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THE EVALUATION OF NAVAL ALCOHOL REHABILITATION PROGRAMS: PROBLEMS AND SUGGESTIONS

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The Evaluation of Naval Alcohol Rehabilitation Programs:

Problems and Suggestions*

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For the military, alcoholism has historically been like the weather: everyone talks about the problem but no one does anything about it. Military organizations have been plagued by alcoholism since the beginning of time, and alcohol problems have been prevalent in every war in which the United States has fought (1). This preponderance of drinking difficulties in military settings could be a natural result of the congregation of men during the heavy drinking years of early adulthood (2), but might also reflect the sailors attempts to live up to the masculine image of the fighting man (3): "You never trust a man who won't drink with you (4)."

In the midst of a milieu in which heavy drinking is encouraged through inexpensive liquor (3,5) and ritualized "Happy Hours" (3,5,6), the man faces the stresses of boredom and isolation (3), crowded living conditions (5), and the loneliness of separation from his family (5). He arrives at a strange duty station or port where the natural place to find companionship is in the nearest bar (5).

To be presented at the National Conference on Evaluation in Alcohol, Drug Abuse, and Mental Health Programs to be held in Washington, D.C., April 1-4, 1974.

Until early 1972, the sailor in the U.S. Navy was placed in a "double bind" where heavy drinking was encouraged (7), while alcohol-related problems were severely punished (4,6,8). Once a label of alcoholism was assigned, peers and superiors were afraid to trust the man to carry out his duty, and questions were raised about possible breaches of security regulations (8). The service is caught between "taking care of one of its own" on the one hand and protecting its "good name, efficient functioning, and reputation for fair discipline" on the other (8).

The establishment of an alcoholism treatment program has not been unanimously accepted and has been seen by some as catering to a man's weaknesses and excusing his lapses of character. Many point out that once the service accepts responsibility for treatment of alcohol problems, it faces the trouble and expense of allowing a man to work who may require limitations in duty stations and security status (8) and exposes itself to the problems of determining future compensations for alcohol-related disabilities (8). Line or staff officers may deal with the problem by looking the other way — either intentionally or unconsciously — and ignoring the man's growing need for help in an effort to protect him from the problems associated with being labeled an alcoholic (8).

The medical officer is caught between his responsibility to help a man in trouble and to satisfy his superiors by protecting the reputation and functional status of the military. He must also deal with his own negative feelings toward the alcoholic (9,10). The quandry is resolved through a number of maneuvers: the older, higher ranking and more career-oriented

patients in whom the military has already invested much time and money may be preferentially selected for treatment while the younger more troublesome men are more often directly discharged (8,11). Once accepted into therapy the patient is likely to be labeled anything but alcoholic (4) -- often receiving a diagnosis of neurosis of the depressive or anxiety type (5).

The alcoholic, perceiving the attitudes of both line and medical officers, may be reluctant to come for treatment. Especially if he is a commissioned or noncommissioned officer, he may be afraid to jeopardize his future career and retirement benefits (3,6) and may stay away from therapy until the problems overwhelm him and he is forced to get help (6,8).

Once treated, the disposition of the man correlates with certain demographic factors. Favorable service outcome is more likely for the patient with longer service and higher rank who comes from a white-collar or skilled workman's family background and who has not had disciplinary problems (7,12). Thus, personal and service attributes other than diagnosis influence the outcome.

These problems are far from esoteric as perhaps 20% of America's servicemen evidence severe drinking problems (13). Thus, it can be reasonably estimated that more than 200,000 alcoholics are in the Armed Services (3) and alcoholics constitute up to 20% of the psychiatric admissions to military medical facilities (3). This is a costly problem with an estimated loss of $3,000 to $4,000 per year per man -- mostly for courts-martial, confinement, and absenteeism -- with only 5% of this figure going for treatment (6) as most alcoholics do not enter therapy. The cost of one general court-martial

alone has been estimated to be more than $14,000 (4).

Treatment for alcoholism in the naval services was up-graded in 1972 when directives were issued outlining the therapeutic and non-punitive actions to be used in dealing with alcoholics. Since then great amounts of therapeutic effort and monies have been directed toward the early recognition and treatment of alcohol problems. During a two-year span, the U.S. Navy has established five Alcohol Rehabilitation Centers (ARC, 375 men total capacity at any one time), 14 Alcoholic Rehabilitation Units (ARU, 210-man total capacity), and two Alcoholic "Dry Docks" (ARD, 30-man total capacity) with a planned extension to 50 ARD's within the near future. These three types of facilities differ in that the ARU's are hospital-based inpatient facilities, the ARC's use non-hospital inpatient settings, and the ARD's are modeled after walk-in clinics. The staff and goals of these facilities differ as some are run by line officers (neither physicians nor psychologists) and some by Navy physicians.

The Navy has, almost overnight, found itself with a program concomitantly treating more than 600 alcoholics with a planned expansion to over 1,300 men after the addition of the proposed new ARD's. This rapid growth is not a response to a new problem but rather an intensive effort to make up for lost time. The treatment facilities have grown so fast that accurate evaluation has been impossible. The absence of well controlled studies of most alcoholism therapies makes it imperative that, in order to maintain the first dictum of treatment, primum non nocere, the present programs must be carefully reviewed.

It might be possible to learn important lessons by looking at small-scale attempts to describe and evaluate military alcoholism treatment programs which were carried out before most of the present special centers were established. In the 1950's a series of anecdotal and descriptive studies of small-scale alcoholism programs were reported (4,14-17). Most showed success rates in excess of 50%, but used short-term follow-up (usually less than one year), with loose designs often lacking in precise definitions of alcoholism or therapeutic goals and utilizing imprecise measuring instruments. Not unlike today, the therapies included antabuse, group or individual therapy and Alcoholics Anonymous.

Program descriptions written in the 1960's and 1970's were similar to the earlier reports in treatment methods, rates of success, and problems with study design (3,5-7, 11,18,19). Most programs were found to be too selective, accepting for treatment only the best risk patients and then only evaluating outcomes for those men who remained in therapy for a set period of time. Two studies were done in the Navy by the Navy Medical Neuropsychiatric Research Unit, San Diego, California, and these will be discussed in more detail.

In one study undertaken by the Unit, biographical data were collected on 4,950 Navy male enlisted psychiatric inpatients at 31 naval hospitals during the period 1967-1968 (7). The outcome for the 142 men with alcoholic discharge diagnoses were compared to the remaining psychiatric patients. The alcoholics were more frequently returned to duty from the hospital (74% vs. 28%) which may have reflected the older age of the alcoholics and the tendency of the military to return to duty more mature men with longer service

histories. Once back on duty, 64% of the alcoholics successfully completed their enlistments and were recommended for re-enlistment by their commanding officers. This high rate of return to duty and high rate of success once back at work resulted from hospital-based inpatient programs -- the majority of which offered the man no special alcoholism treatment. With one exception the special alcoholic rehabilitation programs had not yet been established.

The advantages of special alcoholic rehabilitation facilities were evaluated in 1969 in another study (18). A group of 164 men who had been returned to duty after going through the ARC at Long Beach were matched on alcoholic diagnoses, date of return to duty, pay grade (rank), and length of military service with a group of alcoholic men returned to duty after routine inpatient psychiatric treatment. There were 87 matched pairs; in 39 pairs the ARC and hospital treated patients did equally well as measured by the presence of disciplinary action, recommendations for reenlistment, and subsequent military performance. Of the remaining 48 pairs, in 25 the ARC men had better service performance while in 23 the hospital-based treatment center patients did better. The overall improvement rate by these criteria was 42% with similar results for ARC and hospital treatment programs.

The two Navy Medical Neuropsychiatric Research Unit studies indicated routine inpatient alcoholism therapy was associated with relatively high rates of successful service and may be no less effective than a special alcoholism program. However, both investigations were described by their authors as tentative studies and were done on a small-scale over relatively short time spans. The definition of success employed was based on the ability

of the men to perform in a military setting rather than on degree of emotional comfort.

To justify present and future treatment expenditures and to insure that alcoholism programs are effective, the service needs large-scale and relatively long-term outcome evaluations. The Department of Defense has recognized this need and is presently funding a number of such studies.

Military settings offer some advantages for evaluation research. Large numbers of patients are viewed through a standardized diagnostic scheme and similar record keeping procedures are used in diverse settings. Patients leave a therapeutic program to enter a semi-controlled social milieu where environmental changes can be made to hypothetically maximize chances for recovery. Follow-up procedures are made easier by the central register of service status of all military men and long-term follow-up can be arranged through the veterans system.

The heterogeneity inherent in ARC, ARU, and ARD programs presents the setting for a natural experiment. Men with different demographic backgrounds and different diagnoses can be observed going through different programs to see if a differential therapeutic response occurs. Prognostic factors might thus be elucidated and a process established where men are correctly assigned to the best treatment mode. The data established by careful program evaluation could be sent back to the treatment centers and used to maximize therapeutic effectiveness.

The first step in this process has been the implementation of a uniform data gathering system for all treatment facilities which allows for a standard definition of alcoholism along the lines suggested by the National

Council on Alcoholism (20). The biographical form also outlines factors which may influence prognosis, such as career orientation, education, marital status, and history of disciplinary difficulties. Two standardized personality questionnaires, the short form of the Minnesota Multiphasic Personality Inventory (21) and the Comrey Personality Scale (22), and one anxiety measure, the State Trait Anxiety Inventory (23) are given when the man enters the program and again before discharge from therapy. Plans are being made for re-evaluations at six months and perhaps one and two years. The service record, including promotions and demotions, will be followed for all men until they leave the service. Outcome will be measured by service performance, changes in the personality and anxiety inventories, and by questionnaires sent the man and his commanding officer at various intervals during the follow-up.

To evaluate treatment effectiveness studies must be well controlled. On long-term follow-up about one-third of alcoholics do well -- a remission rate which may be independent of the specific treatment offered (24-27). In addition, most alcoholics have "mini" remissions where for short periods of time their drinking either ceases or diminishes (25,28). Also, when an alcoholic enters therapy he is likely to be in a state of crisis and evidence high levels of anxiety and depression -- levels that revert toward normal with any type of supportive care in a "dry" atmosphere (26,27). The rate of improvement for naval service alcoholics can be expected to be better than the average program because the Navy, being a volunteer group, has already screened out the men who do worst in therapy, those with blatant antisocial histories (29,30), and because service men are employed, a status associated

with a better outcome (31). One could, therefore, expect that any service treatment program would show a substantial rate of improvement but the rate could result from the natural course of alcoholism and the patient selection factors inherent in an industrial-type treatment program. The question is not one of whether service alcoholics improve with therapy, but did they improve faster or slower or in greater or lesser numbers than would have been true for supportive therapy alone.

The establishment of well-controlled studies is not an easy matter. Therapists tend to have implicit belief in the goodness of what they are doing. They may see evaluation as a waste of time and an implied threat to their existence. They depend upon the testimonials of their patients and the comments of their peers to gauge their effectiveness. Many alcohol counselors are "recovered" alcoholics who view their own mode of recovery as "the way." They have fought for years to have the military recognize the need for alcoholism treatment and they now recognize that their program may be in a precarious position -- fighting for existence against fiscal constraints and the objections of those career men who still view alcoholism as a disciplinary matter. The alcohol rehabilitation programs are functioning in an atmosphere of high visibility to the press, Congress, and the fiscal planners in Washington.

These caveats notwithstanding, the alternatives to controlled evaluation are very unsatisfactory. To depend on patients and peers for feedback is to make the same mistake that was made by proponents of bloodletting and purgation in the last century. The fact that patients survive a therapy and

testify to its efficacy is not enough as it does not answer the question of how many more or less would have survived without the treatment. Placing the existence of the program ahead of responsibility to the patient -- no matter how much one believes in the rightfulness of the therapy -- is an abrogation of clinical responsibility.

In this atmosphere, the Navy recognizes the need for evaluation. Programs are asked to justify the monies and efforts spent on treatment, but there is a feeling that the evaluation data should be available "tomorrow." Short-term descriptive results are relatively easy to supply but may not answer the questions posed. Tentative reports describing a program and giving its uncontrolled recovery rate are almost certain to look good as a result of the variable history of alcohol problems and selection of good risk patients.

Such evaluations are of potential harm to the program, the man and the service. While the results look good on paper, they do nothing to insure that men are being helped, not harmed. The Navy is making an effort to insure that useful and relevant data are being established at all treatment facilities. The big questions -- Are we doing something useful? and What kinds of treatment are effective for what kinds of alcoholic patients -- can be answered, but this process will take time. Anything short of careful efforts in this area may be misleading and wasteful.

Summary

Alcoholism programs in the U.S. Navy have grown so fast that accurate evaluation has been almost impossible. Treatment facilities function in an atmosphere of high visibility and fiscal vulnerability and treatment evaluators

encounter pressure from both program opponents who feel such treatment is not the Navy's responsibility and from enthusiasts who are convinced that their therapy program is the best way to get things done. In addition there are organizational pressures to finish the evaluations quickly.

These problems have been recognized and the service has set up the machinery for careful evaluative research. A standardized data gathering network is being implemented and plans have been formulated to do careful well-controlled research utilizing the study advantages inherent in a military setting.

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Footnote

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