal government including the Department of Defense (DoD) and Veterans Administration (VA).

There are many obstacles to carrying out these laws effectively. Today's drinking patterns and styles are a

mixture of imported cultures and indigenous customs.[7] Images are difficult to change. The style of the reckless frontier drinker hangs on even today. The cocktail hour is a firmly implanted American custom. The Navy, in particular, has strong images and traditions which tend to hinder progressive efforts--the free-wheeling, drunken sailor on liberty; the daring pilot with white scarf flying returning from his mission against the Red Baron to his time of revelry; the "officer and gentleman" who is expected to "hold his liquor" regardless of the number of drinks to which he is "subjected."

There is nationwide disagreement about what constitutes correct or appropriate drinking behavior and the confusion is evident among the general public. The various and sometimes embarrassed reactions to persons intoxicated in public places, such as at football games, for example, illustrates the general ambivalence about drinking behavior. If a man is drunk, some people in the crowd will begin trying to control him or someone will call for the police to come to take him away. Some others may resent the intrusion of the police; still others will be less sympathetic to the man who is intoxicated; but most spectators are relieved that they do not have to assume responsibility for doing something about the situation. The reactions of those persons seated close to the drunken man are often unpredictable. A lack of clearly defined standards of social behavior regarding the use of

alcoholic beverages can thus be seen in the uncertain reactions to drunkenness.[8]

In a different social situation, such as a party, there are the possible difficulties of the host with his guests. The serving of drinks is a central element of hospitality in American society. However, for a host to interfere overtly in any way with a person's drinking except to offer him more is the exception rather than the rule. Seldom does a host tell a guest that he has had enough. The host is expected to see that his guests have a good time, but does this obligation entirely override that of protecting the safety and even the lives of the people he is entertaining, and the possible innocent victims of their dangerous driving?[9]

Obstacles to progress in the fight against alcohol abuse and alcoholism range from disagreement about alcohol's place in society to those involving uses of alcohol that interfere with one's usual functioning. Others concern disagreements over how to cope with various drinking behaviors when there is no clear-cut standard of unacceptable drinking behavior in this country. A basic cultural conflict is apparent.

From the standpoint of prevention, a serious difficulty has been created because disapproval of dangerous drinking has been confused with opposition to all drinking.[10] One of

the most important problems is the failure to see the interrelatedness of diverse alcohol problems. These many problems reflect disagreement on basic issues regarding beverage alcohol: is drinking "bad" in itself or possibly dangerous; should it be postponed to later ages, or minimized, or eliminated? What constitutes acceptable or allowable drinking and how can the other types of "unacceptable" drinking be discouraged?[11]

This lack of agreement about what amount of drinking or what kind of drinking behavior is acceptable has contributed to the widespread neglect of problem drinking. Also, myths and misunderstandings exist regarding the nature of alcoholism. It has been viewed as a "moral weakness," a disease, a symptom of underlying psychological disorder, and as a legal or social problem, to name a few. The diversity of such views has both reflected and reinforced the confusion as to what should be done about problem drinkers and, above all, how to approach the larger issue of prevention. Preventive approaches, especially those relating to altered drinking patterns in the American society as a whole, have received little attention.[12]

However, the recent public laws regarding alcohol and public awareness of alcohol problems now make it possible to consider ways of encouraging appropriate drinking behavior--and of discouraging other kinds--while still leaving people

who do not wish to drink entirely free to do so. This approach means seeing that all drinking is not one and the same thing, and that problems are associated with some types of drinking and not with others. This will allow for more discrimination, more effective planning and policy-making--in education, legislation, and personal decision-making.[13]

Americans are now being confronted with the reality that their right to drink must carry with it certain responsiblities. Recognizing that many Americans are drinking to excess, endangering the lives and the welfare of themselves, their families, and all those around them, ways are being sought to encourage personal and social controls, to create a new climate in which every individual understands the effects of alcohol, and assumes responsibility for its intelligent, considerate use--if he chooses to drink.[14]

APPENDIX II

EFFECTS OF ALCOHOL ON MAN

Understanding the effects of alcohol is essential to one who drinks or who is contemplating drinking. He or she must be able to make a rational decision and be able to drink healthfully and responsibly if the decision is made to drink. Also, effect and cause are related, and since the causes of alcohol problems will be discussed later in relation to preventive approaches, a brief look at the effects of alcohol will be helpful. Deeper study of its effects are recommended for individuals contemplating drinking and others who do drink.

Although some of the obvious short- and long-term effects of beverage alcohol are generally well known, this also is an area of misunderstanding. For example, many drinkers who feel they must drive after drinking believe coffee will sober them up or at least speed-up the process. Unfortunately, coffee serves only to keep that person, now with reduced judgement and reactions, awake long enough to get behind the wheel. He would be better off succumbing to drowsiness for a few hours before driving.

The effects of alcohol consumption depend upon a variety of factors such as the rate of absorption, learned expectation, and central nervous system adaption to the drug.[1] The

absorption rate is affected by the speed of drinking, body weight, recent food intake, drinking history and body chemistry, and the type of beverage used. The drinker's present environment, his mood and attitudes, and his previous experience with alcohol all influence its effects.[2] In the normal drinker, drinking may be accompanied by feelings of exhilaration, loss of restraint, enhanced sociability, increased emotional lability, and impairment of performance in certain cognitive and perceptual tasks. Some of the physical signs of intoxication are slurring of speech, impaired motor performance, and, in some instances, disturbances of sensory perception. In the normal drinker, brief periods of drinking leave no discernible behavioral or neurological residue, and therefore do not constitute a persistent health hazard. At the other end of the scale, however, extreme intoxication may lead to a depression of the central nervous system and to a state of stupor with an attendant risk of death.[3]

It is not surprising, therefore, that the depressive effects of alcohol establish a strong relationship between its abuse and the occurrence of accidents, as well as acts of violence. Excessive alcohol intake is associated with a substantial portion of automobile accidents and fatalities (50 percent), other accidents on the streets, on the job, on vacation, and at home; and assaults, homicides, and suicides.[4]

Many of these violent results of excessive drinking are obvious, but the effects of moderate drinking are less obvious. Recent research by Dr. Ernest Noble, M.D., of the University of California, indicates that the cause-and-effect relationship between alcohol and forgetfulness or brain damage is a matter of degree, and that even moderate social drinking may be a cause of the minor but annoying forgetfulness occurring in late middle-aged people.[5]

The long-term effects of alcohol abuse are also less obvious than many of the short-term effects. The effects of alcohol taken in large doses over long periods of time can be disastrous. Long-term abuse of alcohol may result in structural damage to the heart, brain, and liver. In addition, very heavy long-term drinking may cause mental disorders and permanent damage to the nervous system, memory, judgement, and learning; sexual ability may deteriorate severely along with the disintegration of the personality.[6]

Chronic and heavy consumption of alcohol seems to alter the sensitivity of the central nervous system to its effects. This means that larger amounts of alcohol are needed to produce the same effect. This adaption of the central nervous system to the effect of alcohol is termed "tolerance" by pharmacologists. Adaption is common to the chronic use of all addictive drugs and is believed to be a basis of "addiction" or, in more recently adopted terminology, "dependence."[7]

There are differences between an alcohol-dependent individual and the moderate or even heavy drinker. The differences are due, in part, to the adaption process discussed above. Some of these differences are that the alcohol-dependent person:

1. To produce the desired change in feelings and functioning previously attained with smaller amounts of alcohol, must drink relatively much greater amounts through time;

2. Is without the obvious behavioral impairment that a normal drinker would suffer after consuming these very large amounts;

3. Can experience dramatic alterations in behavior and perceptions with the abrupt removal of alcohol. He may suffer from severe tremulousness, hallucinations, disorientation, confusion, delerium, and convulsions--the alcohol withdrawal syndrome.[8]

The importance of a full understanding of the short- and long-term effects of the drug alcohol in the rational decision-making process regarding drinking cannot be overemphasized. As with other areas of the alcohol problem, the more insidious effects of alcohol are often misunderstood or not realized by the general population, whether they are drinkers or non-drinkers. Further study of the effects of alcohol on man is recommended for drinkers or those who contemplate drinking.

APPENDIX III

DEFINING PROBLEM DRINKING

Yet another controversy permeates the literature and reports on alcohol. As early as 1785 America's foremost physician, Dr. Benjamin Rush, termed the intemperate use of beverage alcohol a "disease" and referred to it as an "addiction."[1] Arguments for and against the disease conception of alcoholism have been offered ever since then, especially within the past quarter century after the World Health Organization and the American Medical Association (AMA)designated alcoholism a disease in 1951 and 1956, respectively. It has been argued, for example, that to laymen as well as professionals the term "disease" connotes specific biochemical or physiological disturbances. Critics of the "disease" concept believe that the use of this term may lead many to view alcoholism as a homogeneous disease caused by specific biochemical or physiological disturbances; they therefore recommend that alcoholism not be regarded as a "disease" in that limited medical sense.[2]

Some notable professionals believe that the defining of alcoholism as a "disease" actually hinders treatment and total rehabilitation efforts for many alcoholics. These opponents to the disease conception believe, in general, that alcoholics can be helped to assume responsibility themselves

for their drinking and behavior and for their future; that alcoholism can be more than "arrested;" and that many alcoholics can be not only fully "recovered," but "cured," as well.[3]

Difficulty is also encountered in defining "alcoholism" and "alcoholics." Use of the term "alcoholic" is believed by some to lead to stereotyping of problem drinkers. It is argued that the term implies that the person's major characteristic is thus being described, and that his physical, psychological, and social traits are relatively unimportant. As reported by Plaut in Alcohol Problems: A Report to the Nation,

> There are many types of "alcoholics," and this lack of discrimination between types is as damaging to treatment policies as is the lack of discrimination between different types of drinking and drinkers to the development of effective programs for alcohol problems in general.[4]

The term "addiction" has frequently been applied to alcoholism, and it, too, runs into controversy. However, a World Health Organization Committee suggested that there are numerous types of "drug dependence." This termis used in preference to "addiction." A "drug dependence" condition is said to exist when,

> The individual's consumption of alcohol exceeds the limits acceptable to his culture, when alcohol is consumed at times that are not deemed appropriate in that culture, or when the intake of alcohol

> becomes so great as to cause damage to the health of the drinker or impairment of his social relations. Since use of alcoholic beverages is a normal, or almost normal, part of the culture of many countries, dependence on alcohol is usually apparent as an exaggeration of culturally accepted drinking patterns, and the manifestation of dependence varies accordingly in a characteristic fashion with the cultural mode of alcohol use.[5]

It can be seen that just defining the alcohol problem is a difficult task in itself. However, there are three basic types of definitions of alcoholism: one deals with causes and centers on psychological and/or physiological factors; the second uses social influences as its frame of reference; the third combines the first two and divides alcoholics into categories.

An example of a definition emphasizing psychological characteristics states that: "Alcoholism is a type of abnormal mental reaction; alcohol has been found to be an antidote for some obsessions or emotional depressions."[6]

Most present-day definitions of alcoholism use descriptive social terms rather than causal terms. For example, to the AMA, "Alcoholism is a disease which is characterized by a compulsive drinking of alcohol in some form. It is an addiction to alcohol. The drinking of alcohol produces continuing or repeated problems in the person's life."[7]

The late Dr. E. M. Jellinek, one of the world's foremost scholars on alcohol problems, attempted to divide alcoholics

into categories in a sophisticated definition of alcoholism in his book The Disease Concept of Alcoholism.[8] He devised a new classification of alcoholics: Alpha, Beta, Gamma, Delta, and Epsilon. "Alpha alcoholism is a purely psychological continual reliance on the effect of alcohol to relieve bodily or emotional pain." The drinking of the Alpha alcoholic exceeds the bounds of society, but he still has the ability to control his drinking and to abstain. Also, signs of progression are not evident.

Beta alcoholism, according to Jellinek, is that "in which such alcoholic complications as polyneuropathy, gastritis and cirrhosis of the liver may occur without either physical or psychological dependence upon alcohol." This type of alcoholism may also not progress.

Gamma alcoholism is described as "(1) acquired increased tissue tolerance to alcohol, (2) adaptive cell metabolism, (3) withdrawal symptoms and 'craving,' i.e., . . . physical dependence, and (4) loss of control." In Gamma alcoholism "there is a definite progression from psychological to physical dependence." This form of alcoholism is the most destructive and is the usual type seen in American alcoholism clinics and AA groups.

Delta alcoholism, according to Jellinek, includes the first three characteristics described in Gamma alcoholism "as well as a less marked form of the fourth characteristic--

instead of loss of control there is inability to abstain." This type of alcoholism is common in wine-drinking countries, such as France, where alcoholics can control the amount of intake but cannot abstain.

Epsilon alcoholism, a form of periodic alcoholism, is described by Jellinek as the least known form of alcoholism. Dr. Chafftez, now Director of the NIAAA, and Dr. Demone in their book, Alcoholism and Society, feel that Jellinek's definitions are scholastically valuable, but that they perpetuate the trend to categorize alcoholics into static groups. They believe that it is more important to visualize alcoholism as arising from multiple and varied components which overlap.[9] Therefore, their definition encompasses the three types of definitions above. They define alcoholism as,

> a chronic behavioral disorder manifested by undue preoccupation with alcohol to the detriment of physical and mental health; by a loss of control when drinking has begun although it may not be carried to the point of intoxication; and by a self-destructive attitude in dealing with relationships and life situations. Alcoholism is the result of: a disturbance and deprivation in early infantile relations accompanied by related alterations in basic physiochemical responsiveness; the identification by the alcoholic with significant figures who deal with life problems through the excessive use of alcohol; and a socio-cultural milieu that causes ambivalence, conflict, and guilt in the use of alcohol.[10]

The foregoing discussion and examples are included to illustrate the difficulty scientists and other experts in the

field have had in trying to pin-down just what alcoholism is and to establish an operative concept and definitions. Nevertheless, it comes to this: that a disease is what the medical profession says it is. The fact that they are not able to explain the causes or nature of a condition does not prove that it is not an illness. There are many diseases in the history of medicine whose causes and nature were unknown for many years and some which are still unknown, but they are nevertheless unquestionably medical problems.[11]

In addition, federal law has now designated alcoholism a disease. The military services had difficulty getting around the problem of liability for disability compensation, but their definitions now include the disease concept. Navy definitions are now operative and are the only ones that govern and apply to the Navy's Alcohol Abuse Control Program (AACP). The Navy specifies its definitions in its new policy directive, OPNAV Instruction 6330.1 dated 29 May 1973, which is included as Appendix VII.

The need for operative definitions is obvious, but the terms should be used with the awareness that the condition of alcoholism is not always easily diagnosed or distinguished from other types of problem drinking. The Navy's definition of the problem drinker encompasses this awareness. However, even those cases diagnosed correctly still differ greatly from one

another and are likely to require different types of treatment and assistance.[12] With reference to pertinent definitions in either Chapter I or Appendix VII, some of the important causal theories of problem drinking can be reviewed.

APPENDIX IV

THEORIES OF CAUSES OF PROBLEM DRINKING

Many theorists have claimed that alcoholism is traceable to a specific cause and thousands of studies have been made on this subject by anthropologists, sociologists, physiologists, psychologists, and psychiatrists.[1] However, one of the findings of the Task Force formed by the Secretary of the Department of Health, Education, and Welfare to study and report the consequences of alcohol abuse was that the causal factors have not yet been established; that social, psychological, physiological, and cultural factors all play roles in the development and course of alcohol abuse and alcoholism; and that the full understanding and the interrelationships of these factors needs further study.[2]

The search for a single cause of alcoholism has shifted to interdisciplinary exploration of factors that might account for the development of problem drinking in various types of individuals.[3] Theories include difficulty in managing personal anxieties or tensions, although this characteristic is naturally not limited to problem drinkers. Social processes appear to play a significant role in stimulating excessive drinking, in fostering its non-recognition, or in keeping it under control. Changes in metabolic processes may also influence drinking behavior.[4]

Physiological Factors

Much research effort has been devoted to trying to find a physiological basis, either in alcohol itself, or in the biological makeup of those who drink, which could account for alcoholic drinking and addiction. As yet, these attempts have not succeeded.

Because of the high rate of alcoholism in children of alcoholics (52 %) some hereditary basis is thought to be valid.[5] Yet alcoholism also occurs in the children of total abstainers and in children of alcoholics who are reared away from their parents.

Theories regarding vitamin deficiences and hormone imbalances have also been advanced to explain the causes of alcoholism. However, most of these deficiencies seen in individuals with advanced alcoholism appear to be results, rather than causes, of excessive drinking.[6]

The present state of knowledge has been summed up by the NIAAA:

> The nature of the addictive process, the developmental sequence of events and the central nervous system alterations which define the condition of alcohol addiction are unknown. Beyond the obvious requirement of ingestion of sufficient quantities of alcohol over a long enough period of time, the determinants of alcohol tolerance and dependence remain a matter of conjecture. The development of approaches to these very basic questions constitutes perhaps the major challenge to the biological scientist concerned with addiction.[7]

To date, it cannot be concluded that certain chemicals in specific beverages or physiological, nutritional, metabolic, or genetic defects can explain alcoholic drinking.

Psychological Factors

Psychological factors are of major importance in the development and persistence of alcoholism and other types of problem drinking. Clinicians frequently report that problem drinkers have an unusual amount of stress in their lives. It has been noted that alcoholic patients have often been unable to develop close and meaningful interpersonal relations. They also have difficulty in tolerating frustration and in controlling their impulses. These characteristics are, of course, not unique to problem drinkers, but are found among many persons, especially those with psychological difficulties. However, as stated by the Cooperative Commission on the Study of Alcoholism,

> The reliance on drinking as a means of dealing with personal tensions and discomfort points to the possible key role of psychological factors in the development of the drinking problem. Furthermore, the apparent relationship between emotional crises and changes in drinking patterns suggests that psychological elements play an important role in problem drinking. Thus, while the psychological characteristics that differentiate problem drinkers from persons with other kinds of behavioral problems have not yet been ascertained, many experts do agree that psychological factors are important to the

development and persistence of problem drinking, and even that individuals with certain personality traits are more likely to become dependent on alcohol than others.[8]

Predisposition to Alcohol Problems

Research has also tried to identify pre-alcoholic characteristics. The basic hypothesis is that in the pre-alcoholic stage a personality pattern or constellation of characteristics should be discernible and should correlate with a predisposition toward alcoholism. However, a basic flaw in this approach is that the subjects usually studied are already alcoholics. The question is whether the personality traits observed in these people predate the onset of the alcoholism, or are a consequence of alcoholism. However, the unique and valuable study by the McCords[9] began with a large (255) group of non-alcoholic boys observed in the 1930's and traced them to adulthood, rather than reconstructing backgrounds of identified alcoholics. Some of the boys grew up to be criminals, some alcoholics, and some never came into conflict with the mores of society. The McCords compared the minority who became alcoholics with the majority who had not been defined by their community as "deviants."[10]

In one of their many findings, the McCords identified four types of families which produced only alcoholic sons and stated that, "if a prediction had been made that all,

and only, those boys raised in one of these four types of family environments would become alcoholics prior to middle age, this prediction would have been 93 percent accurate."[11]

Although the McCords admit their theory is necessarily a speculative one, their findings suggest that "predisposition" to alcoholism is established early in life, through a person's intimate experiences with his family. These early influences, particularly in a culture that sets a premium on masculine independence, contribute to alcoholism by heightening dependency conflict and by creating a confused self-image.[12]

Sociological Factors

A highly promising avenue in the study of the causes of problem drinking has been the comparison of drinking practices and alcohol problems within and among various cultures and societies. This basically social and anthropological approach draws also upon physiology, psychology, nutrition, and epidemiology. Its objective is to discover why alcoholism is widespread in some national, religious, and cultural groups, but rare in others.[13]

Alcoholism is a democratic disease found in the ghetto and the suburbs, among all occupational groups, and in virtually all religious denominations in American society. However, there are variations in rates of problem drinkers in different areas of the country, and among different religious and ethnic groups.

Substantial differences in rates of problem drinking have been noted in different cultural groups. The differences reported are so striking and consistent that they cannot be disregarded. Again, the Cooperative Commission reports:

> In the United States higher rates of problem drinking are found among persons from Irish and Anglo-Saxon backgrounds than among those of Italian, Chinese, or Jewish backgrounds. It is of interest to note that in the first two groups the ways of teaching youngsters the "rights" and "wrongs" of drinking are far less clearly defined than in the other groups. In traditional Italian-American, Chinese-American, and Jewish families, much clearer distinctions are usually made between drinking that is not acceptable and drinking that is; there is rather consistent disapproval of drunkenness. In addition, these groups generally introduce young people to alcoholic beverages in the home in a relatively routine and unemotional manner. The relationship between differences in attitude toward normal drinking and different rates of problem drinking strongly suggests that the nature of drinking patterns (and associated attitudes) can influence the extent of problem drinking in a cultural group.[14]

However, only a small minority of drinkers, even among those of Anglo-Saxon or Irish-American extract, develop drinking problems. It is evident that factors other than cultural background are involved. Also, even though relatively small in proportion, there are problem drinkers among Jews, Chinese, and Italian-Americans.

Generally, research has shown that for groups that use alcohol, the lowest incidence of alcoholism is associated

with certain habits and attitudes. These are summarized by the NIAAA in their report, Alcohol and Alcoholism:

> 1. The children are exposed to alcohol early in life, within a strong family or religious group. Whatever the beverage, it it served in very diluted and small quantities, with consequent low blood-alcohol levels.
>
> 2. The beverages commonly although not invariable used by the groups are thosecontaining relatively large amounts of nonalcoholic components, which also give low blood-alcohol levels.
>
> 3. The beverage is considered mainly as a food and usually consumed with meals, again with consequent low blood-alcohol levels.
>
> 4. Parents present a constant example of moderate drinking.
>
> 5. No moral importance is attached to drinking. It is considered neither a virtue nor a sin.
>
> 6. Drinking is not viewed as proof of adulthood or virility.
>
> 7. Abstinence is socially acceptable. It is no more rude or ungracious to decline a drink than to decline a piece of bread.
>
> 8. Excessive drinking or intoxication is not socially acceptable. It is not considered stylish, comic, or tolerable.
>
> 9. Finally, and perhaps most important, there is wide and usually complete agreement among members of the group on what might be called the "ground rules of drinking."[15]

Thus, there is ample evidence that an individual's drinking habits are to a large extent a product of social learning or internalization of group norms and pressures. According

to Jellinek, where heavy drinking is normative behavior there is a greater likelihood of a vulnerable person's adopting this pattern and so exposing himself to the risk of addiction.[16]

Model of Causes of Alcoholism

The interrelatedness of the various causal theories on alcohol problems may best be seen through the use of models. The Cooperative Commission on Alcoholism suggests a tentative model for understanding the causes of problem drinking, even though the precise roles of the various factors have not yet been determined:

> An individual who (1) responds to beverage alcohol in a certain way, perhaps physiologically determined, by experiencing intense relief and relaxation, and who (2) has certain personality characteristics, such as difficulty in dealing with and overcoming depression, frustration, and anxiety, and who (3) is a member of a culture in which there is both pressure to drink and culturally induced built-in confusion regarding what kinds of drinking behavior are appropriate, is more likely to develop trouble than will most other persons. An intermingling of certain factors may be necessary for the development of problem drinking, and the relative importance of the different causal factors no doubt varies from one individual to another.[17]

In summary, alcoholism generally can be considered a "disease" which involves:

(1) a multiplicity of causal factors;

(2) the probable existence of many different courses

of development (rather than a single course of development); and

(3) the need for a variety of treatment and preventive approaches.[18]

APPENDIX V

IDENTIFICATION OF PROBLEM DRINKERS

The diagnosis of alcoholism as an addictive disease is often made only when the illness is in its advanced stages--that is, when the victim is completely unable to control his drinking. He or she may no longer have an established family life or be able to hold a job, or malnutrition, cirrhosis of the liver, or other tissue damage may already be present.[1] One major reason for this is that persons with alcohol problems rarely admit, even to themselves, that they have a drinking problem. Denial is a key characteristic in the behavior of individuals with alcohol problems.

To overcome this major obstacle in programs to control and reduce the incidence of alcohol abuse and alcoholism among the nation's work force, job performance is used as a key element in the identification process. With a proper alcohol abuse control program in effect, employees whose job performance is suffering because of an alcohol problem can be skillfully confronted by a superior and referred for proper counseling and treatment, if warranted and acceptable to the employee. Leading business programs report an approximate 70 percent success rate in returning rehabilitated employees to their jobs.

However, business and governmental alcoholism programs do not have certain advantages that are inherent in a military service program. Ordinarily, a business or government employee with an alcohol problem, unless he or she voluntarily seeks help, will not be confronted with his problem unless it interferes in some way with job performance. It is only then that these types of organizations will confront an employee. The U.S. Navy's program also relies heavily on job performance as an indicator of an individual's possible alcohol problem, but in addition to this the Navy has established a referral network of much greater scope and depth than any this author has examined--which has been a considerable number of leading, model-type programs. This referral network utilizes the existing agencies and command structures in the naval shore establishment, the fleet, and civilian organizations as well. It ties into resources such as the chaplain corps, medical corps, shore patrol, local military and civilian police, the Navy Safety Center, and the local AA, to name a few. In addition, the referral network is used for purposes other than counseling troubled individuals and possible referral of identified problem drinkers for medical diagnosis. These functions include education and preventive measures and administrative duties in the Navy's AACP. Thus, it can be seen that identification of problem drinkers in the Navy extends well beyond the scope of job performance alone.

Many company programs seem to be oriented toward identifying the laborer or wage-earning employee rather than managers and executives. This was a complaint of some labor union representatives at a recent State-sponsored labor-management seminar on occupational alcoholism programs.[2] Indeed, upon examination of some company programs and policies, the responsibility of identification and confrontation of possible problem drinking "employees" is laid directly on supervisors and managers. The Consolidated Edison Company of New York, Inc., has had an alcoholism program since 1947 and is considered a leader among the business community in alcoholism programs. Yet, Consolidated Edison's policy specifically states that the foreman or supervisor has responsibility for identification of employee problem drinking.[3] Nowhere in these programs is it mentioned what should or can be done about supervisors, middle managers or executives with possible drinking problems. The New York Transit Authority's highly successful program has rehabilitated over 4500 employees in 17 years, but according to its program director, Mr. Joe Warren, only one company executive that he knows of has been processed in the program.[4]

The statistics do not hold up the illusion that the percentage of problem drinkers among middle- and upper-level employees is significantly lower than in the worker-laborer level. According to the NCA, 45 percent of alcoholics in

business and industry are at the professional or managerial level, where this type of alcoholism is largely unrecognized. The stigma is evidently greater at those levels.

Business and industry have found the alcoholic executive a particularly expensive burden to bear. Training is costly, salaries are high, responsibilities are vital, and replacement expensive. The disease of alcoholism usually hits executives in prime working years between ages 35 and 50.[5] While progressive absenteeism is one of the early signs of alcoholism among hourly workers, it is usually not among executives. There is greater on-the-job absenteeism among alcoholic executives. These "high-priced, half men" tend to be away from their offices frequently at "meetings" and "appointments." To compensate for lost time, they throw all their creative abilities into a flurry of work, producing more in an hour than most people do in a day.[6] The typical alcoholic executive is so adept at concealing his problem that it is usually only when he is unable to function properly that his drinking problem is identified. However, according to Dr. Gordon Kemmet of Eastman Kodak, when the effect of Kodak's program finally reached the higher organizational levels, several of Kodak's upper echelon executives were successfully treated and returned to their jobs. This gave the program an enormous shot-in-the-arm.[7]

A double standard in the identification process with regard to alcohol-troubled officer and enlisted personnel does not exist in the Navy's AACP written policies. Nor does the Navy appear to disregard or hide statistics on their officer (managers and executives) problem drinkers. Quite the opposite. Yet, there is ample evidence of the effects of stigma on the officer ranks in the Navy.

Nevertheless, the stigma associated with alcohol problems usually tends to inhibit only voluntary requests for counseling and/or treatment. Although voluntary action by troubled individuals is preferred to involuntary referral, the Navy's program for identification and referral provide a wide range of methods to attain the desired goal. This goal, in any alcohol abuse control program, is to reach troubled individuals who are abusing alcohol as early as possible in order that the condition can be prohibited from fully developing into alcoholism.

In summary, identification of problem drinkers is an element of both secondary and tertiary prevention. There are difficulties in getting a problem drinker to accept help or getting a problem drinker into a counseling, referral and treatment process.

An individual's characteristic denial of his alcohol problem and the societal stigma associated with such problems are the major obstacles in the identification process. In

business, industrial and governmental programs, this identification process is based almost solely on job performance.

The U.S. Navy's identification and referral program, although utilizing job performance as one method also, is much more extensive and thorough than non-military programs. The Navy has an advantage over civilian organizations due to its existing command and organizational structure. This extensive resource includes, for purposes of identification and referral of alcohol abusers, commands and agencies such as the chaplain corps, medical corps, investigative service, shore patrol, local military police, and the Naval Safety Center.

The Navy, as well as business and industry, has difficulty in identifying its "high-priced, half men"-- executives and managers with alcohol problems. But the Navy's AACP policies and organization for identification and referral provide numerous methods and opportunities for meeting its objective with its alcohol-troubled members at all levels and ranks. (Chapter IV) This objective is to intervene as early as possible where an individual is abusing alcohol to prohibit further development of his or her alcohol problem.

APPENDIX VI

TREATMENT AND REHABILITATION

Alcoholism is a treatable disease. A person with a drinking problem can be helped at any stage as long as treatment and rehabilitation resources are available, and the stigma of having an alcohol problem is not allowed to interfere. Moreover, such resources are now available in the U.S. Navy, as well as in business, industry and government. Unfortunately, the stigma still tends to inhibit a person's voluntary decision to seek help. Many people in our society still think of alcoholism as a form of moral weakness, rather than as an illness--an attitude which encourages individuals with drinking problems and their families to hide, rather than admit, their problems and seek treatment.[1] Slowly, however, this attitude is being changed through educational efforts.

Help for the problem drinker can be provided by a doctor, a clergyman, a local welfare agency, a clinic, a social worker, psychologist or psychiatrist, a general hospital or psychiatric hospital, or the local chapter of Alcoholics Anonymous. Many large business or industrial firms and labor unions also have programs to help their alcoholic employees and members find treatment and rehabilitation.

AA is probably the best known and most successful single program offering help to people with drinking problems. AA is a group in which members help themselves

and one another in a type of group therapy setting based on mutual experience for mutual support.[2]

Many other community and social agencies offer referral services or direct help. Local affiliates of the National Council on Alcoholism exist in many communities, and most States and many communities have official alcoholism programs where help can be found or sources of treatment recommended.[3]

No one particular type of therapist--physician, clergyman, AA member, psychologist, or social worker--will have better results than another. The chances for a successful recovery apparently depend more on the motivation of the patient. Different patients respond to different treatments. The earlier the treatment is begun, the better the chances for success, although some patients have been treated successfully after many years of excessive drinking.[4]

The system through which persons with alcohol problems receive help has been a random one. However, the situation is improving at the local, state, and especially the national level to provide a more coordinated system.[5] For example, at the State level, for a State to receive its share of grants provided by PL 91-616, the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970," it is required to develop a comprehensive alcoholism plan. The NIAAA, also established by the Act of 1970, has been encouraging States to adopt a Uniform Alcoholism and

Intoxication Treatment Act. The general thrust of State legislation has reflected a movement toward reform since 1966, and it has been reinforced by the Act of 1970. Some of the leading States in alcohol reform legislation and progressive programs have been North Carolina, Hawaii, Maryland, North Dakota, Connecticut, Florida, and Massachusetts, as well as the District of Columbia.[6]

The $10 to $12 billion bill paid each year by business, industry, and government as a result of lost time, medical expenses, poor job efficiency, and accidents due to alcohol-troubled employees is now recognized as too high a price to pay.[7] A conservative estimate places 240,000 of these employees with the U.S. Government,[8] the U.S. Navy having over one-eighth of these in its ranks.

Over 500 corporations today have personnel policies and alcoholism programs consonant with the view that alcoholism is a treatable illness. Generally, this approach calls for helping an alcohol-troubled employee locate resources for help, rather than ignoring his needs and worth, and firing him. Overall average results are heartening. Some of the leaders in the business segment of our society are Eastman Kodak, Dupont, Consolidated Edison of New York, the New York Transit Authority, and Allis Chalmers. Most such companies report large savings in money in conjunction with 60 to 80 percent effectiveness rates in their rehabilitation programs.[9]

The New York Transit Authority, for example, has had an excellent program in effect for 17 years and realizes a savings of over $1 million yearly in sick pay alone.[10]

The primary goal of treatment is to help the drinker alter his drinking pattern and handle his problems without resorting to irresponsible use of alcohol, and to develop a new life-style not revolving around the use of alcohol. For the individual addicted to alcohol, recovery is best maintained by total abstention.[11]

The Navy utilizes many of the same helping resources and techniques mentioned above, as well as much of their own resources and innovations in their relatively new program.

In summary, the primary goal of treatment is to help the problem drinker change his drinking pattern and life-style in order that he may handle his problems without resorting to alcohol abuse. Many sources of help are available and chances for successful recovery are excellent.

APPENDIX VII

DEPARTMENT OF THE NAVY
Office of the Chief of Naval Operations
Washington, D.C. 20350

OPNAVINST 6330.1
Pers-PcG-KWA-mb
29 May 1973

OPNAV INSTRUCTION 6330.1

From: Chief of Naval Operations
To: All Ships and Stations (less Marine Corps field addressees not having Navy personnel attached)

Subj: Alcohol abuse and alcoholism among Navy personnel

Ref: (a) SECNAVINST 5300.20 of 18 May 1972, Alcohol abuse and alcoholism among military and civilian personnel of the Department of the Navy (NOTAL)

Encl: (1) Definitions
(2) Policy Implementation
(3) Alcohol Abuse Control Program Implementation Guidelines for All Ships and Stations
(4) Alcohol Abuse Control Program Implementation Guidelines for Specific Commands

1. Purpose. To promulgate the policies established by reference (a) relative to alcoholism and alcohol abuse among naval personnel; to assign responsibility, and to provide guidelines for implementing these policies. This instruction incorporates all provisions of NAVOP-Z115 (CNO MSG 011400Z AUG 72).

2. Definitions. Terms used in this instruction are defined in enclosure (1).

3. Background

a. Scope of the Problem. An initial BUPERS-sponsored survey of active duty personnel shows a need for concern over the relatively large percentage of officers and enlisted members who have experienced unfavorable social consequences, behavior problems, impaired performance of duty, damage to health, injury, or financial and family problems related to drinking. These habitual alcohol abusers may be alcoholics, or potential alcoholics. Alcohol abuse and alcoholism to any degree constitutes an unacceptable loss to the Navy in training investment and operational efficiency and a high cost in resources and human suffering.

b. Solutions. Post-treatment studies in connection with Navy Alcohol Rehabilitation Centers show that about two-thirds of the men and women treated are being effectively restored to duty. Successful local programs have been initiated by several commands, utilizing medical, chaplain, and recovered alcoholic personnel on board to assist in early identification of alcohol abusers and alcoholics, to conduct preventive education programs, to rehabilitate many less difficult cases, and to help members treated at rehabilitation facilities maintain sobriety and good performance after their return to duty stations.

4. Policy Implementation. Paragraph 5 of reference (a) is reproduced and attached herewith as enclosure (2) in order to insure the widest possible distribution of this very important policy statement. The CNO subscribes completely to that policy and directs that the following additional considerations be carefully adhered to in its implementation:

a. Alcoholism is an illness for treatment and rehabilitation purposes.

b. Alcoholism is not compensable for disability purposes.

c. While the basic individual responsibility for prevention and treatment is recognized, commands are responsible for identifying alcoholics and ordering them into rehabilitation whether or not they first seek or volunteer for treatment. See enclosure (3), subparagraph 3a.

d. While responsibility for success or failure of rehabilitation after treatment lies with the individual, commands can provide invaluable assistance to the rehabilitee by providing him firm, understanding support in the actions necessary to the maintenance of sobriety.

e. Commands must make every effort to confront and eliminate the stigma which has long been associated with alcoholism.

5. **Action.** It is the responsibility of personnel at all levels of command and supervision to adhere to these policies and to the appropriate guidance provided in enclosures (3) and (4). Enclosure (3) lists responsibilities of all Navy commanders and enclosure (4) lists responsibilities of the following addressees: Chairman, Drug and Alcohol Abuse Advisory Council; Chief of Naval Personnel; Chief, Bureau of Medicine and Surgery; Judge Advocate General; Chief of Information; Director, Naval Investigative Service; Commander, Navy Recruiting Command; Chief of Chaplains; Chief of Naval Training; and Commander, Naval Safety Center.

6. **Reports.** Report symbol OPNAV 6330-2 and OPNAV 6330-3 are assigned the reporting requirements set forth in paragraphs 6 and 10, respectively, of enclosure (4).

M. F. WEISNER
Vice Chief of Naval Operations

Distribution:
SNDL Parts 1 and 2

Stocked:
COMNAVDIST WASH DC
(Supply & Fiscal Dept.—Code 514.3)
Wash. Navy Yard
Wash., DC 20374

DEFINITIONS

1. The following definitions are intended solely for the administration of the programs set forth in this instruction. They are not intended to modify or influence definitions applicable to statutory provisions and regulations which relate to determinations of misconduct and line of duty, military disability benefits, and criminal or civil responsibility for a person's acts or omissions.

a. Alcoholism. A nonratable disease characterized by psychological and/or physical dependency on alcohol.

b. Alcoholic (Alcohol Dependent). A general reference to an individual who suffers from alcoholism, as defined above.

c. 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.

d. Alcohol Addiction. A physiological condition in which there usually is a marked change in tolerance to alcohol, and consumption of alcohol is necessary for the prevention of withdrawal symptoms.

e. Detoxification. The process of establishing physiological equilibrium to include the elimination of alcohol from the body. Elimination of alcohol occurs by means of natural metabolic processes, to include excretion, and normally occurs within 6 to 24 hours from cessation of drinking in otherwise healthy individuals. Establishment of physiological equilibrium is a slower process, and may require medical support to prevent the occurrence of severe withdrawal symptoms. Detoxification is the first step in the treatment process.

f. Intoxication. A state of impaired mental and/or physical functioning, resulting from the presence of alcohol in a person's body. This condition does not necessarily indicate alcoholism as defined herein, nor does the absence of observable intoxication necessarily exclude the possibility of alcoholism.

g. Problem Drinker (Habitual Alcohol Abuser). A person who may or may not be an alcoholic, but whose use of alcohol conforms to the definition of alcohol abuse herein.

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

i. Withdrawal Syndrome. A complication of detoxification in alcohol addiction which is a potentially serious condition. It includes intense anxiety, and degrees of mental and physical impairment, and may progress from tremors and convulsions through hallucinations and delirium to death. Recovery from the acute phase usually occurs 2 to 5 days after the onset.

j. Effective Restoration to Duty. An objective evaluation after treatment wherein the alcoholic or alcohol abuser is found to have demonstrated overall work performance and conduct equal to, or better than, the minimum standards required of all members of equivalent rank or rate for retention in the naval service. Primary indicators are the commanding officer's recommendation for retention, reenlistment or promotion; satisfactory fitness reports or performance evaluations; and the absence of serious disciplinary or medical problems.

Policy

a. The Department of the Navy recognizes that the disease, illness, or condition known as alcoholism is preventable and treatable, and requires the application of enlightened attitudes and techniques by command, supervisory, and health service personnel. Prevention is the responsibility of the individual. Enlightened policies toward alcoholism can assist individuals in recognizing and accepting their personal responsibility for its prevention. The individual also bears primary responsibility for obtaining treatment. Nevertheless, the Department will undertake to identify and treat such individuals whether they first seek treatment or not. When not treated, alcoholism can lead to complications, e. g., alcohol addiction, withdrawal syndrome, psychiatric illnesses, and various organic illnesses. An alcoholic is not to be considered physically unfit for military service or employment on the basis of h[illegible]lcoholism, because it can be arrested. However, an individual must act[illegible]ly seek and cooperate in treatment or rehabilitation efforts or he may be determined to be unsuitable for further military service or employment and may be separated.

b. The Department of the Navy's policies related to standards of behavior, performance, and discipline must be firmly maintained and affirmed. These standards, however, will be applied to the individual's demonstrated conduct rather than to his use or abuse of alcohol. Alcoholism, in itself, should not be considered as grounds for disciplinary action. However, an individual's demonstrated conduct resulting from his use or abuse of alcohol should be evaluated and necessary disciplinary or administrative action taken as required. Consideration should be given to the judicious use of suspended punishment to channel an alcoholic into an effective treatment program. Appropriate action in cases of breaches of discipline involving alcohol abuse will be dependent upon all the facts and circumstances of each case.

c. The Department of the Navy recognizes that society has often associated a stigma with alcoholism which has little basis in fact and which is counterproductive to successful rehabilitation. The effects of this stigma have served to reinforce the alcoholic's or alcohol abuser's denial of his problem and to encourage supervisory and medical personnel to cover up in an attempt to protect the individual's career. In order to bring the alcohol problem out into the open where it can be treated, stigmatic effects must be reduced to the minimum. Accordingly, continued service, job security, or promotion opportunity will not be denied solely on the basis of prior alcoholism or alcohol abuse, provided that the individual has participated in his successful treatment and recovery. Notwithstanding the

above, any misconduct, misbehavior, or reduction in performance resulting from alcoholism or alcohol abuse must necessarily be considered in performance evaluations, duty assignments, continued service, job security, and promotion opportunity.

d. The Department of the Navy recognizes that alcohol abuse and alcoholism integrally involve the family of the abuser and the alcoholic; and that the recovery process is generally faster and stronger when the family can participate. Within the resources available, rehabilitation programs should be designed to accomplish this end.

e. It is the private decision of an individual to use or not to use alcoholic beverages lawfully unless his use of alcohol interferes with the efficient and safe performance of his duties, reduces his dependability, or reflects discredit on the Department of the Navy. It is, however, Department policy to promote attitudes of responsibility with respect to alcohol in those persons who choose to drink, to promote the social acceptability of an individual's decision not to drink, and to provide both drinkers and nondrinkers with realistic information on alcohol and alcoholism.

f. The Department of the Navy has a particular responsibility for counseling and protecting its members against alcohol abuse, preventing and deterring alcohol abuse, and for attempting to restore and rehabilitate military and civilian personnel who abuse alcohol or who are alcoholics.

g. It will be the responsibility of personnel at all levels of command and supervision to adhere to these policies and to the specific guidance provided in enclosures (2) and (3) of SECNAVINST 5300.20.

ALCOHOL ABUSE CONTROL PROGRAM IMPLEMENTATION GUIDELINES FOR ALL SHIPS AND STATIONS

1. Scope

a. Navy commanders are tasked to carry out those program aspects best accomplished at the local level. Alcohol abuse often leads to alcoholism and, when not treated, can lead to serious complications--e.g., addiction, withdrawal syndrome, psychiatric and organic illnesses, and untimely death by accident, suicide, or disease. Each command has a particular responsibility for counseling and protecting its members against alcohol abuse, for preventing and deterring alcohol abuse, and for identifying and attempting to restore and rehabilitate personnel who abuse alcohol or who are alcoholics.

b. Concerted command effort will repay all of the resources and time expended on an alcohol program, and will show a long-term "profit" through improved operations, total productive man hours available, lower recruiting and training costs, and maintenance of quality in an All Volunteer Navy. Reduction of human suffering, happier Navy families, and increased morale are also important benefits. Although an increasing alcohol problem is noted among younger members, a majority of patients being treated at rehab centers are highly qualified career navymen with an average of 10 years' service. The following guidance will assist commands in establishing simple but effective programs to achieve these goals.

2. Education and Prevention

a. Although prevention of alcoholism is the individual's personal responsibility, commands shall establish educational programs to provide information to all hands about the responsible use of alcohol, and the dangers of alcohol abuse which can lead to alcoholism. Films (MN 11046F and MN 11288) and printed materials have been distributed for this purpose; medical officers may be called upon for group lectures; and specialists are available to assist commands through Human Resource Development Centers (HRDC) at Newport, RI; Norfolk, VA; San Diego, CA; and Pearl Harbor, HI. Additionally, more than 700 active duty navymen now comprise the BUPERS referral network of recovered alcoholics who have volunteered to help their commands in connection with preventive education, identification, and alcohol counseling needs. Those who have completed special training are being designated to their commanding officers as qualified for collateral duty alcohol counselor (CODAC) and assigned Navy Enlisted Classification 9521. A half-day education package to be presented for commands by teams of drug abuse

education specialists and selected CODACs can be scheduled through the nearest HRDC. Additional resources and training aids shall be provided as they become available.

b. Commands are responsible for implementing remedial education programs to correct the excessive drinking habits of members identified as alcohol abusers. Some of these individuals may be potential or early stage alcoholics whose illness has not yet progressed to the point of clearly diagnosable alcoholism. In many cases, the illness may require 5 to 15 or more years of drinking to develop readily identifiable symptoms other than periodic alcohol abuse. Consequently, remedial education must be specific and address the problem cases at hand, whereas all hands education programs are general and informational in character. For example, therapeutic counseling is one essential component of the remedial effort required to help a given individual. Local command resources should be utilized, including the doctor, chaplain, and collateral duty alcohol counselor (CODAC), if available. Additional guidance and consulting assistance can be obtained through the nearest Human Resource Development Center (HRDC).

c. To minimize the incidence of alcoholism, commands should make every effort to eliminate institutional practices which may almost subliminally encourage personnel to drink through peer pressure or outmoded customs. It is often expected, under present customs and beliefs that, to be a "real Navyman," one must join in drinking excessive quantities of alcohol as a badge of courage, a mark of respect, or a symbol of adulthood and virility. On the contrary, an increasing tolerance for alcohol in large amounts is a positive symptom of alcoholism. Consequently, moderation should be emphasized at ship's parties and picnics, happy hours, "wetting down" and advancement celebrations, initiations, hail and farewell parties, graduations, beach parties, etc. Educational programs, as well as leadership and example set by officers and petty officers, are essential to changing attitudes in this regard. Additionally, recovered alcoholics and others who choose to abstain from drinking should be encouraged to attend and participate in traditional Navy functions, which in themselves are a welcome part of Navy life, and nonalcoholic beverages should be made available.

d. Commands shall, to the extent practicable, encourage social activities and greater use of recreational facilities at overseas and isolated bases which are not alcohol-oriented. Recent studies show that a significantly higher incidence of excessive alcohol a[illegible] and potential alcoholism is found among personnel who do not utiliz[illegible] outlets for recreation and entertainment other than base clubs, which center primarily, or exclusively, around the liquor bar. Both

innovation and salesmanship can help prevent alcoholism by promoting use of hobby shops, game rooms, libraries, facilities and equipment for both day and night time sporting events, better movies (changed more frequently), educational courses, and clubs that are not oriented toward alcohol consumption.

e. Essential to all education and prevention efforts is an effective information program. A primary goal is to eliminate the stigma previously associated with alcoholism by explaining the nature of this treatable illness. Publicity should be directed to changing attitudes toward drinking, and presenting the factual reasons why a good alcohol abuse control program can minimize alcohol abuse and alcoholism. The plan of the day, ships paper, local area news media, posters, and other available means should be utilized to reach all hands and their dependents. Simple statements of policy are not enough; the reasons behind the policies must be brought out.

3. Identification and Referral. To facilitate the identification and the screening process, commands should:

a. Acquaint supervisory personnel with the symptoms of alcoholism and alcohol dependence so they can recognize those in need of medical referral. They must use discretion, because many abusers are not alcoholics. Medical officers can be helpful in teaching supervisors by providing layman's explanations of symptoms covered in Department of the Navy Publication NAVMED P-5116, Section VII and Appendix E.

b. Require all medical officers in the command to familiarize themselves with the "Criteria for Diagnosis of Alcoholism" (NAVMED P-5116, Appendix E) and other pertinent references and BUMED guidance.

c. Educate all personnel about alcoholism to enable, where possible, self-identification and voluntary requests for treatment.

d. Cooperate with the Commander, Naval Safety Center, in the establishment of Alcohol Safety Action Programs (ASAP) for execution at the local level, to identify drunk drivers and other members involved in alcohol related traffic accidents, violations, etc., in order that they may be adequately counseled and, where necessary, treated.

e. Cooperate with local shore patrol, and military and civilian police in identifying members reported for other infractions of the law involving alcohol, such as drunk in public, drunk and disorderly, altercations and family quarrels where the member is drunk, etc., in order that they may be adequately counseled and, where necessary, treated.

f. Make clear entries in officer and enlisted service records, stating the nature and extent of alcohol involvement in all disciplinary cases brought to official attention for any reason whatever. This is essential, because frequency and degree of alcohol abuse is a primary means for doctors to differentiate between occasional abusers and those members suffering from alcoholism who must be sent to a treatment facility.

g. Document uneven or continuously unsatisfactory performance on the part of a member resulting from alcohol abuse.

h. Refer all apparent alcoholism or alcohol abuse problems to the medical officer for prompt evaluation in order to separate simple abusers, who need remedial education, from alcohol dependent individuals needing therapeutic counseling and/or treatment at an alcohol rehabilitation facility. Medical officers shall be required to review all available data, record abstracts, medical history and other available records in making diagnoses of individuals referred for suspected alcoholism. Commands having custody of such records are required to make them available to the examining physician for his review at the time of examination.

i. Require members who are found to be alcohol abusers (but who are not diagnosed as alcoholics) to attend remedial preventive education classes, and carry out such disciplinary and/or administrative actions, if any, as the case warrants.

j. In all cases where alcoholism is diagnosed, follow the guidelines provided in paragraph 4 below. If disciplinary action is pending, it should be resolved prior to transfer. After candidly presenting the officer or enlisted member with factual evidence of his drinking problem, commands should consider the judicious use of suspended punishment to channel the individual into an effective alcohol education or treatment program. Punishing an offender without ensuring proper education or treatment, as well as excusing him because of overindulgence, are both ineffective courses of action in most cases of habitual alcohol abuse. A pending threat of disciplinary action, which can only be set aside by the individual's demonstrated motivation during treatment and satisfactory performance after return to duty, can be beneficial in achieving long term rehabilitation. For example, reducing a man in rating before treatment gives him a feeling of hopelessness and an excuse to drink again because he has "already lost it"--whereas a suspended sentence often provides motivation for abstinence while treatment takes effect.

4. Transfer for Treatment. It is a command responsibility to present officer and enlisted personnel with evidence of problem drinking, to identify those having an alcohol problem, to refer them for medical diagnostic evaluation, and to order them into treatment if prescribed--whether or not they first seek or volunteer for treatment.

a. Although serious cases will normally be transferred to a treatment facility, much can be done for habitual abusers and early stage alcoholics at the local level with available resources. When needed, detoxification can be accomplished at the nearest naval hospital or dispensary. Recovered alcoholics in the BUPERS referral network have volunteered to assist their commands during off duty hours. They have developed special expertise in the rehabilitation techniques of Alcoholics Anonymous (A.A.), and many are being given additional paraprofessional training as collateral duty alcohol counselors (CODAC). Commands, using the resources of the CODAC, doctor, chaplain and/or other interested individuals, can establish a local rehabilitation effort to include individual and family counseling, alcohol education, and A.A. group support. Positive command attitude, directional authority and support are essential to success at the local level. Except for isolated bases and units deployed at sea, community alcoholism services (such as Alanon, Al-Ateen, etc.) are also usually available at little or no cost.

b. Special short courses and seminars for doctors, nurses and chaplains are available for these personnel while in CONUS; TAD and travel are funded by BUPERS on request. Consulting services to help commands establish local alcohol programs are obtainable from Human Resource Development Centers.

c. Alcohol abuse and alcoholism integrally involve the family of the abuser and the alcoholic, and the recovery process is generally faster and stronger when the family can participate. Within the resources available, commands shall establish local referral and rehabilitation programs designed to accomplish this end. Dependents of active duty and retired personnel who are suffering from alcoholism are eligible for treatment under CHAMPUS at civilian facilities.

d. Where local command programs have not yet been established, or in cases where an individual's performance fails to improve sufficiently in local rehabilitation, refer the patient to an appropriate medical facility for subsequent transfer via medical channels to an Alcohol Rehabilitation Center (ARC) or Unit (ARU) is required. Procedures for authorized transfer of an individual member for hospitalization and/or rehabilitation at ARCs or ARUs are as follows:

(1) Commands shall contact the nearest military medical treatment facility which will coordinate the movement of the member to an ARC or ARU, as appropriate.

(2) The medical treatment facility shall provide detoxification and preliminary treatment if indicated.

(3) In cases where extended medical treatment is required prior to such assignment, the medical treatment facility shall report to the Chief, Armed Services Medical Regulating Office (CHASMRO) the date the patient is expected to be available. When detoxification and preliminary treatment are not required, the medical treatment facility shall report the member to CHASMRO for designation of an appropriate ARC or ARU.

(4) Commands shall retain individuals at their regularly assigned duty stations where hospitalization is not required while awaiting notification of availability of an ARC/ARU by CHASMRO. Whenever possible, commands should use such individuals productively in normal work assignments, and continue local rehabilitation efforts while awaiting disposition. Where ship movements dictate, the member's command will coordinate with the medical treatment facility and the nearest naval station for temporary arrangements to have the man available for transfer to an ARC/ARU on the date indicated by ASMRO.

(5) When the ARC/ARU designation is received from CHASMRO, the medical treatment facility shall notify the member's command to effect transfer of the member (TAD or TEMDU under treatment, whichever is applicable under current BUPERS and BUMED directives) from their command for movement of the individual in the aeromedical evacuation system, where applicable, for transfer to the designated ARC or ARU.

(6) Whenever practicable, the member shall be returned to his original duty station upon completion of rehabilitation, which will normally be within 45 to 60 days.

5. Follow-on and Disposition. Judicious follow-on practices and methods for handling individuals after treatment can do much toward getting individuals who have an alcohol problem to step forward at the outset and accept treatment without fear of damaging their reputations and careers. Such proper practices also make the task of sympathetic supervisors and doctors easier. In the past, they have been hesitant to recommend that an individual be treated for alcoholism because to do so could jeopardize a member's career

potential or retirement benefits. The following guidance addresses some of the important problem areas:

a. Alcoholic persons must be held accountable for their performance and behavior, even during the active phase of this illness. If, however, an individual has participated in his successful treatment and recovery, the fact that he has been diagnosed an alcoholic and treated for this illness will not be held against him in any way. This policy should be carefully applied in the following specific areas:

(1) Retention. Successfully recovered alcoholic members shall not be discharged or retire involuntarily by reason of their alcoholism, so long as they are otherwise eligible and qualified for duty.

(2) Job Specialty. Treated individuals shall be assigned in rate or specialty by cognizant detailers the same as other personnel, and commands will utilize them in billets appropriate to their capabilities, and as needed by the command.

(3) Hazardous Duty. Recovered alcoholics who have demonstrated their sobriety and are otherwise qualified for hazardous duty shall be utilized in the same way as other members having similar qualifications. For example, aircrew personnel and air controllers shall first be returned to a restricted flying status for a period of about 3 months and then, if they have maintained sobriety, they shall be returned to unrestricted flying (BUMEDINST 5300.4 of 1 Dec 72 applies).

(4) Security Clearances. During the period an individual is undergoing rehabilitation for alcohol abuse or alcoholism and during any period a "recovered alcoholic" is undergoing further observation and evaluation leading to possible "effective restoration to duty", as those terms are defined in enclosure (1), the security clearance of such an individual normally shall not be revoked. During such period(s), however, the individual shall be placed under such restriction with respect to assignment and access to classified information as is deemed necessary by the commanding officer to protect the interest of national security.

(5) Promotion. A record of treatment for prior alcohol abuse or alcoholism shall not in itself deny an individual the opportunity for advancement. Such members shall be evaluated on the basis of their qualifications and overall performance and conduct, the same as all other members.

b. Alcoholism and alcohol abuse are not in themselves offenses which constitute grounds for punishment. However, members who commit offenses while drinking are still responsible for their actions. They must accept the consequences for any misconduct or misbehavior, whether committed before or after they receive treatment. Judicious use of suspended punishment should be considered, whenever appropriate, in order to motivate an alcoholic into treatment.

c. Standards of performance shall also be maintained and applied uniformly to all personnel. An alcohol abuser or alcoholic who evidences substandard performance because of drinking shall have the facts entered in his record the same as any other poor performer. Consequently, his actual performance and conduct records shall play an important role in determining matters of retention, duty assignment, promotion, etc. The fact that an individual abuses alcohol or is an alcoholic does not in any way justify a lowering of standards. Therefore, it is of substantial advantage to the individual and the command to identify problem drinking in its early stages and take corrective action before the individual's performance and conduct record has degenerated to an unacceptable level.

d. Once an individual has been identified and treated for alcoholism, the responsibility for success or failure of rehabilitation lies with the individual. The command can do much, however, toward providing firm understanding support for the rehabilitee in maintaining his personal program of recovery. He should be accepted back into the command environment without stigma and be assigned meaningful duties commensurate with rank or rate. He should be made aware that he will be judged only on his performance and conduct in comparison with his peers. Because of the nature of the man's illness, a relapse involving return to drinking does not necessarily imply failure; so long as the individual's general performance and behavior show an upward trend, consideration should be given to a second treatment period. Any subsequent prolonged relapse or series of frequent relapses which do not yield to local counseling, coupled with an individual's substandard performance, or conduct, may be considered failure of rehabilitation and can result in administrative discharge by reason of unsuitability.

e. Where question exists as to proper disposition, the case should be submitted with all pertinent facts to CHNAVPERS for decision by the appropriate officer or enlisted review board.

ALCOHOL ABUSE CONTROL PROGRAM IMPLEMENTATION GUIDELINES FOR SPECIFIC COMMANDS

1. The Chairman, Drug and Alcohol Abuse Advisory Council, a responsibility assigned to the Chief of Naval Personnel, shall have cognizance over policy implementation, and shall coordinate all aspects of the Alcohol Abuse Control Program (AACP) assigned to the various headquarters bureaus and commands.

2. The Chief of Naval Personnel is specifically tasked to:

a. Continue the development, implementation and expansion of control program elements required to reduce the incidence of alcohol abuse and alcoholism among naval personnel.

b. Provide resources, including facilities, funding and manpower required to carry out the approved goals of the AACP.

c. Maintain the program director and necessary supporting staff under the command of the Project Manager, Human Resource Development Project Office, to supervise the day-to-day operational requirements of the AACP.

d. Provide specialized training, through inhouse and/or external facilities, for AACP headquarters and field administrative personnel, professional and paraprofessional therapists, collateral duty alcohol counselors assigned to naval commands, and such other personnel as may be determined to be necessary for program implementation.

e. Establish and operate as field commands the Alcohol Rehabilitation Centers (ARC) required to treat alcohol dependent members on active duty, and provide specialized training for staff personnel.

f. Coordinate with the Chief, Bureau of Medicine and Surgery, the necessary BUPERS support for alcohol rehabilitation units at naval hospitals, to include providing paraprofessional enlisted and civilian counselors; also, the funding of specialized training for medical personnel and the provision of selected items of equipment and materials needed in treatment of alcoholic patients.

g. Coordinate with the Chief of Naval Training the implementation of Navy-wide education and prevention programs to provide information about alcohol and the dangers of alcohol abuse which can lead to alcoholism.

h. Establish review boards empowered to consider officer and enlisted alcohol problem cases, to assist in identification of alcohol abusers, and to ensure proper and expeditious disposition of such cases.

i. Revise, as necessary, all pertinent BUPERS instructions, notices, manuals and other directives to reflect the policies and procedures set forth in this instruction. Additionally, promulgate new instructions as necessary to guide commands in handling problem cases and in implementing the alcohol abuse control program at local command levels. The following general guidelines shall govern case disposition:

(1) Every individual having recurring record entries concerning separate alcohol involved incidents shall be given a medical examination which includes specific consideration of alcoholism. If the member is diagnosed alcoholic by a medical officer, with or without other complications, he must be treated at a Navy alcohol rehabilitation facility before he is separated from the naval service.

(2) Refusal by an alcoholic to cooperate in his own rehabilitation while in a rehabilitation facility, or repeated relapses after treatment when coupled with substandard performance or conduct, shall constitute cause for administrative discharge. Alcohol abusers who are found not to be suffering from alcoholism shall be processed as appropriate under current instructions.

(3) All members of the Navy who have been diagnosed alcoholic, and who are subsequently administratively discharged under honorable conditions, shall be advised of their eligibility for continued treatment and referred to the Veterans Administration office or hospital nearest their intended residence at time of discharge.

j. Provide detailed instructions to officer and enlisted selection boards to guide them when considering records of alcohol abusers and recovered alcoholics. A record of treatment for prior alcohol abuse or alcoholism shall not in itself deny an individual the opportunity for advancement. It is a policy requirement that continued service in an individual's occupational specialty, security clearance, and promotion opportunity shall not be denied solely on the basis of prior alcoholism or alcohol abuse, provided that the individual has cooperated in his successful treatment and recovery.

k. Evaluate the overall alcohol program effectiveness, as well as the achievement of goals and milestones approved for its various elements, to include programs concerned with prevention, identification, treatment and proper disposition; also, implement changes required to meet the needs shown by such periodic evaluations.

l. Assign official members, as directed by the Secretary of the

Navy, to represent the Navy Department on the Department of Defense Task Group on Alcoholism.

3. The Chief, Bureau of Medicine and Surgery, is specifically tasked to:

a. Establish procedures for safe detoxification of alcohol dependent personnel at all Navy medical facilities; support Alcohol Rehabilitation Units (ARU) at major naval hospitals in CONUS and overseas, and expand the ARU concept into additional hospitals as the need may require.

b. Support the Alcohol Rehabilitation Centers, operated by CHNAVPERS, through assignment of appropriate medical staff personnel; encourage doctors and nurses to participate in and support local command rehabilitation programs.

c. Sponsor research programs aimed at improving methods for treatment and rehabilitation of alcoholics.

d. Provide guidance to the Physical Evaluation Board and other appropriate medical boards considering alcohol problem cases, and monitor such boards' actions to ensure proper disposition of patients; provide suitable representation on appropriate BUPERS boards, when requested.

e. Review and revise all applicable BUMED instructions, regulations and procedural guidances, and promulgate such new instructions and changes as may be required to conform with the policies set forth in this instruction.

f. Coordinate with CHNAVPERS the establishment of appropriate training programs in alcoholism and alcohol abuse for Medical Department personnel, and provide adequate criteria and guidance to enable prompt medical identification, diagnosis, referral, and administrative processing of alcohol abusers and alcoholics. This training and guidance shall be provided to ensure thorough familiarity of all medical personnel with the latest treatment techniques and diagnostic criteria, including symptom indicators reported in medical and personnel records.

g. Coordinate with CHNAVPERS the procedures and criteria for admission of patients to ARCs and ARUs, and promulgate such joint or separate instructions as necessary to implement these requirements.

h. Arrange through the BUMED representative to the Chief, Armed Services Medical Regulating Office, for the timely regulation of all alcoholic inpatients being referred for treatment at ARCs and ARUs, and provide for prompt reporting of statistics to CHNAVPERS.

4. The Judge Advocate General, in conjunction with CHNAVPERS, is specifically tasked to:

a. Ensure that all Judge Advocates are fully cognizant of the legal aspects of the policies and provisions set forth in this instruction, with particular emphasis on procedures to ensure identification and effective treatment vice ineffective punishment of alcoholics.

b. Recommend to the Drug and Alcohol Abuse Advisory Council changes to legislation and/or Navy instructions, and guidance as may be required from time to time to ensure achievement of AACP goals and conformance with the provisions of this instruction, Department of Defense directives and applicable Federal laws.

5. The Chief of Information, assisted by appropriate BUPERS and BUMED staff personnel, shall publicize and support the policies and procedures set forth in this instruction. Fundamental guidelines for public affairs efforts with regard to alcohol abuse and alcoholism should project the Navy image of responsibility in drinking habits vice prohibition, treatment vice punishment for individuals suffering from alcoholism, and freedom of choice vice obligation to drink. News releases, feature stories, films, interviews, etc., should be utilized to service all appropriate internal and external communications media in disseminating information which shall emphasize the need for the alcohol program effort, the dangers of alcohol abuse, and the personal and military justification for requiring responsible drinking habits. Other aspects which should be widely publicized include: the danger in attitudes which equate overindulgence with virility and sophistication; symptoms and means of detecting alcoholism; benefits of early treatment for alcoholism; the need for eradication of the stigma associated with alcoholism; acceptance of the recovered alcoholic in the Navy community; rehabilitation success stories attributable to participation in the alcohol abuse control program and other pertinent program objectives.

6. The Director, Naval Investigative Service, shall report to CHNAVPERS all cases coming to his attention where there is evidence of alcohol involvement in order to assist in the gathering of alcohol abuse incidence data, and in the early identification of alcohol abusers and alcoholics who are in need of remedial education and/or treatment.

7. The Commander, Navy Recruiting Command shall, to the extent practical, identify and screen out habitual problem drinkers and alcohol dependent individuals seeking enlistment in the Navy, and shall refer such individuals to local civilian community facilities for counseling and/or treatment. Medical personnel conducting physical examinations of Navy applicants must be familiar with and utilize "Criteria for the Diagnosis of Alcoholism" as published in Drug Abuse (Clinical Recognition and Treatment, Including Diseases Often Associated) TB MED 290 / NAVMED P-5116 / AFP 160-33, and other appropriate DOD guidance.

8. The Chief of Chaplains, under the command of the Chief of Naval Personnel, shall assign chaplains to designated billets at Alcohol Rehabilitation Centers, and shall sponsor and request implementation of a training program for Chaplain Corps personnel to enhance their capabilities for identifying alcohol abusers and alcoholics, and for counseling members of the Navy and their dependents with regard to alcohol abuse and alcoholism.

9. The Chief of Naval Training, in conjunction with CHNAVPERS, the Director of Naval Education and Training, and the heads of other appropriate bureaus and commands, shall develop and implement programs as outlined in reference (a) enclosure (3), to provide for continuing education of all Navy personnel with regard to alcohol, alcoholism and the dangers of alcohol abuse. Initial efforts shall include the insertion of pertinent material in training curricula at all appropriate schools, ranging from basic training to the senior service schools.

10. The Commander, Naval Safety Center, in conjunction with CHNAVPERS, is authorized and shall conduct direct liaison with appropriate offices of the U. S. Department of Transportation aimed at developing Alcohol Safety Action Programs (ASAP) for implementation at all Navy shore installations. Such Navy ASAP efforts shall be supervised by local installation commanders in cooperation with civilian community police and traffic safety officials, where appropriate. Commander, Naval Safety Center, shall make quarterly letter summary reports to CHNAVPERS, (Pers-Pc6) on all accidental deaths and injuries in which alcohol was determined to be a contributing factor.

NOTES

Chapter I

1. Memorandum from Ira H. Cisin and Don Cahalan, Bureau of Social Science Research, Inc., to Captain James A. Baxter, U.S.N., Director, Alcohol Abuse Control Program, "Supplementary Analysis of Drinking Problems, Navy Pilot Study," Washington: 28 February 1973.

2. F.M. Harrison, "The Alcohol Problem in the Navy," Quarterly Journal of Studies on Alcohol, 1944, v. 5, p. 425.

3. U.S. Navy Dept., Bureau of Naval Personnel (Pers Pc61), "USN Alcohol Abuse Control Program Briefing Sheet," Memorandum for the Record, Washington: 2 March 1973.

4. Interview with Mr. Mark Keller, Editor of the Quarterly Journal of Studies on Alcohol, Rutgers University Center for Alcohol Studies, New Brunswick: 20 April 1973.

5. W.G.H. Bosma, "Children of Alcoholics: A Hidden Tragedy," Maryland State Medical Journal, 1972, v. 21 (No. 1), p. 34.

6. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, First Special Report to the U.S. Congress (Washington: U.S. Govt. Print. Off., 1972), p. vii.

7. Thomas F.A. Plaut, Alcohol Problems - A Report to the Nation (New York: Oxford University Press, 1967), p. 12.

8. U.S. Dept. of Health, Education, and Welfare, p. 67.

9. Plaut, p. 45.

10. U.S. Office of Naval Operations, "Alcohol Abuse and Alcoholism Among Naval Personnel," OPNAVINST 6330.1 (Washington: 29 May 1973), encl. (1), p. 1-2.

Chapter II

1. Comptroller General of United States, Alcoholism Among Military Personnel (Prepared for the Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare - United States Senate) (Washington: U.S. Govt. Print. Off., 1971).

2. Comptroller General of United States, Alcoholism Among Military Personnel (Prepared for the Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare - United States Senate) (Washington: U.S. Govt. Print. Off., 1971), p. 1.

3. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, First Special Report to the U.S. Congress (Washington: U.S. Govt. Print. Off., 1972), p. 21.

4. U.S. Dept. of Health, Education, and Welfare, p. 31.

5. Don Cahalan and Robin Room, Problem Drinking Among American Men (New Brunswick, N.J.: Rutgers Center of Alcohol Studies, Rutgers University, 1969).

6. Letter from Ira H. Cisin and Don Cahalan, Bureau of Social Science Research, Inc., to Captain James A. Baxter, USN, Director, Alcohol Abuse Control Program, "Report of Pilot Study of Attitudes and Behavior of Navy Personnel concerning Problem Drinking." BSSR Report No. 452, Washington: 28 February 1973, p. 9.

7. E.M. Jellinek, The Disease Concept of Alcoholism (New Haven, Conn.: Hillhouse Press, 1960), p. 38.

8. Letter from Cisin and Cahalan to Captain James A. Baxter.

9. Memorandum from Ira H. Cisin and Don Cahalan, Bureau of Social Science Research, Inc., to Captain James A. Baxter, U.S.N., Director, Alcohol Abuse Control Program, "Supplementary Analysis of Drinking Problems, Navy Pilot Study," Washington: 28 February 1973, p. 2.

10. U.S. Navy Dept., Bureau of Naval Personnel (Pers Pc61), "USN Alcohol Abuse Control Program Briefing Sheet," Memorandum for the Record, Washington: 2 March 1973.

11. J.J. Zuska, Captain, MC, USN, "Alcoholic Education and Rehabilitation," Speech, Surgeon General's Conference, Long Beach, Ca.: 22 May 1970 (revised 1 February 1973), p. 2.

12. Memorandum from Cisin and Cahalan to Captain Baxter, p. 9.

13. Letter from Cisin and Cahalan to Baxter, p. 2.

14. Ibid., p. 44.

15. Ibid., p. 4.

16. U.S. Navy Dept., Bureau of Naval Personnel (Pers Pc61).

17. Interview with Captain James A. Baxter, USN, Director, U.S. Navy Alcohol Abuse Control Program, Bureau of Naval Personnel, Washington: 30 April 1973.

18. U.S. Navy Dept., Bureau of Naval Personnel (Pers Pc61).

19. "Baxter Cites Counselors of Navy's Alcohol Drive," Navy Times, 25 April 1973, p. 39.

Chapter III

1. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, First Special Report to the U.S. Congress (Washington: U.S. Govt. Print. Off., 1972), p. ix.

2. Interview with Mr. Mark Keller, Editor of the Quarterly Journal of Studies on Alcohol, Rutgers University Center for Alcohol Studies, New Brunswick: 20 April 1973.

3. U. S. Dept. of Health, Education, and Welfare, p. 3.

4. Marvin A. Block, Alcohol and Alcoholism (Belmont, Ca.: Wadsworth Publishing Co., 1970).

5. Various speakers (Governor Phillip Noel, R.I.; Dr. Frank Seixas and Mr. Ross Von Wiegand, National Council on Alcoholism; Mr. Joe Warren, New York Transit Authority; Dr. R. E. Brubaker, Winchester-Western Division of Olin Corp.), "Rhode Island Labor-Management Seminar on Occupational Alcoholism," Conference, Cranston, R.I.: 11 April 1973.

6. Thomas F.A. Plaut, Alcohol Problems - A Report to the Nation (New York: Oxford University Press, 1967); U.S. Dept. of Health, Education, and Welfare; Elizabeth D. Whitney, ed., World Dialogue on Alcohol and Drug Dependence (Boston: Beacon Press, 1970); and Rupert Wilkinson, The Prevention of Drinking Problems: Alcohol Control and Cultural Influences (New York: Oxford University Press, 1970).

7. Wilkinson, p. 5

8. Whitney, p. 235-238.

Chapter IV

1. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, First Special Report to the U.S. Congress (Washington: U.S. Govt. Print. Off., 1972), p. 101.

2. U. S. Navy Dept., Bureau of Naval Personnel (Pers Pc6), "Bulletin #3, Captain's Column," Alcohol Abuse Control Program Newsletter, Washington: February 1973.

3. "Un Exemple d'information Medicale In Public: l'alcoolisme," (An Example of Medical Information for the Public: Alcoholism), Article from Aggressologie, Paris 8 (Spec. 26.): 1967, p. 113-117, reported in Quarterly Journal of Studies on Alcohol, April-June, 1970, p. 523-524.

4. Elizabeth D. Whitney, ed., World Dialogue on Alcohol and Drug Dependence (Boston: Beacon Press, 1970), p. 40.

5. U.S. Dept. of Health, Education, and Welfare, Joint Conference on Alcohol Abuse and Alcoholism, DHEW Pub. No. (HSM) 73-9067. (Washington: U.S. Govt. Print. Off., 1972), p. 7-8.

6. Letter from System Development Corporation to Director, U.S. Navy Alcohol Abuse Control Project, "U.S. Navy Alcohol Abuse Control Program: Follow-up Survey, Evaluation of Pilot Education Seminars," Santa Monica: 28 February 1973.

7. Interview with Commander Al Kelley, USN, Head, U.S. Navy Drug and Alcohol Abuse Education Project, Bureau of Naval Personnel, Washington: 30 April 1973.

8. Letter from System Development Corporation, p. 22.

9. Ibid., p. 1.

10. Interview with Commander Al Kelley.

11. U.S. Navy Dept., Bureau of Naval Personnel (Pers Pc4), "U.S. Navy Drug Abuse Education Program." Memorandum for the Record, Washington: 15 March 1973, p. 1.

12. Interview with Commander Al Kelley.

13. U.S. Congress, Senate, Committee on Armed Services, Subcommittee on Drug Abuse in the Military, Staff Report on Drug and Alcohol Abuse Among U.S. Military Personnel and Dependents in Germany, 92nd Congress, 2nd sess., 1972, p. 10.

14. U.S. Navy Dept., Bureau of Naval Personnel (Pers Pc6), p. 8.

15. Letter from System Development Corporation.

16. National Institute on Alcohol Abuse and Alcoholism, Alcohol and Alcoholism (Rockville, Md.: NIAAA, 1972), p. 14.

17. Don Cahalan, Problem Drinkers: a National Survey (San Francisco: Jossey-Bass, 1970).

18. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, p. 35.

19. Kenneth Goodall, "Meditation As A Drug-Trip Detour." Psychology Today, March 1972, p. 20.

20. "Newport Naval Base Happenings," The Newport Navlog, 8 June 1973, p. 8-9.

21. Comptroller General of United States, Alcoholism Among Military Personnel (Prepared for the Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare - United States Senate)(Washington: U.S. Govt. Print. Off., 1971), p. 3.

22. J.J. Zuska, Captain, MC, USN, "Alcoholic Education and Rehabilitation," Speech, Surgeon General's Conference, Long Beach, Ca.: 22 May 1970 (revised 1 February 1973), p. 2.

23. Telephone conversation with Major John G. Murphy, U.S. Air Force, Drug and Alcohol Abuse Control Program, Washington: 16 March 1973.

24. Officers' Club Highlights, Newport, R.I., Monthly Bulletin, Naval Base, Newport, R.I.: June 1973, p. 3.

25. Thomas F.A. Plaut, Alcohol Problems - A Report to the Nation (New York: Oxford University Press, 1967), p. 141.

26. Ibid., p. 141.

27. Navy Times, 16 May 1973.

28. Interview with Captain James A. Baxter, USN, Director, U.S. Navy Alcohol Abuse Control Program, Bureau of Naval Personnel, Washington: 30 April 1973.

29. Ibid.

30. P.M. Le Gô, "Le Depistage Precoce de L'ethylisme," (The Early Detection of Alcoholism), Pr. Medicine, 1968, v. 76, p. 579-580.

31. M. Kili Barda and S. Stojiljkvic, "The Importance of Psychiatric Screening in the Prevention of Alcoholism." Alckoholizam, Beograd, Yugoslavia, 1968, v. 8(No. 4), p. 72-79.

32. Interview with Captain Baxter.

Chapter VI

1. Roger J. Williams, Nutrition Against Disease (New York: Putman, 1971), p. 174.

2. H.T. Blane, "Trends in the Prevention of Alcoholism," Psychiatric Research Reports, 1968, v. 24, p. 1-9.

3. Interview with Mr. Mark Keller, Editor of the Quarterly Journal of Studies on Alcohol, Rutgers University Center for Alcohol Studies, New Brunswick: 20 April 1973.

Appendix I

1. Marvin A. Block, Alcohol & Alcoholism (Belmont, Ca.: Wadsworth Publishing Co., 1970), p. 1.

2. lian Dock, "The Clinical Value of Alcohol," In: Salvatore P. Lucia, ed., Alcohol and Civilization (New York: McGraw-Hill, 1963).

3. National Institute on Alcohol Abuse and Alcoholism, Alcohol and Alcoholism (Rockville, Md.: NIAA, 1972), p. 2.

4. Ibid.

5. Morris E. Chaffetz and Harold W. Demone, Jr. Alcoholism and Society, 4th ed. (New York: Oxford University Press, 1970), p. 12.

6. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, First Special Report to the U.S. Congress (Washington: U.S. Govt. Print. Off., 1972), p. vii.

7. NIAAA, p. 7.

8. Thomas F.A. Plaut, Alcohol Problems - A Report to the Nation (New York: Oxford University Press, 1967), p. 7.

9. Ibid.

10. Ibid., p. 8.

11. Ibid., p. 10.

12. Ibid., p. 12.

13. Ibid., p. 16.

14. NIAAA, p. 2.

Appendix II

1. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, First Special Report to the U.S. Congress (Washington: U.S. Govt. Print. Off., 1972), p. 42.

2. National Institute on Alcohol Abuse and Alcoholism, Alcohol and Alcoholism (Rockville, Md.: NIAAA, 1972), p. 4.

3. U.S. Dept. of Health, Education, and Welfare, p. 42.

4. Ibid., p. 41.

5. George Getze, "Forgetfulness May Be Linked to Social Drinking, Expert Says," The Los Angeles Times, 9 March 1973, p. 1.

6. NIAAA, p. 7.

7. U.S. Dept. of Health, Education, and Welfare, p. 38.

8. Ibid.

Appendix III

1. National Institute on Alcohol Abuse and Alcoholism, Alcohol and Alcoholism (Rockville, Md.: NIAAA, 1972), p. 8.

2. Thomas F.A. Plaut, Alcohol Problems - A Report to the Nation (New York: Oxford University Press, 1967), p. 43.

3. Arthur H. Cain, The Cured Alcoholic (New York: The John Day Co., 1964), and
Margaret O. Hyde, Alcohol as a Mind Drug (New York: McGraw-Hill, 1968).

4. Plaut, p. 43.

5. Ibid., p. 45.

6. Morris E. Chaffetz and Harold W. Demone, Jr. Alcoholism and Society, 4th ed. (New York: Oxford University Press, 1970), p. 33.

7. Ibid., p. 34.

8. E.M. Jellinek, The Disease Concept of Alcoholism (New Haven, Conn.: Hillhouse Press, 1960).

9. Chaffetz and Demone, p. 36.

10. Ibid., p. 38-39.

11. Jellinek, p. 12.

12. Plaut, p. 41.

Appendix IV

1. Morris E. Chaffetz and Harold W. Demone, Jr. Alcoholism and Society, 4th ed. (New York: Oxford University Press, 1970), p. 31.

2. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, First Special Report to the U.S. Congress (Washington: U.S. Govt. Print. Off., 1972), p. viii.

3. National Institute on Alcohol Abuse and Alcoholism, Alcohol and Alcoholism (Rockville, Md.: NIAAA, 1972), p. 13.

4. Thomas F.A. Plaut, Alcohol Problems - A Report to the Nation (New York: Oxford University Press, 1967), p. 37.

5. Juha Partanen, et al., Inheritance of Drinking Behavior (Helsinki: Finnish Foundation for Alcohol Studies, 1966).

6. NIAAA, p. 13-14.

7. Ibid.

8. Plaut, p. 45-46.

9. Joan McCord and William McCord, Origins of Alcoholism (Stanford: Stanford University Press, 1960).

10. Ibid., p. vii.

11. Ibid., p. 95.

12. Ibid., p. 164.

13. NIAAA, p. 15.

14. Plaut, p. 48.

15. NIAAA, p. 16.

16. E.M. Jellinek, The Disease Concept of Alcoholism (New Haven, Conn.: Hillhouse Press, 1960), p. 28-29.

17. Plaut, p. 49.

18. Ibid., p. 45.

Appendix V

1. National Institute on Alcohol Abuse and Alcoholism, Alcohol and Alcoholism (Rockville, Md.: NIAAA, 1972), p. 17.

2. Various speakers (Governor Phillip Noel, R.I.; Dr. Frank Seixas and Mr. Ross Von Wiegand, National Council on Alcoholism; Mr. Joe Warren, New York Transit Authority; Dr. R. E. Brubaker, Winchester-Western Division of Olin Corp.), "Rhode Island Labor-Management Seminar on Occupational Alcoholism," Conference, Cranston, R.I.: 11 April 1973.

3. Consolidated Edison Company of New York, "Alcoholism: Con Edison's Program," Around the System, March 1973, p. 8.

4. Various speakers.

5. Susan Margetts, "The Staggering Cost of the Alcoholic Executive," Dun's Review, 1968, v. 90(5), p. 32-34.

6. High-Priced Half Man (New York: Reprinted with permission of the Journal of American Insurance by the National Council on Alcoholism, 1972), p. 2.

7. National Council on Alcoholism, "The Eastman Kodak Program--A Favorable Climate," Labor-Management Alcoholism Newsletter, November-December 1972, p. 3.

Appendix VI

1. National Institute on Alcohol Abuse and Alcoholism, Alcohol and Alcoholism (Rockville, Md.: NIAAA, 1972), p. 17.

2. U.S. Dept. of Health, Education, and Welfare, Alcohol, DHEW Pub. No. (HSM) 71-9048. (Washington: U.S. Govt. Print. Off., 1971), p. 9.

3. Ibid., p. 10.

4. NIAAA, p. 17.

5. Ibid., p. 19.

6. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, First Special Report to the U.S. Congress (Washington: U.S. Govt. Print. Off., 1972), p. 90-95.

7. Ibid., p. 2.

8. Comptroller General of United States, Alcoholism Among Military Personnel (Prepared for the Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare - United States Senate) (Washington: U.S. Govt. Print. Off., 1971), p. 1 and 22.

9. U.S. Dept. of Health, Education, and Welfare, Alcohol and Health, p. 2.

10. High-Priced Half Man (New York: Reprinted with permission of the Journal of American Insurance by the National Council on Alcoholism, 1972), p. 5.

11. U.S. Dept. of Health, Education, and Welfare, Alcohol, p. 10.

BIBLIOGRAPHY

Alcoholics Anonymous. Alcoholics Anonymous. New York: Alcoholics Anonymous World Services, Inc., 1955.

Anderson, C.L. "Control del Alcoholismo." Quarterly Journal of Studies on Alcohol, October-December, 1972, p. 596.

Bacon, S.D. "Prevention Can Be More Than a Word." Realizing the Potential in State Alcoholism Programs, Proceedings of the Northeast States Conference on Alcoholism . . . New Haven, Conn. 18-20 May 1959. Hartford: Connecticut Commission on Alcoholism, 1959, p. 5-18.

"Baxter Cites Counselors of Navy's Alcohol Drive." Navy Times, 25 April 1973, p. 39.

Blane, Howard T. The Personality of the Alcoholic. New York: Harper and Row, 1968.

_____. "Trends in the Prevention of Alcoholism." Psychiatric Research Reports, 1968, v. 24, p. 1-9.

Block, Marvin A. Alcohol and Alcoholism. Belmont, Ca.: Wadsworth Publishing Co., 1970.

Blum, Eva Marie and Blum, R.H. Alcoholism: Modern Psychological Approaches to Treatment. San Francisco: Jossey-Bass, 1967.

Bosma, W.G.H. "Children of Alcoholics: A Hidden Tragedy." Maryland State Medical Journal, 1972, v. 21 (No. 1), p. 34-36.

Business Week. "Business Copes with Alcoholics." Business Week, 26 October 1968, p. 97-100.

Cahalan, Don. Problem Drinkers: A National Survey. San Francisco: Jossey-Bass, 1970.

Cahalan, Don, et al. American Drinking Practices: A National Study of Drinking Behavior and Attitudes. Monograph No. 6. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1969.

Cahalan, Don and Room, Robin. Probem Drinking Among American Men. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, Rutgers University, 1969.

Cain, Arthur H. The Cured Alcoholic. New York: The John Day Co., 1964.

Chafetz, Morris E., et al., ed. Frontiers of Alcoholism. New York: Science House, 1970.

Chafetz, Morris E. "The Prevention of Alcoholism." International Journal of Psychiatry, 1970-71, v. 9, p. 329-348.

Chafetz, Morris E, et al. "Alcoholism: Its Cause and Prevention." New York State Journal of Medicine, 1962, v. 62, p. 1614-1625.

Chafetz, Morris E. and Demone, Harold W., Jr. Alcoholism and Society. 4th ed. New York: Oxford University Press, 1970.

"Challenge: To Change Thinking." Alcohol Health and Research World, Spring 1973, p. 18-20.

Cole, Jonathan O. "Clinical Research in Alcoholism." Psychiatric Research Reports, March 1968.

Comptroller General of the United States. Alcoholism Among Military Personnel. (Prepared for the Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare - United States Senate) Nov 1971. Washington: U.S. Govt. Print. Off., 1971.

Consolidated Edison Company of New York. "Alcoholism: Con Edison's Program." Around the System, March 1973, p. 4-15.

Department of Defense. "Alcohol Abuse Program Explained." Commanders Digest, 28 December 1972, p. 1-7.

Doyle, Thomas J. Identification of the Alcoholic Employee. New York: Consolidated Edison of N.Y., Inc., 26 March 1971.

"Drug Report Urges Treatment." The Providence Journal, 23 March 1973, p. 3.

Edwards, G.A. "A Doubtful Prognosis. "International Journal of Psychiatry, 1970-71, v.9, p. 354-358.

Efron, Vera, and Keller, Mark. Selected Statistics on Consumption of Alcohol, 1850-1968, and on Alcoholism, 1940-1968. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 197[illegible].

Filkins, L.D. "Community Response to Alcoholism and Highway Safety." Conference, University of Michigan, Ann Harbor, Mich.: November 1969.

Foster, Willard O., Jr. "The Early Alcoholic: Kindness vs. Confrontation." Maryland State Medical Journal, 1970, v.19, p. 31-32.

Getze, George. "Forgetfulness May Be Linked to Social Drinking, Expert Says." The Los Angeles Times, 9 March 1973, p. 1.

Goodall, Kenneth. "Meditation As a Drug-Trip Detour." Psychology Today, March 1972, p. 20.

Habbe, Stephen. Company Controls for Drinking Problems. New York: National Industrial Conference Board, Inc., 1969.

Harrison, F.M. "The Alcohol Problem in the Navy." Quarterly Journal of Studies on Alcohol, 1944, v.5, p. 413-425.

"High Cost of R.I. Alcoholism Outlined." The Providence Journal, 15 March 1973, p. 2.

High-Priced Half Man. New York: Reprinted w/permission of the Journal of American Insurance by the National Council on Alcoholism, 1972.

Hoff, E.C. "Alcoholism Prevention in a Drinking Society." International Journal of Psychiatry, 1968, v.5, p. 54-56.

Hollister, A.C. "Alcoholism is Not the Frustrating, Untreatable Disease It Used to Be." California Health, 1968, v.25 (no. 3), p. 1-6.

Hughes, Harold E., Senator. "Alcoholism: Funding with Foresight." Alcohol Health and Research World, Spring 1973, p. 21-23.

Hyde, Margaret O. Alcohol as a Mind Drug. New York: McGraw-Hill, 1968.

Interview with Captain James A. Baxter, USN, Director, U.S. Navy Alcohol Abuse Control Program, Bureau of Naval Personnel. Washington: 30 April 1973.

Interview with Mr. Julian Granger, Special Assistant to Senator Harold Hughes, Iowa. Washington: 15 March 1973.

Interview with Commander Al Kelley, USN, Head, U.S. Navy Drug and Alcohol Abuse Education Project, Bureau of Naval Personnel. Washington: 30 April 1973.

Interview with Mr. Mark Keller, Editor of the Quarterly Journal of Studies on Alcohol, Rutgers University Center for Alcohol Studies, New Brunswick: 20 April 1973.

Interview with Mr. Donald G. Phelps, Director, Division of Prevention, National Institute on Alcohol Abuse and Alcoholism. Rockville: 2 May 1973.

Interviews with Chief Petty Officer Bill Butler, USN, and Mr. Tom Heaney, Alcohol Abuse Control Branch, Human Resources Development Center. Newport, R.I.: April-July 1973.

Ivy, A.C. "Alcohol is the Cause of Acute and Chronic Alcoholism. Quarterly Journal of Studies on Alcohol, October-December 1972, p. 865-866.

Jellinek, E.M. The Disease Concept of Alcoholism. New Haven, Conn.: Hillhouse Press, 1960.

_____. "Government Programs on Alcoholism: A Review of Activities in Some Foreign Countries." Quarterly Journal of Studies on Alcohol, 1965, v 26, p. 186-169.

Kessler, Raymond G. and Roebuck, Julian B. The Etiology of Alcoholism. Springfield, Ill.: Charles C. Thomas, 1972.

Letter from Donald G. Phelps, Director, Division of Prevention, National Institute on Alcohol Abuse and Alcoholism to Commander Jerry Tappan, Naval War College. "Statement of Purpose." Washington: 27 March 1973.

Letter from Ira H. Cisin and Don Cahalan, Bureau of Social Science Research, Inc., to Captain James A Baxter, USN, Director, Alcohol Abuse Control Program. "Report of Pilot Study of Attitudes and Behavior of Navy Personnel concerning Problem Drinking." BSSR Report No. 452, Washington: 28 February 1973.

Letter from System Development Corporation to Director, U.S. Navy Alcohol Abuse Control Project. "U.S. Navy Alcohol Abuse Control Program: Follow-up Survey, Evaluation of Pilot Education Seminars." Santa Monica: 28 February 1973.

Letter from the Chief of Staff, U.S. Air Force to Major Air Force Commanders. "Alcohol Abuse Control Program." Ser: DPX. Washington: 28 August 1972.

McClelland, David C. "The Power of Positive Drinking." Psychology Today, January 1971, p. 40.

McCord, William and McCord, Joan (with Jon Gudeman). Origins of Alcoholism. Stanford, Ca.: Stanford University Press, 1960.

Maddox, George L., and McCall, Bevode C. Drinking Among Teen-Agers. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1964.

Mann, Marty. New Primer on Alcoholism. 12th ed. New York: Holt, Rinehart and Winston, 1972.

Margetts, Susan. "The Staggering Cost of the Alcoholic Executive." Dun's Review, 1968, v. 10(5), p. 32-34.

Mello, N.K. and Mendelson, J.H., eds. Recent Advances in Studies of Alcoholism. Washington: U.S. Gov't. Print. Off., 1971.

Memorandum from Ira H. Cisin and Don Cahalan, Bureau of Social Science Research, Inc., to Captain James A. Baxter, USN, Director, Alcohol Abuse Control Program. "Supplementary Analysis of Drinking Problems, Navy Pilot Study." Washington: 28 February 1973.

Memorandum from Vice Chief of Naval Operations to Chief of Naval Operations. "Alcohol Abuse Program." Washington: 6 September 1972.

Mendelson, J.H. "Another Doubtful Prognosis." International Journal of Psychiatry, 1970-71, v.9. p. 368-371.

Message from the Chief of Naval Operations to all Navy Officers and Enlisted. "Alcohol Abuse and Alcoholism Among Naval Personnel." Washington: 2 August 1972.

"The Military Meditators." Navy Times (Family Supplement), 4 July 1973, p. 7-9.

National Clearinghouse for Alcohol Information. "'Drink Responsibly is Plea of Beverage Industry Ads." Alcohol and Health Notes, December 1972, p. 5.

_____. "Russians Taking Hard Time on Use of Alcohol Drinks." Alcohol and Health Notes, December 1972, p. 5.

_____. "Army Alcohol and Drug Control Team Active." Alcohol and Health Notes, December 1972, p. 5.

_____. "New United States Program Attacks Problem of Drinking Driver." Alcohol and Health Notes, December 1972, p. 1.

National Council on Alcoholism. "Criteria for the Diagnosis of Alcoholism." American Journal of Psychiatry, v. 129: 2 August 1972.

_____. "The Eastman Kodak Program--A Favorable Climate." Labor-Management Alcoholism Newsletter, November-December 1972, p. 1-15.

National Institute on Alcohol Abuse and Alcoholism. Alcohol and Alcoholism. NIAAA Publication, Rockville, Md., 1972.

_____. Occupational Alcoholism: Some Problems and Some Solutions. NIAAA Publication, Rockville, Md., 1973.

"Newport Naval Base Happenings," The Newport Navlog, 8 June 1973, p. 8-9.

"NHL Czar Wages War on Alcohol," Newport Daily News, 8 May 1973, p. 14.

Ohrt, Valerie A., Major, USAF. "Hope for the Air Force Alcoholic." Unpublished Thesis. Air University, Montgomery, Ala.: 1970.

"Peoria Mayor Back in City Hall-Sober." The Los Angeles Times, 23 March 1973, p. 4.

Pitman, D.J., and Gordon, C.W. Revolving Door: a Study of the Chronic Police Case Inebriate. Monograph No. 2, New Brunswick, N.J.: Rutgers Center of Alcohol Studies. 1958.

Plaut, Thomas F.A. Alcohol Problems - A Report to the Nation. New York: Oxford University Press, 1967.

Pollmer, Elizabeth. Alcoholic Personalities. New York: Exposition Press, 1965.

"Preventing the Development of Alcoholism." Connecticut State Medical Journal, June 1971, p. 380-381.

Ritson, B. "Personality and Prognosis in Alcoholism." British Journal of Psychiatry, 1971, v. 118, p. 79-82.

Rubington, E. "The Hidden Alcoholic." Quarterly Journal of Studies on Alcohol, October-December, 1972, p. 667-683.

Sadler, M. and Hollet, J.F. "Company/Union Programs for Alcoholics." Harvard Business Review, September 1972, p. 22-24.

Saint, E.G. "Alcohol and Society," Medical Journal of Australia, 1969, v.2., p. 69-76.

Schuckit, Marc A. Alcoholism and Sociopathy -- Diagnostic Confusion. (Awaiting publication in Quarterly Journal of Studies of Alcohol).

Seixas, Frank A. "Medical Education and a Community Approach to Alcoholism." Rhode Island Medical Journal, 1970, v. 53(4), p. 191-193.

Shenkman, M. "Prevention and Early Detection of Alcoholism," Journal of the Medical Society, 1972, v.69, p. 19-23.

Shoemaker, Randall. "DoD Begins Drive to Aid Alcoholics." Navy Times, 22 March 1972, p. 2.

"The Soviet People Think that the State Should Be More Stringent about Drunkeness." Quarterly Journal of Studies on Alcohol, April-June 1970, p. 515.

Tähkä, Veikko. The Alcoholic Personality. Helsinki: The Finnish Foundation for Alcohol Studies, 1966.

Tamerin, John S., et al. "The Upper-Class Alcoholic: A Syndrome in Itself." Psychosomatics, 1971, v. 12(3), p. 200-204.

Telephone conversation with Dr. Seldon Bacon, Director, Center of Alcohol Studies, Rutgers University. New Brunswick, N.J.: 9 April 1973.

Telephone conversation with Dr. Adolph J. Brink, Medical Director, Southern New England Telephone Company, New Haven, Conn. 10 April 1973.

Telephone conversation with Dr. Thomas J. Doyle, Executive Director-Medical Department, Consolidated Edison Company of New York. 17 April 1973.

Telephone conversation with Major John G. Murphy, U.S. Air Force, Drug and Alcohol Abuse Control Program, Washington. 16 March 1973.

Thomas, Patrick A. "Alcoholism gets a treatment from business; Insurers take a sober look at facts of alcoholism." Business Insurance, 21 December 1970 and 4 January 1971.

Tomorowicz, W. "Jutro Alkoholismu w Polsce." (The Future of Alcoholism in Poland). Quarterly Journal of Studies on Alcohol, October-December, 1972, p. 894.

U.S. Congress. Senate. Committee on Armed Services. Subcommittee on Drug Abuse in the Military. Staff Report on Drug and Alcohol Abuse among U.S. Military Personnel and Dependents in Germany. 92nd Congress, 2nd sess. 1972.

_____. _____. _____. Staff Report on Drug Abuse in the Military, 92nd Congress, 1st sess., 1971

_____. _____. Committee on Labor and Public Welfare. Hearings before the Subcommittee on Alcoholism and Narcotics. Military Drug Abuse, 92nd Congress, 1st sess., 9 and 22 June 1971.

_____. _____. _____. Special Subcommittee on Alcoholism and Narcotics. Examination of Drug Abuse and Alcoholism in the Armed Forces, 91st Congress, 2nd sess., 17 and 18 November, 2 and 3 December 1970.

_____. _____. Congressional Record, 93rd Congress, 1st sess., v. 119, no. 35, 6 March 1973.

U.S. Department of Health, Education, and Welfare. Alcohol. DHEW Pub No. (HSM) 71-9048. Washington: U.S. Govt. Print., Off., 1971.

U.S Department of Health, Education, and Welfare. Alcohol and Health. First Special Report to the U.S. Congress. DHEW Pub No. (HSM) 73-9031. Reprinted 1972. Washington: U.S. Govt. Print. Off., 1971.

_____. Joint Conference on Alcohol Abuse and Alcoholism. DHEW Pub No. (HSM) 73-9051. Washington: U.S. Govt. Print. Off., 1972.

U.S. Navy Department. "Alcohol Abuse Control Program (Pers Pc6)." Memorandum for the record on ASMRO statistics for 1972. Washington: 29 January 1973.

_____. Bureau of Naval Personnel. "Drug and Alcohol Education and Action Programs and Personnel Resources." BUPERSINST 6710.1A. Washington: 4 April 1973.

_____. _____. (Pers Pc4). "U.S. Navy Drug Abuse Education Program." Memorandum for the Record. Washington: 15 March 1973.

_____. _____. (Pers Pc6). "Bulletin #3, Captain's Column." Alcohol Abuse Control Program Newsletter. Washington: February 1973.

_____. _____. (Pers Pc61). "USN Alcohol Abuse Control Program Briefing Sheet." Memorandum for the Record Washington: 2 March 1973.

_____. Secretary of the Navy. "Alcohol Abuse and Alcoholism Among Military and Civilian Personnel of the Department of the Navy." SECNAV INSTRUCTION 5300. 20. Washington: 18 May 1972.

Various speakers (Governor Phillip Noel, R.I.; Dr. Frank Seixas and Mr. Ross Von Wiegand, National Council on Alcoholism; Mr. Joe Warren, New York Transit Authority: Dr. R. E. Brubaker, Winchester-Western Division of Olin Corp.). "Rhode Island Labor-Management Seminar on Occupational Alcoholism." Conference. Cranston, R.I.: 11 April 1973.

Voas, Robert B. "Court-based Treatment Program." The Alcoholism Digest, January 1973.

Weil, Andrew. "The Natural Mind: A New Way of Looking at the Higher Consciousness. Psychology Today, October 1972, p. 51-96.

Whitelock, Paul, et al. "Personality Patterns and Alcohol Abuse in a State Hospital Population." Journal of Abnormal Psychology, August 1971, p. 15-16.

Whitney, Elizabeth D., ed. World Dialogue on Alcohol and Drug Dependence. Boston: Beacon Press, 1970.

Williamson, Rupert. "The Prevention of Drinking Problems: Alcohol Control and Cultural Influences." New York: Oxford University Press, 1970.

Williams, Lincoln. Alcoholism. London: E. & S. Livingston Ltd., 1956.

Williams, Roger J. Alcoholism: The Nutritional Approach. Austin: University of Texas Press, 1959.

_____. Nutrition Against Disease. New York: Putman, 1971.

Wilinski, J. "The Antialcoholism Campaign in Poland." Quarterly Journal of Studies on Alcohol, January-March, 1969, p. 173-177.

Wuska, J.J., Captain, MC, USN, "Alcoholic Education and Rehabilitation." Speech. Surgeon General's Conference, Long Beach, Ca." 22 May 1970 (revised 1 February 1973).

UNCLASSIFIED
Security Classification

DOCUMENT CONTROL DATA - R & D

(Security classification of title, body of abstract and indexing annotation must be entered when the overall report is classified)

1. ORIGINATING ACTIVITY (Corporate author)	2a. REPORT SECURITY CLASSIFICATION
Naval War College Newport, Rhode Island	UNCLASSIFIED
	2b. GROUP

3. REPORT TITLE

Prevention of Alcoholism and Other Drinking Problems in the U.S. Navy.

4. DESCRIPTIVE NOTES (Type of report and inclusive dates)

Advanced Research Paper

5. AUTHOR(S) (First name, middle initial, last name)

Jeremy R. Tappan

6. REPORT DATE	7a. TOTAL NO. OF PAGES	7b. NO. OF REFS
20 July 1974	167	Numerous

8a. CONTRACT OR GRANT NO.	9a. ORIGINATOR'S REPORT NUMBER(S)
b. PROJECT NO.	
c.	9b. OTHER REPORT NO(S) (Any other numbers that may be assigned this report)
d.	

10. DISTRIBUTION STATEMENT

Release ~~only to DDC users. Document not subject to DoD distribution regulations~~

11. SUPPLEMENTARY NOTES	12. SPONSORING MILITARY ACTIVITY
	Naval War College Newport, Rhode Island

13. ABSTRACT

A study of the concept of prevention of alcohol problems and the program for the reduction of the U.S. Navy's high incidence of problem drinking. The extent of the Navy's alcohol problem, current theories of prevention, and the Navy's solution to the problem are examined in an effort toward significant reduction of personnel casualties due to the misuse of alcohol. There is a serious alcohol problem in the Navy, and it will not be overcome solely by treatment and rehabilitation of problem drinkers. The long-range solution is a comprehensive, widely-supported and multifaceted program of prevention. The U.S. Navy has established a viable and extensive prevention program as a vital element in its relatively young alcohol abuse control program. However, an early and serious obstacle in preventive efforts is the skepticism and lack of involvement of command managers. No significant reduction in the high incidence of problem drinking in the Navy will be made unless middle- and upper-level command managers believe in and are directly involved in this long-range prevention concept. Recommendations are made to involve management more directly, to further enhance existing Navy preventive measures, and to maximize the effectiveness of the Navy's present and future prevention programs.

DD FORM 1 NOV 68 1473

UNCLASSIFIED
Security Classification