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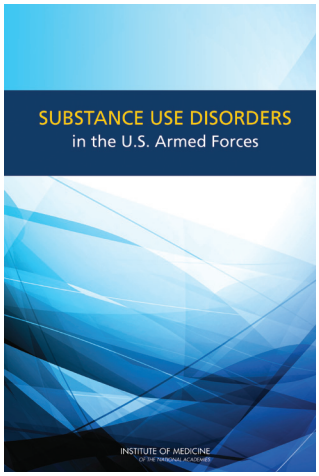
Substance Use Disorders in the U.S. Armed Forces



A whistleblower incident at a U.S. Army base in the Midwest, coupled with rising rates of alcohol and prescription drug abuse, raised Congressional concern about substance abuse within the armed forces. Like many sectors of society, the U.S. military has a long history of alcohol and other drug misuse and abuse. Substance use disorders extend to all branches of the military and can be exacerbated by deployment. In recent years, the face of the issue has been transformed by skyrocketing prescription painkiller use. Military physicians wrote nearly 3.8 million prescriptions for pain medication in 2009, more than quadruple the number of such prescriptions written in 2001. Some have attributed these trends to combat-related injuries and strains from carrying heavy packs, body armor, and weapons over mountainous terrain during multiple deployments.

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In order to better understand current substance use problems within the U.S. military, the Department of Defense (DoD) asked the Institute of Medicine (IOM) to analyze policies and programs that pertain to prevention, screening, diagnosis, and treatment of substance use disorders (SUDs) for active duty service members in all branches, members of the National Guard and Reserve, and military families. The IOM committee presents its findings and recommendations in *Substance Use Disorders in the U.S. Armed Forces*.

A Public Health Crisis

The DoD and individual military branches—the Air Force, Army, Marine Corps, and Navy—have developed and implemented policies to manage sub-

stance use, some dating back to the Vietnam era. Because substance abuse impairs military readiness, DoD policy sets high standards for performance and discipline and consequently strongly discourages heavy drinking, illicit drug use, and tobacco use by members of the military.

Yet alcohol and other drug use in the armed forces remain unacceptably high, constitute a public health crisis, and both are detrimental to force readiness and psychological fitness. The IOM asserts that the highest levels of military leadership must acknowledge these alarming facts and combat them using an arsenal of public health strategies, including proactively attacking substance use problems before they begin by limiting access to certain medications and alcohol.

Additional structural changes involve prescribers, who should routinely check local prescription drug monitoring programs before dispensing medications with high abuse potential. Health care professionals also should be trained to recognize worrisome patterns of prescription drug use and medication-seeking behaviors and should be given clear guidelines for referral to specialty providers. Routine screening for unhealthy alcohol use and mechanisms to support brief interventions would permit health care professionals to point out the risk of excessive alcohol consumption. Placing such interventions within the familiar context of primary care would reduce the stigma attached to seeking care for substance use disorders.

Since the start of the wars in Iraq and Afghanistan, alcohol abuse among returning military personnel has spiked. In 2008, nearly half of active duty service members reported binge drinking. (See chart.) Among the environmental changes endorsed by the committee are curbing easy access to relatively inexpensive alcohol on military bases through consistent enforcement of regulations on underage drinking—especially important because a considerable portion of military personnel are younger than the legal drinking age. The committee also recommends paring down the number of outlets that sell alcohol, restricting their hours of operation, and reducing the type and amount of alcohol purchased.

In addition to seeking to reduce binge drinking and DUIs, the committee recommends that military leaders encourage members to seek help. The IOM committee identifies a number of barriers that limit access to substance use disorder care—including availability, gaps in insurance coverage, stigma, fear of negative consequences, and lack of confidential services—and recommends remedies for each.

For example, the committee applauds the Army's implementation of the Confidential Alcohol Treatment and Education Pilot, which demonstrated that active duty service members use confidential treatment when given the opportunity to do so. The committee recommends that such programs be expanded within the Army and to the other military branches as well. Delivering such services without taking disciplinary actions promotes better care, builds troop resilience, and encourages individuals to seek help rather than hide problems.

Increasing the Use of Evidence-Based Programs and Practices

The policies and programs sponsored by the DoD and the military branches advocate the adoption and implementation of evidence-based practices—which are integral to providing high-quality, effective substance use care—but provide few details about which practices to use.

Fully implementing the evidence-based guideline for treating substance use disorders that the DoD already has developed, *VA [Veterans Affairs]/DoD Clinical Practice Guideline for Management of Substance Use Disorders*, would help in carrying out the committee's recommendations for routine screening and effective treatment. The committee also calls for enhanced use of technology, provision of confidential care, and greater use of continuing care options.

Further, there is a difference between evidence-based practices, whose design relies on evi-

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dence gleaned from the scientific literature, and *effective* evidence-based practices, which have been rigorously evaluated and have demonstrated success. The DoD must take the lead in assuring the consistency and quality of substance use disorder services and should require improved data collection, the committee recommends. Each military branch needs to ensure that its programs work by evaluating such tangible outcomes as reducing rates of SUDs, reducing relapses, and improving overall outcomes among participants. The committee advises that evaluation of prevention programs' effects be done annually.

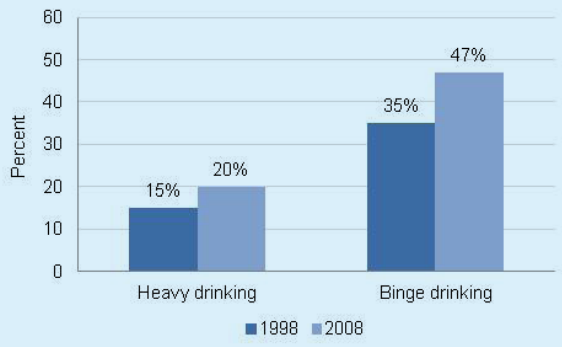
Expanding Access to Care

The committee's review revealed substantial unmet need for substance use disorder treatment services as well as outdated policies and practices that serve as barriers to such care. The Military Health System provides treatment both directly and through TRICARE insurance benefits. Yet, TRICARE does not cover intensive outpatient services, office-based outpatient services, and certain evidence-based pharmacological therapies which are standard components of care for substance use disorders.

Currently, SUD services are restricted to certified Substance Use Disorder Rehabilitation Facilities, which has led to an expensive reliance on hospital-based treatment far from service members' homes. The committee recommends that the TRICARE benefit be expanded to include care in intensive outpatient and office-based settings, which would allow patients greater access to care.

The TRICARE SUD benefit is out-of-date with current standards for evidence-based care and needs to be revised without delay. If the DoD fails to make these needed changes to the TRICARE SUD benefit in a timely manner, the committee recommends that Congress consider taking action to mandate such DoD policy changes.

CHART: Alcohol Use by Active Duty Service Members



Creating a 21st Century Workforce

Alcohol and other drug treatment counselors who leveraged their own personal experiences to help patients begin and maintain stable recovery were the standard care providers in the 1960s. In the intervening decades, however, the needs of patients seeking substance use disorder treatment have become more complex because patients frequently use more than a single substance. Counselors with graduate degrees have become more prevalent and health care reform is likely to create

a future demand for counselors who are licensed independent practitioners.

Rather than expanding a 20th century workforce, the DoD needs to structure and staff substance use disorder treatment services for the 21st century, the committee writes. The emerging model of care relies on multidisciplinary treatment teams with carefully prescribed roles and training. Emphasizing outpatient services, relying on group therapy, and using computer-assisted cognitive behavioral training may help to increase caseloads and enhance productivity.

Conclusion

Grappling with the public health crisis of substance use and misuse within the ranks of the armed forces will require the DoD to consistently implement prevention, screening, diagnosis, and treatment services and take leadership for ensuring that these services expand and improve.

This endeavor will update the definition of a functional soldier. The DoD can meet this standard by effectively and affordably rehabilitating members of the military who seek such assistance and retaining them within the military, an investment on behalf of the people who voluntarily risk their lives for their country.

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