



Picture Day in the Village, by Martin J. Cervantez, oil on canvas, Afghanistan, 2009.
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Chapter 17

ETHICAL AND FORENSIC ISSUES INVOLVING SUBSTANCE USE IN THE MILITARY

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INTRODUCTION

Alcohol use and the military share a long and tumultuous history. Perhaps the best point in time illustrating this complicated relationship is found in the greatest conflict ever fought in North America—the US Civil War. During this war, the boundaries between alcohol's recreational use, medicinal value, and motivational role were especially blurred. Alcohol use softened the rough edges of a brutal war, was prescribed liberally by military surgeons for all aches and pains, and was a frequent incentive dispensed by commanders to deserving troops. Despite alcohol's many apparent advantages, a dark side was increasingly illuminated as the war dragged on.

Scholars carefully examining alcohol's influence during the Civil War agree that military discipline universally suffered.¹ One authoritative estimate concluded that 18% of all general courts-martial offenses during the Civil War were alcohol related.¹ Only the most egregious acts resulted in a court-martial, which left an untold number of—although amply documented in soldiers' writings—various official reports and the observations by wartime newspaper reporters of alcohol-fueled fighting, insubordination, and desertions. Perhaps most important were the alcohol-induced degradations in warfighting capabilities. Intoxicated soldiers stumbled on road marches, lost their direction, could barely aim their weapons, and were easy prey for the enemy.

Several Civil War campaigns exemplified the perils of alcohol use. The Battle of the Crater fought in 1864 at Petersburg, Virginia, showcased the disastrous effects of alcohol on leadership.² Brigadier General James Hewett Ledlie, in command of the 1st Division of the Army of the Potomac, had a career marred by his intemperate habits.² The central feature of the Battle of the Crater was the Union Army's surreptitious construction of an explosive-laden tunnel extending beneath the Confederate lines. It fell to Ledlie to seize the momentum following the explosion and attack the shaken Confederate troops. Through a mixture of miscommunications and befuddled leadership Ledlie failed miserably. In a biting denunciation, "The general remained behind in his bombproof [shelter] drinking rum with another division commander while his men were slaughtered."³

Confederate General Nathan George "Shanks" Evans was a fearless warrior with a passion for alcohol. During the First Battle of Manassas Evans caused a stir of sorts by insisting his aide carry a small barrel of whiskey on the battlefield to gratify the general's immediate needs.⁴ Over the next 2 years rumors and innuendo of problem drinking continued to swirl

around Evans. In 1863 the general's drinking became such a liability that Confederate authorities ordered a court-martial. Evans was acquitted, but perhaps in a more telling judgment, was never permitted to command troops again.^{3(p474)}

The Civil War witnessed nascent efforts that would later gather momentum and sweep across America, advocating abstinence. This moral crusade intoned that "the records of the Civil War abundantly show, there was still much drunkenness among the common soldiers and the officers, and not a few of the defeats of the Northern armies were occasioned by the intoxication of officers."⁵ The Union Army needed to look no further than the first major campaign of the war.

The Union Army's stunning defeat at the First Battle of Manassas sent an overconfident military reeling. After a brief period of reflection, one of the causes for failure was assigned to Colonel Dixon S Miles.⁶ Miles was the 5th Division Commander for a reserve unit that allegedly sat idly by as Union troops were overwhelmed by their Confederate foes. Colonel JB Richardson accused Miles of battlefield inebriation, launching a Court of Inquiry. An equal number of prosecution and defense witnesses testified at the inquiry. George B Todd, an assistant surgeon, testified that, "It is my impression that he was intoxicated . . . He was unsteady on his horse . . ."⁶ Another physician, JJ Woodward, served on the accused officer's staff. Woodward ascribed Miles' odd behavior to a bout of diarrhea.

The Court of Inquiry, which met for 13 days and rendered a rather inconclusive judgment, agreed "that Colonel JB Richardson was justified in applying the term drunkenness to Colonel DS Miles condition . . ."⁷ Notwithstanding that finding, "The Court is of opinion that evidence cannot now be found sufficient to convict Colonel Miles of drunkenness before a court-martial; that a proper court could only be organized in this army with the greatest inconvenience at present; and that it will not be for the interests of the service to convene a court in this case."⁸ It was a fateful decision.

Now vindicated by the Court of Inquiry, Miles resumed his military career, eventually assuming control of Union forces guarding Harpers Ferry.⁸ Contraband whiskey poured into Harpers Ferry as the sympathetic general turned a blind eye. Despite numerous warnings from other officers, sentry reports, and his observations, Miles minimized the gathering Confederate force. In all fairness to Miles, even a sober commander could have been fooled by the Confederate strategy. In any event, Miles' confusing behavior rekindled concerns that he had

resumed his problem drinking.⁸ Confederate forces aided by Miles' poor battlefield decisions quickly took aim on the virtually helpless Union troops. Miles, "confused and possibly drunk . . ." surrendered his command along with 12,000 soldiers. Roughly 10 minutes after raising the white flag, an artillery shell killed Miles.⁹

The lessons learned from the Civil War are not sympathetic to alcohol. The intoxicating beverage impaired judgment, memory, coordination, and concentration—attributes clearly antithetical to a successful war. In subsequent wars, America's military again confronted alcohol, but the addition of illicit drug use complicated the reaction. The timeline stretching from the Civil War to Operations Iraqi Freedom and Enduring Freedom documents a bumpy road in the military's evolving response. At any point along the continuum, innumerable examples exist documenting the damage of drug and alcohol abuse.^{10,11}

At the same time, a discernible trend is detectable. What once was an accepted part of military life is now ancient history.

Current Army regulations explicitly deglamorize alcohol abuse. One of the core principles succinctly states, "Alcohol and drug abuse is detrimental to a unit's operational readiness and command climate and is inconsistent with Army values and the warrior ethos. The Army strives to be free of all effects of alcohol and drug abuse."¹² In a further testament to this effort, the US Central Command issued General Order Number 1 that proscribes specific activities. The order prohibits the "Introduction, purchase, possession, sale, transfer, manufacture, or consumption of any alcoholic beverage within the countries of Kuwait, Saudi

Arabia, Afghanistan, Pakistan, and Iraq."¹³ The same order provides similar language regarding controlled substances, the possession of drug paraphernalia, and the misuse of prescription medications.^{13,14}

Unless stated otherwise in this text, all references are from the US Army policies. For completeness sake at this point, the Air Force's Alcohol and Drug Abuse Prevention and Treatment is governed by the Air Force Instruction 44-121.¹⁵ The Department of the Navy's substance abuse prevention and control is governed by the Secretary of the Navy Instruction 5300.28E.¹⁶ The Marine Corps' substance abuse program is governed by the Marine Corps Order 5300.17.¹⁷

One of the chief instruments in achieving a drug free military involves mandatory drug testing. The rise in drug abuse during the Vietnam War was a clarion call to action. The problem accelerated into 1980 when a survey reported that nearly 50% of enlisted personnel admitted using an illicit drug in the preceding 10 days.¹⁴ In response to the epidemic, the US military developed and launched the first wide scale random drug testing program. The results were amazingly successful. Less than a decade after deployment, the rate of drug use declined to less than 10%.^{14(p10-11),18}

The US military's evolution toward an alcohol and drug free culture now relies on a triumvirate. Substance abuse can be any combination of a medical disorder, disciplinary issue, or legal matter. As such, clinicians, commanders, and attorneys may all contribute to an outcome. Each has its own language, prerogatives, and presumptions. The remainder of this text will be devoted to clinicians to try to address some of the myriad ethical and forensic issues that inevitably arise in modern day practice.

FORENSIC AND ETHICAL CONSIDERATIONS IN CLINICAL PRACTICE

Every healthcare profession, whether it is in medicine, mental health, or addictions treatment, has a professional code of ethics to which its members are held accountable. Members are expected to maintain a thorough understanding of the ethical standards of their respective organizations and ensure that they respond in good faith to honor those provisions. Ethical dilemmas emerge for clinicians in substance abuse treatment

when command's need to know constrains their ability to provide unqualified assurances of privacy and confidentiality to their patients. Clinicians entering the military's healthcare system from private practice are particularly aware of their dual responsibilities to both patients and command as they acclimate to the requirements of delivering substance abuse treatment in the context of a regulation-based "Command Program."

LIMITS OF CONFIDENTIALITY AND THE LIMITED USE POLICY

The clinician must carefully explain the limits of confidentiality to prospective patients before the initial clinical interview can proceed. Service members are entitled to know that commanders will be informed of their referral to the clinic, the nature of their concerns, and the recommended treatment. Given the likely

inhibitory effect that this policy could have on patient disclosure, it is particularly important that a discussion of confidentiality limits be balanced by a discussion of the protections afforded the patient under the Army's limited use policy.¹² It is hoped that knowledge of these protective clauses will mitigate the patient's

predictable fears of adverse repercussions that might ensue from his or her disclosures of substance use.

The Army's limited use policy offers many protections. For example, although urinalysis test results conducted in the context of treatment are reported to the chain of command, these are considered "protected evidence" as defined within the Army's limited use policy. As such, they are not subject to disciplinary action. The Army's limited use policy also covers "information concerning drug or alcohol abuse or possession of drugs incidental to personal use, including the results of a drug or alcohol test, collected as a result of a soldier's emergency medical care."¹² The limited use policy is not intended to protect a service member from disciplinary or adverse administrative actions that may already be underway. It does not protect service members from the potential consequences of command-directed drug testing nor does it prevent the clinician from disclosing "knowledge of certain illegal acts which may compromise or have an adverse impact on mission, national security, or the health and welfare of others."^{12(p71)} The protections of the limited use policy were incorporated into the Army regulations to encourage self-referrals and foster a climate in which individuals who abuse alcohol and other drugs can feel safe to disclose an accurate picture of their history of use.

The limited use policy offers fairly broad assurances of protection to an individual seeking rehabilitation, and for many individuals, these assurances are sufficient for them to begin their recovery. However, the military's stance regarding illegal drug use and its potential for adverse consequences cannot be dismissed. Staff must ensure that patients understand the distinction between consequences related to disciplinary actions that would fall under the Uniform Code of Military Justice and other potential consequences that would likely still be experienced as adverse, although not subject to the code. For example, security clearance status can be altered in the face of serious substance problems. Clinical privileges can be placed in abeyance, if work performance has been compromised due to substance use. Administrative separations may be initiated in cases in which the command finds a service member to be unsuitable for continued service by virtue of the severity of his or her substance problem. In other circumstances, the regulation is more explicit. It stipulates that it is the commanders' responsibility to process all soldiers for separation who are "identified

as illegal drug abusers, all soldiers involved in two serious incidents of alcohol-related misconduct within 12 months, all soldiers involved in illegal trafficking, distribution, possession, use, or sale of illegal drugs, and soldiers convicted of driving while intoxicated or driving under the influence a second time during their career."^{12(p56)} In these matters, the regulation is clear; the commander's role is to initiate these actions, in consultation with the local Judge Advocate General office. In most cases, the clinician remains in a supportive counseling role. The regulation stipulates that it is the commander's role, in consultation with the Judge Advocate General, to make administrative decisions regarding a service member's military status; it is the Army Substance Abuse Program (ASAP) clinician's role to make treatment recommendations. When the clinician's treatment recommendations are not supported by the command, this conflict moves up the respective chains of command for resolution.

Per Army Regulation (AR) 600-85, soldiers may seek program information and discuss some preliminary concerns in an anonymous manner. However, should an evaluation be necessary, the regulation requires that the unit commander be notified.^{12(p54)} Furthermore, the regulation requires that counselors discuss treatment considerations with the command, and that these discussions include the service member's diagnosis, prognosis, and progress.

As might be expected, many service members are reluctant to self-refer because of this mandatory involvement of command in their care. The Institute of Medicine discussed these findings in its 2012 report, *Substance Use Disorders in the US Armed Forces*.¹⁸ Recommendation 8 of the Institute of Medicine's report concludes that low self-referral rates "corroborate reports of the perceived stigma of receiving treatment for SUDS [substance use disorders]" and recommends that confidential services be developed.¹⁸ It commended the Army's Confidential Alcohol Treatment and Education Pilot, a pilot program that appears to hold promise in attracting a broader range of military personnel across ranks. It offers alcohol treatment outside the normal duty day, thus affording service members the opportunity to participate without command involvement or to varying degrees of command notification at the service member's request. This treatment alternative seems to "foster a system in which individuals seek help instead of hiding problems."¹⁸

INFORMED CONSENT

In clinical practice, informed consent serves as an important foundation for treatment. After patients have been fully advised of their treatment options

and the potential risks and benefits of those treatment options are explained, they are encouraged to collaborate in the creation of a treatment plan consistent

with the severity of the problem and their perceived readiness for change. Informed consent represents the clinician's duty to disclose the range of treatment considerations so that the patient can make a reasoned decision regarding his or her care. This concept is predicated on the principle of autonomy, the patient's right to make decisions regarding fundamental issues in his or her life to include healthcare. In substance abuse treatment, however, this principle can be difficult to put into clinical practice. The dynamics of substance use and the complicating features of denial and minimization can interfere with sound decision-making, particularly in the early treatment stages. These psychological defense mechanisms often raise serious safety concerns that require modification in the implementation of the principle of autonomy. "When a patient is in denial about his or her abuse

of alcohol or drugs, deference to patient autonomy can shift. The principles of autonomy and privacy, so critical to honest communication between physician and patient, can sometimes in the context of drug and alcohol abuse, seem to work against what the physician sees as the patient's best interests."¹⁹ In these situations, the commander's role in directing service members into treatment can be a lifesaving intervention. Clark and Brooks, in considering these "Ethical Issues in Addiction Treatment," concludes that "the physician has an ethical duty to act if there is reason to believe that the patient's use of alcohol or drugs is affecting his or her health."¹⁹ In Alcoholics Anonymous parlance, coercive treatment in such cases provides the opportunity to raise the bottom so that individuals can receive help before enduring damage has been suffered.

DISCLOSURE OF SUBSTANCE ABUSE AND METHOD OF DISCOVERY

In spite of the protections offered by the limited use policy, clinicians may find themselves making a routine behavioral health diagnosis and encounter substance abuse concerns that may become a focus of inquiry by military attorneys or commanders. Patients may reveal these concerns during evaluation for administrative separation, a command-directed evaluation, or ongoing treatment for other behavioral health issues, or when they present this issue as the sole concern for a self-referral seeking substance abuse treatment.

During any session, the patient may reveal both substance abuse and behavioral health issues. Some issues may require disclosure under service regulations for substance abuse; others may require confidentiality under rules for privilege; and some information may require a decision to disclose some information and keep other portions confidential. The clinician has to decide what to report to the command and what to keep privileged. How much is required under AR 600-85? How much is required under enlisted and officer administrative separation regulations and command evaluation regulations? And how much is required to be kept privileged and possibly referred for treatment under rules of professional responsibility?

Clinicians can refer to regulations covering substance abuse programs and abuser identification. AR 600-85, paragraph 7-8, Medical Identification, allows clinicians some discretion in whether to disclose this information to the command and whether the patient must be referred to a program for rehabilitation or treatment.

- (1) If a soldier reveals, as part of a routine medical screening with a physician or other healthcare

clinician, his or her personal abuse of alcohol or other drugs, the healthcare clinician will evaluate further, with possible ASAP referral for in-depth evaluation and rehabilitation. The revelation of personal abuse, by itself, will not subject the individual to adverse administrative action. Urinalysis which may follow such disclosure will be covered under the Limited Use Policy. The healthcare clinician will provide information about the soldier's alleged alcohol or other drug use immediately to the commander should it appear that any of the following conditions exist:

- (a) The abuse by the soldier is current.
- (b) Impaired judgment is evident.
- (c) Potential danger to others exists as a result of alcohol or other drug use (for example, Chemical or Nuclear Surety Programs, aviator).
- (d) . . . Drug use impacts the soldier's judgment, reliability, or trustworthiness to protect classified information.^{12(p7-1a)}

If none of the above conditions exists, the disclosure remains under the protections of confidentiality within the clinician-patient relationship. However, if the clinician finds that one of the above conditions exists, with respect to the substance abuse disclosure, and consequently reveals the same to the patient's command, the remainder of the patient's behavioral health concerns that are not otherwise subject to disclosure do not become available to the command.

In some instances, behavioral health clinicians may be the initial recipients of self-referrals. A patient may choose to report substance abuse and a desire to seek treatment to a clinician rather than a member of the chain of command. From a legal viewpoint, a clinician at a military treatment facility is defined as an authorized person to receive self-referrals. In this instance, AR 600-85, paragraph 7-3a, and other service regulations contain directions on reporting the use to the command and referring the patient for testing and to a treatment program for evaluation.¹²

Limited use policies restrict the use that can be made of a patient's self-referral, and subsequent test results, in disciplinary actions.¹² Patients seen for emergency treatment of suspected or an actual substance overdose are considered self-referrals, which requires a report

to the command and referral to treatment and protections of the limited use policies. Finally, if a patient does not reveal substance abuse to a clinician, but the clinician notes it as an issue, the clinician may refer the patient to treatment and then report the matter to the patient's command.¹²

An entirely different scenario occurs when the patient is referred to the clinician for a command-directed behavioral health evaluation.²⁰ This referral, which generally occurs in a nonemergent setting, is where the patient is advised in writing by the clinician that the conversation is not confidential and that the results of the evaluation are released to the command. The results of this evaluation are generally used for administrative action, such as separation from active duty.

PRIVILEGE

Privilege, covered by Military Rule of Evidence 513, covers psychiatrists, psychologists, and licensed social workers, as well as their assistants. No general physician-patient privilege exists in the military. Moreover, numerous exceptions to the psychotherapist-patient privilege exist. For instance, no privilege exists if a covered clinician is conducting a command-directed evaluation²¹; if the clinician believes the patient is a

danger to himself or herself, others, or the mission²¹; or when a duty to report information is required by federal or state law or service regulation.¹² As discussed above, there is a duty to report substance abuse in some cases, although this duty would not extend to other behavioral health issues disclosed during that same session under the regulation unless it were a command-directed behavioral health evaluation.

THE EMPLOYEE ASSISTANCE MODEL

Substance abuse treatment in a military setting has many advantages over practice in the private sector, deriving in large measure from the nature of the relationship between practitioner, patient, and the command. Treatment is predicated on an employee assistance program (EAP) model in which motivation to maintain one's military career incentivizes treatment engagement. Having manpower conservation as its primary mission, ASAP acknowledges the central role of the command in the introductory words of the rehabilitation section of the AR 600-85, asserting that "the unit commander's attitude and direct involvement are critical in the soldier's successful rehabilitation process. Command support must be positive and clearly visible. The commander must be aware of the soldier's immediate problem identified during the biopsychosocial evaluation and be familiar with the counseling strategies and goals addressed in the rehabilitation plan."¹²

Implementation of this EAP strategy begins with the rehabilitation team meeting, which ideally is conducted as a face-to-face meeting involving the command, the clinician, and the service member about to be enrolled in treatment. The rehabilitation team

meeting provides an opportunity for the commander to encourage the service member's involvement in treatment, express support for other service members receiving treatment, and acknowledge the challenge and hard work that will be required to successfully complete treatment. It is important to convey this message to new enrollees in treatment, regardless of the nature of their referral, and emphasize that ASAP appointments be considered equivalent to any other medical appointment and prioritized as such. In expressing their support and respect for treatment and their belief in the efficacy of this care in repairing careers, commanders have an invaluable role in the destigmatization of substance abuse treatment, both in the eyes of the service member and to others in the chain of command.

To fully harness the potential of the EAP construct, command must next articulate the potential adverse consequences that could ensue if the service member fails to comply with treatment. In presenting the possibilities of retention and separation, the service member is presented with a paradigm of choice. Barring any preexisting adverse disciplinary actions or legal problems that would preclude retention in service, it

is the service member's actions that dictate whether he or she is separated or retained.

Herein is the beauty of the EAP model in substance abuse treatment delivery. Harnessing the power and authority of their rank and responsibilities, commanders can serve as powerful agents for change in a manner similar to that described by Winick and Wexler in their discussion of therapeutic jurisprudence.²²

To optimize clinical outcomes from the lessons emerging from drug court treatment literature, commanders—like drug court judges—“need to understand how to convey empathy, how to recognize and deal with denial, and how to apply principles of behavioral psychology and motivation theory.”^{19(p550)} The

authors maintain that individuals more readily comply “when they are given a sense of voice and validation and treated with dignity and respect.”¹⁹ These principles can be conveyed from the outset of treatment in the rehabilitation team meeting. The commander's role on the rehabilitation team, when implemented to optimize its therapeutic potential, can have a powerful impact on a service member's willingness to accept help. For many service members, the commander's presence is critical in maintaining engagement in treatment, particularly when motivation is low and insight is limited. Gradually, the military is moving forward in its efforts to deglamorize alcohol use. Leadership's role in supporting recovery cannot be overstated.

EXPERT CONSULTANTS AND WITNESSES

Military law, through Rules for Courts-Martial, Military Rules of Evidence, and case law, provides procedures and guidelines for the use of expert consultants and expert witnesses. Physicians and other medical and behavioral health clinicians may serve as experts in military justice proceedings and serve in two roles:

- (1) as a consultant or assistant to either the prosecution or defense, and
- (2) as an expert witness for either side during the trial or presentencing phase of the court-martial.

This may occur whether the clinician has treated the patient or merely for the clinician's expertise, even though he or she has no contact with anyone involved in the court-martial. If the clinician is treating either a victim or an accused person, this will affect whether he or she can serve in either role without conflict, and for which side. If he or she is not the treating clinician, the clinician can generally serve in any role, barring other conflicts.

An expert consultant or assistant is someone who advises the trial team. In the case of a clinician, advice given is generally about the accused person's, victim's, or witness' behavioral health; history of substance abuse; or pre- and post-offense behaviors. This advice may come in the form of simply answering questions about the effect of substances on one's ability to function, to reviewing behavioral health records, interviewing witnesses, reviewing an opposing expert witness' conclusions and opinions, and rendering independent medical opinions. Attorney-client privilege covers an expert consultant when assigned to work with a defense attorney and accused. As such, conversations remain privileged and the prosecution is not allowed to discuss the case with the expert

consultant or have access to any of his or her work or opinions. An expert consultant may be involved in only the trial preparation phase or the sentencing phase, or he or she may sit with counsel during trial to assist with questioning witnesses whose testimony involves expert matters.

If the clinician is treating, or has treated, someone involved in the case, this will limit the role that he or she can play in providing assistance. For instance, a clinician who treated an accused service member could not become a consultant to the prosecution team. A clinician who treated a victim could not render advice to the defense team. However, a clinician who is treating an accused service member could become the expert consultant for the defense team. The government counsel may not present behavioral health evidence about an accused service member unless he or she opens the door to these issues. If a counsel is considering using the accused's treating clinician as his or her expert consultant, and believes he or she may eventually call the consultant as an expert witness, some difficulties can ensue if the defense has issues that it does not want disclosed by the treating clinician. The intersection of Patient-Psychotherapist (Military Rule of Evidence 513) privilege becomes a concern here.²¹

Expert witnesses differ significantly from expert consultants. Expert witnesses are permitted to testify in cases where their testimony would help the trier of fact. Clinicians who serve as expert witnesses will assist counsel by explaining those matters to a panel or a judge. In particular, expert witnesses in this area often explain to lay persons how a particular condition, such as one related to substance abuse, can affect a victim, accused person, or even a witness. An expert witness may also offer advice to the government or defense team that he or she is testifying on behalf of, but no protection exists for these conversations. Expert wit-

nesses may be interviewed by and have their opinions and work turned over to the opposing counsel. An expert witness' role may range from evaluating the case file, reviewing witness statements, interviewing witnesses, reviewing medical records and other experts'

opinions, and testifying about his or her conclusions in these areas, to providing background information on a topic such as substance abuse and how it affects behavior, without reference to any party or occurrence in the case.

ALCOHOL RELATED OFFENSES

The *Manual for Courts-Martial United States (2012 Edition)* (MCM)²¹ identifies numerous offenses (punitive articles) related to the consumption of alcohol, to include the following:

- Article 111 (Drunken or reckless operation of vehicle, aircraft, or vessel);
- Article 112 (Drunk on duty);
- Article 134 (Drunk on station);
- Article 134 (Drunk and disorderly); and
- Article 134 (Drunkenness—incapacitating oneself for performance of duties through prior indulgence in intoxicating liquor or drugs).

A service member may also be subject to prosecution by state or federal authorities for drunk driving or other drug and alcohol related crimes. Alcohol testing in the military is not mandatory, but commanders may conduct alcohol screening tests and confirmation tests as required, on the whole or a part of their units to ensure their units' security, military fitness, and good order and discipline.

The main criminal offense related to wrongful drug use under the MCM is Article 112a (wrongful use, possession, etc, of controlled substances).²¹ A controlled substance means any substance that is included in schedules I through V established by the Controlled Substances Act. Additionally, the use and/or possession of controlled substance analogues; chemicals, propellants, or inhalants; banned dietary supplements; prescribed or over-the-counter medications (when misused); or naturally occurring substances (such as Jimson weed) may be prohibited by local law or punitive regulations that are promulgated at individual military installations.

The consumption of alcohol or drugs is generally considered a voluntary act. Perhaps in rare cases the service member might claim consumption was coerced, and those claims would be vetted through the judicial process. The MCM does not recognize voluntary alcohol or drug intoxication as a defense to wrongdoing. Instead, the degree of intoxication may become an important factor in determining the service member's mental state. Some crimes require a specific mental intent such as premeditated murder. Intoxica-

tion might sufficiently impede the service member's judgment, memory, attention, and coordination to the point where the planning inherent in premeditation becomes questionable.

A hypothetical case will help illustrate the point. A service member looked forward to his birthday celebration at a local bar. As soon as the duty day was over, the service member and several of his coworkers headed to the bar. What began as a jovial affair soon gave way to an alcohol-fueled forum complaining about work. As the night wore on the complaints about work became more strident and eventually the birthday celebrant and another service member started trading insults. By now both service members were clearly intoxicated, with slurred speech and unsteady gait. The verbal sparring between the pair progressed to a fistfight. A particularly vicious blow sent the birthday celebrant stumbling against a table and striking his head. The service member died at the scene. In the subsequent court-martial, a clinician called as an expert consultant testified. Based on an extensive clinical interview and review of collateral records such as the police report, the clinician estimated the blood alcohol level of the surviving service member. The clinician then described the relationship between the blood alcohol level and the subsequent physiologic and behavioral impairment. The mitigating evidence succeeded in lessening the original charge of premeditated murder, and the service member was eventually convicted of unpremeditated murder.

This hypothetical case illustrates how a clinician may interact with the military judicial system. In this example, the defense attorney requested the clinician's help. The attorney hoped to explain the death as an unfortunate consequence of alcohol intoxication. Although the voluntary consumption of alcohol does not prevent the service member's responsibility, it may lessen the punishment. As an expert consultant, the clinician needs to conduct a thorough clinical assessment to determine the extent to which—if any—alcohol use contributed to the alleged misconduct. The consumption of alcohol by itself is not sufficient because the primary purpose of the assessment is to determine impairment.

A service member accused of wrongdoing may invoke alcohol or drug intoxication as a mitigating

factor, hoping to reduce the potential punishment. Situations do exist when intoxication may actually aggravate the wrongdoing and increase the range of permissible punishments. A motor vehicle crash, for example, particularly if injuries are involved, could expose the intoxicated driver to harsher penalties.

Although the MCM does not recognize voluntary drug or alcohol intoxication as excusing criminal culpability, in some situations a service member could pursue an exculpatory argument. A few unusual clinical disorders may excuse criminal wrongdoing. As in every legal case, the success of such a defense would rest with the fact finder, be it the military judge or the jury.

Intoxication is a normal and expected outcome of alcohol or illicit drug use. Service members consuming alcohol or illicit drugs can reasonably expect the substance to affect their mental and physical performance. Certain specific clinical disorders are not within the domain of expected outcomes from alcohol or illicit drug consumption. For example, a service member with a substance related withdrawal, particularly if associated with perceptual disturbances, could raise the insanity defense.

The MCM provides extensive guidance to conduct an "inquiry into the mental capacity or mental responsibility of the accused."²¹ Rule 706 of the MCM permits such an inquiry if "there is reason to believe that the accused lacked mental responsibility for any offense charged or lacks capacity to stand trial . . ." ²¹ The inquiry is conducted by a board composed of one or more officers and "each member of the board shall be either a physician or a clinical psychologist. Normally, at least one member of the board shall be either a psychiatrist or a clinical psychologist."²¹ A legally constituted board is expected to address four specific areas:

- (A) At the time of the alleged criminal conduct, did the accused have a severe mental disease or defect? (The term "severe mental disease or defect" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as nonpsychotic behavior disorders and personality defects.)
- (B) What is the clinical psychiatric diagnosis?
- (C) Was the accused, at the time of the alleged criminal conduct and as a result of such severe mental disease or defect, unable to appreciate the nature and quality or wrongfulness of his or her conduct?
- (D) Is the accused presently suffering from a mental disease or defect rendering the ac-

cused unable to understand the nature of the proceedings against the accused or to conduct or cooperate intelligently in the defense? ²¹

A hypothetical case illustrates a scenario where an inquiry into the mental responsibility of an accused was triggered by a service member's alleged substance related misconduct. The service member in this example was in the Army National Guard. He received orders to an overseas area of combat operations. Before the activation, the soldier was unemployed and spent the days drinking alcohol. His tolerance to alcohol was significant. Just before boarding the military aircraft the soldier abstained from alcohol, possibly because he was concerned that his use would be detected. The soldier's long flight was uneventful, but the next day he began experiencing some mild anxiety and tremulousness. His first night's sleep in the foreign country was particularly troubled, with numerous arousals and vivid dreams. Over the next few days the soldier's tremor worsened, he was sweating profusely, and was distinctly uncomfortable, all of which was attributed to anxiety about the looming combat operation. The prominent signs and symptoms of alcohol withdrawal made their appearance after 4 days of enforced alcohol abstinence.

An undetected alcohol withdrawal seriously degrades fitness for duty. In this hypothetical case, the alcohol withdrawal took a decidedly downward turn when both cognitive and perceptual disturbances occurred. The soldier became increasingly suspicious, irritable, and agitated. He confided to another soldier his belief that the unit commander was "plotting" to harm him. When pressed for details, the soldier rambled about being "scared" and about the need to "protect" himself. The recipient of the message took no action. The service member's paranoia culminated with a vicious attack on the company commander. Shortly after the assault, the service member was arrested. A few days after the assault, the service members' mental state returned to normal. The military defense counsel requested an inquiry into the accused soldier's mental capacity and mental responsibility.

A duly constituted board examined the service member. Board members conducted a series of clinical interviews, reviewed the investigative reports, and spoke with family members. At the conclusion of the comprehensive assessment, the board found that the service member suffered from a severe mental disorder at the time of the assault and made a diagnosis of an alcohol induced psychotic disorder with an onset during withdrawal. The board also opined, given his irrational thinking and hallucinations, that he was unable to appreciate the nature and quality or wrongfulness

of the alleged misconduct. Since the service member had recovered when the board performed the clinical evaluation, there was no further mental disease render-

ing the accused unable to understand the nature of the proceedings or to conduct or cooperate intelligently in his defense.

DRUG RELATED OFFENSES

Article 134 of the *MCM* proscribes impaired duty performance that results from the wrongful overindulgence in alcohol or drugs.²¹ Illicit drug use is monitored in the military through mandatory biochemical testing programs. Confirmed use of illicit substances can expose the service member to a wide range of administrative and criminal sanctions.

The current challenges confronting the military are the misuse of prescription medications, particularly opioid analgesics and the endless chemical creation of designer drugs. Designer drugs are synthetic compounds that produce varying degrees of intoxication. The behavioral effects can be sedative, stimulating, hallucinogenic, or any combination. Designer drugs are so named because of the relative ease of chemically tweaking the compound giving birth to a new variant. Producers of designer drugs make these changes to circumvent criminal sanctions. Authorities will no sooner legally ban a substance than the producers will invent a new one. Another reason for the popularity of designer drugs is the supposed difficulty detecting their use through laboratory analysis.

In reality, just about any compound can be detected through laboratory assessment. The rate-limiting step in the detection of designer drugs is awareness. Commanders and clinicians need to remain informed as the drug landscape changes. Military law and administrative regulations prohibit the use of designer drugs.²³

A far more complicated scenario arises with the alleged misuse of prescription analgesics. In these situations, it may be impossible to untangle what appears to be prescription drug abuse from an iatrogenic dependence, a normal physiologic response to the

medication, or an under-treated medical condition. Any of these situations could produce drug-seeking behavior. The medical legal challenge, particularly for a clinician, is to carefully try to tease the strands apart while maintaining a humanistic eye toward the person's medical situation. A hypothetical clinical example will help illustrate the issue.

A severely wounded service member underwent a series of surgical operations that culminated in bilateral above the knee amputations. As expected, the service member's recovery was painful and lessened through prescribed opioid use, and his rehabilitation was slow but steady. The service member's mood was dysphoric, mostly due to a transition from the acute postsurgical pain to a chronic phantom limb pain. In spite of the lancing pain, his opioid analgesics were titrated down. The service member complained bitterly about the residual pain, and various nonopioid analgesics were prescribed resulting in very little pain relief. While on convalescent leave, the service member resorted to using his wife's opioid analgesic, previously prescribed following a dental procedure. When the service member returned to his military unit he was randomly selected for a urine drug test. He tested positive for the nonprescribed opioid, setting in motion a chain of events that—if unbroken—could lead to administrative and legal sanctions. The service member was referred for clinical evaluation to a military substance abuse program because of the positive drug test. The clinician conducted a careful assessment, including consultations with the service member's medical and surgical team before concluding that the under-treated pain disorder was the real culprit.

CLINICAL ASSESSMENT OF SUBSTANCE USE IN THE CRIMINAL SETTING

The frequency of substance use related misconduct almost guarantees that a military clinician will at some point be involved in the judicial process. It usually begins with an attorney calling the clinician, particularly if the request is for expert consultation. At this point the clinician should clearly understand what the attorney wants. In some cases the attorney may simply need an expert consultant to explain a specific substance's general effects. Other situations such as a formal "inquiry into the mental capacity or mental responsibility of the accused"²¹ require more extensive

work. Part of the clinician's effort to best assist the judicial process should include an understanding of the attorney's formulation of that part of the legal case that needs behavioral input. For example, is the attorney seeking to excuse the alleged misconduct by arguing that substance use vitiated mental responsibility?

Once the purpose for the forensic assessment is established, the clinician should have a better sense of the scope of the ensuing evaluation. In most cases of alleged criminal misconduct, the clinician asks the attorney to provide the charge sheets, police reports,

sworn statements, and any other pertinent investigation documents. Best clinical practice awaits receipt and review of these important materials before clinical interviews are conducted. The nature and scope of the subsequent clinical assessment is determined by the legal questions posed, the cooperation from those interviewed, and the clinical complexities. For example, a partially cooperative soldier accused of a serious crime, with both a serious mental disorder and long history of substance misuse, probably requires more time and attention. Even so, every effort should be made to expeditiously complete the assessment, but unavoidable delays—perhaps from complicated inquiries—should be communicated to the attorney.

In most cases of substance use related misconduct, the forensic assessment is broadly guided by three considerations, represented by the acronym TIC:

- T – Time period
- I – Impairment
- C – Consumption

The clinician should expand the assessment's span of inquiry to include the time periods before, during, and after the alleged misconduct. Substance use produces fairly predictable physiological and behavioral impairments, and the clinician should investigate their presence or absence. In terms of consumption, the clinician should screen for all substance use to include the misuse of prescription medications and over-the-counter formulations. Consumption trends include such discussions as the manner in which the substance is used, its frequency, cost, and where procured.

A hypothetical example will help illustrate the application of the acronym TIC. A service member was deeply in debt, mostly from a rash of imprudent purchases. Every night while returning home the service member passed an isolated convenience store. His desperate financial situation raised the notion of robbing the store. The service member rarely drank alcohol, but to bolster his nerves and determination, he drank a glass of wine a few hours before entering the store. After demanding the money from the startled clerk, the service member fled the area. A camera recorded the robbery and led to his arrest. Although the service member cited his alcohol consumption as a mitigating factor, it would probably fail because his intent to rob the store preceded the alcohol use.

Another case will illustrate the importance of examining the time period after the alleged misconduct occurred. In this example, the same service member reported consuming nearly a whole bottle of wine be-

fore the robbery. The service member claimed he was intoxicated and did not remember entering the store. The clinician next focused the evaluation on the service member's behavior after he left the store. According to eyewitness accounts, including two police officers, the service member left the store and fled the area by car. A high-speed chase with police in close pursuit followed. The service member's skillful maneuvering temporarily evaded the police, at which point he abandoned the car and hid in a large crowd. After a few days the service member was finally apprehended at home. In this case, the service member also cited his alcohol consumption as a mitigating factor, but his evasive behavior, performance of complex physical activities, and continuous planning suggest that he was not significantly impaired.

Estimating the degree of intoxication based simply on the amount of substance consumed is less useful than focusing on the impairment. A number of factors collude to make such an assessment inherently inaccurate. In some cases, the accused service member may purposely overstate the amount of substance used, hoping to prove his or her incapacitation. Investigative reports that detail the observations of other persons may also be inaccurate. For example, at some point everyone drinking at a bar for an extended time loses track of consumption. The absorption of alcohol can also be affected by food consumption, the person's mental state, and any preexisting physical or mental disorder. Substances also differ in the degree to which tolerance develops, meaning it takes more consumption to achieve behavioral and physiologic effects. Over time some individuals can develop a significant tolerance to alcohol, for example. Such individuals may have a very high blood alcohol level, but because of their tolerance, display no behavioral impairments.

As previously alluded to, an interesting anomaly of the medical legal evaluation of substance use is the person's willingness to admit and often exaggerate use, which contrasts markedly with the typical clinical presentation where denial of alcohol and drug use is the norm. Clinicians should proceed with caution and must consider the possibility of malingering. The obvious goal of malingering, by consciously and willfully exaggerating one's substance use, is to avoid the consequences of the alleged misconduct. The best antidote for malingering is a comprehensive clinical evaluation, which may require multiple clinical interviews, a careful perusal of investigative reports, discussions with spouses and coworkers, a review of pertinent personnel records, one's medical history, and any prior substance abuse treatment.

SUMMARY

As medical professionals navigate the intersection between treatment and the law, ethical conflicts may arise as a result of their dual-professional status; they should also be aware of the ethics obligations of the legal professionals with whom they will interact. The principal ethical conflict will arise as tension between demands of the medical profession and the profession of arms is similar to the tension faced by military attorneys.

As officers, medical professionals owe a duty of loyalty and service to the nation, the military, and their patients. Clinicians may at times feel conflicted by this dual agency, mentally wrestling with prioritizing the needs of the patient versus the military. For example, when a soldier presents with symptoms that may be appropriately classified alternatively as qualifying for a medical evaluation board²⁴ or as suitable for administrative discharge,²⁵ the treating clinician may feel conflicted. A medical evaluation board may preserve substantial medical or veterans' benefits for the soldier at considerable administrative/evaluation costs to the government. However, administrative discharge may save or eliminate those costs to the government at only a moderate cost in follow-on benefits for the soldier. This situation may put the healthcare clinician in the position of choosing which diagnosis is most appropriate, weighing all available considerations, which may include the express preference of the soldier. Soldier preference may be particularly important because substance abuse—which has yet to be discovered by the command—may expose the soldier to future criminal liability if his or her service continues.

For the healthcare clinician, applicability of relevant exceptions to the Health Insurance Portability and Accountability Act can also become an exercise in ethical decision-making.²⁶ Health Information Privacy Regulation provides guidance on the application of the Health Insurance Portability and Accountability Act to the military practice. Chapter 2 in this volume offers guidance regarding the disclosure of protected health information without patient consent. Of the available exceptions to the general rule of disclosure only with patient consent, issues of patient substance abuse (and attendant behavior/health/treatment is-

ues) may implicate disclosure exceptions for abuse victims, judicial and administrative proceedings, law enforcement purposes, and for "specialized government functions" (ie, disclosures to commanders). In most cases, there is no "reasonable person" standard involved; rather, these exceptions allow disclosures at the medical clinicians' discretion. Exercise of this discretion—and the implicit balancing of interests involved—can create ethical dilemmas for practitioners.

An additional set of ethical concerns for medical professionals is the myriad ethical concerns faced by military (and civilian) attorneys assigned to assist various players that may have a stake in the medical evaluation/treatment system. From the military treatment facility commander, to the soldier's unit commander, the trial counsel (prosecutor), and the soldier's trial defense attorney or soldier's counsel (for medical evaluation issues), lawyers will be involved in giving advice and seeking clinician input. These attorneys will represent different interests and may see their own ethical obligations split between loyalty to the uniform and loyalty to the individual soldier.

Substance misuse in the military raises myriad ethical and medical legal issues. Intoxication is antithetical for a fit-to-fight military. As a consequence, a broad array of treatment programs, administrative regulations, and laws work together to balance the service members' clinical interests with the military's needs. From a practical standpoint this means that clinicians, commanders, and attorneys may all meet at the same crossroad, requiring some communication and understanding if any positive movement is to occur.

The clinician's fundamental contribution is a thoroughly informed medical opinion. A clinician that diligently and methodically gathers the necessary information is well poised to determine the medical-legal relationship between substance use and impairment, assist and advise commanders, and provide the best care for the service member. Through a combination of professional expertise, awareness of pertinent legal issues, a determined impartiality, and a thorough clinical assessment, the foundation is laid for best understanding the ethical and forensic issues involving substance use in the military.

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