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MARINE CORPS DRUG PREVENTION REVIEW

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SUMMARY

Problem: The U.S. Marine Corps has adopted and enforced a zero tolerance policy toward drug use for more than two decades. When Marines test positive for drugs the military loses valuable personnel and the readiness of their entire units is negatively affected. Individual units and commands are instructed to conduct their own needs assessments and continually improve local efforts to curtail drug use, but it is also important to evaluate service-wide drug prevention policy and programs and modify limitations that may exist at the broadest level. Furthermore, the state-of-the-art in civilian drug prevention programs continually evolves. To improve Marine Corps drug prevention efforts, it is important to review this literature and assess its implications for the service.

Objective: The primary objective of this effort was to reduce drug use within the Marine Corps. To achieve this primary goal, during the first phase of the project, the research team was asked to conduct a thorough review of programs and to make recommendations as to how the Marine Corps might improve its current drug prevention efforts. The results of this evaluation will further be used to develop a Marine Corps specific drug prevention program in the second phase of the project. This technical report describes the results of the first phase.

Approach: A thorough literature review of drug prevention programs was conducted by means of 3 sources: pertinent electronic databases, school and university programs described on the Internet, and articles and references from consultants in the field of drug prevention. To understand the insights of Marine Corps personnel regarding the service's current drug prevention efforts, a series of focus groups was conducted at various Marine Corp bases. The focus groups interviewed personnel from different strata of the Marine Corps and obtained opinions regarding the effectiveness of their current drug prevention programs as well as ideas for improving them.

Results: More than 25 drug prevention programs from national, state and community levels were examined. A large majority of programs have been targeted toward students at the primary and secondary school levels. Nineteen common components of drug prevention programs were identified across studies. Some of the common components were information on the

consequences of drug use, decision-making skill training, public pledges not to use drugs, values clarification, goal-setting, stress management, self-esteem building, resistance/life/safety skills training, norm-setting, peer assistance, and alternative activities. Information on the consequences of drug use was the most common component across programs. The style and structure of drug prevention programs appears to play an important role in their overall efficacy. The most effective programs utilized the components of norm-setting and life skills training. Effective programs also tended to have an interactive small group educational format. They were intensive, including 10 or more sessions and follow-up boosters. Finally, educational programs that were part of a comprehensive drug prevention campaign appeared to be more effective. Results from the focus groups centered on 4 specific areas. Participants discussed the risk factors for drug use among Marines, the actual experiences of personnel in Marine Corps drug prevention programs, views regarding what is currently most effective, and views regarding how prevention might be improved. Based on results from the literature review and feedback from the focus groups, this report concludes with ongoing, short-term, and long-term recommendations for Marine Corps drug prevention.

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INTRODUCTION

In September 2001, the Naval Health Research Center (NHRC) was tasked by the Office of Prevention and Intervention, Headquarters U.S. Marine Corps, to evaluate and modify its current drug prevention efforts, making use of the best available research in the area. The services have had a zero tolerance policy toward drug use for more than two decades. Personnel are routinely tested as they enter basic training, and the military conducts random drug tests of all personnel. The military loses valuable personnel when they test positive for drugs.

The overall objective of this effort was to reduce drug use within the Marine Corps. The project involved NHRC personnel, civilian consultants with expertise in drug prevention, and Marine Corps Drug Demand Reduction Coordinators (DDRCs). The duration of the entire project is expected to be 2 years. This is an interim report at the conclusion of the first year. In this initial phase, NHRC conducted an efficacy evaluation of existing Marine Corps drug prevention efforts and reviewed existing military and civilian drug prevention programs. The goal of these assessments was to identify those programs that have been most effective in reducing drug use in systematic outcome studies and to make recommendations regarding how these programs might be modified and implemented within the Marine Corps.

In the second year, the project team will develop a Marine Corps drug prevention program and an educational program for junior noncommissioned officers (NCOs) regarding their role in drug prevention efforts. These programs will then be tested in a pilot program at Marine Corps installations in the San Diego area.

First Year Objectives

1. Review the breadth of drug prevention programs currently used throughout the Marine Corps.
2. Review existing civilian drug prevention programs and identify those programs that have been most effective in reducing drug use in systematic outcome studies.
3. Make recommendations regarding how effective civilian programs might be modified to create a standard prevention program that can be used throughout the Marine Corps.

Structure of This Report

This study was conducted primarily by reviewing literature describing drug prevention programs and outcome studies that have been conducted to evaluate their effectiveness. Additionally, in order to understand the perceptions of Marine Corps personnel regarding the

service's current drug prevention efforts, the project team conducted a series of focus groups (Emery, Ritter-Randolph, Strozier, & McDermott, 1993; Krueger, 1994). The focus groups explored beliefs about the scope of the problem of drug use within the Marine Corps, personal opinions regarding the efficacy of current Marine Corps drug prevention programs, and suggestions as to how these programs might be improved. The first half of this technical report presents information regarding the literature review. The second half discusses the methods and results of the focus groups. The report concludes with our recommendations for Marine Corps Drug prevention programs and policies.

LITERATURE REVIEW

Methods

For this review, the research team searched for literature on drug prevention in three ways. First, the team searched electronic databases for academic and military literature. Second, the team searched for programs currently in place at schools and universities that have been listed on the Internet. Finally, the research team members and consultants were asked for articles or programs with which they may personally be familiar in the area of drug prevention.

Through these resources, the research team identified an extensive number of articles and studies on drug prevention. These articles were then separated into two groups. The first included reviews and meta-analyses that have been conducted on the drug prevention literature. The second included articles that describe specific programs, their implementation, and their efficacy. This report first addresses the general findings summarized by researchers writing reviews and meta-analyses. It then presents a table of various programs that have been specifically described in the literature.

Results

Drug prevention programs include a wide variety of educational and skill-building components, which have been assumed to influence the likelihood of drug use. Table 1 lists the components that have been identified in reviews of the drug prevention literature (Belcher & Shinitzky, 1998; Donaldson et al., 1996; Hansen, 1992; Schaps, Churgin, Palley, Takata, & Cohen, 1980; Sexter, Sullivan, Wepner, & Denmark, 1984; Tobler, 1986, 1997; Tobler & Stratton, 1997). It should be noted that most drug prevention programs include more than one

type of component. Comprehensive programs include a variety of components and engage multiple target audiences in prevention efforts.

The most common program component is information dissemination. Almost all programs give participants some type of information about drugs and the consequences of their use. This component is based on the assumption that participants do not understand the nature of drugs and the seriousness of the health risks they pose. Educating people about these risks should make them less likely to use drugs (Belcher & Shinitzky, 1998).

Another group of components common in drug prevention programs includes strategies that alter affect and motivation. These programs assume that program participants have not developed the internal strength or the personal resolve to resist pressures to use drugs. These types of programs try to build self-esteem or help participants develop values and goals that are incompatible with drug use.

Skill-building components are based on the idea that participants do not have the life skills to deal with the myriad stresses that impinge on them. Drug use is a recourse that some turn to when they cannot manage their problems in more constructive ways. Teaching participants the skills to address their problems should reduce the likelihood that they will turn to drugs.

A particularly influential model that has been used in developing prevention program curricula is the Social Influence Model, suggesting that social pressures are the primary factors influencing drug use. A number of program components focus on these types of social influences, such as making public pledges not to use drugs, training participants to refuse drugs and resist peer pressure, correcting exaggerated perceptions of the normativity and acceptability of drug use, and increasing participants' awareness of social and media influences that promote drug use (Donaldson et al., 1996; Hansen, 1992).

Environmental and contextual efforts may focus on parents and community members, such as programs that teach parents how to be more effective in communicating and counseling children about drugs or community advertising campaigns that raise public awareness about the problem of substance use. Some provide alternative activities based on the idea that people use drugs when they are bored or do not have more constructive activities readily available. Employers, schools, and sports programs may have specific policies prohibiting drug use, and they may enforce those policies through drug testing and through specific sanctions for violation. Rather than addressing the needs of the user, some prevention efforts attempt to reduce the

supply of drugs available. Finally, timely treatment may be part of a comprehensive program. Persons with substance use problems are identified as efficiently as possible and referred for treatment before serious harm or consequences can occur.

So far, research on drug prevention has not systematically identified which program components are necessary and sufficient for an effective program (Donaldson et al., 1996; Hansen, 1992). In fact, there is not enough research to evaluate the unique efficacy of most of the components listed in Table 1. However, a number of studies have been done that suggest some components may be more important than others. For instance, components that reduce the social influences promoting drug use have fared well in outcome research. Within the social influence genre, norm-setting in particular has consistently been found effective. Programs that attempt to modify beliefs about the social prevalence of drug use appear to have an impact on behavior (Botvin, Griffin, Diaz, & Ifill-Williams, 2001; Donaldson et al., 1996; Hansen, 1992). When students learn that drug use is not as prevalent among their peers as they may have thought, they may feel less social pressure to use drugs themselves.

Some components included in social influence programs, such as public pledges, have not been individually evaluated well enough to draw conclusions about how much they contribute to overall program effectiveness (Hansen, 1992). Probably the most common social influence strategy employed in drug prevention programs is resistance skill training (i.e., “just say no”). However, research suggests that resistance skill training alone may not be effective in preventing drug use (Hansen & Graham, 1991). Two possible reasons for this have been suggested (Donaldson et al., 1996). First, teaching students how to resist pressure to use drugs may only help those participants who want to resist those pressures. Second, emphasizing ways to reject invitations to use drugs may lead students to expect pressure from their friends when the expectation is unwarranted and to assume that more of their friends use drugs than is the case. To counteract this latter possibility, it may be effective to combine norm-setting with resistance skills training.

Social and coping skills training may additionally help to prevent drug use (Botvin, 2000; Botvin, Epstein, Baker, Diaz, & Ifill-Williams, 1997; Botvin et al., 2001). However, research on the effectiveness of this type of training has largely been based on the Life Skills Training Program implemented in New York State (Botvin, 2000; Botvin, Baker, Filazzola, & Botvin, 1990; Botvin, Baker, Dusenbury, Botvin, & Diaz, 1995; Botvin et al., 1997; Botvin et al., 2001; Botvin et al., 2000; Botvin, Schinke, Epstein, & Diaz, 1994; Botvin, Schinke, Epstein, Diaz, &

Botvin, 1995; Botvin, Schinke, & Orlandi, 1989). This fairly comprehensive program teaches adolescents how to build effective personal relationships, to resist advertising appeals, to build self-esteem, to manage anxiety, to communicate effectively, and to be assertive. In particular, it coaches students in resisting peer pressure to use substances. The drug education component focuses on immediate rather than long-term consequences of substance use, and it illustrates how drug use is not as socially acceptable or as common as participants might think. After 6 years, participants in this program reported less illicit drug use, including marijuana, inhalants, heroin and other narcotics, and hallucinogens, than did controls (Botvin et al., 2000). Because so many components are included in this program it is difficult to tell which are most important. At least in the case of inhalants, the authors reported that intentions to use and beliefs regarding peer expectations might have mediated program effectiveness. (Botvin et al., 2001).

Aside from specific content, the facilitation style and structure of drug prevention programs seems to play an important role in their effectiveness (see Table 2). As might be expected, research suggests that programs that are facilitated faithfully without eliminating elements, are more effective (Botvin et al., 1989; Pentz et al., 1990). Additionally, there is indication that programs that are peer-led are more successful than are programs led by teachers or other adults. However, Tobler and Stratton (1997) found that the overall level of peer-interaction involved in a program may be most important. After accounting for the level of interaction facilitated between group participants, group leadership (peer, teacher, other leader) was not related to outcome.

White and Pitts (1998) reviewed the current literature on drug prevention and noted that programs with an intensive structure (10 or more sessions) and programs that include some follow-up or booster sessions may be more likely to have lasting effects. Comprehensive programs that have included a number of different educational components and target a number of different audiences within the community have also been shown to have a more lasting impact (Botvin et al., 2001; Hansen, 1992). Finally, programs have been more effective when they have included small rather than large groups of participants (Tobler & Stratton, 1997). This may be somewhat interrelated with group interaction level. Small groups are often more interactive than are large groups.

Table 1*Common Components of Drug Prevention Programs*

Component	Description
Drug Education	
Information	Programs educate participants about drugs and about the consequences of substance use.
Affective and Motivational	
Self-esteem	Programs help participants develop a sense of self-worth and individual value. Students learn to identify their strengths and talents and to avoid dwelling on failures and weaknesses.
Values	Programs help participants to clarify and strengthen their own value systems so that they will be less vulnerable to pressures that might encourage them to use drugs.
Goals	Programs teach participants how to set goals and try to motivate them to work towards those goals. These programs also emphasize the ways participants' goals are incompatible with substance use.
Skill-Building	
Decision-making	Programs teach participants how to make good choices. This may include strategies for weighing the pros and cons of substance use as well as strategies for making more general decisions in life.
Stress and coping	Programs teach participants coping skills to help them manage stressful and difficult life situations.
Interpersonal	Programs teach a broad range of social and communication skills. Participants learn to build stable relationships rather than focusing specifically on substance use.
Safety	Programs teach students how to protect themselves and others from physical harm when drugs and alcohol are involved.
Academic or vocational	Programs help participants become more competent in school and/or help them develop practical, vocational or generic life skills.
Social Influence	
Resistance training	Programs teach students how to resist peer pressure to use substances and help them avoid seeking social approval through drug use. Programs may use assertiveness training and role-playing to help participants refuse drugs and they may teach students about adult and media pressures to use drugs.
Norm-setting	Programs modify exaggerated ideas regarding the prevalence of peer drug use and educate participants about true prevalence rates. This helps to dispel incorrect assumptions about how normative and acceptable substance use is.

Pledges	Programs encourage participants to make a public commitment not to use substances. Some may also help participants to become activists themselves in preventing drug use within their communities.
Peer support	Programs enlist the help of peers in counseling participants and in helping them to solve problems and avoid substance use. They may set up “buddy systems” or create support groups for students with shared problems. Some programs use peer facilitators and encourage group interaction and cohesion in presenting drug prevention curricula.
Environmental and Contextual	
Parental support	Programs teach parents better communication and parenting skills and encourage them to help and counsel children about substance use, including their own.
Community support	Programs try to make the whole community more aware of their drug prevention efforts, initiate public add campaigns that advertise anti-drug messages, or encourage community advisory panels to get involved in preventing drug use within the community.
Alternatives	Programs provide alternatives to substance use for participants to become involved in such as work, sports, leisure, or cultural activities.
Contingencies	Programs involve reward/token economies or policies of disciplinary action for substance use. They may require abstinence from drug use for membership. Such programs may screen potential members for drug use before accepting them and they may rely on drug testing to verify on-going compliance.
Treatment referral	Programs attempt to identify those who do have a problem with substance abuse and refer them to treatment.
Supply reduction	Rather than addressing the issues of the user, drug prevention efforts may focus on reducing the accessibility and supply of drugs.

(Donaldson et al., 1996; Dusenbury, 1999; Hansen, 1992; Sexter et al., 1984; Tobler, 1986, 1997; Tobler & Stratton, 1997; Tricker & Cook, 1989)

Table 2*Characteristics of Effective Drug Prevention Programs*

Characteristic	Description
Components	
Norm-setting	Modifying beliefs about the social prevalence of drug use appears to modify behavior as participants come to believe that they do not have to use drugs to fit in with their peers.
Life skills training	Teaching social and communication skills may help participants build stable relationships without reliance on substance use.
Structure	
Intensive	Intensive programs including 10 or more sessions may be more likely to effect lasting behavioral change.
Booster sessions	Following up with booster sessions after the completion of a program appears to prolong the impact of the program on behavior.
Comprehensive	Programs that include a number of different types of educational components and target multiple sectors within the community may have more lasting effects.
Small group	Programs presented to small groups rather than large audiences have been found to be more effective.
Facilitation	
Interactive	Programs that involve participants in extensive interaction or that involve peers as facilitators have been more effective than programs that do not.
Complete	Programs are likely to be more effective when the curriculum is followed faithfully rather than when it is partially implemented.

(Botvin et al., 2001; Botvin et al., 1989; Hansen, 1992; Pentz et al., 1990; Tobler & Stratton, 1997; White & Pitts, 1998)

Table 3 lists specific drug prevention programs identified in the literature. Most have targeted students in primary and secondary schools. However, there were some that were developed for use at universities, in businesses, or throughout larger communities. For each program, the table lists bibliographic references, target audience, program content, and results of any outcome research that may have been done to evaluate it.

Table 3***Drug Prevention Programs***

Program Name	References	Target Population	Description	Outcomes
University Programs				
Athletic Prevention Programming and Leadership Education (APPLE; U of Virginia & the NCAA)	(Grossman & Smiley, 1999)	College athletes from NCAA member institutions	Information, Peer Support, Contingencies, Treatment Referral. Assists prevention teams from NCAA institutions to assess and develop comprehensive strategies for drug prevention within their athletic programs.	This study assessed progress towards implementing prevention strategies. No study of substance use outcomes was conducted.
Student to Student (STS; San Diego State U)	(Clapp, Burke, & Stanger, 1998)	College students and administrators	Peer Support. Peer assistance program focused on reducing alcohol and drug problems on campus.	This report describes the organizational and philosophical development of the STS program. No outcome evaluation was conducted.
Virginia Intervention Education Weekend (VIEW; U of Virginia)	(Grossman, Canterbury, Lloyd, & McDowell, 1994)	College students	Peer Support. Weekend workshop designed to teach teams of students from different universities how to organize drug prevention programs on their campuses.	Of 28 teams, 46% reported that program implementation was on track as planned. No evaluation of drug use outcomes was conducted.
The Adolescent at Risk (Arizona State U)	(Robinson, Roth, Gloria, Keim, & Sattler, 1993)	College students	Information. 5-week psychoeducational module targeting substance abuse.	This study reported an increase in knowledge regarding substance use, but no effect on attitudes towards use or on actual behavior.
Freshman Workshop on Alcohol and Drugs (East Michigan U)	(Ametrano, 1992)	College students	Information. Substance-abuse prevention education (4 sessions over a 2-week period).	In this evaluation the prevention program had no effect on drinking or drug use.

Recovering Person's Prevention Project (RPP; Central Michigan U)	(Rapaport, Minelli, Reyes, & Norton, 1991)	Multiple subgroups of students (i.e. sororities, counseling majors)	Peer Support. Group of recovering chemically dependent students and community members involved in education and outreach.	This report describes the implementation of this program. No evaluation of substance use outcomes was conducted.
Workplace Programs				
PeerCare	(Becker, Hall, Fisher, & Miller, 2000)	Employees at a large U.S. transportation company	Information, Norm-Setting, Peer Support, Alternatives, Community Support, Treatment Referral. A comprehensive, peer-facilitated drug prevention program was compared with the company's standard employee assistance program, a drug testing program, and a managed health care program.	Study in progress, outcomes not yet reported.
SAY YES! "Health Choices for Feeling Good"	(Cook, Back, & Trudeau, 1996)	Employees at a Northeastern Manufacturing Facility	Information, Goals, Resistance Training.	Program participants' attitudes toward healthy behaviors and desire to reduce drinking improved more than did those of control group participants. No effects on alcohol use were found. Rates of drug use were too low for analysis.
Peer Referral Networks	(Bamberger & Sonnenstuhl, 1995)	Members of the Association of Flight Attendants across the United States	Peer Support, Treatment Referral.	Utilization of an employee drug treatment program was higher in communities where peer referral networks were more embedded and were viewed as trustworthy and credible. No evaluation of substance use behaviors was done.

3M Alcohol and Other Drug Prevention Program	(Stoltzfus & Benson, 1994)	Employees at a small Midwestern manufacturing plant	Information, Values, Decision Making, Peer Support, Community Support.	Evaluation found a decrease in alcohol consumption in comparison with controls at follow-up. No evidence for change in marijuana use was noted, but this may be due to very low rates of use at baseline.
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Primary and Secondary School Programs

Drug Abuse Resistance Education (DARE; National)	(DeJong, 1987; Ennett, Tobler, Ringwalt, & Flewelling, 1994; Harmon, 1993; Lynam et al., 1999).	Elementary school students (subsequently adapted for junior high students)	Information, Decision-Making, Pledges, Stress Management, Self Esteem, Resistance Training, Interpersonal Skills, Alternatives. Seventeen lessons offered once a week for 45-60 minutes. Taught by law enforcement officers.	In large studies and meta-analysis, the effects of DARE were absent or weak. May be due to low overall base rate of drug use for children at this age. Largest effects were on knowledge and social skills rather than drug use.
Towards No Drug Abuse (TND)	(Dent et al., 1998; Dent, Sussman, & Stacy, 2001; Sussman, Dent, Stacy, & Craig, 1998)	Alternative high school students	Information, Decision-Making, Interpersonal Skills. Classroom-based program for high-risk students (9 sessions).	Reductions in hard drug and alcohol use, but not marijuana or tobacco, at 1-year follow-up.
Life Skills Training Program (New York)	(Botvin et al., 1990; G.J. Botvin et al., 1995; Botvin et al., 1997; Botvin et al., 2001; Botvin et al., 2000; Gilbert J. Botvin et al., 1995)	Middle/junior high school students	Resistance Training, Interpersonal Skills, Self Esteem, Norm-Setting, Pledges. Fifteen class periods plus 10 follow-up sessions in 8th grade and 5 follow-up sessions in 9th grade.	Results showed a reduction in smoking and marijuana use, especially when peer leaders and booster sessions were involved. An increase in alcohol use was noted for some groups, especially those led by teachers.
Trading Cards Program (TC)	(Harris & Ludwig, 1996)	Elementary school students	Peer Support. Drug-free high-school students act as role models for drug-free behavior and social competence for elementary students.	This program was effective in exposing children to anti-drug messages. Changes in actual drug use were not evaluated.

Michigan Model for Comprehensive School Health Education (Detroit, Michigan)	(Shope, Copeland, Marcoux, & Kamp, 1996)	5 th to 8 th grade students	Information, Resistance Skills Training. Initial 6-hr training in resistance skills, followed by 6-8 sessions on alcohol and drugs.	There were effects on cigarette use and total knowledge in younger students. Older students showed a reduction in tobacco and marijuana use. There were no effects on alcohol or other drugs. All effects were diminished at 1-year posttest.
Communities That Care – The Seattle Social Development Project	(Hawkins, Catalano, & Miller, 1992; O'Donnell, Hawkins, Catalano, Abbott, & Day, 1995)	Elementary school students	Interpersonal Skills, Parental Support, Teacher Effectiveness Training.	Girls were somewhat less likely to use tobacco, drugs, or alcohol. No significant effects found for boys.
Network of Drug-Free Youth (Nebraska)	(Nelson-Simley & Erickson, 1995)	7 th to 12 th grade students	Peer Support. Peer-led prevention retreats and follow-up assistance to established youth groups.	This program involved a self-selected group. However, most maintained their initial drug-free status over a 6-year evaluation.
Adolescent Learning Experiences in Resistance Training (Project ALERT; California)	(Bell, Ellickson, & Harrison, 1993; Ellickson & Bell, 1990; Ellickson, Bell, & McGuigan, 1993)	7 th and 8 th grade students	Information, Resistance Training, Norm-Setting. Eleven sessions plus follow-up assessment regarding changes in smoking and drug use.	There were early effects on cigarette and marijuana use, which disappeared by entry into high school. ALERT did not affect alcohol use or cigarette smokers.
Here's Looking at You 2000 (HLAY 2000; North Carolina)	(Kim, McLeod, & Shantzis, 1993)	K to 12 th grade students	Information, Decision-Making, Stress Management, Self-Esteem, Social Skills. (12-32 sessions).	This study had considerable attrition and problems with implementing posttests. No impact on any outcome measures was noted.
Under Pressure Program (Chicago)	(Safer & Harding, 1993)	Junior and senior high school students	Resistance, Decision-Making. Series of theatrical performances introduce scenarios associated with decision-making and substance abuse.	Only a short-term change in attitudes was found.

Self-Management and Resistance Training (Project SMART; National)	(Graham, Johnson, Hansen, Flay, & Gee, 1990; St. Pierre, Kaltreider, Mark, & Aikin, 1992)	7 th grade students (adapted for 13 year-old members of Boys and Girls Clubs)	Information, Pledge, Resistance Training, Norm-Setting, Alternatives, Decision-Making, Goal Setting, Stress Management, Self Esteem; 12 sessions (Adaptation condensed the curriculum to 9 sessions, but added 3 sessions on prevention of sexual activity and a 2-year booster program for peer leaders).	Using the standard program, there were reductions in tobacco and alcohol use, with weaker reductions in marijuana use. There was no significant effect of adding booster programs in Boys and Girls Clubs. However, there may have been a possible ceiling effect due to attrition and club participation.
Adolescent Decision-Making Program (ADM; Connecticut)	(Snow, Tebes, Arthur, & Tapasak, 1992)	Initiated with 6 th grade students	Decision-Making. Multi-year, classroom-based intervention focused on helping students make rational choices and negotiate group dynamics.	This study found a reduction in tobacco use, but an increase in alcohol use. This could be due to a bias in attrition from the study.
Peer Pressure Resistance Training (North Carolina)	(Hansen & Graham, 1991)	Junior high school students	Information, Resistance Training, Norm-Setting. Twenty-two 45-min. lessons about the social and health consequences of using alcohol and drugs, how to identify and resist peer and advertising pressure, and correcting erroneous perceptions of prevalence and acceptability of alcohol and drug use.	Normative education produced a reduction in the onset of use and in drug-related problems.

Midwestern Prevention Project (Kansas and Missouri)	(Anderson Johnson et al., 1990; Mary Ann Pentz et al., 1989; M.A. Pentz et al., 1989; Pentz et al., 1990)	Early adolescent population of Kansas City	Information, Resistance Training, Parental Support, Community Support; School-based program combines Resistance Training for students with Communication Training for teachers, and a mass media campaign (10 sessions plus 10 follow-up assignments to be done with parents).	Found short-term reductions in alcohol, cigarette, and marijuana use. Reductions for tobacco and marijuana held at 3-year follow-up. Reductions were equivalent for high- and low-risk youths.
Napa Project (California)	(Malvin, Moskowitz, Schaeffer, & Schaps, 1984; Malvin, Moskowitz, Schaps, & Schaeffer, 1985; Moskowitz, Schaps, Schaeffer, & Malvin, 1984; Schaps, Moskowitz, Malvin, & Schaeffer, 1986)	K to 12 th grade students	Information, Decision-Making, Values Clarification, Stress Management, Alternatives, Goal Setting, Resistance Training, Interpersonal Skills, Peer Support. A series of seven school-based prevention strategies was implemented in various combinations throughout a school district during a 5-year period.	Only a specific drug education component showed some positive short-term effects on attitudes toward drug use among girls.
Positive Alternatives for Youth (PAY; Virginia)	(Cook, Lawrence, Morse, & Roehl, 1984)	Junior and senior high school students	Interpersonal Skills, Self Esteem. Series of alternative classes meeting 2-3 times per week during school hours and focusing on interpersonal skills and positive behaviors.	Only an impact on reported liquor use was noted. There was little overall impact by the 2 nd year.

Community Programs

National Youth Anti-Drug Media Campaign	(DeJong & Wallack, 2000; Kelder, Maibach, Worden, Biglan, & Levitt, 2000)	U.S. youth aged 11-13 and their parents	Information, Norm-Setting, Resistance Training. Public ad campaign.	Results not yet published. Preliminary results suggest effects on parental attitudes but not those of youths (Bowman, 2002).
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Nevada Bureau of Alcohol & Drug Abuse (BADA)	(Clapp & Early, 1999)	Elementary through high school-aged children, most from ethnic-minority- or low-socioeconomic-backgrounds or from the juvenile justice system.	This study evaluated five different programs funded by BADA. The programs focused on Information, Academic/Vocational Skills, Vocational Skills, Family Support, Alternatives, and Pledges.	This was a qualitative study so the results reflect the feedback of informants and focus groups. The findings suggested that program participants' academic performance improved, their self-esteem increased, and their social skills and social tolerance improved.
"It takes a village to raise a child" (Massachusetts)	(Homonoff, Martin, Rimpas, & Henderson, 1994)	Adults interested in being role models	Information, Self-Esteem, Decision-Making, Stress Management. Nine modules focus on training adults to teach children personal and social skills.	No evaluation reported.
Fighting Back (National)	(Spickard, Dixon, & Sarver, 1994)	Children and adolescents	Loose collection of community-tailored intervention efforts funded by the Robert Wood Johnson Foundation.	Outcome evaluation has not been completed.
Adolescent Substance Abuse Prevention Education Network (ASPEN; Illinois)	(Sarvela & Ford, 1993).	Pregnant teens	Decision-Making, Information. Self-administered series of 8 educational modules on substance abuse and health completed during prenatal visits.	This study reported lower drug use and better pregnancy health/outcomes.
Trial of Computer-Assisted Instruction	(Rickert et al., 1993)	Adolescents (<i>M</i> age = 15.5) attending a medical clinic	Information. Comparison of computer assisted vs. physician delivered format.	Increased knowledge was noted in both intervention groups. Girls preferred the computer format, while boys preferred clinician delivery.

Implications for the Marine Corps

Drug use within the Marine Corps has dropped significantly since the early 1980s. The worldwide Department of Defense (DoD) Survey of Health Related Behaviors Among Military Personnel (SHRB) clearly documents this decrease (Bray et al., 1999). In 1980, 48% of Marines participating in this survey acknowledged illicit drug use in the previous year, while only 7.2% of participants in 1998 said they had used drugs in the previous year. Actually, illicit drug use dropped across the entire U.S. DoD during this same time frame (1980 = 36.7%; 1998 = 6.0%) and this has been ascribed to the implementation of urinalysis testing throughout the military services starting in the early 1980's (Jones, 1995). Still, within the DoD population, drug use remains markedly higher among junior enlisted personnel where self-reported use was at 14% in the 1998 SHRB.

At present, Marine Corps drug prevention relies heavily on urinalysis testing and subsequent disciplinary action for those who test positive (U.S. Marine Corps, 2001a). Each Marine Corps unit is responsible for screening all of its members annually. Additionally, units must test 10% of their population monthly. They must test every Marine reporting to a new command for duty and all Marines reporting in after a leave of absence within 72 hours. In 1998, 34% (DoD = 25%) of the Marines in the DoD SHRB reported that they had been tested in the last 30 days, and 94% (DoD = 87%) in the past year (Bray et al., 1999).

In addition to drug testing, the Marine Corps has a service-wide requirement for drug prevention education (U.S. Marine Corps, 2001a). The Marine Corps directive regarding this states that "a thorough prevention education program must address the entire scope of drug and alcohol abuse, both legal and illegal....Marines at all levels will receive prevention education and training at least annually." Beyond this annual requirement, commands are encouraged to make the training interactive and skill-oriented in addition to providing information about substance use and its consequences. However, beyond the minimal requirement of an annual informational program on substance use including both illegal drugs and alcohol, there is no standard program or required material to be presented. As a result, the exact nature of drug education varies from command to command in terms of program content, audience size, total presentation time, and level of group interaction facilitated.

As part of our review of drug prevention literature, we collected materials from Marine Corps drug education programs currently in use. We found that their content was generally

focused on information dissemination regarding the nature of illegal drugs, their effects on the body, and the consequences of using illegal drugs while serving in the Marine Corps.

Furthermore, it is not possible to determine exactly how much time is devoted specifically to illegal drugs, as opposed to alcohol, in actual practice. However, results from the focus groups presented later in this report indicate that alcohol receives the most attention.

The effectiveness of Marine Corps drug education has not been systematically assessed. However, research suggests that the impact of the typical drug prevention program on behavior may be small. For instance, the authors of one meta-analysis found that the average effect size reported in the prevention program outcome studies they reviewed was only .037 (White & Pitts, 1998). Based on this, these authors concluded that prevention programs only influence about 3.7% of their participants to reject or perhaps just delay the use of illegal drugs. It is difficult to weigh the individual and social benefits of this small impact against the costs of implementing prevention programs. However, another review found that there may be substantial differences in the average effect depending on program characteristics (Tobler & Stratton, 1997). For example, programs that had an interactive presentation format had an average effect size of .30, while those that were noninteractive had an average effect size of just .035. This leads to the conclusion that the specific characteristics of the program are not trivial and in fact may make a considerable difference in effectiveness.

One of the goals of this review is to consider programs that the Headquarters U.S. Marine Corps Office of Prevention and Intervention might implement service-wide, which would encompass those characteristics that have been shown to be most effective. Most existing programs that have been systematically evaluated and found effective, target students in primary and secondary schools. University athletic departments and high-risk workplaces are probably most similar to the military context. However, few illicit drug prevention programs have been designed to target these populations, and the few that have been developed tend to be implemented only in one location with little or no systematic evaluation.

Historically, workplaces have not been very involved in drug prevention (Dusenbury, 1999; Vicary, 1994). Their efforts have largely been restricted to Employee Assistance Programs (EAPs). The goal of EAPs is to provide timely referral and treatment for those with substance use problems or other types of life difficulties that might have an impact on personal well-being and work performance. As in the Marine Corps, a number of employers with workers in high-

risk occupations have initiated drug-testing programs to ensure that employees are not impaired by substance use on the job. In some occupations testing is federally mandated, as is the case in the transportation industry. Quest Diagnostics Inc., a leading provider of drug-testing in the United States, developed a Drug Testing Index to track the percentage of positive tests in the workplace (Quest Diagnostics, 2001; Washington Crime News Services, 1999). They report that in 1988, 13.6% of tests were positive, but by 1999 only about 3% were positive, a decline of 65%.

Some companies have become involved in community outreach, joining coalitions for drug prevention or organizing employees to take part in school or community prevention programs (Varisco, 2000; Vicary, 1994). A few workplaces have organized peer drug prevention networks that train and encourage employees to identify coworkers who may need help, to refer coworkers for services, and to participate as volunteers in drug prevention activities. Becker et al. (2000) describe an evaluation study of a program of this type called PeerCare, which was initiated by a large transportation company. Becker et al. planned an extensive evaluation of this program. However, no results were available at the time of this report. In a review of workplace drug prevention, Dusenbury (1999) concluded that state-of-the-art drug prevention programs have yet to be designed and evaluated for the workplace.

Among college athletes, The National Collegiate Athletic Association (NCAA) has a program of drug-testing for all participants in championship games. The NCAA has also attempted to strengthen drug prevention programs within athletic programs at member universities (Grossman & Smiley, 1999; Tricker & Cook, 1989). In a survey of trainers in NCAA-affiliated athletic associations, Tricker and Cook (1989) found that the majority of athletic associations had instituted their own drug testing programs, and 66% of trainers said that 90% or more of their athletes are tested each year. Trainers believed that drug testing reduced drug use within their programs, and they indicated that 5% or fewer of their athletes test positive. Very few trainers reported that any extensive amount of drug prevention education had been implemented through their associations. Specifically, 95% said drug education was offered zero to two times per year.

Drug testing may deter some athletes from using substances and there is evidence that the proportion of athletes who use illegal drugs is about the same or perhaps less than the proportion in the general population of college students (Nattiv & Puffer, 1991). But drug testing alone has

not resolved the problem of drug use among athletes. As a result, the NCAA has instigated a program to encourage athletic associations to broaden their drug prevention efforts (Grossman & Smiley, 1999). This program, called APPLE (Athletic Prevention Programming and Leadership Education), works with teams of representatives from NCAA member associations to plan comprehensive prevention programming. The areas of focus include (a) recruiting practices, (b) expectations and attitudes, (c) substance use education, (d) program policies, (e) drug testing, (f) referral for counseling, and (g) disciplinary action. As is the case with almost all programs designed for audiences other than primary and secondary schools, this program has unfortunately not been assessed to see if it impacts actual substance use behaviors among college athletes.

FOCUS GROUPS

Methods

Participants

Twenty-one focus groups were conducted for this study, each including 3 to 12 Marines. Among the groups, there were 144 men (87%) and 22 women (13%). Participants were chosen in order to represent the full spectrum of Marine Corps personnel involved in drug prevention programs. With this goal in mind, participants for these focus groups were chosen from both the East and West coasts and from both ground and air commands. The groups were comprised of 17- to 24-year-old Marines who had never tested positive, as well as a subgroup who had tested positive. They included groups of Marine Corps leaders and groups of Substance Abuse Control Officers (SACOs) responsible for implementing drug prevention programs within their commands. Participants were a convenience sample of Marines recruited by DDRCs at 4 locations. Specifically, at Marine Corps Air Station (MCAS) Miramar, MCAS Cherry Point, Camp Pendleton and Camp Lejeune, 4 groups were conducted, including:

- 17- to 24-year-old enlisted Marines who had never tested positive for drug use
- Marines who had tested positive for drug use
- Junior staff noncommissioned officers (NCOs)
- SACOs

In addition, at Marine Corps Recruit Depot (MCRD) San Diego a group of recruits who had not yet entered basic training participated. At MCAS Miramar, an additional group of junior

officers and a group of senior NCOs participated. At MCAS Cherry Point, separate groups were held for male and female 17- to 24-year-olds and for male and female junior NCOs. Finally, 2 senior officers and 5 DDRCs responsible for the drug prevention programs at their respective installations were interviewed individually by phone.

Instrument

The group facilitators had a set of general questions that they used to guide the course of the focus group discussions (see Table 4). For each question, the facilitator would listen to the group's first responses. After participants had a chance to express their initial thoughts, the facilitator would follow-up with a series of bulleted prompts in order to explore more specific information if it had not been addressed spontaneously. The areas that the protocol covered were (a) participants' beliefs about the extent of the problem of illegal drugs within the Marine Corps, (b) their experiences of Marine Corps drug prevention programs, (c) their beliefs about what aspects of current drug prevention efforts are effective, and finally, (d) their suggestions as to how the Marine Corps could improve its efforts. For specific groups of participants such as SACOs, DDRCs, Marine Corps leaders, and participants who had tested positive for drugs, there were some supplementary questions added to the topics listed below. These are listed more specifically in Appendix A.

Procedure

Focus Groups. The focus group discussions were held at five installations: Camp Pendleton, CA; MCAS Miramar, CA; MCRD San Diego, CA; MCAS Cherry Point, NC; and Camp Lejeune, NC. The DDRCs from MCAS Miramar, MCAS Cherry Point, and MCRD San Diego, as well as the Director of the Substance Abuse Counseling Center at Camp Pendleton, recruited the participants and arranged the locations in which to hold the focus groups.

Three consultants with expertise in the field of drug use prevention facilitated the focus groups (see Appendix B). An NHRC staff member also participated in each discussion to take notes on participants' responses. Each session was audiotaped so that the research team could clarify hand-written notes and so that a second team member could review each discussion for additional information.

Table 4*Focus Group Topics*

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1. Is there a problem with illegal drug use in the Marine Corps?
 - Impact on readiness?
 - Impact on the lives of personnel?
 - Could you describe the typical Marine Corps drug user? (single/married, lives on/off installation, age, officer/enlisted)
 - When, where, and under what circumstances do Marines use drugs?
 - Role of alcohol in drug use?
 2. How does your command work to prevent drug abuse?
 3. In what ways are Marine Corps drug prevention programs effective?
 - SACO's role?
 - Prevention education programs?
 - Urinalysis testing (Predictability, frequency, is everyone tested, are all samples analyzed, why might some commands not conduct tests)?
 - Leadership example?
 - Deglamorization of drug use?
 - Alternative activities? (Single Marine Program)
 - Timely referral when there is a problem?
 - Appropriate intervention or disciplinary action?
 - Enforcement of treatment or disciplinary action?
 4. How well do drug prevention programs help the Marines who need it most (those most at risk for drug use)?
 5. How can Marine Corps drug prevention programs be improved?
 - Single Marine Program?
 - Role of SACO?
 - Urinalysis Program?
 - Zero tolerance policy?
 - Disciplinary action?
-

At the beginning of all of the focus groups, the facilitators introduced themselves and the NHRC staff members with them. They read and explained the focus group procedures as outlined in the informed consent form and invited participants to ask any questions they may have had (see Appendix C). The facilitator then gave participants time to check the box on the consent form indicating that they were willing to participate in the study. Participants returned this copy of the informed consent form to the facilitator and received an additional copy for their personal records.

Phone Interviews. A subgroup of DDRCs, senior staff NCOs, and senior officers who could not meet in the same location to participate in the focus groups were contacted individually by NHRC staff members and interviewed by phone. The DDRCs who participated in phone interviews recommended senior leaders at their commands for interviews. They made the first contact with these potential participants and obtained their permission for an NHRC staff member to contact them. NHRC staff members first called participants in order to further explain the purpose and process of the research and to schedule a time for the interview.

Informed consent was obtained from participants in the phone interviews in several stages. When NHRC staff first contacted each participant, the staff member explained the interview informed consent form to the participant over the phone. Afterward, if the participant was interested in taking part in the interview, the staff member e-mailed him or her an electronic copy of the informed consent information along with a list of the general discussion topics for the interview. The staff member further scheduled a time for the interview. At the time of the interview, the researcher again explained the procedures outlined in the informed consent form to the potential interviewee, and gave him or her the opportunity to ask questions. Finally, if he or she verbally agreed to participate in the research as explained, the interviewer checked the box at the bottom of the consent form.

Results

The focus groups conducted for this study shared extensive amounts of information about Marine Corps drug prevention programs. Despite myriad comments, there was substantial overlap in the issues raised across different types of groups. In this section we have summarized common responses into four broad categories. These are (a) risk factors for drug use, (b) current programs, (c) currently effective practices, and (d) suggestions for improving drug prevention. Under each of these categories, we have listed ideas and issues that were raised across multiple

groups in a summary table followed by a narrative discussion of the points listed. Appendix D further lists suggestions for improving Marine Corps drug prevention programs mentioned uniquely by specific types of groups.

What are the risk factors for drug use within the Marine Corps?

Each of the focus groups was asked to discuss what type of Marine is most likely to use drugs and under what circumstances Marines are most likely to use drugs. In Table 5 we have cited the factors most often mentioned as risks for drug use within the Marine Corps.

Table 5

What Are the Risk Factors for Drug Use Within the Marine Corps?

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1. Young Marines
 2. Lack of connection and commitment to the Marine Corps
 3. Vulnerability of single Marines to peer pressure
 4. Drug waivers
 5. Loneliness, isolation, boredom, work stress, and depression
 6. Availability of drugs
 7. Long periods of liberty/leave
 8. Cultural acceptability of alcohol use
 9. Availability of information on how to predict or invalidate drug testing
 10. Inconsistent or delayed punishment for drug use
-

Young Marines. Young Marines may often be immature and inexperienced. Boot camp may also be a disillusioning experience for some, and the transition to duty is a vulnerable time. Some of the SACOs and DDRCs particularly felt that young Marines come into the Marine Corps from a peer culture that is fairly accepting of drug use. They frequently know more than drug reduction specialists do about the current drug scene. Young Marines between the ages of 17 and 24 may be more vulnerable to drug use because they are more likely to experience other risk factors for use as well, such as low commitment to the service, loneliness, and peer pressure.

Lack of commitment to the Marine Corps. Early in their career, many Marines have not made family commitments or personally accepted responsibility for their own performance at work. They are therefore less likely to take the potential health or career consequences of drug use seriously. Those who came in to escape problems at home or to find a temporary job may also be less committed. At the extreme, focus group participants thought testing positive was an easy way out for Marines who have decided they do not want to be in the Marine Corps.

Recruits entering with drug waivers. The Marine Corps gives a number of drug waivers to new recruits each year. A common assumption among focus group participants was that these people are more likely than others to continue using drugs after entering the service and to test positive for drugs. Several groups indicated that simply joining the Marine Corps is not likely to change such preexisting behaviors. If Marines used drugs before they enlisted, simply being in a different situation will not ensure that they stop using drugs. Persons with histories of drug use may not have received any counseling or treatment regarding their drug use prior to entering the Marine Corps. Focus group participants thought that some recruits may plan to stop using illegal drugs, but they may turn to them again in order to relieve stress once they experience the demands of service life. They also may abstain for a while and then begin again, because they become convinced that despite the zero tolerance policy, a large percentage of the Marine Corps uses drugs. Finally, some may not really have a clear plan to abstain from drugs; for example, one focus group participant who had tested positive for drugs said that he knew he used drugs, and he knew the Marine Corps policy on drug use, and he was not sure why he originally thought he could successfully adapt to service life.

Vulnerability of single Marines to peer pressure. Young, single Marines may be more vulnerable to peer pressure because they have to develop and maintain a network of friends.

Although most respondents had heard about the Single Marine Program, few said they had participated in activities. Most often they were not considered socially fashionable. Many also did not want to socialize with other Marines during their free time. They wanted to meet new people. In particular, single Marines were concerned about meeting people to date. Given the high percentage of men within the service, they sought social venues off base. Several focus group participants thought young single Marines sometimes use drugs or alcohol to impress women or to go along with a girl who is using at a party or at a bar.

Loneliness, isolation, boredom, work stress, and depression. Focus groups thought that Marines use drugs as a coping strategy to deal with negative emotions such as boredom. Even if activities where drugs and alcohol were not emphasized are provided, getting to them may be seen as too much effort at the end of the week, or as too expensive. Some Marines also said they felt a lot of work stress due to repetitive or menial tasks, and drugs and alcohol were ways of escaping from that stress and boredom. The fact that the Marine Corps may not meet their expectations or that junior enlisted personnel may not feel valued or respected, may exacerbate these feelings. Focus groups of junior and senior enlisted personnel, as well as one group of participants who had tested positive, raised the idea that drugs are a way to combat depression (Abraham & Fava, 1999; Weiss, Griffin, & Mirin, 1992). Some said that mandatory separation from families and being stationed in isolated areas can contribute to this, particularly around the holidays. One participant suggested that Marines may try to hide their depression and they may not be familiar enough or comfortable enough to make use of available counseling resources.

Availability of drugs. Most Marines indicated that it was easy to obtain illegal drugs throughout the United States. Furthermore, bases in or near countries where underage drinking is legal or where drug laws differ from the United States (e.g., Mexico and Okinawa) pose a unique

problem. Some respondents mentioned how available opium was overseas, and that it was often added to drinks as an accepted practice.

Clubs were particularly mentioned as places where drugs were easy to obtain. Marines thought that the club drug Ecstasy, in particular, was becoming more popular because an efficient test has yet to be developed to detect it. Marines who know they are likely to be tested will choose to use Ecstasy because they believe they can get away with it. Marines also suggested that if they have to drive back on base after leaving a bar or club, using drugs was less of an immediate problem, since some installations test for alcohol at the gates.

Long periods of liberty or leave. Although leave was generally seen in a positive light, participants thought it provided opportunities for drug use. Long periods of leave allow time for drugs to clear from the user's system before he or she has to return and take a drug test. Time also allows the user to recover fully to perform his or her duties without negative or obvious consequences. Participants may go home during a long leave where they are around old friends who use drugs, which may further increase the risk. However, staying on base over a holiday could also encourage use because, as noted earlier, it leads to feelings of loneliness. Young Marines, in particular, may lack funds for travel during holidays.

Alcohol use. Alcohol was almost unanimously considered to contribute to drug use, both through its ability to impair judgment and its association with the club scene. The acceptability of alcohol use within the Marine Corps culture makes it a particular problem. Many respondents mentioned that alcohol is often an accepted part of Marine Corps activities and that higher-ranking personnel frequently use alcohol in the presence of the younger Marines.

Information on how to predict and invalidate urinalysis tests. Information on how to flush your system of drugs and beat urinalysis tests is available on the Internet and by word-of-

mouth. Respondents mentioned such remedies as taking golden seal or niacin and drinking large amounts of water. Many thought the drug testing at their command was not done randomly. Patterns in the timing of tests were often easy to identify, allowing them to prepare ahead. For instance, testing was more likely after extended periods of leave; those who work irregular shifts, such as night crews, were less likely to be tested; and testing tended to increase after someone in the command tested positive. A number of young Marines also had the impression that officers and NCOs had more friends and connections that would warn them about upcoming tests.

Inconsistent or delayed punishment for drug use. All Marines in the focus groups agreed that the zero tolerance policy is inconsistently enforced. The lack of, or the perception of the lack of, consistent and serious consequences for drug use within the service may encourage some to take their chances with drugs. One senior leader agreed that even the threat of a less than honorable discharge might not appear to be very serious to some. Young Marines may not believe that this will inordinately affect their opportunities in the civilian world in the long run.

How are current Marine Corps drug prevention policies and programs experienced by Marines?

All of the focus group discussions explored participants' experiences of Marine Corps drug prevention programs as they are currently implemented. The intent was to find out how Marine Corps drug prevention programs are being presented and what impression they are leaving on their target audience. How does the average Marine perceive the Marine Corps drug prevention program?

Table 6*What Does the Marine Corps Currently Do to Prevent Illegal Drug Use?*

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1. Urinalysis testing
 2. Recruit screening
 3. Marine Corps policies
 4. Disciplinary action for those caught using illegal drugs
 5. Drug education
 6. Alternative activities
 7. Leadership support and example
 8. Substance Abuse Control Officers
-

Recruit screening. The Marine Corps drug prevention program begins before Marines have entered the service. The reputation of the zero tolerance for drug use in the U.S. Armed Services is the first stage of the program. This is coupled with the screening process that recruits must go through to enter the Service. Those with a history of illegal drug use are not recruited without a waiver. The relationship of drug waivers to the zero tolerance policy was raised repeatedly in many focus groups. Many respondents felt that drug waivers send a mixed message about how serious the Corps really is about drug use.

Urinalysis testing. All participants had experience with urinalysis testing. The urinalysis program was implemented somewhat differently from location to location, based on the guidance of specific commanding officers. Participants reported being tested as infrequently as once a year and as frequently as several times a month. Some participants mentioned that they had to be tested when they checked in for duty at a new command and when they reported in after leave. They might be tested after a long weekend or after holidays, particularly a major holiday like Christmas. Some units tested anyone who had been on leave for more than 15 days. There was some discrepancy in exactly how much time they had to report in, after a leave.

Some felt the testing was more predictable depending on how their unit organized the program. For example, Tuesdays and Thursdays seemed to be popular testing days in one unit. By contrast, some units conducted surprise tests first thing in the morning or even in the middle

of the night so users would not have the opportunity to eliminate the traces of drug use from their systems. Participants generally seemed to think that subjects were chosen for testing at random, and everyone in the unit was eligible to be called. There were some groups on the West Coast that said their senior officers were able to avoid getting tested. Other groups reported that they saw their senior officers come in for testing like everyone else. Finally, some younger enlisted Marines thought that they were disproportionately represented among positive drug tests because they had not learned how to beat the system as had more senior personnel.

There were some areas where group participants were unclear about the urinalysis testing procedures. One group mentioned that testing seemed to depend on whether the unit had the funding to support it. Apparently, they were told that testing was not being done because the unit did not have the funds for collection vials. A couples of groups were not sure if all of the samples were always tested or if some of the samples were routinely left out.

Marine Corps policies. When asked what the Marine Corps policy was, all of the Marines who participated in the focus groups responded with the zero tolerance policy. Most said they were aware of the policy even before they entered the service. Focus group participants said that explanations of the policy could be as simple as being told “Don’t do it” or “If you get caught, you’ll get kicked out.” Participants also indicated that their commands would blacklist specific businesses and areas known for drug use. Marines were not allowed to go to these places.

Disciplinary action. Participants described the consequences of drug use for Marines who test positive or were otherwise caught using drugs. These included processing for separation from the Marine Corps and some type of punishment, such as a reduction in rank, loss of clearance necessary for work, assignment to menial tasks, separation from the unit, confinement to barracks, time in the brig, or referral to a Correctional Custody Unit (CCU). There was also discussion about group punishments that might occur when a Marine tests positive for drugs. For instance, unit leaders might talk about what happened with the whole unit and make an example of the Marine or mandate that the whole unit attend drug education on a Saturday. In this instance, education classes took on a punitive image. A few group participants mentioned that people caught for drugs might be sent for counseling. Counseling after testing positive also took on a negative image with some respondents. Several groups commented that Narcotics Anonymous (NA) meetings were mandatory, but pointless and geared toward addicts rather than recreational users.

The exact disciplinary action taken appeared to vary widely from command to command and from case to case. Although the policy in the Marine Corps is zero tolerance, all of the focus groups discussed the fact that not all Marines caught for drug use are discharged. Participants talked about people they personally knew who had been caught but appeared to receive little if any punishment. Others who were caught for a first offense might find themselves quickly out of the service with a dishonorable release. All groups raised the issue that the adjudication process was too lengthy after a Marine tested positive. Even those respondents in the process of being separated felt that delays in becoming officially separated make it harder to “get on with your life.” Some respondents who had tested positive had waited between 6 and 9 months before they knew what would actually happen to them. Another Marine noted that it took almost a year even to be notified that he had tested positive.

Some of the more senior leaders and drug prevention personnel mentioned that the length of time it took to process Marines out was largely defined by legal requirements and complications. There were a few respondents who noted that Marines who test positive need time to gather evidence for a case in their defense, so immediate separation could prove to be unnecessarily detrimental to an individual’s career. The younger enlisted Marines who participated in the focus groups did not mention these legal issues. However, they consistently talked about how Marines in process for separation reduce the overall morale of their units. While they are in process, they are unable to perform their regular duties, and the menial tasks they are given do not appear to contribute anything of value. They may openly discuss their drug use and ways to beat the system with others and they may continue to get into trouble, thinking they have nothing to lose.

Drug education. Most participants said that the drug programs they had participated in covered the positive and negative psychological, physical, and interpersonal effects of drug use as well as the possible consequences of using drugs on their careers in the Marine Corps. Presenters usually used lectures or educational videos to teach the material. Drug education programs were not highly valued by the majority of Marines in the focus groups. Respondents generally indicated that these programs fulfilled a Marine Corps policy requirement, but that the programs were long, boring and repetitive, including information with which they were already familiar. Many young enlisted personnel also had to think for a little while about what specific drug prevention training they may have been given. They had not received much training, if any.

One Marine said that education consisted of being handed written materials with the instruction, “Here, read this.” Some respondents had attended classes for alcohol prevention, but not for drug prevention. One respondent pointed out that many Marines join the Corps to get away from spending a great deal of time in a school classroom. The drug education programs replicate a style of learning they came to the Corps to escape.

The number of times Marines participated in drug prevention education programs and the size of the audience were dependent on the direction of Marine Corps commanders. Commanding officers may request that programs be presented to entire companies or to individual units. Both practices were reported. A number of focus group participants said that the programs they participated in involved large audiences with little opportunity for interaction or questions. Some mentioned that education programs might be shortened in order to fit the attention span of the audience or to fit other scheduling priorities. Although it is mandatory for the classes to be offered, at some commands only those who are available when classes are scheduled attend.

Senior leaders and drug prevention personnel indicated that each command creates a training plan for the year. Although creating a drug prevention training plan is one of the responsibilities of the unit SACO, based on our participants’ comments, this does not seem common. Drug prevention personnel indicated that the SACOs do not have enough time to perform a needs assessment on the unit or create a unique training plan. Training plans may be put together by a training officer who might schedule a yearly training day when substance abuse prevention education can be offered in conjunction with other types of required training such as the prevention of sexual harassment or suicide. A few commanders request additional drug education programs for their commands, typically about 2-3 per year. In some units, drug prevention messages were sometimes presented with command safety briefs at the end of each week. In one focus group, the participants said they had recently had a safety stand-down specifically on substance abuse, where an entire day was focused on prevention.

Although DDRCs do not have the opportunity to design or control the drug prevention training plans for specific commands, they try to create opportunities to present drug prevention messages. DDRCs talked about networking with other healthcare personnel in order to present drug prevention information in as many forums as possible. They organized specific activities such as full-day sporting events to heighten drug prevention awareness. DDRCs also worked to

make their drug education programs interesting and pertinent to Marines. One DDRC tried constantly to keep up with the new drug information on the Internet and incorporate it in PowerPoint presentations. She mentioned how powerful it was for Marines to hear the detrimental effects of drugs on their health, stating damage from specific substances that could contribute to impotence, brain cell damage, lung damage, and in certain cases, death.

Alternative activities. We asked each focus group whether they felt there were enough recreational activities available at their command and whether boredom played a role in drug use. A number of people believed it did play a role. However, these were generally focus group and phone interview participants at installations in remote areas. At three of the four locations where we conducted focus groups, participants said there were plenty of activities they were aware of that the Marine Corps provided for them. Although participants in these groups agreed that the Corps offered plenty to do on base, many did not want to participate. Part of this was because they wanted to leave the environment in which they worked and get away from the people they worked with when they were off duty. They also noted that the activities on the installation might not fit their personal interests. Participants looking for a place to drink and to meet people to date said there may not be a club on their installation for junior enlisted personnel, or that the club available might not appeal to the younger crowd. One young Marine who had tested positive for drugs said even though there were plenty of activities, he simply enjoyed doing drugs. If he wanted to go to a movie, he would do drugs and go to the movie.

Leadership example and support. Few Marines talked about leadership example as an important part of Marine Corps drug prevention. The few that did tended to be senior leaders themselves. However, we specifically asked all of the focus groups and phone interview participants to think about how the example and support of Marine Corps leaders influenced drug prevention programs. As might be expected, participants felt that some leaders were more supportive of drug prevention programs than were others. This was most easily recognizable in the way they structured drug prevention programs under their personal command. For example, respondents got the impression that some units did not care if people used drugs if they tested only sporadically. SACOs did not necessarily say that their commanding officers did not support them; however, they did say that the role of SACO was most often assigned as a collateral duty, perhaps along with other burdensome or unwanted command duties. Only a very small number of SACOs indicated that this assignment was their primary duty. Even the adequacy of the office

space allotted them suggested that the job of SACO was not a priority. One group noted that their office space was also the copy room.

The way Marine Corps leaders enforced the zero tolerance policy further came across as an indication of their commitment and support for drug prevention. However, the way this was interpreted by young Marines was complex. Some seemed to believe that leaders who automatically separated all Marines who tested positive for drugs were very serious about drug use. By contrast, others suggested that this was the easy way out. These respondents saw the case-by-case approach as evidence of a leader's willingness to make tough decisions and think things through, rather than take a "cookie cutter" approach to enforcement that ultimately lost the Corps money and manpower. Still, to other Marines, the way leaders dealt differently with those who tested positive suggested that they had a double standard and were playing favorites.

One enlisted Marine noted that he had seen the attitudes of some leaders regarding illegal drug use change over time from "just don't get caught" to "don't do it." This may reflect a growing awareness of the importance of supporting drug prevention efforts within the service more generally. Some Marines noted that their leaders urge them to bring problems to them first, rather than getting help from "outside the shop." They want to resolve those problems within the unit and avoid a bad reputation for their command. Finally, some Marines thought more drug prevention efforts focused on alcohol than drugs, although the majority of the participants indicated that they personally think alcohol is a greater problem in the Marine Corps than are drugs. A number of young enlisted personnel commented that some NCOs (especially Corporals) drink, and may even buy liquor for others, especially people they work with. In at least one unit, junior leaders were selling drugs to the enlisted Marines.

Substance Abuse Control Officers. We asked participants if they knew what the SACO's responsibilities were. Most participants were aware of who their SACOs were and thought SACOs were primarily responsible for drug and alcohol programs within their units. A number of participants said that they had to check in with the SACO when they first reported at a new command and they checked out with him or her when they left a command. Only one or two respondents said they did not know who their SACO was. All of the groups indicated that SACOs primarily run the urinalysis testing. Some young enlisted Marines said they did not think SACOs did much, while others thought they were very busy with testing. Additionally, some participants mentioned that the SACO is available so people who have problems can come to

them, people are sent to the SACO when they have an alcohol- or drug-related incident, and the SACO keeps track of the treatment and aftercare for people who get in trouble.

The SACOs themselves discussed how difficult it is to run their programs, because drug prevention was not viewed as a top priority. Many SACOs felt that they could not keep up with all the tasks required by the position and that only the basic duties were performed. They also said that due to the stressful nature of the position, many people leave early, creating a high turnover rate. The position was supposed to be filled for a minimum of one year; however, this is not always the case. In fact, one group indicated that a unit can “easily go through one SACO per quarter,” making continuity a problem. The DDRCs noted that high turnover has a negative effect on the drug prevention program, because Marines are unable to develop a relationship of trust with their SACOs and therefore are less apt to turn to them for help.

What aspects of Marine Corps drug prevention efforts do personnel perceive to be effective?

Table 7

What Marine Corps Drug Prevention Measures Are Effective?

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1. Public awareness of the zero tolerance policy
 2. Urinalysis testing
 3. Specific types of drug education programs
 4. Specific types of punishments
 5. Commander's with supportive attitudes toward drug prevention
 6. Offering incentives for participation in drug prevention
 7. Alternate activities
 8. Mentoring
-

Zero tolerance and urinalysis testing. Despite perceived inconsistencies in the way it is enforced, all Marines were aware of the zero tolerance policy. Most regarded it as a good policy. They thought it was clear and easy for everyone to understand. Additionally, there was a consensus that the urinalysis testing was the primary method for enforcing the zero tolerance policy. Focus group participants thought that urinalysis testing prevents drug use, especially in

people who are not habitual users. Lastly, many agreed that truly random testing and surprise testing are the most effective means of reducing drug use.

Drug education. Most Marines felt that drug education programs contained sufficient information about the consequences of drug use. Marines particularly indicated that they liked gory images in the education programs illustrating the most extreme consequences of drug use. DDRCs and young Marines alike said that bringing in former users who have suffered negative consequences as a result of drug use catches people's attention. Real-life experiences have an impact that mere lecturing does not. Several respondents mentioned a speaker who was paralyzed and in a wheelchair who "really made them think." DDRCs also brought in guest speakers to address specific topics and add variety. Participants in focus groups on both sides of the country mentioned a guest speaker they liked who used hypnosis to illustrate how substance use impairs your ability to function. A number of DDRCs indicated that they tried to make their presentations pertinent to the interests and concerns of young Marines and that they tried to make the format as interactive as possible.

Some participants believed that drug prevention education in the Marine Corps was helpful in deterring people who do not use from using. However, they did not think it kept people who already used from continuing to use. Drug education may help the person who has not yet used drugs make the right decision in a high-risk situation, such as under stress or out with friends at a party or a club.

Disciplinary action. Many participants expressed doubts that the brig was a very effective punishment. One participant thought that neither the brig nor CCU were effective. However, two groups mentioned that the CCU program seemed to be better than the brig. One, in particular, discussed a clear change in attitude among Marines returning to the unit from CCU. By contrast, Marines who spent time in the brig did not seem affected.

Several young Marines also specifically mentioned that making public examples of people was an effective way of preventing drug use. Several participants who had tested positive for drugs explained that they felt immediately rejected by their units once the news was public. One respondent who had tested positive said, "the whole platoon looks down on you." Several respondents cited events at which rank was publicly stripped or names of users were published in the base newsletter. Senior enlisted personnel thought that it is important to communicate accurate information about personnel who are caught using drugs in order to avoid rumors.

In addition to discipline, those who tested positive mentioned participating in probationary programs. A few said that they had to submit to a urinalysis test twice per week for a year, and attend 3 AA meetings per week. One participant who had attended the AA program said; “in 2 Thursday night meetings, I learned more than all the stuff they ever taught here ... I heard real life stories from people like me, and that was the best part.” A participant from another unit pointed out a discrepancy that if someone “pops” for drugs, he or she only has to attend one NA meeting per week, but if it is alcohol, he or she must attend 3 meetings per week. After participating in a probationary program for one year without “getting into any trouble” they would not be discharged. Another respondent remarked that his SACO remained involved with him after he tested positive, and he had to report to his SACO if he wanted to go on leave. This close monitoring seemed effective in helping him stay out of further trouble.

Leader’s attitudes toward drug prevention. The senior leaders who participated in focus groups and interviews raised a number of concerns about illegal drug use and they all said it was an important problem. In particular, they were concerned about the impact on readiness and morale. When a Marine tests positive, it places more of a burden on others who must shoulder his or her responsibilities. When a Marine tests positive it reflects poorly and is an embarrassment to his or her unit. At a personal level, a Marine’s career is ruined when he or she tests positive. Using drugs also reflects on a Marine’s willingness and commitment to serve honestly and honorably. At the same time, senior leaders seemed concerned about the amount of time that it takes to maintain the urinalysis program and to offer drug education programs. One senior leader said that he would probably would not entertain the possibility of spending any more time on drug prevention than he must at present. He would have to be very convinced that taking that time would produce effective results.

Several DDRCs commented that a lot of the success of the drug prevention program depends on the attitude of the commander. Because commanding officers have discretion over how drug prevention policies are implemented within their command, they truly define and shape Marine Corps drug prevention. According to the DDRCs, there are some commanders who are fully behind the drug prevention program. They require frequent, random urinalysis testing and may request drug education training more than once per year. Many other commanders simply meet the minimum requirements. One DDRC thought that those who scheduled

additional trainings tended to have fewer problems with drug related incidents or positive drug tests.

Incentives. To create some incentive for Marines to participate in drug prevention presentations, some of the DDRCs mentioned that they used small token gifts. These might include key chains or magnets. DDRCs believed that this was an effective tool in encouraging Marines to be more interactive during drug education programs. One young enlisted Marine suggested that the incentives could be more substantial, such as the opportunity to go on recreational trips.

Alternative activities. As noted earlier, at three of four focus group locations, participants agreed that there were enough alternatives to drug use at their installations. Some group participants seemed to think that Marines just have to become familiar with and take advantage of all of the activities available. In one group of junior NCOs, a participant said that she tries to point out events or activities to young Marines when they come to her complaining of boredom. A senior officer thought that the Single Marine Program was quite effective at offering Marines more “wholesome” alternate activities at his location. The program organized group activities for singles on base and also in the community. He further believed that group activities were an excellent way to bring the Marines together, build relationships and team spirit, and help boost morale. If there are enough positive activities, Marines feel a greater sense of cohesion, and they do not need to seek more detrimental activities for entertainment.

Mentoring. SACOs who utilized their position as one of the unit members to make close contact with the Marines were appreciated. One Marine said that his unit SACO came and talked to them during working hours in small groups, almost one-on-one. He and his unit appreciated the fact that they did not have to take an hour out of their own lunchtime to get the information. Their SACO brought the answers to them instead of waiting for them to seek him or her out. A few DDRCs also mentioned how important it was to have good, devoted SACOs who would not quit easily. However, they also pointed out that finding such devoted SACOs was not always easy.

A group of junior NCOs talked at length about the importance of unit cohesion and the role that peer support can play. One participant said her unit assigned junior NCOs as mentors to younger enlisted personnel in order to help them. Another young woman explained that after some problems in her unit, they sat down as a group and made a plan to spend more time

together and be more supportive. She believed this had clearly made a difference. Finally, the Welcome Aboard Program was seen by one senior officer as effective at helping to establish supportive roles. Each new Marine and his or her family are assigned an NCO to show them around the base upon their arrival. He said that this way Marines immediately have a connection with someone they can look up to and hopefully turn to with questions or problems.

A senior officer viewed his role not just as an authority figure, but also parental figure. If he could help young Marines achieve the goals they entered the service for and be successful in their assignments they would be less likely to use drugs. However, he mentioned that times have changed so much that he rarely has much time to spend with the younger Marines. In past years, senior officers would more often spend time with their troops on a personal level at sporting events or barbecues. When they feel that ranking officers really care about them and their welfare, it makes an important difference in the lives and attitudes of young Marines. A “firm, fair, and compassionate,” approach wins a lot more over, than does screaming or yelling at them. *How do Marines believe current drug prevention efforts could be improved?*

Table 8

How Could the Marine Corps Improve Its Drug Prevention Programs?

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1. Consistency and adherence to the zero tolerance policy
 2. More frequent and random urinalysis testing
 3. Improved drug education
 4. Modify the role of the Substance Abuse Control Officer
 5. Revise the Marine Corps Order
 6. Build morale and cohesion within units
 7. Provide programs for high-risk Marines
 8. Develop more low-cost activities for enlisted personnel
-

Enforcement of the zero tolerance policy. While there was some disagreement among Marines in the focus groups as to how the zero tolerance policy should be enforced, there was agreement that enforcement should be more consistent. Although strict enforcement of zero tolerance was the prevailing sentiment, a number of respondents argued for a case-by-case

approach. One young Marine felt that the motivation of the individuals themselves should be a deciding factor. Those who test positive should be given a second chance if they want it. Those who just want to get out should be separated as soon as possible. One senior leader indicated that he may sometimes retain the wrong Marine, but in the case where he is proved wrong, he can then follow through with separation. For those instances where he is able to help a Marine get back on track it is worth having flexibility in the zero tolerance policy.

Many respondents took a hard line approach. Marines know the policy on drug use and should be immediately removed from the Corps if they test positive. This is typified by remarks such as “If you get nailed, then you should do time and then get kicked out, because you deserve it.” Proponents of this perspective believed that inconsistent enforcement sends the wrong message about drug use to Marines. It facilitates drug use because it encourages Marines to think they can get away with it. Even those who had tested positive for drugs complained that the policy was not enforced consistently. One Marine said it would be “retarded” if he were not separated for his drug use. At the very least, most Marines thought that the discipline given should be consistent from unit to unit and across ranks.

Several participants said that overall discipline within the Marine Corps had become slack. The response to illegal drug use is just a case in point. Disciplinary action is both too easy and too slow. The adjudication process is lengthy once a Marine tests positive. Marines who test positive become “dead weight.” Since they are most often restricted from doing their jobs, the Marine Corps’ investment in training them is lost regardless. Furthermore, those who test positive should be in the brig, not with their units, so that they do not overly affect morale.

Participants from several different focus groups mentioned that public nonjudicial punishments could be used more often. They thought that announcing the names of drug positives in front of the entire unit, describing the punishment, or actually being stripped of rank in front of one’s fellow Marines was effective. Participants felt that this ritual delivers a clear message of zero tolerance in the Marine Corps and should be practiced more frequently as a deterrent to drug and alcohol abuse.

Urinalysis testing. Many groups indicated that random testing is not done often enough, and that the testing schedule is too predictable. Random testing should be increased and scheduled at unexpected times. For instance, respondents in the drug positive group said that giving drug tests after leave periods is ineffective. Marines expect to be tested at that time, and it

is relatively easy to be prepared for the test if you “do drugs early in the weekend.” Senior enlisted and officers should all visibly participate in urinalysis testing. At some commands this already appeared to be the case. At others, enlisted personnel had the impression that officers and senior leaders may not be participating. Many mentioned that being closely observed giving urine samples was an uncomfortable social interaction. Leaders who are willing to undergo that scrutiny along with their troops send a proactive signal that they take zero tolerance seriously.

Drug education. Participants had a number of suggestions as to how drug prevention education could be improved. Overall, focus group participants thought that drug prevention needed to be more visible and that less energy should be spent in reacting after Marines tested positive than was spent on prevention ahead of time. The prevailing attitude, according to one DDRC, is to get the required training over with quickly and efficiently, and get Marines back to their duties. This results in reactive rather than proactive prevention. Marines tend to get drug education after an incident where someone tests positive.

Across the board, groups agreed that classes should be smaller. This would facilitate more discussion and interaction and less lecture, which most Marines found boring. Classes could be run by civilian experts or trained peer-rank personnel. Civilian experts could then make themselves available to answer questions confidentially. Many thought there should be a confidential sanctuary for people who admit to having a problem, but who have not tested positive. If someone wants help it should be available without fear of being disciplined for being honest and forthcoming. Some Marines who were aware of others who had problems felt that they had to choose between covering for a fellow Marine and “snitching” and that some middle ground would be helpful.

Comments about how curriculum content might be improved were mixed. Some Marines wanted more classes and more information, while others stated that the classroom setting was not the method most likely to reach the typical Marine. Other Marines placed emphasis on physical fitness and the biological effects of drug use, and they thought that this emphasis was important to continue. Others thought information on physical effects was well and good, but they needed more knowledge about general life skills. A proactive program would help Marines get the living skills and community support they need to make the right decisions in high-risk situations. Some participants said that discussing the effects of drug use on your military career should be prioritized. They mentioned that they would like to hear from more Marines who have used

drugs in the past and have experienced the negative consequences of use. It would be helpful to hear from people who have bottomed out and then “cleaned themselves up.”

Substance Abuse Control Officers. Most of the focus group respondents, and in particular the most junior enlisted, had few suggestions as to how the role of the SACO might be improved. Respondents did suggest that SACOs, DDRCs, and Counseling Center personnel visit each shop more often and talk to people personally. Another group talked about the possibility that younger Marines might be trained as SACOs. However, they seemed to conclude that younger enlisted Marines might be more willing to compromise the urinalysis program and warn their friends when they were going to be tested. By contrast, a group of junior NCOs and officers suggested that the urinalysis testing program should be taken off the shoulders of the units entirely and given to health professionals from hospitals or medical clinics. Marines seemed to think that the job of the SACO was a burden within their commands and that there was a certain inherent conflict of interest in having one of their own run the program.

The SACOs had numerous suggestions as to how their jobs could be improved. Being a SACO was viewed by some as detrimental to their careers because it was not a highly valued duty. SACOs noted repeatedly that their job was too time-consuming to be a part-time duty. It should be a separate billet. It would also help if all SACOs had assistants. A lack of time and recognition of the importance of the SACO's role by unit commanders may contribute to inconsistent completion of duties according to some SACOs and DDRCs. When SACOs realize they cannot fulfill all of their responsibilities they pick and choose among those they would rather do. In addition to more time, SACOs felt they needed more training. Even when training was available, some SACOs felt that they were unable to attend due to time constraints. Finally, SACOs are not counselors and are not allowed to do counseling, but they have to monitor the aftercare for those who are in treatment. Some felt that they were forced into a position where they need counseling skills, therefore it would be better to train them as counselors.

SACOs are responsible for making sure people receive treatment when they have been referred to the Alcohol Treatment Facility (ATF). However, they do not necessarily have the power to do that. Battalion and company leaders may refer Marines to the SACO, but if it is left up to the Marine to show up without communicating directly with the SACO, then the referral may slip through the cracks. Leaders also may not make treatment their priority. Marines were sometimes sent out on operations even if they had an ATF appointment scheduled. If an

appointment was missed simply because a Marine did not show up, the SACO was held responsible. Some SACOs actually drove Marines to appointments in order to make sure they got there. Other SACOs resorted to having Marines sign statements saying they knew when their appointments were. Then if they did not show up, they could not claim that the SACO had not told them about it.

SACOs expressed considerable concern about the new computer program they must use to track urinalysis testing. They said the program locks up and then has to be completely downloaded again and the rosters reentered. Some had trouble printing from the program. There were sometimes discrepancies in the batch numbers where the bar codes did not match the urinalysis samples. A substantial part of this problem seemed to be a lack of adequate training and adequate computer equipment. SACOs did not understand why they were having difficulties and the “Help” function only covers how to install the program. It does not provide any help in running it subsequently. Participants were under the impression that updates were coming out, but they did not know when that would happen. One SACO said he had stopped using the program completely and had gone back to the old method.

SACOs also commented on the potential lack of confidentiality and certitude of truly surprise random testing. Apparently, in several units the SACO does not have his own office or computer and must use a computer in a common area where it is not possible to work confidentially. One commented that the mere fact that he was spending more time at the computer than usual always indicated to everyone else that there “must be something up,” and consequently the word quickly spread that a “surprise drug test” was coming.

Revise the Marine Corps Order. Some DDRCs and senior leaders felt that the Marine Corps Order provided them with all of the directives they needed to do their jobs. However, many participants expressed frustration at the structure of the manual. It seemed to be arranged in loosely related segments. A user has to consult several sections to get a complete picture of the drug program duties and procedures. In addition, the process by which the Order was drafted and distributed seemed protracted and confusing to some. Several revisions came about after the Order was disseminated, so that users following the mandates in early drafts had to adjust their actions after the fact. Several DDRCs and SACOs suggested reorganizing the new Order so that all the drug and alcohol information appears together.

According to one DDRC, the current Order was written to give more discretion at the unit level instead of dictating a lockstep plan. This format allows flexibility, but it can also be vague. In particular, the exact role of the SACO should be clarified. The definition of the SACO is given, but the directive does not give information regarding the prerequisites for the position and it does not specifically state that the appointment must be made in writing. SACOs and DDRCs alike commented that the new Order depicts the SACO position as a personal service rather than a duty assignment. The Order does not specify how to perform specific tasks. With key information left out, the Order seems like the “Reader’s Digest condensed version,” in one SACO’s words. In particular, it does not provide enough guidance for new SACOs, who must rely on their coworkers to learn the day-to-day job. Respondents were also concerned that the amount of training previous Orders had provided for had been cut in the most recent version. The current Order leaves amount and type of training largely up to the discretion of unit leadership. Lastly, the Order does mandate that SACOs should be appointed for at least a year. However, as noted previously, the one-year appointment rule is not always followed. SACOs repeatedly suggested that commands should adhere to this rule.

Build moral and cohesion within units. The subjects of morale and cohesion were raised several times among participants, particularly by junior leaders, NCOs, and senior leaders. It seemed especially important in units stationed overseas, submerged in foreign cultures and far from home. However, some seemed to believe it was easier to build cohesion outside the United States. Marines naturally rely on each other more in remote locations. Participants suggested it might help to build more hospitable barracks with common areas for barbecues and team sports. Living quarters should create a comfortable atmosphere that fosters interaction.

Provide programs for high-risk Marines. Several DDRCs and a few senior officers mentioned the need for special programs for high-risk Marines, particularly those coming in with drug waivers. Programs should be put in place to give these Marines extra help. Suggestions included individual counseling or groups where Marines with drug waivers could “talk out their problems.” In one of the drug-positive focus groups we conducted, a young Marine said, “If I had a place like this to come to and talk to other people like me, it would really help me not to go looking for trouble.” Another suggestion was to have a mentor or a SACO assigned, one-on-one, to high-risk Marines from the beginning, so that there is someone with whom they have a connection and to whom they can turn before it is too late. One group of SACOs suggested

conducting a research study of Marines entering with drug waivers to identify the exact percentage of persons with waivers who continue to use drugs. That information could then be used to identify high-risk recruits and focus proactive prevention efforts on them. Several respondents were uncomfortable with the idea of singling out particular Marines because it could be construed as prejudicial. However, others felt that Marines who have signed waivers have singled themselves out and should be able to get special help.

Provide more low-cost programs for Marines. Few Marines said that they were interested in participating in the Single Marine Program. Most did not perceive the program as popular or appealing. One senior officer believed that the program needed to focus more on helping young Marines meet new people. He suggested coordinating activities within neighboring communities, for instance, inviting similarly aged singles from junior colleges to take part in activities on base and vice versa. Activities might include all day sporting events, trips to the beach, family days, mess nights, and team-building activities. He believed that since “they work hard, they should also play hard,” and giving Marines more choices for wholesome activities would help them to avoid “popping a pill to feel better.”

Particularly in isolated areas, some participants mentioned the need for more low-cost activities for “all” enlisted personnel, not just single Marines. They saw a need for more inexpensive activities on and off base for those who are struggling financially, with or without families. One DDRC mentioned that the Marine Corps should “imitate the Air Force” because the Air Force seems to offer many programs and alternative activities to their personnel that are free or at little cost. One DDRC pointed out examples of Air Force bases having plenty of accessible and available gyms, as well as many basketball courts. She thought that these types of things would contribute to overall morale and help keep Marines away from drugs and alcohol.

CONCLUSIONS AND RECOMMENDATIONS

This section makes final recommendations for Marine Corps drug prevention based on a synthesis of the review of literature and the focus group study discussed in this report. Table 9 summarizes these recommendations. The first group in the table includes on-going goals that the Marine Corps and the wider DoD are already working to address. The second set includes short-term goals that could immediately and feasibly be addressed. The last set includes long-term

recommendations, which could be considered by the Marine Corps for the future. These long-term recommendations would involve more extensive cultural, structural, and policy changes.

Table 9

Recommendations for Marine Corps Drug Prevention

Ongoing Recommendations
1. Enlist the cooperation of senior leaders for drug prevention more effectively.
2. Improve training and support for SACOs.
3. Improve the randomness and accuracy of drug testing for all personnel.
4. Improve communication among drug demand reduction personnel.

Short-Term Recommendations
5. Implement a stand-alone substance abuse order.
6. Adopt more effective education strategies for drug prevention.
7. Encourage anti-drug leadership and peer mentoring among junior NCOs.
8. Initiate a drug prevention media campaign within the Marine Corps.

Long-Term Recommendations
9. Reestablish a drug exemption program for self-referred Marines.
10. Reevaluate and/or clarify the use of the zero tolerance policy.
11. Establish the role of SACO as a full-time position or as separate collateral duties.
12. Eliminate conflicts of interest in the chain of command for substance abuse prevention.

Ongoing Recommendations

More fully enlist the cooperation of senior leaders for drug prevention. Because commanding officers play an important role in fully implementing drug prevention programs, it is important to find ways to fully enlist their support. Senior leaders can be encouraged to look

for opportunities to be vocal about their commitment to uphold Marine Corps drug prevention policies and their own personal opposition to drug use. Senior leaders need to be aware of the variety of programs available to them and should be encouraged to make more use of them. Fully supporting the role of the SACO is another key element. The duty of the SACO should be assigned in a way that marks it as a position of importance. The level of competency required to receive the SACO assignment suggests something about its importance. The adequacy of the facilities, equipment, and support given the SACO to accomplish his/her responsibilities communicate his/her value within the command.

Improve training and support for SACOs. A primary ongoing effort in the Marine Corps is providing quality training and clear guidelines for SACOs so that they can adequately fulfill their duties. SACOs need more specific guidance regarding the extent and the limitations of their responsibilities for drug prevention education, treatment referral, and for substance abuse problems that may arise within their units. Through the Headquarters, U.S. Marine Corps Office of Prevention and Intervention and the assistance of the DDRCs, the SACO training is already under revision. This training should be routinely updated and DDRCs should visit unit SACOs and evaluate the adequacy of the training provided.

It would also be helpful to set up formal times when SACOs within a command or at neighboring commands can meet with each other to share information and support each other. SACOs who participated in discussions for this study commented that even the brief time they spent in the focus groups had been useful in learning how to deal with problems they were having, particularly with the new urinalysis computer software. Similarly, a Web site for SACOs could help provide current information on drug prevention and provide a forum for discussion. Forms and checklists used by SACOs could also be made available on a Web site.

Improve the randomness and accuracy of drug testing for all personnel. Two primary issues should be considered in improving the randomness and accuracy of drug testing. First, the DTP (Drug Testing Program) is a DoD-wide software program designed to ensure the randomness of drug testing and the efficient tracking and management of drug-testing records. Program 5.1.2 is the current version, and its usage has been mandatory since December 1, 2001, per DoD directive. The software was developed to provide SACOs and their counterparts in other services a tool to alleviate errors and maintain historical data on all tests performed. The software has great potential to decrease the predictability of test days and to increase confidence in the accuracy of test results. However, there are some issues that need to be addressed before SACOs can fully utilize the capabilities of the software. Personnel who have been using the system successfully for a while maintain that many problems can be eliminated by concentrating on three components: adequate user training; computer hardware that can handle the current version of the software; and operating system software that is compatible with the drug screening software. As the DTP is initiated, it is imperative that personnel have the training and material resources to implement it successfully.

The second issue is improving perceptions among Marine Corps personnel about the accuracy and efficiency of drug testing. The focus groups and interviews conducted for this study indicated two common assumptions: first, that it is not hard to predict the times urinalysis tests will occur, and second, that there are a number of ways to “beat the system.” These are important perceptions to modify, because the likelihood of getting caught is currently the Services’ most powerful drug prevention tool. It is important to take visible steps to improve drug testing and then use the media to publicize these measures. For instance, random drug testing could be done at unannounced checkpoints on Marine Corps installations, independent of

specific units or command testing programs. Publicizing the initiation of the DTP could also heighten perceptions of the effectiveness of testing.

Improve communication among drug demand reduction specialists. It would be helpful to increase the amount of communication among Marine Corps drug prevention specialists. DDRCs and other prevention specialists are actively discussing ways that they can increase interaction among themselves and share updated information on successful drug prevention program efforts. For instance, DDRCs within the West Coast area (Yuma, Twenty-nine Palms, Camp Pendleton, Miramar, and MCRD San Diego) have already agreed to meet quarterly at alternate sites. A standing annual conference of all personnel would be helpful, and DDRCs could play a more active role in detailing the conference agenda. Prevention specialists also suggested that they might use the Internet more effectively in order to stay abreast of each other's efforts.

Short-Term Recommendations

Implement a stand-alone substance abuse order. The Marine Corps Order directs leaders both in procedures and in the importance of drug prevention programs. Commands will generally conduct training only as they are required. Although the existing Marine Corps Order contains information about drug prevention training, testing, referral for services, and adjudication of cases, the structure of the Order makes it difficult to provide an integrated overview of drug prevention policies. In place of the Marine Corps Order (MCO 1700.24), which covers multiple and disparate programs, it would be helpful to draft a stand-alone order for substance prevention. This would provide more emphasis and clarity to the directives. All of the instructions for substance abuse prevention and treatment could be organized together in a more streamlined fashion. A stand-alone order could be also be more thorough in describing the way drug

prevention programs should be carried out. In particular, it could be more specific about the prerequisites, training requirements, and responsibilities for the SACO position.

Adopt the most effective drug prevention education strategies. It is important to ensure that the most effective aspects of existing drug prevention programs (see Table 2) are incorporated into Marine Corps drug prevention. First, the drug prevention programs that have had some efficacy in changing actual levels of illicit drug use have all focused on the importance of peer norms in encouraging drug use. Second, our review of successful civilian drug programs, as well as interviews with DDRCs, indicate that small discussion groups have greater efficacy in drug prevention than larger, lecture-style group sessions. While large groups have the appearance of efficiency, since they disseminate information in a short period of time to a large number of people, small group interaction has in practice been more productive than broad-based informational sessions. Small groups allow participants to ask questions instead of simply listening passively and to make contact with mentors and peers whose opinions about their behavior matter to them. It would be helpful to target programs at the unit level, where the most peer interaction already occurs among Marines.

Programs should be presented completely as designed. Outcomes from a recent Marine Corps alcohol prevention program emphasize the importance of presenting programs in their entirety. Initial results from the Battalion Alcohol Skills Intervention Curriculum (BASIC) program have not shown an impact on alcohol use. However, facilitators and Marine Corps leaders generally did not present the entire BASIC protocol. This may have been because the program is complex and the facilitators felt unprepared, or it may have been a failure to market the program effectively. Such factors should be taken into account in designing future programs.

Intensive programs that include 10 or more sessions, as well as boosters, have been shown to be more effective. However, given the time constraints of the Marine Corps this may not be feasible. Because there is little time available for drug education programs, it is particularly important for the Marine Corps to implement drug prevention education in conjunction with other prevention strategies in a comprehensive program. Comprehensive programs that use multiple methods to influence multiple audiences have been more effective.

One of the goals for this project is to develop a Marine Corps-specific drug education module. This module will be designed with a small group discussion format in order to facilitate interaction between peers, and it will focus on influencing participants' assumptions about the social norms for drug use within the Corps. The module will include an audiovisual introduction and presentational slides. The goal of the program will be to introduce drug prevention messages that can be reinforced through a public media campaign in the context of a comprehensive prevention program. It will also provide basic information regarding the Marine Corps policy regarding illegal drug use and the drug testing policy.

Encourage anti-drug leadership and peer mentoring among junior NCOs. Among the more influential individuals in the daily lives of E1s to E3s are junior NCOs (E4s and E5s). Junior NCOs have the most contact with nonrated personnel, are nearly or exactly the same age, and were relatively recently nonrated themselves. Junior NCOs are seen by many new Marines as realistic role models, as individuals who have enjoyed success in the Marine Corps through actions and attributes, and as models of a future within their own reach. On a daily basis, junior NCOs influence the performance of first-term personnel through explicit and implicit communication of expectations. Non-rated personnel in turn seek the approval (or at least avoid the disapproval) of their corporals and sergeants. Thus, face-to-face formal and informal

communication between NCOs and E1s to E3s could be an important point of intervention in a drug prevention program.

This project will explore a number of possible ways that NCOs might be trained and organized to act as mentors in drug prevention. The primary goal will be to design a leadership training program that will encourage NCOs to act as role models for drug prevention. There are a number of components that might be included in this. First, NCOs could be formally trained to be facilitators for Marine Corps Drug Prevention education programs. Second, in a more informal way, NCOs could be taught how to identify junior personnel who might be at risk for drug use as well as other types of problems. This focus should include information regarding resources available within the Marine Corps to which persons can be referred, and it should encourage an attitude of support for those who access helping resources before problems escalate. Finally, NCOs could help reinforce messages publicized through a public media campaign. They could be encouraged openly to express their own attitudes toward drug use. This project will identify the most feasible of these possibilities and develop a leadership training program for junior NCOs. It will explore the possibility of incentives for NCOs willing to volunteer in drug prevention, both within the Marine Corps and within the civilian community.

Initiate a drug prevention media campaign within the Marine Corps. Initiating a public media campaign based on a social norms approach is one way the Marine Corps could work to further reduce illegal drug use. The goal would be to create an atmosphere of reverse peer pressure, suggesting that drug use is not normative among Marines as many might presume. Marines need to be aware that it is a small minority of their colleagues who use drugs, and that this type of behavior is unusual. Marines need to be aware of the important declines in drug use over the past two decades within the service, and they should be aware of the comparative rates

for drug use among their civilian peers in the general U.S. population. Finally, it is important for them to know the attitudes of the majority of their fellow Marines toward illegal drugs and towards those who use them.

Many Marines come from lower socioeconomic backgrounds and/or relatively high-risk communities; many have had exposure in their youth to illegal drugs. Among them are individuals who joined the Marine Corps in order to achieve and move ahead in society. Frequently, they have younger siblings, other relatives, or friends at home who continue to be subject to these same risks. Young Marines may not fully appreciate the fact that they are now role models themselves in the lives of friends and family at home. A potentially powerful message, therefore, is that avoiding drug use helps support others who face pressure to use drugs. Conversely, using drugs sets a negative example that could actually put loved ones at risk. Videotaped testimonials of Marines and their family members could be recorded as part of a promotional campaign to express this point.

Lastly, it is important to increase awareness of the likelihood of testing positive in a random urinalysis sweep. As noted previously, the true strength of the urinalysis program is not in the number of people actually caught for drug use, but in the number deterred from using because they know they may be tested. It is important to use the public media to increase public perceptions of the randomness of testing and of the possibility of getting caught despite various methods of avoiding or invalidating the tests.

Long-Term Recommendations

Reinstitute a drug exemption program for self-referred Marines. At the present time there is no avenue for Marines to obtain confidential help for emotional or physical addiction to illegal drug use without personally paying for treatment through an independent provider. The Corps should make some provisions for Marines to obtain confidential treatment at no or low cost. The

Marine Corps has had a drug exemption program in the past, and very few personnel made use of it. Most likely very few Marines will access the program if it is instituted again. Despite this, Marines should be encouraged to address issues before they become serious problems. If a drug exemption program is reinstituted, there is also the concern that Marines will take advantage of it simply to be protected from prosecution for drug use. However, it would be possible to design a policy that provides confidential treatment, without excluding Marines from drug-testing and from potential prosecution if their use is detected independently of their participation in treatment.

Increase consistency in enforcing the zero tolerance policy. Every focus group conducted discussed the fact that the zero tolerance policy is inconsistently enforced. This was probably the topic of conversation that consumed the most total discussion time. The enforcement of zero tolerance is clearly a concern throughout the Marine Corps, as the 2001 Noncommissioned Officer Symposium also recently raised the topic and recommended that zero tolerance be consistently enforced. In response, the Commandant of the Marine Corps clarified the policy in an All Marine Message (ALMAR). As delineated in ALMAR 046/01, the directive is enforced:

...all Marines, regardless of grade, are processed for administrative separation by reason of misconduct, due to drug abuse. However, commanding officers can recommend retention and commanding generals may suspend separation for one year. If no further disciplinary action is taken against the Marine, then the Marine may remain on active duty to their EAS. This policy is designed to be fair to the Marine, the commander, and the Marine Corps. No requests for reenlistment by Marines with in-service drug use were approved in FY01. (U.S. Marine Corps, 2001b)

The promulgation and enforcement of the zero tolerance policy is a complex issue. Because it was an area of concern for all of the focus groups, it might be helpful for the Corps to readdress it. Most importantly, it appears that the policy is commonly misunderstood, despite the fact that most Marines believe they understand it well. Focus group participants believed “zero tolerance” means that Marines caught for illegal drug use will be discharged without exception. However, they knew of many cases where a Marine caught for illegal drug use had been retained. In reality, the policy states that Marines who use illegal drugs will be “processed” for

separation, but they may complete their current term of service at the discretion of commanding officers.

In light of this, it is not the consistent enforcement of the policy as written that is problematic. It is, first, the widespread misconception of the policy among Marines. Second, it is the further perception that Marines who use illegal drugs are treated differently for the same offense. Finally, when troops see a Marine who has tested positive remain in the Corps, they may assume that drug use does not necessarily carry serious consequences. In order to change perceptions regarding the consistency and fairness with which cases of illegal drug use are handled, the service could create more extensive guidelines for commanding officers delineating how cases of illegal drug use should be managed. Whether more specific guidelines are provided or not, the administrative and legal actions taken in cases of drug use could be communicated clearly to the troops so that they are aware of the seriousness of the disciplinary action taken.

Establish the role of SACO as a full-time position or as separate collateral duties. The responsibilities of the SACO are complex and diverse enough that the position should either be a full-time billet, or the responsibilities should be divided among multiple personnel. If it were a full-time billet, personnel could be trained more effectively, turnover could be reduced, and personnel could spend more time evaluating and planning prevention efforts. Alternatively, it might be more effective to divide the responsibilities of the SACO and assign them to separate personnel. In particular, there is an inherent conflict of interest in combining the responsibility for urinalysis testing with the responsibility for drug prevention and drug treatment. Urinalysis testing is an investigative and law enforcement role. Positive test results lead to administrative or legal action and potential separation from the Corps. Prevention and training are aimed at

changing perceptions and behaviors in order to support and help personnel to be retained as successful Marines.

In the Marine Corps, conflicting roles put SACOs at a disadvantage in fulfilling their assignments. They must simultaneously teach, befriend, and monitor the Marines in their own units. As one SACO put it, “We need to get away from being snitches and toward being real counselors.” More than one research participant suggested that the drug testing responsibilities of the SACO should be taken over by Marines in medical or law enforcement ratings or by full-time, trained civilian personnel. Centralizing the urinalysis testing program for entire installations under the control of these types of personnel would eliminate the duplication of training and resources required to support unit SACOs, and it would free them to focus on other responsibilities. It would reduce the likelihood of errors or mismanagement in the testing process, and it would make it easier to implement truly random testing. Modifying the role of the SACO within the Marine Corps may require substantial restructuring of current programs. However, these issues should be considered.

Eliminate conflicts of interest in the chain of command for substance abuse prevention. DDRCs participating in phone interviews and drug prevention specialists contributing to this review were all concerned about conflicts of interest in the Marine Corps chain of command for substance abuse prevention. Drug prevention and treatment programs for the Marine Corps fall under Marine Corps Community Services (MCCS). MCCS covers a broad range of activities, including recreation and retail within the service community. Drug and alcohol prevention may not be as large a priority within this chain of command as is needed. Additionally, MCCS is responsible for sales of alcohol on installations. Preventing alcohol abuse itself is a major focus of the Office of Prevention and Intervention. In particular, the role alcohol may play in increasing illegal drug use is a primary concern (Jones, Oeltmann, Wilson, Brener, & Hill, 2001). MCCS programs that support alcohol sales and advertise venues that sell alcohol are sometimes in conflict with the efforts of drug demand reduction specialists. Marine Corps drug prevention

personnel need to be in a position to evaluate the role of alcohol critically within the service community. Falling under the umbrella of MCCS makes this impossible.

REFERENCES

- Abraham, H. D., & Fava, M. (1999). Order of onset of substance abuse and depression in a sample of depressed outpatients. *Comprehensive Psychiatry*, 40(1), 44-50.
- Ametrano, I. M. (1992). An evaluation of the effectiveness of a substance-abuse prevention program. *Journal of College Student Development*, 33, 507-515.
- Anderson Johnson, C., Pentz, M. A., Weber, M. D., Dwyer, J. H., Baer, N., MacKinnon, D. P., & Hansen, W. B. (1990). Relative effectiveness of comprehensive community programming for drug abuse prevention with high-risk and low-risk adolescents. *Journal of Consulting and Clinical Psychology*, 58(4), 447-456.
- Bamberger, P., & Sonnenstuhl, W. J. (1995). Peer referral networks and utilization of a union-based EAP. *Journal of Drug Issues*, 25(2), 291-312.
- Becker, L. R., Hall, M., Fisher, D. A., & Miller, T. R. (2000). Methods for evaluating a mature substance abuse prevention/early intervention program. *The Journal of Behavioral Health Services & Research*, 27(2), 166-177.
- Belcher, H. M. E., & Shinitzky, H. E. (1998). Substance abuse in children: Prediction, protection, and prevention. *Archives of Pediatrics and Adolescent Medicine*, 152(10), 952-960.
- Bell, R. M., Ellickson, P. L., & Harrison, E. R. (1993). Do drug prevention effects persist into high school? How project ALERT did with ninth graders. *Preventive Medicine*, 22, 463-483.
- Botvin, G. J. (2000). Preventing drug abuse in schools: Social and competence enhancement approaches targeting individual-level etiologic factors. *Addictive Behaviors*, 25(6), 887-897.
- Botvin, G. J., Baker, B., Filazzola, A. D., & Botvin, E. M. (1990). A cognitive-behavioral approach to substance abuse prevention: One-year follow-up. *Addictive Behaviors*, 15, 47-63.
- Botvin, G. J., Baker, E., Dusenbury, L., Botvin, E. M., & Diaz, T. (1995). Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association*, 273(14), 1106-1112.
- Botvin, G. J., Epstein, J. A., Baker, E., Diaz, T., & Ifill-Williams, M. (1997). School-based drug abuse prevention with inner-city minority youth. *Journal of Child & Adolescent Substance Abuse*, 6, 5-19.
- Botvin, G. J., Griffin, K. W., Diaz, T., & Ifill-Williams, M. (2001). Drug abuse prevention among minority adolescents: Posttest and one-year follow-up of a school-based preventive intervention. *Prevention Science*, 2(1), 1-13.
- Botvin, G. J., Griffin, K. W., Diaz, T., Scheier, L. M., Williams, C., & Epstein, A. E. (2000). Preventing illicit drug use in adolescents: Long-term follow-up data from a randomized control trial of a school population. *Addictive Behaviors*, 25(5), 769-774.
- Botvin, G. J., Schinke, S. P., Epstein, J. A., & Diaz, T. (1994). Effectiveness of culturally focused and generic skills training approaches to alcohol and drug abuse prevention among minority youths. *Psychology of Addictive Behaviors*, 8(2), 116-127.
- Botvin, G. J., Schinke, S. P., Epstein, J. A., Diaz, T., & Botvin, E. M. (1995). Effectiveness of culturally focused and generic skills training approaches to alcohol and drug abuse prevention among minority adolescents: Two-year follow-up results. *Psychology of Addictive Behaviors*, 9(3), 183-194.

- Botvin, G. J., Schinke, S. P., & Orlandi, M. A. (1989). Psychosocial approaches to substance abuse prevention: Theoretical foundations and empirical findings. *Crisis*, 10(1), 62-77.
- Bowman, D. H. (2002, June 12). *Anti-drug ad campaign falls flat, study says* [Internet]. Education Week, Editorial Projects in Education. Retrieved June 17, 2002, from the World Wide Web: <http://www.edweek.org/ew/newstory.cfm?slug=40drug.h21>
- Bray, R. M., Sanchez, R. P., Ornstein, M. L., Lentine, D., Vincus, A. A., Baird, T. U., Walker, J. A., Wheelless, S. C., Guess, L. L., Kroutil, L. A., & Iannacchione, V. G. (1999). *1998 Department of Defense Survey of Health Related Behaviors Among Military Personnel* (Final RTI/7304/006-FR). Research Triangle Park, NC: Research Triangle Institute.
- Clapp, J. D., Burke, A. C., & Stanger, L. (1998). The institutional environment, strategic response, and program adaptation: A case study. *Journal of Applied Social Sciences*, 22(2), 87-95.
- Clapp, J. D., & Early, T. J. (1999). A qualitative exploratory study of substance abuse prevention outcomes in a heterogeneous prevention system. *Drug Education*, 29(3), 217-233.
- Cook, R., Lawrence, H., Morse, C., & Roehl, J. (1984). An evaluation of the alternatives approach to drug abuse prevention. *The International Journal of the Addictions*, 19(7), 767-787.
- Cook, R. F., Back, A., & Trudeau, J. (1996). Substance abuse prevention in the workplace: Recent findings and an expanded conceptual model. *The Journal of Primary Prevention*, 16, 319-339.
- DeJong, W. (1987). A short-term evaluation of Project DARE (Drug Abuse Resistance Education): Preliminary indications of effectiveness. *Journal of Drug Education*, 17(4), 279-294.
- DeJong, W., & Wallack, L. (2000). The drug Czar's anti-drug media campaign. *Journal of Health Communication*, 5(1), 77-82.
- Dent, C. W., Sussman, S., Hennesy, M., Galaif, E. R., Stacy, A. W., Moss, M., & Craig, S. (1998). Implementation and process evaluation of a school-based drug abuse prevention program: Project Towards No Drug Abuse. *Journal of Drug Education*, 28(4), 361-375.
- Dent, C. W., Sussman, S., & Stacy, A. W. (2001). Project Towards No Drug Use: Generalizability to a general high school sample. *Preventive Medicine*, 32, 514-520.
- Donaldson, S. I., Sussman, S., MacKinnon, D. P., Severson, H. H., Glynn, T., Murray, D. M., & Stone, E. J. (1996). Drug abuse prevention programming: Do we know what content works? *American Behavioral Scientist*, 39(7), 868-883.
- Dusenbury, L. (1999). Workplace drug abuse prevention initiatives: A review. *The Journal of Primary Prevention*, 20(2), 145-156.
- Ellickson, P. L., & Bell, R. M. (1990). Drug prevention in junior high: A multi-site longitudinal test. *Science*, 247(March), 1299-1305.
- Ellickson, P. L., Bell, R. M., & McGuigan, K. (1993). Preventing adolescent drug use: Long-term results of a junior high program. *American Journal of Public Health*, 83(6), 856-861.
- Emery, E. M., Ritter-Randolph, G. P., Strozier, A. L., & McDermott, R. J. (1993). Using focus group interviews to identify salient issues concerning college students' alcohol abuse. *College Health*, 41, 195-198.
- Ennett, S. T., Tobler, N. S., Ringwalt, C. L., & Flewelling, R. L. (1994). How effective is drug abuse resistance education? A meta-analysis of project DARE outcome evaluations. *American Journal of Public Health*, 84(9), 1394-1401.

- Graham, J. W., Johnson, C. A., Hansen, W. B., Flay, B. R., & Gee, M. (1990). Drug use prevention programs, gender, and ethnicity: Evaluation of three seventh-grade project SMART cohorts. *Preventive Medicine, 19*, 305-313.
- Grossman, S., Canterbury, R. J., Lloyd, E., & McDowell, M. (1994). A model approach to peer-based alcohol and other drug prevention in a college population. *Journal of Alcohol and Drug Education, 39*(2), 50-61.
- Grossman, S. J., & Smiley, E. B. (1999). APPLE: Description and evaluation of a substance abuse education and prevention program for collegiate athletics. *The Journal of Primary Prevention, 20*(1), 51-59.
- Hansen, W. B. (1992). School-based substance abuse prevention: A review of the state of the art in curriculum, 1980-1990. *Health Education Research, 7*(3), 403-430.
- Hansen, W. B., & Graham, J. W. (1991). Preventing alcohol, marijuana, and cigarette use among adolescents; Peer pressure resistance training versus establishing conservative norms. *Preventive Medicine, 20*, 414-430.
- Harmon, M. A. (1993). Reducing the risk of drug involvement among early adolescents: An evaluation of Drug Abuse Resistance Education (DARE). *Evaluation Review, 17*(2), 221-239.
- Harris, J. L., & Ludwig, M. (1996). The Trading Cards Program: An evaluation of use of high school role models for drug abuse prevention. *Journal of Health Education, 27*(3), 183-186.
- Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112*(1), 64-105.
- Homonoff, E., Martin, J., Rimpas, D., & Henderson, M. (1994). It takes a village to raise a child: A model of training for prevention of youth abuse of alcohol and other drugs. *Child and Adolescent Social Work Journal, 11*(1), 53-61.
- Jones, J. R. (1995). *A change in the Navy's drug testing policy: How will it affect costs and the probability of detecting drug users?* (Master's Thesis NHRC: 002125). Monterey, CA: Naval Postgraduate School.
- Jones, S. E., Oeltmann, J., Wilson, T. W., Brener, N. D., & Hill, C. V. (2001). Binge drinking among undergraduate college students in the United States: Implications for other substance use. *Journal of American College Health, 50*(1), 33-38.
- Kelder, S. H., Maibach, E., Worden, J. K., Biglan, A., & Levitt, A. (2000). Planning and initiation of the ONDCP National Youth Anti-Drug Media Campaign. *Journal of Public Health Management Practice, 6*(3), 14-26.
- Kim, S., McLeod, J. H., & Shantzis, C. (1993). An outcome evaluation of Here's Looking at You 2000. *Journal of Drug Education, 23*(1), 67-81.
- Krueger, R. A. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Thousand Oaks, CA: Sage.
- Lynam, D. R., Milich, R., Zimmerman, R., Novak, S. P., Logan, T. K., & Martin, C. (1999). Project DARE: No effects at 10-year follow-up. *Journal of Consulting and Clinical Psychology, 67*(4), 590-593.
- Malvin, J. H., Moskowitz, J. M., Schaeffer, G. A., & Schaps, E. (1984). Teacher training in affective education for the primary prevention of adolescent drug abuse. *American Journal of Drug and Alcohol Abuse, 10*(2), 223-235.

- Malvin, J. H., Moskowitz, J. M., Schaps, E., & Schaeffer, G. A. (1985). Evaluation of two school-based alternatives programs. *Journal of Alcohol and Drug Education*, 30, 98-108.
- Moskowitz, J. M., Schaps, E., Schaeffer, G. A., & Malvin, J. H. (1984). Evaluation of a substance abuse prevention program for junior high school students. *The International Journal of Addictions*, 19(4), 419-430.
- Nattiv, A., & Puffer, J. C. (1991). Lifestyles and health risks of collegiate athletes. *Journal of Family Practice*, 33(6), 585-590.
- Nelson-Simley, K., & Erickson, L. (1995). The Nebraska "Network of Drug-Free Youth" program. *Journal of School Health*, 65(2), 49-52.
- O'Donnell, J., Hawkins, J. D., Catalano, R. F., Abbott, R. D., & Day, L. E. (1995). Preventing school failure, drug use, and delinquency among low-income children: Long-term intervention in elementary schools. *The American Journal of Orthopsychiatry*, 65(1), 87-100.
- Pentz, M. A., Anderson Johnson, C., Dwyer, J. H., MacKinnon, D. M., Hansen, W. B., & Flay, B. R. (1989). A comprehensive community approach to adolescent drug abuse prevention: Effects on cardiovascular disease risk behaviors. *Annals of Medicine*, 21(3), 219-222.
- Pentz, M. A., Dwyer, J. H., MacKinnon, D. P., Flay, B. R., Hansen, W. B., Wang, E. Y. I., & Johnson, C. A. (1989). A multicommunity trial for primary prevention of adolescent drug abuse. *Journal of the American Medical Association*, 261(22), 3259-3266.
- Pentz, M. A., Trebow, E. A., Hansen, W. B., MacKinnon, D. P., Dwyer, J. H., Johnson, C. A., Flay, B. R., Daniels, S., & Cormack, C. (1990). Effects of program implementation on adolescent drug use behavior: The Midwestern Prevention Project (MPP). *Evaluation Review*, 14(3), 264-289.
- Quest Diagnostics. (2001). *Drug use in the general U.S. workforce increased in first half of 2001, according to Quest diagnostics 'Drug Testing Index'* [Internet]. Author. Retrieved June 21, 2002, from the World Wide Web: http://www.questdiagnostics.com/brand/business/b_bus_lab_emp_drugtesting_index.html
- Rapaport, R. J., Minelli, M. J., Reyes, S., & Norton, P. (1991). Involving recovering students and community members in alcohol and other drug-abuse prevention. *Journal of College Student Development*, 35, 136-138.
- Rickert, V. I., Graham, C. J., Fisher, R., Gottlieb, A., Trosclair, A., & Jay, M. S. (1993). A comparison of methods for alcohol and marijuana anticipatory guidance with adolescents. *Journal of Adolescent Health*, 14(3), 225-230.
- Robinson, S. E., Roth, S. L., Gloria, A. M., Keim, J., & Sattler, H. (1993). Influence of substance abuse education on undergraduates' knowledge, attitudes and behaviors. *Journal of Alcohol and Drug Education*, 39(1), 123-130.
- Safer, L. A., & Harding, C. G. (1993). Under Pressure Program: Using live theatre to investigate adolescents' attitudes and behavior related to drug and alcohol abuse education and prevention. *Adolescence*, 28, 109.
- Sarvela, P. D., & Ford, T. D. (1993). An evaluation of a substance abuse education program for Mississippi delta pregnant adolescents. *Journal of School Health*, 63(3), 147-152.
- Schaps, E., Churgin, S., Palley, C. S., Takata, B., & Cohen, A. Y. (1980). Primary prevention research: A preliminary review of program outcome studies. *The International Journal of the Addictions*, 15(5), 657-676.

- Schaps, E., Moskowitz, J. M., Malvin, J. H., & Schaeffer, G. A. (1986). Evaluation of seven school-based prevention programs: A final report on the Napa Project. *The International Journal of the Addictions*, 21(9-10), 1081-1112.
- Sexter, J., Sullivan, A. P., Wepner, S. F., & Denmark, R. (1984). Substance abuse: Assessment of the outcomes of activities and activity clusters in school-based prevention. *The International Journal of Addictions*, 19(1), 79-92.
- Shope, J. T., Copeland, L. A., Marcoux, B. C., & Kamp, M. E. (1996). Effectiveness of a school-based substance abuse prevention program. *Journal of Drug Education*, 26(4), 323-337.
- Snow, D. L., Tebes, J. K., Arthur, M. W., & Tapasak, R. C. (1992). Two-year follow-up of a social-cognitive intervention to prevent substance use. *Journal of Drug Education*, 22(2), 101-114.
- Spickard, W. A., Jr., Dixon, G. L., & Sarver, F. W. (1994). Fighting back against America's public health enemy number one. *Bulletin of the New York Academy of Medicine*, 71(1), 111-135.
- St. Pierre, T. L., Kaltreider, D. L., Mark, M. M., & Aikin, K. J. (1992). Drug prevention in a community setting: A longitudinal study of the relative effectiveness of a three-year primary prevention program in Boys and Girls Clubs across the nation. *American Journal of Community Psychology*, 20(6), 673-706.
- Stoltzfus, J. A., & Benson, P. L. (1994). The 3M alcohol and other drug prevention program: Description and evaluation. *The Journal of Primary Prevention*, 15, 147-159.
- Sussman, S., Dent, C. W., Stacy, A. W., & Craig, S. (1998). One-year outcomes of Project Towards No Drug Abuse. *Preventive Medicine*, 27, 632-642.
- Tobler, N. S. (1986). Meta-analysis of 143 adolescent drug prevention programs: Quantitative outcome results for program participants compared to a control or comparison group. *The Journal of Drug Issues*, 16(4), 537-567.
- Tobler, N. S. (1997). Meta-analysis of adolescent drug prevention programs: Results of the 1933 Meta-analysis. In W. J. Bukoski (Ed.), *Meta-analysis of drug abuse prevention programs* (Vol. NIDA Research Monograph 170, pp. 5-68). Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health.
- Tobler, N. S., & Stratton, H. H. (1997). Effectiveness of school-based drug prevention programs: A meta-analysis of the research. *The Journal of Primary Prevention*, 18(1), 71-127.
- Tricker, R., & Cook, D. L. (1989). The current status of drug intervention and prevention in college athletic programs. *Journal of Alcohol and Drug Education*, 34(2), 38-45.
- U.S. Marine Corps. (2001a). *Marine Corps Personal Services Manual* (Marine Corps Order P1700.24B): Author.
- U.S. Marine Corps. (2001b). *Results of the 2001 Noncommissioned Officer Symposium* (ALMAR 046/01). Washington, DC: General J. L. Jones, Commandant of the Marine Corps.
- Varisco, R. (2000). NIDA reaches out to the nation. *NIDA Notes*, 15(2), 12-13.
- Vicary, J. R. (1994). Primary prevention and the workplace. *The Journal of Primary Prevention*, 15(2), 99-103.
- Washington Crime News Services. (1999). Workplace drug use continues to decline. *Narcotics Enforcement & Prevention Digest*, 5(23), 3.
- Weiss, R. D., Griffin, M. L., & Mirin, S. M. (1992). Drug abuse as self-medication for depression: An empirical study. *American Journal of Drug and Alcohol Abuse*, 18(2), 121-129.

White, D., & Pitts, M. (1998). Educating young people about drugs: A systematic review.
Addiction, 93(10), 1475-1487.

APPENDICES

Appendix A: Supplemental Focus Group Topics

Poolees

1. What is the substance abuse prevention program like at your school?
2. Is there a problem with illegal drug use among poolees coming into the Marine Corps?
3. What do you think the USMC's position is on illegal drug use and alcohol abuse?
 - What and how much information have you received from Marine Corps representatives about the Marine Corps drug and alcohol abuse policies?
 - Do the Marine Corps representatives you have encountered seem to believe in and uphold the service's drug prevention policies?
4. Do you believe Marine Corps recruiting policies and practices are effective in preventing illegal drug use within the Marine Corps?
5. Do you think illegal drug use or attitudes regarding use will change among recruits after entering the Marine Corps?
6. What do you think should be of most concern to people who are planning drug prevention programs for the Marine Corps?
 - What drugs are the biggest problems? (most common, most detrimental)
 - What are the worst consequences of drug use? (physical effects, social effects, emotional effects)
 - Why do people use drugs?
7. How do you think the Marine Corps can better prevent substance abuse?
8. How would you try to help someone if they had a substance abuse problem?

Drug Positive

1. How do you feel about the way the Marine Corps handled things when you tested positive for drugs?
 - Reaction of other Marines?
 - The amount of time the legal process took?
 - What was the chain of events (what happened)?
 - Appropriateness of disciplinary action?

- What do you think of the way Marine Corps leaders make the decision to separate versus retain Marines who have used drugs?
- Was the process fair?

Junior Leaders

1. In what ways are you personally involved in the prevention of illegal drug use within your command?
2. What do you think about the way Marine Corps leaders support drug prevention programs?
 - Do your officers and SNCOs (senior noncommissioned officers) model appropriate behavior toward illegal drug use?
 - Do they support drug and alcohol prevention programs equally?
 - Has your command bought into all aspects of the Marine Corps drug policies?
 - Do you believe in all aspects of the Marine Corps drug prevention policies?

Senior Leaders

1. What is the role of the Substance Abuse Control Officer (SACO) within your command?
 - What activities does the SACO conduct?
 - What is the relative importance of SACO duties relative to his or her other responsibilities within the command?
 - What have you discovered about your unit through the substance abuse prevention needs assessments conducted by the command SACO?
2. In what ways are you involved in the prevention of illegal drug use within your command?
3. What do you think about the way Marine Corps leaders support drug prevention programs?
 - Do your officers and SNCO's model appropriate behavior toward illicit drug use?
 - Do they support drug and alcohol prevention programs equally?
 - Has your command bought into all aspects of the Marine Corps drug prevention program (Marine Corps Order)?
 - Do you believe in all aspects of the Marine Corps drug prevention program (Marine Corps Order)?
 - What guidelines do you believe are most influential in the decision of whether to ultimately retain or separate Marines who test positive for drugs?

- Do some officers and SNCOs look the other way when a drug incident occurs, especially if it is an otherwise good Marine?

Drug Demand Reduction Coordinators (DDRCs)

1. Could you please describe the educational prevention programs that you sponsor?
 - What specific programs are sponsored?
 - Who administers the training?
 - How frequently does the training occur?
 - Who is the target audience?
 - How many participants are typically in a training session?
 - How long does each training program take?
2. How typical are your programs of Marine Corps Drug prevention programs more generally?

Substance Abuse Control Officers

1. What is your unit's policy regarding illegal drug use?
 - Is the policy clear?
 - Is the policy administered fairly, regardless of rank?
2. How do you feel about your role as SACO?
 - What duties take up most of your time?
 - What duties are most important in preventing drug use?
 - Do you have time to effectively run your command's drug prevention program?
 - What is the relative importance of your SACO responsibilities relative to other duties you have?
 - Do you have the outside resources to run an effective drug prevention program?
 - Do you feel that you have enough guidance and training to do your job well?
3. What have you discovered about your unit when conducting the substance abuse prevention needs assessment?
4. What are the most important parts of the drug prevention program that you have designed for your unit?
 - How easy has it been to implement your plan within your unit?

- What role do the Marines from your unit play in drug prevention? Are they involved in giving drug prevention training?
5. What measures of effectiveness have been most helpful in documenting the success of your prevention plan?
 6. How do you feel about conducting the urinalysis program?
 - Importance of the program
 - Effectiveness of the program
 7. How supportive are Marine Corps leaders of drug prevention programs?
 - How supportive has your commanding officer been of your unit's drug prevention plan?
 - Do all your officers and SNCOs (senior noncommissioned officers) model appropriate behavior toward illicit drug use?
 - Do they support drug versus alcohol programs equally?
 - Has your command bought into all aspects of the Marine Corps drug prevention policy?
 - Do you believe in all aspects of the Marine Corps drug prevention policy?
 - Do some officers and SNCOs look the other way when a drug incident occurs, especially if it is an otherwise good Marine?
 8. What do you think about the support you get from the Marine Corps Community Services regarding substance abuse prevention and treatment?
 9. How can the Marine Corps drug prevention program best be improved?
 - What would help you be more effective as the SACO?
 - How can the Substance Abuse Counseling Centers/Drug Demand Reduction Coordinators better assist you at the unit?
 10. If there were something that you could change, which would have a positive impact on your unit regarding substance abuse, what would it be?

Appendix B: External Consultants and Focus Group Facilitators

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Appendix C: Informed Consent Forms

Focus Groups

PRIVACY ACT STATEMENT

1. Authority. 5 U.S.C. 301
2. Purpose. Research information will be collected in research study #32258 titled, “Marine Corps Drug Prevention Project,” to enhance basic knowledge or to develop procedures to improve the prevention of illness, injury, or performance impairment.
3. Routine Uses. Research information will be used for analysis and reports by the Departments of the Navy and Defense, and other U.S. Government agencies. Use of the information may be granted to non-Government agencies or individuals by the Navy Surgeon General following the provisions of the Freedom of Information Act or contracts and agreements. I voluntarily agree to its disclosure to agencies or individuals identified above, and I have been informed that failure to agree to this disclosure may make the research less useful. The “Blanket Routine Uses” that appear at the beginning of the Department of the Navy’s compilation of medical databases also apply to this system.
4. Voluntary Disclosure. Provision of information is voluntary. Failure to provide the requested information may result in failure to be accepted as a research volunteer in an experiment, or in removal from the program.

VOLUNTARY CONSENT TO PARTICIPATE

1. You are being asked to volunteer to participate in a research study titled, “The Marine Corps Drug Prevention Project.” The purpose of this study is to review the drug prevention programs currently used throughout the Marine Corps, to assess their efficacy in view of current research on public health and drug prevention, and to make recommendations regarding how current drug prevention programs might be improved. You are being asked to participate for a total of 1.5 hours on a day scheduled between March 1 and May 31, 2002. Approximately 200 volunteers will participate in this study.
2. During your participation, you will be joining other research volunteers in a group discussion about opinions regarding the extent of the problem of drug use in the Marine Corps and impressions and experiences regarding participation in Marine Corps drug prevention programs. Please keep in mind that we are interested in both your positive and your negative feedback regarding these Marine Corps programs.

3. The clearest risk of your participation is the possibility that you may disclose specific information about yourself or someone you know that could have legal repercussions or military career implications. You are strongly cautioned not to reveal any incriminating information during this interview. This includes information regarding any illegal behavior that you may have engaged in or information regarding the illegal behavior of any specific individuals with whom you are acquainted. If you do, your complete protection cannot be guaranteed, because other participants could reveal the information to others.
4. The only benefit(s) that you may expect from your participation in this research is the opportunity to contribute to improving Marine Corps drug prevention programs.
5. During this study, in order to protect the privacy of other group members and yourself, do not to use last names or ranks in conversation. Furthermore, you are invited to wear civilian clothes and, if you so desire, to use any name you choose on your nametag rather than your actual name. Finally, do not disclose any information discussed in this group with anyone other than a member of the Naval Health Research Center (NHRC) staff conducting this study. The privacy of the information you share during this group discussion will be protected by keeping all audiotapes, hand-written notes, and transcriptions of the discussion in a locked file at NHRC, with access limited to study investigators. Computer data files will be stored in compliance with NAVMEDRSCHDEVCOMINST 5870.4. NHRC will not collect or store any personal identifiers, real or fictitious, with any of the data from this discussion.
6. If you have questions about this study, contact Dr. Valerie Stander, NHRC, P.O. Box 85122, San Diego, CA 92186-5122; DSN 553-7174; Commercial (619) 553-7174. For questions about the treatment of you and other personnel who participate in this study, contact Stephanie Booth-Kewley, Chair, NHRC Institutional Review Board (619) 553-8465.
7. Your participation in this study is completely voluntary. You may leave at any time without penalty and without losing any benefit you would otherwise receive. If you decide to leave the group, simply tell the group leader and you will be able to go immediately.
8. Dr. Valerie Stander is responsible for storing all consent forms and research records related to this study.
9. At this time, please feel free to ask any questions you may have about this study, the possible risks, as well as any of the other information contained in this consent form.

All of my questions have been answered to my satisfaction. By marking the box below, I give my voluntary informed consent to participate in the research as it has been explained to me, and I acknowledge receipt of a copy of this statement for my own personal records.

☐

Phone Interviews

PRIVACY ACT STATEMENT

1. Authority. 5 U.S.C. 301
2. Purpose. Research information will be collected in research study #32258 titled, “Marine Corps Drug Prevention Project,” to enhance basic knowledge or to develop procedures to improve the prevention of illness, injury, or performance impairment.
3. Routine Uses. Research information will be used for analysis and reports by the Departments of the Navy and Defense, and other U.S. Government agencies. Use of the information may be granted to non-Government agencies or individuals by the Navy Surgeon General following the provisions of the Freedom of Information Act or contracts and agreements. I voluntarily agree to its disclosure to agencies or individuals identified above, and I have been informed that failure to agree to this disclosure may make the research less useful. The “Blanket Routine Uses” that appear at the beginning of the Department of the Navy’s compilation of medical databases also apply to this system.
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2. During your participation, you will be interviewed by phone about your opinions regarding the extent of the problem of drug use in the Marine Corps and your impressions and experiences regarding participation in Marine Corps drug prevention programs. Please keep in mind that we are interested in both your positive and your negative feedback regarding these Marine Corps programs.

3. The clearest risk of your participation is the possibility that you may disclose specific information about yourself or someone you know, that could have legal repercussions or military career implications. You are strongly cautioned not to reveal any incriminating information during this interview. This includes information regarding any illegal behavior that you may have engaged in or information regarding the illegal behavior of any specific individuals with whom you are acquainted.
4. The only benefit(s) that you may expect from your participation in this research is the opportunity to contribute to improving Marine Corps drug prevention programs.
5. We will be tape-recording this conversation, because we do not want to miss any of your comments. However, in order to protect your privacy, do not use your own or other's last names or ranks in the conversation. If you so desire, feel free to use any first name you choose for yourself rather than your actual name. The confidentiality of the information you share during this research will be protected by keeping all audiotapes, handwritten notes, and transcriptions from the interview in a locked file at the Naval Health Research Center (NHRC). Only study investigators will be allowed to see the information. Computer data files will be stored in compliance with NAVMEDRSCHDEVCOMINST 5870.4. NHRC will not collect or store any personal identifiers, real or fictitious, with any of the data from this interview.
6. If you have questions regarding this study contact Dr. Valerie Stander, NHRC, P.O. Box 85122, San Diego, CA 92186-5122; DSN 553-7174; Commercial (619) 553-7174. For questions regarding your research participation or that of other persons, contact Stephanie Booth-Kewley, Chair, NHRC Institutional Review Board (619) 553-8465.
7. Your participation in this study is completely voluntary. If you do not want to participate, there will be no penalty and you will not lose any benefit to which you are otherwise entitled. You may also end your participation in this study at any time. If you need to stop, simply tell the researcher and the interview will end immediately.
8. Dr. Valerie Stander is responsible for storing all consent forms and research records related to this study.
9. At this time please feel free to ask questions about this study, its related procedures and risks, as well as any other information that has been explained to you.

NHRC Researcher:

I have answered all of the participant's questions to his or her satisfaction. By checking the box below, I indicate that the participant gave his or her voluntary informed consent to participate in the research as explained by me.

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*Appendix D: Suggestions Unique to Specific Groups***Table D1***How Could the Marine Corps Improve Its Drug Prevention Programs?*

Groups of 17- to 24-year-old Marines	
1.	Senior leaders and officers should visibly participate in urinalysis program (West Coast only).
2.	Teach Marines more about life skills rather than just physical fitness training.
3.	Marines enter the Corps to get away from going to school, so drug education classes are not the best format for them to learn.
4.	Provide more opportunities for community service as alternative activities, such as Big Brothers, Big Sisters.
Marines Who Have Tested Positive for Drugs	
1.	Provide counseling or support groups for Marines after they have tested positive
Junior NCOs and Junior Officers	
1.	Make sure funding is available for drug prevention and drug testing.
2.	Improve methods of testing Marines so they cannot flush their system.
3.	Improve the example junior NCOs set for young enlisted.
4.	Provide more constructive work for those who test positive; menial tasks are unproductive.
5.	Officers need to be more involved like they were when there were mass barracks and single sergeants still lived there.
6.	Lower the drinking age on base to stop people from going outside where they are more likely to use drugs.
7.	Do not lower the drinking age for younger Marines.
8.	Train junior enlisted to be SACOs.
9.	Do not train junior enlisted to be SACOs; they will be more likely to warn their friends about testing times.
10.	Conduct a study of those who enter with drug waivers to see whether that really raises the likelihood of drug use.
11.	Keep up with society – adapt culturally, provide Internet access, etc.
12.	Teach Marines that friends who get in trouble with alcohol and drugs are not really friends.
13.	NCOs should be more aware of who is coming in late or tired during PT and talk to them about getting help.
14.	100% ID checks at the gate; check for drug and alcohol use.

15. Have mentoring programs and match up older Marines with younger Marines.
16. Drug testing should be done by Naval Hospital staff, not Marine staff.
17. SACO should be more involved in helping to direct people toward alternative activities.
18. Make sure people have enough free time.

Senior NCOs and Senior Officers

1. Help Marines meet the personal goals with which they entered the Corps.
2. Make sure promotion policies are consistent and fair.

Substance Abuse Control Officers (SACOs)

1. Make drug prevention education separate from safety briefs and other types of prevention programs.
2. It would be helpful if there were something that could be done in the case of positive drug tests that do not meet criteria for disciplinary action.
3. SACO should have his or her own office space and computer for confidentiality and efficiency.
4. SACOs should have access to individual histories of personnel and better access to civilian police blotter.
5. SACOs need more standard procedures for keeping cases files and transferring them from one unit to another.
6. The job of SACO should be a separate billet rather than a collateral duty.
7. Company and Battalion leaders need better systems to track referrals to the SACO to make sure that the SACO is aware of them and they do report in.
8. Clarify the prerequisites for the SACO duty in writing.
9. Restrict Marines from training or deployment while they are in process of screening and referral for substance abuse treatment.
10. Give Marines more responsibility and minimize boring, meaningless work.
11. Do not put legal drinking age and underage roommates together.
12. Some restrictions actually increase problems, such as breaking up units and forcing Marines to drink off base.
13. Require Marines with waivers to go through treatment prior to entry into the Marine Corps.
14. Marine Corps Community Services (MCCS) representatives should attend SACO meetings.
15. SACOs need to move away from the role of "snitch" and into the role of counselor.

Drug Demand Reduction Coordinators (DDRCs)

1. All branches of the Department of Defense should communicate and work together better.
2. Do not mix profit and non-profit organizations. Drug prevention should not be part of MCCS.

3. Managers who micromanage are not helpful.
 4. Drug prevention programs need more funding.
 5. Funding needs to come earlier in the year.
 6. Alcohol Abuse Specialists mentioned in the Marine Corps Order do not exist but would be helpful.
 7. SACOs should be civil servants, not Marine Corps personnel.
 8. It should be mandatory to have a SACO in every unit.
 9. There should be a DDRC at every base.
 10. Start working with women, informing them about date rape drugs and improving decision-making skills.
 11. Identify and track measurable indicators of success for drug prevention programs.
 12. DDRCs need to be more abreast of current drug cultures and paraphernalia.
 13. Do more surprise health and welfare checks among the troops, look for paraphernalia.
 14. Find ways to make prevention the SACOs' first priority rather than drug testing and treatment referral.
 15. Educate and encourage Marines to report illegal drug use more often.
 16. More interaction and exchange of helpful ideas among DDRCs would be helpful.
 17. More DDRCs should have assistants.
 18. Needs assessments should be done more often.
 19. SACOs should be chosen more carefully to be sure they are competent and committed.
 20. Make clearer restrictions for Marines visiting or stationed in foreign countries where drug laws are different than they are in the United States.
 21. Increase communication between SACOs and DDRCs.
 22. Have DDRCs more active in the Single Marine Program and other recreational activities to make them more visible.
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