[COMMITTEE PRINT]

95TH CONGRESS
2d Session
} HOUSE OF REPRESENTATIVES

DRUG ABUSE IN THE ARMED FORCES OF THE UNITED STATES

A REPORT

OF THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

NINETY-FIFTH CONGRESS

SECOND SESSION

SCNAC-95-2-14

Printed for the use of the
Select Committee on Narcotics Abuse and Control

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INTRODUCTION

As set forth in House Resolution 77, 95th Congress, 1st session (1977), the Select Committee on Narcotics Abuse and Control, chaired by Congressman Lester L. Wolff, is mandated to conduct a continuous, comprehensive study and review of the problems of narcotics abuse and control. One of the most significant and far-reaching areas of that mandate is to conduct a continuing and comprehensive study and review of the problems of narcotics abuse and control as it relates to drug abuse in the Armed Forces of the United States.

To that end, a special task force of committee representatives was created to investigate drug abuse in the military. The central question addressed by the task force was the extent of drug abuse within our Armed Forces. The question of drug abuse within the military and its potential consequences was most recently posed in a study directed by Dr. David Marlow of the Walter Reed Army Institute of Research (WRAIR) in 1976.[1] The task force, chaired by Congressman Glenn English, began operations in the spring of 1977 and included visits to Army, Navy, Air Force, and Marine Corps installations throughout the United States, Asia, and Europe.

Members of the task force interviewed hundreds of officers and enlisted personnel. The committee developed its own research tool, the Drug Abuse Opinion Survey, that provided the most up-to-date information on the extent of the drug abuse problem in the military.

The committee conducted five hearings (appendix B) with representatives of the White House, Department of Defense, Army, Navy, Marine Corps, and Air Force. Their purpose was to gather information on what DOD and the various military branches were doing to assess the extent and impact of the drug problem and what was being done to combat that problem. The hearings began on April 27, 1978, with DOD representatives and spanned a 3-month period, ending with a second DOD hearing on July 27, during which Deputy Secretary of Defense Charles Duncan outlined a 12-point program to intensify DOD's efforts in the area of prevention, detection, identification, and treatment of drug abuse.

The committee found, to its dismay, an alarming lack of information on the extent and impact of the military drug problem. The problems created by the paucity of information were further exacerbated by a lack of standardized programs and nonuniform reporting procedures from service to service. What did exist, under an indifferent philosophy prevailing within DOD, was a hodgepodge of relatively uncoordinated activities. DOD's 12-point plan is a welcome attempt to provide top-level emphasis and coordination throughout the military in an effort to gain control of the problem.

[1] Appendix A.

DISCUSSION

I. General Findings

In an effort to gather information on the overall military drug abuse problem, members of the task force visited military installations of the various services in the United States, Europe, and Asia.[2] Interviews were conducted with personnel representing all levels of service from base commanders to recruits engaged in basic training. In general, the level of drug abuse at any particular installation seemed to reflect the drug abuse pattern prevalent in the surrounding community, and the type of drug used appeared directly related to the availability of that drug within that community. Thus, heroin abuse is more of a problem among military personnel in Europe, particularly in Germany, where it is more readily available than in the United States. As an example, when members of the committee were in the Frankfurt area in November 1976, they found more than 300 heroin cases had been reported within the V Corps Command in over a 1-year period.[3] The use of hashish is more prevalent in Germany where its availability is high, whereas marihuana abuse among personnel in the United States is more likely to occur.

Regardless of the location or service branch, one problem continually surfaced during each task force visit, namely, that of command perception. Base commanders and other high-ranking personnel seriously underestimated the extent of the problem on their own installations. Part of each visit consisted of requesting enlisted personnel and junior officers to complete the committee's Drug Abuse Opinion Survey. Detailed analysis of the survey responses will be presented in a subsequent section of this report; however, it is of interest at this time to point out that survey respondent's perception of the drug abuse situation on their installation differed considerably from those in the higher command. Reasons suggested for this wide variance in perception are the apparent lack of open communication channels between the high command and enlisted personnel and the age differential between the two groups. Junior officers, who deal on a daily basis with enlisted servicemen and servicewomen and are more aware of their needs and problems, had a much better perception of the extent of the drug abuse problem on their installation and in their own units. Although differences between junior officers and enlisted personnel did surface, they are probably more a reflection of the responsibilities placed on the junior officers.

[2] Appendix C.
[3] Hearing, April 27, statement of Congressman Gilman.

Another possible explanation for the base commanders underestimating the extent of the drug problem on their installation is the stigma attached to drug abuse. There is a philosophy throughout the military that drug abuse equates with poor command and that it is therefore easier to have a tendency to deny the existence of a problem than to face it head-on. There is little incentive for a junior officer to ferret out drug abusers in his unit. To the contrary, if an officer does take the initiative to "clean up his unit," the very fact that he does discover a problem may be interpreted as poor leadership with its obvious reflection on his record. For the young officer contemplating a career in the military, such a revelation can be harmful.

The stigma of drug abuse is but a manifestation of a larger attitudinal and philosophical school of thought that prevails throughout the military into the highest reaches of the Department of Defense. At no place is the philosophy better illustrated than in the Office of the Secretary of Defense's organizational chart. During the committee's April 27, 1978, hearing, former Assistant Secretary of Defense for Health Affairs, Dr. Robert Smith, testified that during his tenure as Assistant Secretary, he had not once met with the Secretary of Defense or the Deputy Secretary of Defense to discuss drug abuse.[4] Dr. Smith testified he was the only Assistant Secretary who did not report directly to the Secretary of Defense. At the same hearing, Acting Assistant Secretary for Health Affairs Vernon McKenzie testified the chain of command was the same as during Dr. Smith's tenure and that he, too, had never met with the Secretary of Defense on drug-related matters.[5]

The organization of the Secretary of Defense's office was not the only problem discovered by the task force. The atmosphere relating to the emphasis placed on health is very aptly described in the following excerpt from the testimony of Dr. Smith before the task force on April 27:[6]

> . . . When I arrived in 1976, Health Affairs was authorized 78 persons. This was to carry out overall supervision of the military health care system, which represents 185 hospitals, about 200 clinics, with a budget of about $4 billion. I was successful under the previous Administration in establishing the Defense Health Council supported by six additional persons who were assigned to the Council's activities.
>
> I had direct access to the Secretary of Defense's office. Clearly, in the new administration there is a decreased emphasis on all health matters in the Defense Department to include drug and alcohol programs. Our personnel authorization was cut from 47 to 33, or a 30 percent cut.
>
> Additionally, upon my departure, the staff supporting the Defense Health Council was eliminated. Adding these individuals to our other personnel cuts, we had nearly a 40 percent personnel loss within a 1-year period.
>
> It was, and is, my judgement that to do an effective and credible job in health, an authorization in excess of 53 people is absolutely required.
>
> In addition to the personnel cuts, I was not permitted direct access to the Secretary or Deputy Secretary, I was required to report to the Secretary for Manpower and Reserve Affairs, and that is an extremely cumbersome method and causes long delays in many actions.
>
> Finally, there was an effort to downgrade the Office of Health Affairs to a subordinate unit of Manpower and Reserve Affairs, which has already been alluded to.

[4] Hearing, April 27, testimony of Dr. Robert Smith.
[5] Hearing, April 27, testimony of Mr. McKenzie.
[6] Hearing, April 27, testimony of Dr. Smith.

To summarize, it is clearly difficult, if not impossible, with the lack of interest in, and the inadequate resources allocated for the Health Affairs Office, to have any new effective health initiative.

It is extremely difficult to work in a state of chronic anxiety over what next may happen to the Health Affairs Office. It is difficult just to keep your head above water on a day-to-day basis. The lack of support in the Health Affairs Office affected each of component offices, one of which was the Office of Drug and Alcohol Abuse Prevention.

There are four professionals presently assigned to ODAAP. They no longer have a secretary, as I chose to eliminate that position in the recent 25 percent DOD staff reduction, in order to protect the professional capacity that existed in that office.

I have no complaints with the quality of the present staff. They are excellent people. But there simply are not enough of them to do a proper job. I don't believe that they can answer all the correspondence and attend the meetings. They operate largely in a totally reactive mode to outside pressures from DOD, the military departments, Congress and the White House. They have not had the time to do long-range and innovative planning and the execution of initiatives that could improve, significantly, the problems of drug and alcohol abuse in the military.

A recent congressionally mandated Defense Health Study of ODAAP recommended creation of a short-term task force and the expansion of the ODAAP staffing from four to ten in order that the problems of substance abuse can be effectively addressed.

No one in the Secretary's office or in the Department or in the military departments agreed with, or supported this recommended increased effort to combat drug and alcohol abuse in the military.

For the moment, ODAAP is doing the best it can with what it has available. It could be so much more.

There are concerned individuals at all levels of the military who have the desire to attack the drug abuse problem by increasing their efforts on all fronts. However, the management style and philosophy within the Department of Defense and the stigma of drug abuse discovery that prevails throughout the military present serious obstacles to those efforts.

The committee was distressed to learn that the Department of Defense has very little definitive data as to the extent of the drug problem throughout the military. The drug program that does exist is woefully understaffed and undertrained and consists primarily of efforts on the part of the individual services. Each branch of the military as well as each military command within each service has its own education, detection, prevention, and treatment programs that receive varying degrees of emphasis and no coordination between them. In general, they all suffer from inadequacy of one form or another. Education programs directed toward prevention of drug abuse often are presented in a superficial manner. Detection and prevention efforts are often understaffed, underequipped, and operate with undertrained personnel. Treatment programs often suffer from a lack of facilities as well as properly trained personnel.

Of great concern to the committee is the fact that a standardized reporting system does not exist.[7] Not only is it difficult to compare the nature and extent of drug abuse from service to service, but it is often difficult to draw meaningful comparisons between commands within the same military branch.

Consulting firms have conducted surveys in years past in an attempt to measure the nature and the extent of the drug abuse problem—the most recent having been conducted by the Arthur D. Little Company in 1974. That survey data is now nearly 4 years old. Attempts by the

[7]Hearing, April 27, statement of Congressman English.

military to gather data have, at best, been feeble and subject to individual interpretation. For example, the Army administers a quarterly questionnaire consisting of 80 questions relating to the overall military environment.[8] Although the questionnaire is administered quarterly, questions dealing with drug abuse are included only semiannually, are limited in number, provide ambiguous choices for the respondent, and are open to interpretation. The question dealing with cannabis abuse asked, "Which term best describes your use of marihuana or hashish during the last 6 months" The responses provided are "never," "sometimes," or "frequently." Obviously, respondents' perceptions will vary widely and nothing definitive can be interpreted from the results nor is there a differentiation between marihuana and hashish. These questions do not allow enough of an indepth look at the problem. Heroin, LSD, and "hard drugs" are all categorized together, yet there are differences in terms of addiction potential, price, usage, and availability.

An effort was made by the committee to collect data that would allow for a general assessment of the extent and nature of the drug abuse problem. To this end, a survey instrument was developed to measure enlisted personnel and junior officers' perceptions of the problem. This unscientific instrument, the Drug Abuse Opinion Survey, has provided to the committee's dismay, the most recent comprehensive information available.

II. Drug Abuse Opinion Survey

Separate Drug Abuse Opinion Surveys were developed for officers and enlisted personnel (Appendix D). The surveys were designed to generally assess the extent of the drug abuse problem in the military as perceived by the respondents. No attempt was made to identify the drug habits, if any, of the individuals participating in the survey.

The survey population consisted of 213 officers and 2,120 enlisted personnel representing all branches of the military. In an effort to maintain anonymity, no demographic data were solicited from the respondents and the questionnaire was administered by committee staff members. This procedure allowed enlisted personnel to complete the survey in the absence of a superior, thereby providing an atmosphere in which the respondent would feel comfortable and respond more freely.

A drug problem was defined as "a sufficiently high amount of drug abuse as to have a negative impact on the combat preparedness, discipline, or effectiveness of our military personnel." The survey refers to some drugs specifically by name, but also includes a category of nonalcoholic (other) drugs. This category includes such drugs as phencyclidine (PCP), lysergic acid diethylamide (LSD), mescaline, opium, methadone, codeine, and over-the-counter drugs. Polydrug use was defined as two or more drugs being used simultaneously. The latter category includes alcohol abuse combined with the abuse of a second drug; a combination of significant concern to the committee.

As might be anticipated, there are differences in response between the two questionnaires on some questions, but a remarkable amount of agreement on others. Officers have responsibility of command and

[8] Hearing, May 14, testimony of General Johns.

it should be expected that their perceptions will differ to some degree from those of enlisted personnel.

In response to the question regarding a drug problem in the military, 93 percent of the enlisted personnel and 100 percent of the responding officers believe there is a drug problem. The extent of the problem is considered "moderate to great" by 85 percent of the officers and 74 percent of the enlistees; a highly significant response.

The drug most commonly used is marihuana or hashish with 78 percent of the officers and 65 percent of the enlisted personnel believing "half or more" of the men/women in their unit use this drug. Tetrahydrocannabinal (THC) is the active ingredient of marihuana and hashish, the difference in the drugs being concentration and form of use. The second most common usage category was that of "other drugs" in which 21 percent of the officers and 25 percent of the enlistees believe "half or more" people in their unit are involved with drugs in this category. Comparison of other drugs used reveals a matching correspondence between the two surveys with "uppers" being the third drug used by "half or more" followed by "downers," then cocaine, and heroin.

Although price must be considered, availability is a major factor in determining the drug of choice. There is unanimous agreement between officers and enlisted personnel that marihuana is the easiest drug to purchase, followed by "uppers and downers" (a tie on both questionnaires), "other drugs," cocaine, and heroin. It is of interest to compare the ease of availability against the drugs most commonly used. In so doing, an enlightening correspondence emerges: namely, there is a relationship.

When asked if the drug problem has an effect on job performance, discipline, morale, and/or combat readiness, there was agreement that these categories are affected, but a significantly greater percentage of officers responded affirmatively. The same trend is reflected in the perception of a drug-abuse problem within the respondents' own unit or installation, where 82 percent of the officers, but only 42 percent of the enlisted personnel considered their unit or installation problem to be "moderate to great."

There is little support from officers or enlisted personnel for the random urinalysis testing program. Neither group considered it effective in identifying drug users, or an effective deterrent. The general consensus was that it should not be reinstituted.

Other survey results of interest are that only 60 percent of all respondents think they could go into combat today and perform to the best of their ability. The surveys also gathered data on the causes of drug abuse and the problem of polydrug abuse; subjects to be discussed in a subsequent section of this report.

III. Nature and Impact of the Drug Problem

The Drug Abuse Opinion Survey provided the committee with valuable data on the nature of the drug problem, but even more enlightening were committee findings during onsite visits. The questionnaire identified general causative categories, such as boredom, experimentation, coping with tension, and environmental considerations. Onsite interviews were more specific.

Boredom is nurtured by a number of factors. By their very nature, military units are trained for combat or combat support roles and, in the absence of hostilities, boredom very rapidly permeates these highly trained units. Another factor of growing significance is the decline of purchasing power of the dollar against foreign currencies. Military personnel overseas, particularly enlistees, cannot "make it" on the local economy; and as a result are spending an increasing amount of leisure time on base where recreational facilities are very often inadequate. The committee discovered only about 45 percent of our troops in the lower grades are taking any kind of leave, and only 50 percent of those leave their immediate area.[9]

Tension results from being under stress. A stressful situation may result from isolation, pressure under training and performance of duties or peer pressure. Of the enlisted personnel responding on the Drug Abuse Opinion Survey, 60 percent said they used drugs to cope with the tensions of day-to-day living.

The causes listed above are compounded for those personnel stationed overseas. In addition to the monetary problems experienced on a foreign economy, arrival in a foreign country exposes young personnel to new languages, traditions, and customs. If not adequately prepared, the cultural shock experience can be devastating. In some foreign countries, U.S. military personnel are not accepted socially within the surrounding community, which cultivates a feeling of rejection. This lack of local community acceptance creates a particularly difficult problem for those members of our Armed Forces who are also members of the various ethnic minority groups.

The length of tour overseas is a major factor in the drug abuse problems. The committee discovered that most drug problems begin to occur after 18–24 months of duty.[10] The combination of a foreign culture, isolation from family, restricted interaction with the local environment and, possibly, peer pressure results in a buildup of tension and boredom, a condition for which many seek escape through drugs.

Of growing concern is the ever-increasing problem of polydrug use. When officers were asked if the use of alcohol may be covering up the simultaneous use of other drugs, 41 percent said yes. Of these, almost 90 percent believe "half or more" personnel who use alcohol are engaged in polydrug use. A second form of polydrug abuse is the use of two or more nonalcoholic drugs simultaneously. The area of polydrug abuse is in dire need of indepth research activities to determine its full impact.

The survey data indicate that cannabis abuse, either through marihuana or hashish, is by far the most common category of drug abuse. In addition to its relatively low cost and ready availability, its use is further encouraged by the move, particularly in the United States, to decriminalize marihuana. The decriminalization movement has tended to create a more permissive attitude in our society that has been misinterpreted by military personnel who are governed by the Uniform Code of Military Justice (UCMJ) and not civilian law. In his testimony of May 24, Gen. William Henry Fitts expressed the opinion

[9] Hearing, May 24, testimony of General Fitts.
[10] Hearing, May 24, testimony of General Fitts.

that many of today's young soldiers would not include hashish or marihuana in the category of drug abuse.[11]

The incidence of hard drug usage, principally heroin, is much smaller than for the so-called soft drugs, but is nevertheless a cause for much concern due to the potency of the drug. The heroin problem is of particular concern in Germany where it is cheaper than in the United States and up to 6 to 10 times more pure. To further intensify this concern, the committee has learned that a 30 percent increase in the poppy crops of Pakistan and Afghanistan this year will result in an increase in heroin availability in Germany this year that may well attain epidemic proportions. This increased supply is of concern to our military personnel because of the relationship between the use of this (heroin) drug and its availability.

Drugs are more readily available in some parts of the world than in other areas and the ease of availability directly contributes to the overall drug problem. Military personnel are continually monitoring the environment surrounding military installations for signs of an increase in usage and availability that may signal the installation is in a potential problem area or "hot spot." Clearly, availability is one indicator of a hot spot along with law enforcement and DEA trend data. A marked increase in the number of positive "hits" resulting from command-directed urinalysis tests is a particularly significant indicator due to the fact that it indicates military personnel are being directly affected. Where data are available, the Drug Abuse Warning Network (DAWN), is also a valuable tool in identifying hot spots. As a specific example, the civilian heroin overdose rate in Germany has been steadily climbing since 1973. To underscore the degree to which the availability of deadly pure heroin has been invading Germany, the number of known heroin overdose deaths reported in Berlin has increased from six (6) in CY–1973 to 84 in CY–1977. Trend data similar to this has resulted in the metropolitan areas of Berlin, Frankfurt, Kaiserslautern, Munich, Stuttgart, Nuremberg, and Heidelberg. With the possible exception of Heidelberg, each of these areas would still be hot spots regardless of a U.S. military presence.[12] As in many other countries, drug abuse in Germany is no longer simply an "American problem." The Navy and Air Force send ships and planes all over the globe, with many ports of call in areas of high availability such as Guam, Thailand, and Pakistan.[13] None of the military branches are immune to contact with high-availability areas.

Directly related to availability of drugs is the method by which they travel from the source through the peddler to the eventual user. The primary source of heroin for Germany is the poppy fields of the Mideast countries such as Pakistan and Afghanistan. The opium is either shipped into Turkey where it is processed into heroin or is processed in the country of origin prior to shipping into Turkey, which is a transshipping point. The heroin can enter Europe by a number of routes such as land routes through Italy and Austria or

[11] Hearing, May 24, testimony of General Fitts.
[12] Hearing, May 24, testimony of General Fitts.
[13] Hearing, June 16, testimony of Captain Winchester.

by sea. An easy and safe access is through Berlin, using Turkish national laborers, who have work permits, as carriers. Estimates are that while 85,000 Turkish nationals are in Berlin legally, an additional 15,000–20,000 are there illegally.

The unique political and geographical circumstance of Berlin provides a gateway for commuting Turkish nationals to travel from East to West Germany with a minimum of controls. There are no customs' searches, only routine identification inspections when passing from East to West Berlin since no recognized international boundary is involved. It is widely acknowledged that the vast majority of major traffickers through Berlin are Turkish who arrive by train, private vehicle, and by air at Shoenfeld Airport in the GDR.

An encouraging sign of progress is the recent interest the GDR has shown in working with the United States to develop a more effective interdiction effort. Through the exchange of intelligence information and technical training that can be provided by the United States, the GDR could significantly tighten customs' controls at its international borders. Unfortunately, the prospects of tightening sector crossing points within the city of Berlin are not as promising.

The questionnaire data suggest that military personnel, to a degree, may be involved in trafficking but it is generally believed to be at the local level, and more often than not the drug involved is hashish. In the testimony of General Fitts on May 24, he stated that in Germany, approximately 250 U.S. soldiers each quarter year are apprehended for some form of offense, by and large hashish-related.[14] He further testified that more than 60 percent of those apprehended were peddling hashish compared to approximately the same percentage of apprehended civilians handling the harder drugs.[15]

It is generally believed that much of the drug abuse occurs off base and off duty. However, committee representatives have heard numerous reports of drugs readily available and used in enlisted barracks and on board ships at sea.

In an attempt to create a profile of the enlisted drug abuser, it is generally recognized that a non-high school graduate is more likely than a high school graduate to be involved with drugs. In terms of ethnic distribution, military police and criminal investigators in Europe estimate that of those arrested for drug abuse offenses, approximately 50 percent are Caucasian, 45 percent black, and the remaining 5 percent all others.[16] In terms of abuse by rank, it is estimated about 90 percent of the hard drug abuse is done by those ranked E–1 through E–4.[17] This information tends to support a rather widely held belief that there is a relationship between drug usage by age, education, and ethnic groups. The mental category of the abuser may also be a factor in the extent of abuse particularly in the Army where almost 60 percent of the enlisted personnel are classified in the low mental categories 3B or 4.[18] The lower mental categories are not as prevalent in the Air Force and Navy.

The impact of the drug abuse problem can be evaluated in terms of its impact on job performance, discipline, morale, and other cate-

[14] Hearing, May 24, testimony of General Fitts.
[15] Hearing, May 24, testimony of General Fitts.
[16] Hearing, May 24, testimony of General Fitts.
[17] Hearing, May 24, testimony of General Fitts.
[18] Hearing, May 24, testimony of General Johns, p. 51.

gories. However, the ultimate impact, of which the foregoing are a part, is the effect of drug abuse on the combat readiness of U.S. military forces. The question of illicit drug use resulting in adverse effects on the mission of U.S. Armed Forces was first raised in 1975 by the WRAIR study referred to in the introduction of this report. The actual effect of drug abuse on the true combat readiness is not known at this time and its measurement poses some very elusive questions. Drugs affect the senses in various ways. Vision is impaired, physical dexterity is reduced, spatial relations distorted and mental conditions are altered from the norm. In this age of sophisticated weaponry and intricate tactical maneuvering, it is generally agreed that the use of drugs would have some effect.

IV. Personnel Reliability Program

All of the military services submit readiness reports on all units to the Department of Defense. They rely solely on commanders' judgment to assess whether or not the use of drugs impacts on performance of duty, and judgment is very subjective. More research is needed in the area of the effect of drug abuse on performance and hence, real combat readiness.

Of particular interest to the committee was a Department of Defense report (Appendix E) for the years 1975–76 on the Nuclear Weapons Reliability program which indicated 3,444 individuals were transferred from nuclear weapons duty because of drug and alcohol abuse. Individuals entering the program are carefully screened for reliability and personality. Urinalysis testing along with psychological and background evaluations are part of the screening process. After acceptance into the program, there are six reasons for dismissal. They are alcohol abuse, drug abuse, negligence or delinquency in performance of duty, court martial, behavior indicative of a contemptuous attitude toward the law, and any significant physical, mental, or character aberration. For the calendar year 1976, the largest number of personnel disqualified from the program was for drug abuse with alcohol abuse the lowest number of disqualifications.[19] The 1977 figures show that of 118,000 people in the Personnel Reliability Program, approximately 5,000 were disqualified last year, about 30 percent of which were for drug abuse. Of that, the highest disqualifier by far was for cannabis abuse—either marihuana or hashish.[20] Drug and alcohol abusers constitute a disproportionately high percentage of disqualifications under the program. For those disqualified under any of the remaining four categories, it is of interest to note that those categories describe what can be manifestations of drug related problems.

Of particular interest, under the heading of drug abuse, it is noteworthy that the European Command accounted for far more than its proportionate share of disqualified personnel. For example, although only 20 percent of the total personnel in the program are stationed in Europe, over 50 percent of those discharged from the overall program for narcotics abuse, over two-thirds discharged for abusing depressants, and over three-fourths discharged for abusing stimulants came from Europe.

[19] Hearing, April 27, statement of Chairman Wolff.
[20] Hearing, April 27, testimony of Mr. O'Conner.

Probably the single most disturbing piece of information provided to the committee from the Air Force was the issue of its lenient first-time marihuana offender policy. As it relates to the Personnel Reliability Program the Air Force presented the following interpretation:

The decrease in the number of cannabis disqualifications in calendar year 76 was due, in part, to a more flexible disqualification policy when first time use or experimentation is involved. The revised policy gives the commander the option of not permanently disqualifying a first-time marihuana user (experimenter).

During his testimony of June 2, 1978, Lt. Gen. B. L. Davis commented on the first time marihuana use policy:

We have found that young marihuana smokers respond best to being caught, fined, having a suspended reduction, and being sent back to work with the knowledge that he or she are accountable for their behavior and job performance.

He, however, reassured the committee that drug abuse is incompatible with the requirements of the Personnel Reliability Program. "There are two main points here: the first-time marihuana policy does not result in known drug abusers having access to weapon controls; and our safeguards make it virtually impossible for any one person, much less a drug-intoxicated person, to be in a position to activate a weapon."

However, after Congressman English pointed out that there existed a urinalysis test for marihuana, General Davis was asked if the Air Force would be willing to use such a test.

We would use it selectively. We don't want to—and I don't think anybody wants us to—get into testing everyone. That is the problem with the random urinalysis.

The concern of the committee is that since these are the most highly screened of any of the military, the problem would appear to be much greater in other areas. The committee's Drug Abuse Opinion Survey tends to confirm these data.

Finally, the "mantle of invisibility" phenomenon as defined by the Walter Reed Army Institute for Research (WRAIR) study has led the committee to conclude that intensified efforts are necessary on the part of the Department of Defense to ferret out as thoroughly as possible drug abusers within the military. The WRAIR study found: [21]

The same groups in which drugs are used also support and encourage their fellows to perform as "good soldiers." The "good soldier" label made many soldiers unlikely suspects for significant drug abuse.

In conjunction with the latter finding, these "good soldiers" did not usually involve themselves in behavioral indiscretions which drew the attention of their commanders. Essentially, they functioned quite well within their units surrounded by a "mantle of invisibility." The existence of this situation within Army units led WRAIR to one of its conclusions, i.e., that the involvement of problem soldiers in alcohol treatment programs represented the tip-of-an iceberg below which existed a vast majority of drug abusers who were rather "successful" in their drug abuse. In this context, "successful" means that their drug abuse rarely came to the attention of military authorities.

V. Military Drug Programs

The Department of Defense provides generalized guidelines to the military services for their drug-abuse programs, but it is the responsibility of each service to establish its own detailed program. Although each branch does have a program based on its own needs, each is

[21] Appendix A.

constructed around a central theme of prevention, identification, treatment and rehabilitation. The specific methods used in prevention and identification will follow a general overview of each service's program as described to the committee during the hearings. The treatment and rehabilitation programs will be discussed in a future report after the committee has had the opportunity for an indepth review.

A. AIR FORCE

The Air Force program consists of (1) a drug assessment system, (2) a drug-abuse control program, and (3) a management system. The purpose of the Air Force Drug Abuse Assessment System is to determine the nature and extent of abuse in each operational region so that appropriate countermeasures to the drug abuse threat can be applied. The system is structured into three integrated subsystems operating at base level, major command level, and headquarters level.

The base level subsystem operates through a Drug and Alcohol Abuse Control Committee (DAACC) made up of the base commander or vice commander along with representatives from all agencies with responsibility for components of the drug and alcohol abuse control program. This committee reviews all available indicators of drug abuse and recommends appropriate countermeasures. Indicators reviewed are incident reports, customs reports, arrest and investigation data, urinalysis trends, safety reports, inspector general reports, reports from informed sources, drug trend advisories from higher headquarters, and Drug Enforcement Administration (DEA) reports. The scope of their responsibility is primarily base-level assessment of the drug threat.

The major command subsystem also functions through a Drug and Alcohol Abuse Control Committee. At this level, the scope of responsibility is primarily regional. Membership consists of the major command counterparts to the staff agency participants named at the base level.

At headquarters' level, the focal point is the Drug Abuse Control Office. The scope of responsibility is worldwide and involves regional assessment and development of countermeasure policies and programs. This office worked closely with the DEA using data from their weekly and quarterly intelligence reports, as well as data from the Drug Abuse Warning Network (DAWN).

The Air Force Drug Abuse Control Program involves the five basic elements of prevention, identification, rehabilitation, utilization, and program management. The overall program goals are to:

(*a*) Prevent drug abuse where possible, thereby reducing the adverse impact on individuals and the Air Force mission;

(*b*) Identify drug abuse by all prudent available measures;

(*c*) Rehabilitate abusers and return them to full duty status where possible;

(*d*) Assist those who cannot be productively rehabilitated within the Air Force in their transition to civilian life; and,

(*e*) Accomplish program objectives through sound management.

Management of the drug-abuse programs in the Air Force functions in the same three-layered manner as does the assessment system discussed previously—that is, at Headquarters Air Force, intermediate major commands, and base level.

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At Headquarters Air Force, the drug and alcohol abuse control staff, composed of five manpower positions, is the focal point for Air Force drug abuse management. Responsibility for drug-abuse programs cuts across staff lines, and other agencies are also directly involved in program management.

At each of the major Air Force commands, within the office of the Deputy Chief of Staff for Personnel, exists a staff of two to three individuals who serve as the focal point for major command drug-abuse program management. Responsibility at this level also cuts across staff lines, and many people in various offices are involved with managing the drug program on a daily basis. Their interactions are formalized in the Drug and Alcohol Abuse Control Committee, which was previously discussed.

A drug-abuse office also exists at each Air Force installation. A full-time staff is assigned at over 140 bases worldwide, and at the smaller, geographically separated units, personnel are assigned on a part-time basis. Air Force program personnel are part of an established career field, which is a management approach unique to the Air Force. Personnel are carefully evaluated for entry into the career field where they receive professional training for their jobs and have a specific career track by which they are promoted and otherwise advanced in their careers. There are over 400 officers, enlisted and civilian personnel, in the drug and alcohol abuse career field at Air Force installations worldwide.

B. NAVY

The drug-abuse program in the Navy operates under the principle of strong headquarter-level policy guidance, program development, and compliance monitoring. Local commanders at each echelon are responsible for program implementation and daily management. In addition to the Navy Inspector General's inspection program, drug program staff participate in inspections at all levels to ensure standardization and monitor effectiveness.

Navy policy differs from that of the Air Force in that every individual identified as an abuser, including first timers and experimenters, is held accountable for his or her actions. However, under current guidelines, if the identification is through exemption or urinalysis, the individual is not subject to punitive action.

During the past year, major steps have been taken by the Navy to enhance its ability to control the illegal abuse of drugs and to improve its capability to respond to the adverse effects of such usage. In testimony before the committee on June 16, Capt. Warren H. Winchester, Deputy Assistant Chief of Naval Personnel for Human Resource Management, outlined the steps as follows: [22]

(*a*) Developed and promulgated to all naval activities a drug and alcohol program guide. This guide gives a step-by-step process on how to establish local drug and alcohol programs, procedures to be utilized, requirements which must be adhered to, and identifies local agencies, from law enforcement to treatment facilities, which may be of use to the local commander.

(*b*) Provided specific guidance to all naval activities outlining when and how commander-directed urinalysis should be utilized. This

[22] Hearing, June 16, testimony of Captain Winchester.

guidance specifically delineates a wide variety of behavior-related incidents under which the commander may and should direct urinalysis.

(c) Designed and have in the schoolhouse, a drug and alcohol program manager course specifically designed for middle and upper management. This course is designed for senior enlisted and officers who provide management policy, direction and monitoring of subordinate units programs from the staff level.

(d) Established a cross-training program for both drug and alcohol treatment specialists which results in a more effective and efficient utilization of resources and enhances the ability to counsel and treat the polydrug (including alcohol) abuser.

(e) Expanded the counseling and assistance center (CAAC) network to more than 50 CAAC's worldwide, and inpatient capabilities have been improved at the Navy Drug Rehabilitation Center. Additionally, for those drug-dependent personnel requiring detoxification, facilities are available at naval hospitals worldwide.

(f) Established a family counseling capability for members afflicted with alcoholism and are currently examining ways to expand this service to families of members who are drug dependent.

(g) Developed, field tested and implemented a drug program management improvement workshop, which will be available to all Navy commands during their dedicated human resource management periods. Five human resource management (HRM) centers and nine HRM detachments whose mission is direct command assistance to improve internal management procedures will have the capability of delivering the workshop during the management assistance period.

(h) Initiated and received DOD concurrence for field testing of portable urinalysis kits. Validity of the kits has been proven and validated by lab comparisons.

C. MARINE CORPS

The policy of the Marine Corps is to prevent and eliminate drug abuse and to attempt to restore Marines so involved who have a potential for continued service. To control abuse, it is the Marine Corps' philosophy that commanders must use aggressive leadership, education, urinalysis and law enforcement methods.

A recently initiated program at Quantico, Va., devotes 40 to 100 hours of schooling in drug abuse to graduating lieutenants, staff NCO command, and command staff. In addition, for senior officers, there is a week-long seminar on drug abuse that is presented six times a year.

Other programs are a 5-day course designed for sergeants through captains in leadership positions, a 3-day drug abuse seminar designed for sergeants through majors, and a 2-day drug-alcohol abuse seminar developed for sergeants through majors and presented ten times throughout the year. All of these programs are relatively recent. Treatment and rehabilitation facilities are shared with the Marine Corps by the Navy.

D. ARMY

The Army's program encompasses both drug and alcohol abuse and is, philosophically, a command program as opposed to a medical program. There are 1,700 full-time specialists in the Army program plus law enforcement personnel and some part-time medical people who

function in a consulting role. The program is monitored at the highest level by only six people working under the auspices of the Deputy Chief of Staff for Personnel.[23] The monitoring effort primarily is accomplished by visiting service schools and looking at the instructional programs as well as visiting the major command headquarters. The Inspector Generals' routine business includes monitoring this program as well.

E. PREVENTION

The military service's prevention programs concentrate on two areas. The first revolves around recruiting standards and the screening processes. Although mental standards and educational requirements vary among the services, known hard drug users are rejected by all. Generally, any drug abuse within the immediate 6 months prior to enlistment is disqualifying. Known marihuana users are typically judged on a case-by-case basis, and in some instances waivers are granted. Once enlisted, the primary prevention emphasis is educational. As a rule, the educational programs are targeted for specific audiences such as recruits, supervisors, and general audiences. Prior to assignment into "hot spot" areas, personnel generally undergo a reenforcing educational course that is often repeated upon arrival at the "hot spot". The committee heard testimony to the effect that there may be a negative correlation of drug abuse with preventive education, the rationale being that education may be making drug abusers "smarter" about the types of drugs available and how they can be used.[24] If true, this may be a factor in support of the "mantle of invisibility" referred to in a previous section.

F. IDENTIFICATION

Drug abusers are identified by law enforcement activities, urinalysis, self-referral, medical referral, or command referral. Regardless of the method used in the initial identification, conformation—usually medical—is required before the individual is officially classified as a drug abuser.

Law enforcement identifications can occur in several ways. Since drug use is a violation of the Uniform Code of Military Justice, MPs or CID investigators may act on a tip supplied to them, become involved if unacceptable behavior is reported by concerned individuals or discover abuse during investigation of another situation. For example, the military operates its own military customs units to be discussed in detail in a subsequent section of this report. During routine customs inspections it may be discovered that contraband, in the form of drugs, is being transported. The use of dogs is proving to be a valuable tool in the customs program. Discovery of contraband drugs is only evidence of trafficking, not use, but the individual apprehended can be tested for use, generally through urinalysis.

Urinalysis is proving to be a very useful, albeit controversial, identification tool. Numerous techniques have been developed over the past several years, many of which were fraught with difficulties. In some of the earlier tests, it was not uncommon to see false negative

[23] Hearing, May 24, testimony of General Johns.
[24] Hearing, June 16, testimony of Captain Winchester.

or false positive results and the cross-reactivity with other drugs was often a problem. For example, the urinalysis technique of thin layer chromatography (TLC) can, if not properly conducted, show positive for heroin when quinine is in the urine. An additional problem with some of the techniques is that they can be "beaten."

However, the technique used now by the military is radioimmunoassay (RIA) which integrates highly sensitive radiochemical techniques with immunological techniques to provide urinalysis tests that are highly specific. Tests using RIA are extremely reliable, rarely giving false negatives or positives. The only drug, out of nearly 100 tested, known to cross-react with the morphine (heroin) sensitive test is codeine.[25] The same sensitivity and lack of cross-reactivity is characteristic for other drug tests using the RIA urinalysis technique.

Specimen analysis using the RIA technique is relatively rapid and inexpensive, but it does require a laboratory environment with special equipment. As a result, turnaround time can be rather lengthy since specimens must often be shipped to a distant laboratory. For relatively small populations in isolated environments, such as onboard ship, RIA is not a feasible technique to use. Portable kits, using a new technique that will give onsite analysis, are being tested; however, preliminary results indicate these kits will probably not give results that are as reliable as RIA analysis. At the present time, testing is underway on RIA urinalysis tests that are sensitive to THC (marihuana/hashish) and PCP (angel dust). If successful, the addition of these tests to the identification program will greatly enhance this component of the military programs. At this time routine urinalysis tests are not administered for either THC or PCP.

Probably the biggest controversy surrounding urinalysis is the manner in which it is administered: random urinalysis versus command-directed urinalysis. There is general agreement in the military, supported by the Drug Abuse Opinion Survey, that the random urinalysis testing, no longer in use, was ineffective. Using this method, individuals were selected at random for testing. Survey data indicate it was not effective in identifying drug users nor was it an effective deterrent to drug abuse. Of the enlisted personnel who responded to the survey, 62 percent do not want to see random urinalysis reinstituted. The three most commonly given reasons for not going back to random urinalysis were: it is not a deterrent, useless, and easy to fool.[26] Although the chemical aspect of the test is specific, the random technique can be thwarted. The committee has heard from enlisted personnel that although the tests were random it wasn't all that difficult in many instances to find out when your time was coming, and therefore, to "fool" the test, the individual merely abstaining from drugs for 72 hours or more. Other stories of sample switching and the sale of "clean" urine are also commonplace.

As an alternative to random urinalysis, there is command-directed urinalysis. A discretionary tool of this type allows a commander to test one individual or the entire unit.

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[25] ABUSCREEN radioimmunoassay for morphine, Roche Diagnostic, Nutley, N.J., p. 5.
[26] Drug abuse opinion survey, appendix D.

The remaining identification methods are referral in nature and are self-explanatory. Referral implies entry into a treatment and rehabilitation program. Self-referral is noteworthy in that as an incentive, no legal action is taken against the user.

VI. Military Customs Inspection Program

Of particular interest to the task force has been the extent to which military personnel are engaged in the trafficking and selling of controlled substances. Data compiled for the committee by the U.S. Customs Service reveals that of approximately 90 APO locations overseas, the ten with the greatest number of violations were all located in West Germany (Appendix F). The total number of violations at these ten stations was 1,208.

For fiscal year 1977, the total number of APO mail seizures and the total quantity of drugs seized were as follows:

Drug	Number of seizures	Total quantity
Hashish (pounds)	5,844	58
Marihuana (pounds)	286	365
Heroin (grams)	14	18,29
Cocaine (grams)	14	429
LSD (tablets)	7	9,2
All others (tablets)	50	1,191
Total seizures	6,215	

A comparison of the total number of incoming APO seizures against the number of violations at the top ten locations (1,208) reveals that 20 percent of all violations occurred at 11 percent of the APO locations. However, since the amounts of the individual seizures at the ten German APO stations were not provided by U.S. Customs, it is not known if these violations are indicative of large-scale trafficking through the mail.

The Military Customs Inspection Program (MCIP) was created in February, 1973. All overseas military bases are required by DOD Regulation 5030.49R to establish procedures for the inspection of all cargo; passengers, crew and their baggage; personal and household effects; aircraft; vessels; and mail moving to the United States through DOD transportation and postal channels. Procedures are supervised and controlled by U.S. Customs Operations Officers assigned from the Inspection and Control Division to act as advisors and program accreditors to the U.S. military overseas. This DOD/Customs system of advising and accrediting was established in 1974 through a joint Memorandum of Understanding.

Customs advisors have the responsibility of evaluating the overall inspection program at each installation. Once a program is accredited, reinspections by customs are reduced from 100 percent to random integrity inspections. Presently, Customs Officers are assigned to Military Custom Advisor positions at several locations overseas. There are over 150 predeparture inspection sites located overseas with more than 2,700 full and part-time Military Customs Inspectors (MCI's). MCI's must be of rank E–4 or above, and must undergo a background and security inspection prior to assignment to minimize compromises of integrity.

Determination of the MCI program's effectiveness as a deterrent to smuggling is elusive. Air Force MCI's made 2,002 seizures of controlled substances during the period of January, 1977, to March, 1978, and the program is considered to be highly effective in deterring drug trafficking. The U.S. Customs Service has expressed a high degree of confidence in the Military Customs Inspection Program at accredited locations.[27] Additionally, in the 6-month period beginning in November, 1976, MCI's were able to make the following representative seizures:

(1) Seized 6,000 methamphetamine pills in a mail parcel at Seoul, Korea.

(2) Discovered 1.5 pounds of opium in a shipboard inspection at Rota, Spain.

(3) Discovered 30 pounds of hashish in a shipboard search at Rota, Spain.

(4) Between January and March, 1977, made 89 seizures of narcotics and dangerous drugs in 22 vessel searches at Subic Bay, Philippines.

These figures indicate that it is possible for substantial amounts of drugs to be smuggled through military channels and the efficacy of the program as a deterrent to smuggling is unresolved. Gen. John Johns has testified that the potential certainly exists for DOD members to be involved in drug trafficking and smuggling through DOD transportation systems.[28] The degree to which this potential has been realized, however, remains a matter of conjecture. Definitive information pertaining to overall numbers and quality of seizures, if available, was not made available to the committee. In addition, and somewhat surprising, many high-risk areas report no seizures of controlled substances thereby creating additional questions as to the effectiveness of the customs program.

The lack of factual information prompted Chairman Lester Wolff to make the following statement at the July 27 hearing at which Deputy Secretary for Defense Duncan appeared:

> One of the problems is the question of military customs, and I would just make the recommendation that there be some inquiry into the handling of military customs, not only in Guam but other areas as well, because we do not seem to be making the seizures that are consistent with the traffic that is taking place in various areas of the world. And it may require a beefing up of the military customs systems, and interfacing more carefully with the Customs Service.[29]

VII. Legal Problems

As the task force visited a number of bases, interviews were conducted with representatives of the legal offices. In discussing the legal ramifications of handling drug cases on their installation, the task force was consistently exposed to three major problems. They are: (1) establishing service connection in the prosecution of military personnel by court martial for offpost drug offenses; (2) an apparent lack of appreciation by the DEA, U.S. attorneys, and civilian courts of the military interests in the prosecution of drug offenses, especially where small amounts of drugs are involved; (3) effects of the Posse Comitatus Act (18 U.S.C. 1835) on investigations by military law

[27] Addendum to testimony of Lt. Gen. B. L. Davis.
[28] Addendum to testimony of General John Johns.
[29] Hearing, July 27, statement of Congressman Wolff.

enforcement personnel of offpost drug offenses and onpost offenses involving civilians.

The first problem, establishing service connection in the event of offpost drug offenses, is particularly significant. The central question is the extent to which the military judicial system has influence over members of the military during offduty and offpost activities. The first in a series of cases addressing this topic was the landmark case of *O'Callahan vs. Parker*.[30] O'Callahan was decided in 1968, and a related case, *Relford vs. Commandant*,[31] was decided in 1970. Because of their far-reaching impact, both cases are discussed at length in the Appendix G.

The second problem is equally complicated. It is the apparent lack of appreciation by DEA, U.S. attorneys, and civilian courts of the military interest in the prosecution of drug offenses, especially where small amounts of drugs are involved.

At Fort Campbell and at numerous other installations where interviews were held with local prosecutors, committee members were informed that the military is not often successful in getting State, local, and Federal judges to hear cases involving small amounts of marihuana, cocaine, or other drugs.

In California, where the possession of small amounts of marihuana has been decriminalized, it is virtually impossible for the military to obtain civilian trials of soldiers or sailors who are apprehended in possession of marihuana. This creates an atmosphere of "What can we do about it if the civilians don't do anything about it?" It certainly contributes to hard feelings on the part of soldiers who receive relatively stiff penalties onpost for offenses which go largely ignored outside the gate. It also creates a frustration on the part of military law enforcement officers who are called upon to make drug-related arrests but are practically prohibited from obtaining convictions resulting from those arrests.

The third major problem concerns the effects of the Posse Comitatus Act on investigation by military law enforcement personnel of offpost drug offenses and onpost offenses involving civilians. The original intent of the Posse Comitatus Act was to preclude the military from becoming involved in law enforcement among the civilian population. It is clearly forbidden, for example, to use military troops to patrol the Southwest border for the purpose of keeping out aliens or apprehending smugglers.

The problem here is that in the area of drug law violations, it is often impossible to detect immediately when the civilian pusher ceases to violate laws and regulations clearly under the purview of the military. As can be seen, it is even difficult to determine when the military can step in against its own personnel. Clarification of the prohibition contained in the Posse Comitatus Act, particularly as regards drug investigations, is required because often the military enforcement agencies are required to pursue their investigations offbase, coming into contact with civilians at various stages of the offense.

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[30] 395 U.S. 258.
[31] 401 U.S. 355.

VIII. Defense Medical Research

In fiscal year 1976, the House Appropriations Committee cut off $2.6 million in funds for ongoing drug-related investigations, citing that "defense medical research should be directed at only military unique medical problems. Medical research in fields not unique to military operation should be conducted by the Department of Health, Education and Welfare." (Appropriations Bill Report No. 94–517). DOD originally interpreted this directive to mean *no* inhouse research shall be conducted. It was the committee's understanding that the intent of the House Appropriations Committee's report was to avoid duplication by DOD and HEW. What resulted was a 2-year hiatus amounting to nothing more than an exchange of communications between the two agencies.

In testimony before the committee, Dr. Robert DuPont, then Director of NIDA, stated:

I think there has been an unfortunate interpretation of that (Appropriations Bill 94–517) within the Department of Defense to prohibit research that is clearly related to the service to the combat readiness of the troops. (Investigations into) the specific effects on ability to drive a tank or push a button in a silo, or whatever the other specific tasks are in the military *does not seem to be an HEW responsibility*, but I think the language of the Appropriations Bill (94–517) has been interpreted as, if not prohibiting, at least discouraging the Department from doing that. I think there has been an overreaction to that language within the Department.[32]

HEW interpretation of the congressional directive also differed from that of DOD. In a letter dated May 14, 1976, from James B. Isbister, Administrator, ADAMHA, HEW, to Vernon McKenzie, Acting Assistant Secretary of DOD, Mr. Isbister stated:

There is a reference in the congressional ruling that the military need not carry out research in these areas because it is already being done by the National Institute on Drug Abuse. *We have kept abreast of our mutual interests and recognize that some of our efforts are unique.* It is quite possible that we could not duplicate or initiate such research immediately. A prompt review of the potentially discontinued work might enable us to transfer support so as not to lose research momentum.

This "prompt review" continued in a series of communications from May 14, 1976 to July 24, 1978 between the two agencies. The most recent correspondence is from NIDA to DOD. (Appendix H.)

Several months prior to the initial hearing, the Department of Defense was requested to present its interpretation of House Report 94–517. The response was:

It is the opinion of the Department of Defense that the interpretation of the wording on pages 277 and 278 of House Report 94–517 regarding military medical problems, when taken in the drug and alcohol abuse context, permits the Military Departments to engage in that scientific study and experimentation directed toward increasing knowledge and understanding in those biological-medical and behavioral-social areas of drug and alcohol abuse control which are peculiar to the military profession. For example, research into the effects of drugs and alcohol on the performance of service members performing typical military tasks is considered to be the type of work which the Armed Forces can properly undertake. On the other hand, we believe that research which provides fundamental knowledge for the solution of identified medical/behavioral technologies and of new or improved functional capabilities in the personnel support area—knowledge and capabilities which have relevance equally to civilian as well as to military abusers is available from the National Institute on Drug Abuse and need not be pursued by

[32] Hearing, addendum to testimony of Dr. Robert DuPont.

the Department of Defense. Studies of addiction mechanisms fall into this latter category. The Department of Defense also considers the Report wording to permit general purpose data collection, i.e., activities that include routine product testing and monitoring activities, quality control, surveys and collection of general purpose statistics. Consequently, the military services have continued to engage in general purpose data collection and analysis of the data collected. More specifically, the Department of Defense has recently let a contract to develop an improved survey instrument, as well as to integrate all past surveys, and to analyze them in their entirety so as to present a longitudinal analysis of drug and alcohol abuse prevention and control. In the interest of the assumed objectives of the House Report, the Department of Defense will provide data to the National Institute on Drug Abuse so that maximum use can be made of our analyses and duplication of effort avoided.

There are unquestionably certain key aspects of the drug problem which are indeed specific to the military environment that have yet to be scientifically measured and evaluated. For example, what purpose would knowledge of the levels of drug abuse within the military serve if it is unknown at what level combat readiness will be negatively affected? Tolerance parameters must be established, and this can only be accomplished through investigations into such areas as the effects of various types of drug abuse on military specific tasks and the effects it has on the judgment required to perform military specific operations. Clearly, there are many possible projects that could be considered military unique, and yet DOD has made little attempt to develop them.

Deputy Secretary Duncan addressed this issue of research on drug matters in the committee hearing of July 27, 1978. He stated:

"I do not believe that DOD should be, or could usefully be, in the business of primary research on drug abuse, toxicity hazards, or sociopsychological consequences. Those kinds of research questions are best left to other agencies that are better positioned to do them. This does not mean, however, that we have no contribution to make. We have directed the Office of the Assistant Secretary of Defense for Health Affairs to synthesize and interpret them where necessary, to extend the scientific understanding of the consequences of different kinds of patterns of drug use upon military performance." [33]

It is hoped that the Department of Defense will support research projects which seek to:

(*a*) Identify the extent and patterns of substance abuse in the Army.

(*b*) Determine the impact of such abuse on Army personnel readiness and task performance reliability.

IX. Twelve-Point Drug Abuse Program

Information and data gathered through hearings, onsite visits, and results of the Drug Abuse Opinion Survey seriously disturbed members of the task force. Of equal concern, was the philosophy and attitude of the Department of Defense toward drug abuse problems and the special problems of our overseas forces, particularly those NATO forces stationed in West Germany.

Congressmen Wolff and English expressed these concerns to President Carter in a June 20 meeting at the White House. At that meeting, President Carter agreed to personal intervention with Secretary of Defense Brown and to place the topic of the drug-abuse problem among our NATO troops on the agenda of his July meetings with West German Chancellor Helmut Schmidt.

[33] Hearing, July 27, testimony of Deputy Secretary Duncan.

Deputy Secretary of Defense Charles Duncan did appear before the committee on July 27. At that time, major new policy initiatives in the form of a twelve-point program were set forth. The twelve-point program was well received by members of the task force and is outlined below:

1. Design and administer a comprehensive personnel survey that will measure the extent of the drug problem, where it is located, and what it means in regard to the health and combat readiness of our troops.

2. Augment existing devices for assessing the extent and location of drug problems by engaging the help of the Center for Disease Control Epidemiological Intelligence Service.

3. Redesign of the current drug reporting system to provide for more uniform and ready access to trend data. Target date: Early fall, 1978. The Office of Health Affairs will examine the detection and reporting procedures of DEA's Drug Abuse Warning Network (DAWN) for possible adoption by DOD.

4. Direct accelerated testing of portable urinalysis equipment.

5. Re-emphasize to command and medical personnel the significance of curtailing drug abuse. All major commands will institute mandatory seminars on drug abuse and detection for both Service members and their families.

6. Health Affairs and Manpower staffs have been directed to work with military staffs to identify methods to accurately measure the extent of drug abuse by military dependents and determine how well existing dependent programs are responding. Report due by October 1, 1978.

7. Established a DOD task force to review investigative procedures, criminal intelligence, interdiction techniques and staffing levels to determine DOD needs in regard to different types of law enforcement personnel. Task force report is due September 30, 1978.

8. Examine the investigative and prosecutive follow-through in the United States of arrests made on military installations. The DOD task force examining investigative capabilities (step 7) will also examine what happens to civilians apprehended for drug trafficking on military installations.

9. Establish a Berlin task force to coordinate and enhance anti-drug efforts in West Berlin. The task force is composed of personnel from DEA, DOD, the German Police, and Allied Forces Police. In progress.

10. The Office of Assistant Secretary of Defense for Health Affairs will prepare a report, due June 30, on the scientific information that exists on the relationship between drug usage and military performance.

11. Health Affairs will work with the services, Federal agencies, and law enforcement organizations to develop and test practical evaluation criteria.

12. A physician has been recommended to the White House for the position of Assistant Secretary of Defense for Health Affairs. Gen. John Johns has been appointed Special Assistant for Drug Abuse to the Assistant Secretary of Defense for Health Affairs.

Some of these steps are being carried out at the present time while others are in the planning or developmental stage. The Department

of Defense has agreed to supply target dates for those where none were specified.

In its oversight role, the committee will monitor the implementation and effectiveness of this program, which, if carried out properly, should go a long way towards correcting the deficiencies uncovered by the committee during the past 18 months.

SUMMARY

During the past several months, the task force on drug abuse in the military visited military bases around the world and received briefings from all branches of the military and law enforcement groups concerning drug abuse. As a result of this effort, three central areas of concern relative to military drug abuse emerged. They are (1) identification and treatment of drug abusers, (2) DOD, service, and command attitudes toward drug abuse, and (3) accurate assessment of the nature and impact of the drug-abuse problem.

The task force discovered that not one of the services is able to state with confidence that it has a reliable handle on either identification of abusers or assessment of the impact of the problem. None of the services is able to state the effect of drug abuse on the combat preparedness of thier respective units. Reporting procedures are not standardized within the Department of Defense and emphasis on the drug-abuse problem is minimal.

There are special problems in Europe, particularly in Germany and West Berlin. Heroin shipped through Turkey by way of East Berlin poses difficult control problems due to political interests, especially to the position that the sector line is not an international border. Finally legal problems such as on-base *vs.* off-base usage and the differences between civilian law and the Uniform Code of Military Justice present enforcement problems as well as confusion on the part of military personnel.

Since hearings began on April 27, the extent of the problem and the military's lack of control over it have become widely known. As a result, steps are currently being developed by the Department of Defense to alleviate or eliminate many of the problem areas discovered. As a direct consequence of the efforts of the task force on Drug Abuse in the Military, the following steps have been taken:

(1) Command-directed urinalysis unit sweeps are now uniformly permissible throughout the military.

(2) The executive branch conducted a review of the service indicator systems.

(3) DOD has contracted to perform a drug survey similar in scope to the Arthur D. Little report of 1974.

(4) DOD has contracted to establish a centralized data base to collect all drug-abuse indicators in a uniform and reliable manner.

(5) DOD deemed permissible military-unique drug research.

(6) Raised public and presidential levels of consciousness about the serious nature of the problem.

(7) DOD has developed a twelve-point program to improve their efforts in the area of drug-abuse prevention, detection, identification, and treatment.

(8) Congressman English presented the findings of the task force in testimony before the House Armed Services Subcommittee on Investigations.

FINDINGS AND CONCLUSIONS

1. Drug abusers in the military are identified through law enforcement and investigative agency activity, by commander and supervisor referral, by medical referral, by self-referral, and by urinalysis.

2. There is a serious problem with drug abuse in the military. The problem is directly proportional to the attention given to the problem by unit commanders, to the availability of drugs, and to hardship, isolation, boredom, and other social pressures experienced by some units.

3. There is difficulty in accurately assessing the extent of the drug abuse problem. All techniques used for identification are in some way subject to local-level emphasis on the problem.

4. One difficulty in accurately assessing the extent of the problem is the lack of standard reporting procedures.

5. Officers as well as enlisted (questionnaire data) personnel don't believe random urinalysis was effective.

6. Although command-directed urinalysis can be an effective identification tool, it is completely dependent upon the line supervisor's interest in the drug-abuse problem.

7. The management style and philosophy of the Secretary of Defense dictated that ODAAP (Office of Drug and Alcohol Abuse Prevention), prior to the "12-Point Program," remain a very small and relatively obscure office, inadequate to handle all the activities required to devise policy and supervise policy initiation.

8. The chain of command within DOD, prior to the "12-Point Program," was not constructed toward providing the necessary emphasis on the drug-abuse problem.

9. The Assistant Secretary of Defense for Health Affairs is the only Assistant Secretary who does not report directly to the Secretary of Defense or his Deputy.

10. The effect of drug abuse upon combat readiness is difficult to determine. Currently, the only real method of evaluation is commander judgment, a very subjective tool.

11. Drug abuse constitutes a significant drain upon the military in both human and monetary terms.

12. All branches of the military are opposed to the reinstitution of random urinalysis.

13. There is a need for a unique military drug research program to investigate the effect of drug abuse upon combat readiness.

14. The military customs inspection programs and law enforcement capabilities appear to be inadequate to act as a deterrent to drug abuse.

15. The command attitude toward identifying drug abusers is negative in many cases.

16. It is generally agreed the causes of drug abuse include peer pressure, boredom, tension, lack of recreational opportunities, cultural shock, and length of tour overseas.

17. Major policy initiatives, the 12-Point Program, have been announced.

RECOMMENDATIONS

1. DOD and the military services command should vigorously support the twelve-point program of Secretary Brown and Deputy Secretary Duncan.

2. The debate of command directed *vs.* random urinalysis should be resolved through a military-unique research program.

3. Biases in data at various locations should be eliminated through standardized reporting methods and education directed at improving the uniformity in perception of the drug problem at all levels.

4. An incentive program for commanders who actively seek to expose the full extent of the drug problem should be developed.

5. A research program should be developed that will assess the causes and effects of drug abuse. Special emphasis should be placed on the negative effects of drug abuse on combat readiness, discipline, morale, and job performance.

6. Serious consideration should be given to reducing the length of duty tours overseas. Provide more and better recreational programs and facilities, particularly for troops stationed overseas.

7. Improve the customs inspection programs and law enforcement capability by providing better training and the increased use of detector dogs.

8. Closely examine the prevention, education, and treatment programs for deficiencies in training content, manpower, and emphasis.

9. DOD should be allocated additional resources to assure the increase in emphasis resulting from the twelve-point program will be permanent.

10. Urinalysis tests for marihuana and hashish (THC) and phencyclidine (PCP) should be used as soon as they are tested sufficiently to demonstrate their effectiveness.

11. The Department of Defense should enlist the aid of the Department of State in pursuing diplomatic initiatives directed towards securing the aid of other countries in stemming the flow of drugs in areas where U.S. military personnel are located.

APPENDIX A

WALTER REED ARMY INSTITUTE OF RESEARCH EPIDEMIOLOGICAL STUDY OF DRUG ABUSE

The Walter Reed Army Institute of Research (WRAIR) began an epidemiological study of drug abuse in 1972. In part, the purpose of that study was the collection of a rather broad spectrum of information about military life and conditions as they relate to the initiation, spread, and control of drug abuse within the environment of the Army.

A primary focus of the study was the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP). Overall, methods were used to study the possible relationship between drug abuse and the following environmental factors:

(*a*) The organizational components of military units and life in the barracks.

(*b*) The study of drug using and non-drug using social networks and small-group interaction.

(*c*) The roles and impact of post-wide care-giving delivery systems, i.e., hospital, Army Community Services, welfare and recreation facilities.

Selected findings which emerged from the Walter Reed data as it related to drug abuse and the unique lifestyle of the barracks dwelling soldier are:

(*a*) Barracks residence or residence with fellow soldiers in an off-post situation seems to provide optimum conditions to influence an individual's behavior relative to the use of illicit drugs.

(*b*) Soldiers acquire their drugs largely from barracks mates or from fellow members of their companies.

(*c*) Members of groups informally provide access to drugs depending upon the supplies that exist at a given moment.

(*d*) Drugs are obtained in their (soldiers) hometown, while on pass or leave, in the surrounding community or from other individuals on post.

(*e*) The same groups in which drugs are used also support and encourage their fellows to perform as "good soldiers." The "good soldier" label made many soldiers unlikely suspects for significant drug abuse.

In conjunction with the latter finding, these "good soldiers" did not usually involve themselves in behavioral indiscretions which drew the attention of their commanders. Essentially, they functioned quite well within their units surrounded by a "mantle of invisibility." The existence of this situation within Army units lead WRAIR to one of its conclusions, i.e., that the involvement of problem soldiers in alcohol treatment programs represented the tip-of-the iceberg below which existed a vast majority of drug abusers who were rather "successful" in their drug abuse. In this context, "successful" means that their drug abuse rarely came to the attention of military authorities. In 1975, Dr. David Marlow, the Project Director of the WRAIR study stated:

"Illicit drug use in the Army must be controlled so that the adverse effects on its mission, created by a large endemic population of drug users can be prevented. There exists at present a large number of drug abusers within the service . . . The existence of this pool of drug users holds us continually at risk that an epidemic of addictive type could recur, either when new drug agents are introduced or when old ones (like heroin) become easily available. The possibility that a potential enemy could exploit this weakness constitutes a chronic threat that must constantly be kept in mind."

In a broader scope than the epidemiological study other major research findings of the WRAIR program have included:

(*a*) Documental effects of marihuana on time perceptions, a factor critical to the operation of certain military systems (i.e., aircraft; anti-tank missile guidance, etc.)

(*b*) Defined effects of marihuana and alcohol, alone and in combination, on visual function, a factor critical to night operations and color vision.

(*c*) The development of a urine analysis system.

(*d*) The development of a urine test for methaqualone (a unique problem in overseas areas).

(e) Clinical and laboratory characterization of acute heroin withdrawal syndrome in healthy young short-term users of pure heroin in the military population.

(f) Described performance decrements associated with the discontinuance of regular daily marihuana use.

Upon termination of the WRAIR drug abuse research, and at the direction of ODCSPER, WRAIR prepared a draft outline of a drug abuse handbook for commanders which attempted to synthesize research findings, including those which were incomplete, in a form which would give the small unit commander a context in which to understand drug use in his unit so that he might maximize his effectiveness in dealing with the problem. The draft outline was forwarded to the appropriate agency for inclusion in educational modules developed for service schools.

APPENDIX B

HEARINGS AND PARTICIPANTS

APRIL 27, 1978

Lee Dogoloff, Associate Director, Domestic Policy Staff, The White House;

Dr. Robert Smith, Former Assistant Secretary for Health Affairs, Department of Defense; and

Vernon McKenzie, Acting Assistant Secretary of Defense for Health Affairs, Department of Defense. Accompanied by: E. D. Schmitz, Chief, Office for Drug and Alcohol Abuse Prevention; James F. Holcomb, Director for Identification, Program Evaluation and Research; and T. O'Conner, Chief, Physical and Installation Security Division, Office of Assistant Secretary of Defense (Comptroller).

MAY 24, 1978

Brig. Gen. John Johns, Deputy Chief of Staff for Personnel, U.S. Army; and

Brig. Gen. William Henry Fitts, Chief of Staff for Personnel, U.S. Army, Europe and 7th Army.

JUNE 2, 1978

Lt. Gen. B. L. Davis, Deputy Chief of Staff/Personnel, United States Air Force. Accompanied by: Col. John R. Rogers and Maj. Frederick M. Bell.

JUNE 16, 1978

Capt. Warren H. Winchester, Deputy Assistant Chief of Naval Personnel for Human Resource Management. Accompanied by: Cmdr. J. B. Goodwin, Director, Drug Prevention Division, Bureau of Naval Personnel; C. M. Newman, Office of the Chief of Naval Operations; and R. Tugwell, Head, Narcotics Division, Naval Investigative Service.

Col. Vonda Weaver, Head, Human Resources Branch, U.S. Marine Corps. Accompanied by: Lt. Col. Carson N. Robinson, Head, Drug and Alcohol Abuse Control and James F. Holcomb, Office of Drug and Alcohol Abuse, Office of the Secretary of Defense, the Pentagon.

JULY 27, 1978

Hon. Charles W. Duncan, Jr., Deputy Secretary of Defense.

APPENDIX C

INSTALLATIONS VISITED

Army.—Hood, Campbell, Stewart, Berlin, Bragg, Sill, and Jackson.

Air Force.—McGuire and Holmstead.

Navy/Marines.—Quantico, San Diego NAS, Pendleton, Mirimar, Norfolk, and Rota.

APPENDIX D

DOD-WIDE RESULTS—OFFICER QUESTIONNAIRE

(N=213)

DEFINITIONS

A drug problem.—A sufficiently high amount of drug abuse as to have a negative impact on the combat preparedness, discipline or effectiveness of our military personnel.

Permanent party, lower enlisted personnel.—E–1 through E–6 or ages 17–26.

Other drugs.—PCP, LSD, mescaline, opium, methadone, codeine and over-the-counter drugs.

Polydrug use.—The use of two or more drugs at the same time, including alcohol and another drug (other than tobacco or coffee).

QUESTIONS

1. The committee is attempting to establish whether drug abuse within the military may be a problem. In your opinion, the mulitary has: No problem with drug abuse, none; a small problem with drug abuse, 15 percent; a moderate problem with drug abuse, 58 percent; a great problem with drug abuse, 27 percent; and no reply, less than 1 percent.

2. Would the illegal use of drugs in the military affect any of the following personnel characteristics? Combat readiness, 89 percent; morale, 71 percent; discipline, 89 percent; job performance, 97 percent; other, 19 percent; and the use of drugs does not affect the men/women, none.

3. Based upon your knowledge of the community drug trafficking situation, would you say the following drugs are easy or difficult for the men/women here on the base to obtain?

[In percent]

	No response	Difficult to locate a seller	Easy to purchase
Marihuana	3	6	91
Heroin	19	54	27
Cocaine	16	40	44
Pills:			
Downers	13	10	77
Uppers	15	8	77
Other drugs (nonalcohol)	33	14	53

4. Do you feel that the permanent party, lower enlisted personnel on this installation have: No problem with drug abuse, 0 percent; a small problem with drug abuse, 17 percent; a moderate problem with drug abuse, 61 percent; a great problem with drug abuse, 21 percent; and no reply, 1 percent.

5. Roughly speaking, how many of the permanent party, lower enlisted personnel use:

Marihuana: None, 1 percent; a small number, 19 percent; about half, 37 percent; more than half, 33 percent; almost all, 8 percent; and no reply, 2 percent.

Heroin: None, 15 percent; a small number, 75 percent; about half, 2 percent; more than half or almost all, none; and no reply, 8 percent.

Cocaine: None, 8 percent; a small number, 80 percent; about half, 4 percent; more than half, 1 percent; almost all, none; and no reply, 8 percent.

Pills—downers: None, 1 percent; a small number, 77 percent; about half, 11 percent; more than half, 3 percent; almost all, 1 percent; and no reply, 8 percent.

Uppers: None, 2 percent; a small number, 70 percent; about half, 14 percent; more than half, 7 percent; almost all, none; and no reply, 8 percent.

Other drugs: None, 3 percent; a small number, 67 percent; about half, 13 percent; more than half, 6 percent; almost all, 2 percent; and no reply, 9 percent.

6. Do you see any of the following as a result of drug use on this base?

Additional difficulty the senior or junior NCO has in providing leadership for his unit (lack of respect for his authority): Yes, 64 percent; no, 34 percent; no reply, 2 percent.

Personnel not caring about their jobs: Yes, 72 percent; no, 22 percent; no reply, 6 percent.

Disciplinary problems: Yes, 80 percent; no, 14 percent; no reply, 6 percent.

A lack of unit pride: Yes, 50 percent; no, 42 percent; no reply, 8 percent.

Additional use of alcohol: Yes, 46 percent; no, 46 percent; no reply, 8 percent.

7. The use and abuse of alcohol within the military is widely acknowledged to be an enormous problem today. The Committee is concerned, however, that the use of alcohol may be covering up the simultaneous use of other drugs. Do you feel that drug use may be remaining undetected in this fashion? Yes, 41 percent; no, 55 percent; no reply, 4 percent.

If you answered yes, how many individuals who use alcohol do you think are engaged in polydrug use? All, none; more than half, 5 percent; about half, 8 percent; less than half, 12 percent; and a small number, 16 percent.

8. For which of the following reasons do military personnel use drugs? To relieve boredom, 69 percent; to cope with the tension of day-to-day military living, 49 percent; to experiment/curiosity, 60 percent; to complement an environment that contains inadequate recreational facilities and opportunities, 34 percent; other, 31 percent; and no reply, 1 percent.

9. Given the amount of drug use as you perceive it on this installation, do you think that today the men/women could go into combat and perform to the best of their ability? Yes, 63 percent; no, 34 percent; no reply, 2 percent.

10. Should the DOD have a policy that permits an individual who has been rehabilitated for drug use to reenlist? Yes, 70 percent; no, 26 percent; no reply, 4 percent.

11. Do you think there is more drug abuse here on the base or in the surrounding community? No reply, 6 percent; same, 1 percent; here on the base, 28 percent; in the community, 65 percent.

12. Are there military personnel on the base who supplement their income by dealing in drugs? Yes, 85 percent; no, 5 percent; no reply, 10 percent.

13. Did you think the random urinalysis program was effective in identifying drug users? Yes, 47 percent; no, 48 percent; no reply, 5 percent.

14. Do you think the random urinalysis program was an effective deterrent for drug abusers? Yes, 25 percent; no, 70 percent; no reply, 5 percent.

15. Would you like to see the program reinstituted? Why? Yes, 42 percent; no, 51 percent; no reply, 7 percent.

Yes: A good deterrent, 18 percent; the only truly reliable tool we have for identifying drug users, 20 percent, other, 12 percent.

No: Administratively difficult, 27 percent; not cost effective, 20 percent; not a deterrent, 39 percent; useless, 13 percent; easy to fool, 19 percent; too expensive, 9 percent; and other 10 percent.

16. As long as the men/women in my unit are discreet and do not engage in drug use while on duty, I do not object to such activity: True, 20 percent; false, 78 percent; no reply, 2 percent.

OPINIONS ABOUT DRUG USE—ENLISTED PERSONNEL
(N=2120)

First, some general questions about drug policy:

1. Do you feel the DOD has: No problem with drug abuse, 7 percent; a small problem with drug abuse, 19 percent; a moderate problem with drug abuse, 44 percent; and a great problem with drug abuse, 30 percent.

2. Does this problem affect: Combat readiness, 39 percent; morale, 39 percent; discipline, 54 percent; job performance, 52 percent; does not affect the men/women, 21 percent; and no reply, 3 percent.

3. Are the following drugs easy or hard for the men/women to get?

[In percent]

	No response	Hard	Easy
Marihuana	3	11	86
Cocaine	13	45	42
Heroin [1]	15	58	27
Pills:			
Downers (barbiturates)	9	21	70
Uppers (amphetamines)	10	20	70
Other drugs (nonalcohol)	18	21	61

[1] Base for this category was 2001, not 2120.

4. Do you feel your unit has: No problem with drug abuse, 21 percent; a small problem with drug abuse, 34 percent; a moderate problem with drug abuse, 32 percent; a great problem with drug abuse, 10 percent; and no reply, 3 percent.

5. How many of the men/women in your unit use:

Marihuana: None, 6 percent; a small number, 24 percent; about half, 19 percent; more than half, 24 percent; almost all, 22 percent; and no reply, 6 percent.

Heroin: None, 53 percent; a small number, 31 percent; about half, 2 percent; more than half, 1 percent; almost all, 1 percent; and no reply, 13 percent.

Cocaine: None, 31 percent; a small number, 47 percent; about half, 7 percent; more than half, 2 percent; almost all, 1 percent; and no reply, 11 percent.

Pills—downers: None, 22 percent; a small number, 50 percent; about half, 12 percent; more than half, 4 percent; almost all, 2 percent; and no reply, 11 percent.

Uppers: None, 19 percent; a small number, 47 percent; about half, 14 percent; more than half, 6 percent; almost all, 2 percent; and no reply, 11 percent.

Other drugs: None, 18 percent; a small number, 44 percent; about half, 13 percent; more than half, 6 percent; almost all, 6 percent; and no reply, 13 percent.

6. For which of the following reasons do the men/women use drugs? To relieve boredom, 45 percent; to have fun, 47 percent; to cope with the tension of day-to-day living, 60 percent; to experiment/curiosity, 27 percent; other, 15 percent; and no reply, 4 percent.

7. Given the amount of drugs that men/women in your unit use, do you think that today they could go into combat and perform to the best of their ability? Yes, 56 percent; no, 38 percent; no reply, 6 percent.

8. Should the DOD have a policy permitting an individual to reenlist who has been rehabilitated for drug use? Yes, 74 percent; no, 22 percent; no reply, 4 percent.

9. You are finding more drug use now, in your unit, than you found among the people who were in your high school. True, 51 percent; false, 44 percent; no reply, 5 percent.

10. Do you think that there is more drug use here on the base than in the surrounding community? Yes, 26 percent; no, 68 percent; no reply, 6 percent.

11. To your knowledge, do most military personnel here who use drugs, buy their drugs from military or civilian dealers? Military dealers, 20 percent; civilian dealers, 32 percent; both, 18 percent; no reply, 30 percent.

12. Did you think the random urinalysis program was effective in identifying drug users? Yes, 32 percent; No, 61 percent; no reply, 7 percent.

13. Do you think the random urinalysis program was an effective deterrent for drug abusers? Yes, 26 percent; no, 67 percent; no reply, 7 percent.

14. Would you like to see the program reinstituted? Why? Yes, 29 percent; no, 62 percent; no reply, 9 percent.

Yes: A good deterrent, 14 percent; the only truly reliable tool we have for identifying drug users, 16 percent; other, 6 percent.

No: Administratively difficult, 17 percent; not cost effective, 12 percent; not a deterrent, 27 percent; useless, 27 percent; easy to fool, 27 percent; too expensive, 14 percent; other, 17 percent.

APPENDIX E

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE,
Washington, D.C., August 22, 1977.

Hon. LESTER L. WOLFF,
Chairman, Select Committee on Narcotics Abuse and Control,
House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to your letter of August 9 to Secretary Brown regarding transfer of Department of Defense personnel from nuclear weapon duty because of drug and alcohol abuse.

To assure the highest possible standards of individual reliability in personnel performing duties associated with nuclear weapons, the Nuclear Weapon Personnel Reliability Program was established by DOD Directive 5210.42, revised April 24, 1975 (copy enclosed). Only those candidates who meet the high standards set forth in section V. of the directive are certified as eligible for such duties.

In determining eligibility, candidates for the nuclear weapon program are screened initially. This process identifies those individuals who may be expected to maintain the strict standards required. However, because this process is not, in itself, a guarantee of future behavior, all personnel in the program are evaluated on a continuing basis. During 1975 and 1976 this on-going evaluation resulted in the transfer to nonnuclear duties of just over 4 percent of the personnel in the program.

Enclosed pursuant to your request are statistical breakdowns of the number of personnel disqualified for nuclear related duties, subsequent to certification, for calendar years 1975 and 1976. You will note that, of those disqualification traits or conduct set forth in subsection V. B. of the directive, data submitted for drug abuse are categorized further by type of drug principally involved. Statistics for prior years are not available because of differences in Service reporting criteria prior to the establishment, in 1975, of standardized reporting procedures. There have been no reported incidents of negligence to nuclear weapons by personnel because of drug or alcohol reasons.

The program standards are extremely rigid and strictly applied. Disqualification is an administrative action involving simply a transfer to a nonnuclear assignment. There are provisions for review of each case at a higher echelon of command to insure that individual rights are fully protected and that there is no abuse of the system. When drug or alcohol abuse results in the transfer of personnel from the program, the individuals concerned are referred for evaluation and, if appropriate, for treatment and rehabilitation.

The impact of drug and alcohol abuse on military effectiveness in the nuclear weapon security program has been minimal; however, there has not been a DOD-wide analysis of drug and alcohol abuse on military effectiveness in general.

I share your concern in the serious matter of nuclear security and would like to point out that the Nuclear Weapon Personnel Reliability Program is but one facet of our overall in-depth security system. Other controls, such as specific entry and escort procedures and the two-man rule which prohibits access to a nuclear weapon by any lone person, provide multiple means of assuring weapon security should any one part of the program falter.

I hope this will be helpful to you and the members of the select committee Please let me know if you require additional information.

Sincerely,

JOSEPH J. LIEBLING,
Deputy Assistant Secretary of Defense.

DEPARTMENT OF DEFENSE
ANNUAL DISQUALIFICATION REPORT—NUCLEAR WEAPON PERSONNEL RELIABILITY PROGRAM (RCS DD-COMP (A) 1403)

[Calendar year ending Dec. 31, 1975]

	United States	Pacific	Europe	Total
Number of personnel in PRP on Dec. 31, 1975	89,294	6,881	23,450	119,625
Number of personnel permanently disqualified subsequent to certification, by disqualification category:				
1. Alcohol abuse	58	10	101	169
2. Drug abuse:				
(a) Narcotics	65	9	69	
(b) Depressants	15	8	113	
(c) Stimulants	37	0	155	
(d) Hallucinogens	70	5	37	
(e) Cannabis	731	111	545	
Total drug abuse	918	133	919	1,970
3. Negligence or delinquency in performance of duty	530	22	151	703
4. Court-martial or civil convictions of a serious nature	169	16	160	345
5. A pattern of behavior or actions which is reasonably indicative of a contemptuous attitude toward the law	580	46	96	722
6. Any significant physical, mental, or character trait, or aberrant behavior, substantiated by competent medical authority, which in the judgment of the certifying official is prejudicial to reliable performance of the duties of a particular critical or controlled position	712	66	441	1,219
Total (1 through 6)	2,967	293	1,868	5,128

DEPARTMENT OF DEFENSE
ANNUAL DISQUALIFICATION REPORT—NUCLEAR WEAPON PERSONNEL RELIABILITY PROGRAM

[Calendar year ending December 31, 1976]

	United States	Pacific	Europe	Total
Number of personnel in PRP on December 31, 1976	87,415	5,796	22,644	115,855
Number of personnel permanently disqualified subsequent to certification, by disqualification category:				
1. Alcohol abuse	102	9	73	184
2. Drug abuse:				
(a) Narcotics	45	2	52	
(b) Depressants	22	2	57	
(c) Stimulants	31	0	101	
(d) Hallucinogens	99	1	19	
(e) Cannabis	752	24	307	
Total drug abuse	909	29	536	4,966
3. Negligence or delinquency in performance of duty	612	34	91	737
4. Court-martial or civil convictions of a serious nature	353	5	30	388
5. A pattern of behavior or actions which is reasonably indicative of a contemptuous attitude toward the law	784	23	138	945
6. Any significant physical, mental, or character trait, or aberrant behavior, substantiated by competent medical authority, which in the judgment of the certifying official is prejudicial to reliable performance of the duties of a particular critical or controlled position	818	26	394	1,238
Total (1 through 6)	3,578	126	1,262	4,966

NUCLEAR WEAPONS PERSONNEL RELIABILITY PROGRAM

A. Definitions of critical and controlled positions:

Critical Position.—A position, the incumbent of which, by the nature of his authorized duties:

1. Has access and technical knowledge, or;
2. Can, at battalion/squadron/ship level or below, either directly or indirectly cause the launch or employment of a nuclear weapon; or
3. Controls or uses sealed authenticators, codes, strategic missile computer tapes, emergency action messages, or release procedure for nuclear weapons.

Controlled position.—A position, the incumbent of which, by the nature of his authorized duties:

1. Has access but no technical knowledge; or
2. Controls entry into an exclusion area, but does not have access or technical knowledge.

B. Typical Air Force job positions within the nuclear weapons reliability program for which drug abuse was a disqualifying factor:

Job position [1]	Drugs	
	1975	1976
Communication and cryptographic equipment repairmen	17	1
Missile system analyst	0	12
Bomb/navigation systems repair	19	12
Ground crew chiefs	63	32
Missile mechanics	14	4
Munitions handlers/loaders/mechanics	119	53
Security/law enforcement personnel	453	337
Total	741	483
	1,224	
Total in Air Force PRP current year 1975	61,000	
Total in Air Force PRP current year 1976	57,924	

[1] Only jobs with highest numbers of cases listed.

APPENDIX F

APO locations with greatest number of violations

Army APO—Wildflecken, Germany	146
Army APO—Bamberg, Germany	145
Army APO—Furth, Germany	139
Army APO—Giessen, Germany	128
AF APO—Hahn AB, Germany	120
Army APO—Friedberg, Germany	115
Army APO—Kirchgoens, Germany	111
Army APO—Neu Ulm, Germany	106
Army APO—Baumholder, Germany	101
Army APO—Bad Kreuznach, Germany	97
Total violations	1,208

APPENDIX G

LEGAL PROBLEMS

O'CALLAHAN V. PARKER

O'Callahan, while on an evening pass from his Army post in Hawaii and in civilian attire, broke into a hotel room, assaulted a girl, and attempted rape. Following his apprehension, city police, on learning that O'Callahan was in the armed forces, delivered him to the military police. After interrogation, O'Callahan confessed. He was charged with attempted rape, housebreaking, and assault with intent to rape, in violation of the Uniform Code of Military Justice (UCMJ). He was tried by court-martial, convicted on all counts, and sentenced.

The central question in *O'Callahan* was whether the military had jurisdiction to try by court-martial a soldier who had committed his offense off the post, the offense being unrelated to military considerations.

The Supreme Court held:

". . . a crime, to be under military jurisdiction, must be service connected, and since O'Callahan's crimes were not, he could not be tried by court-martial but was entitled to a civilian trial with the benefits of an indictment by a grand jury and trial by jury.

"The Constitution recognizes that military discipline requires military courts in which not all the procedural safeguards of Constitutional trials need apply, and the Fifth Amendment exempts cases arising in the land or naval forces or in the militia, when in actual service in time of war or public danger from the requirement of prosecution by indictment and the right to trial by jury.

"If the case does not arise 'in the land or naval forces,' the accused gets: 1) the benefit of an indictment by a grand jury, and 2) a trial by jury before a civilian court as guaranteed by the sixth amendment.

"A court martial (which is tried in accordance with military traditions and procedures by a panel of officers empowered to act by two-thirds vote presided over by a military law officer) is not an independent instrument of justice but a specialized part of an overall system by which military discipline is preserved.

"The fact that O'Callahan at the time of his offense and of his court-martial was a member of the Armed Forces does not necessarily mean that he was triable by court-martial.

"To be under military jurisdiction a crime must be service connected lest all members of the Armed Forces be deprived of the benefits of grand jury indictment and jury trial.

"There was not even a remote connection between O'Callahan's crime and his military duties, and the offenses were peace time offenses, committed in American territory which did not involve military authority, security, or property."

The Supreme Court also stated in *O'Callahan* that there is a great difference between trial by jury and trial by selected members of the military forces. It is true that military personnel because of their training and experience may be especially competent to try soldiers for infractions of military rules. Such training is no doubt particularly important, when an offense charged against a soldier is purely military, such as disobedience of an order, leaving a post, etc. But whether right or wrong, the premise underlying the Constitutional method for determining guilt or innocence in Federal courts is that laymen are better than specialists to perform this task. This idea is inherent in the institution of trial by jury.

A court-martial is tried, not by a jury of the defendant's peers, which must decide unanimously, but by a panel of officers empowered to act by a two-thirds vote. The presiding officer at a court-martial is not a judge whose objectivity and independence are protected by tenure and undiminishable salary and nurtured by the judicial tradition, but a military law officer. Substantially different rules of evidence and procedure apply in military trials.

RELFORD V. COMMANDANT

In a case decided by the Supreme Court in 1970, *Relford* v. *Commandant*, the Supreme Court expanded on the reasoning set forth in the *O'Callahan* case two years earlier.

The *Relford* case acknowledged the confusion which *O'Callahan* had caused in determining whether a Federal civilian court or military court had jurisdiction. *Relford* differed from *O'Callahan* in that *Relford* kidnapped and raped two women on the property of Ft. Dix. The court, attempting to set forth guidelines for determining whether a particualr offense was "service-connected," set forth the now famous twelve criteria for determining this matter. They are:

1. The serviceman's proper absence from the base.
2. The crime's commission away from the base.
3. The commission at a place not under military control.
4. The commission within our territorial limits and not in an occupied zone of a foreign country.
5. The commission in peace time and its being unrelated to authority stemming from the war power.
6. The absence of any connection between the defendant's military duties and the crime.
7. The victims not being engaged in the performance of any duty relating to the military.
8. The presence and availability of a civilian court in which the case can be prosecuted.
9. The absence of any flouting of military authority.
10. The absence of any threat to a military post.
11. The absence of any violation of military property.

12. The offense being among those traditionally prosecuted in civilian courts.

Because *Relford* had committed his offenses on a military installation, his conviction was affirmed. The court stressed that the military has an essential and obvious interest in the security of persons and of property on the military enclave. It also stressed the responsibility of the military Commander for maintenance of order in his command and his authority to maintain that order. The court recognized the impact and adverse effect that a crime committed against a person or property on a military base, thus violating the base's very security, has upon morale, discipline, reputation and integrity of the base itself, upon its personnel and upon the military operation and the military mission. Interestingly enough, the court also stated that it recognized "the distinct possibility that civil courts, particularly non-Federal courts, will have less than complete interest, concern, and capacity for all the cases that vindicate the military's disciplinary authority within its own community." The court also recognized its inability to meaningfully draw any line between a post's strictly military areas and its non-military areas, or between a serviceman's on-duty and off-duty activities and hours on the post.

APPENDIX H

RECENT CORRESPONDENCE FROM NIDA TO DOD

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION,
Rockville, Md., July, 24, 1978.

HON. ROBERT N. SMITH,
Assistant Secretary of Defense (Health Affairs),
The Pentagon, Washington, D.C.

DEAR MR. SMITH: The National Institute on Drug Abuse (NIDA) shares your concern and that of others who have studied the nature of the drug abuse problem in the military services, and we are prepared and willing to help you launch a program of studies to assess the extent and consequences of illicit drug abuse among the military.

The epidemiological research supported by NIDA over the past four years (and earlier by the National Institute of Mental Health and the Special Action Office for Drug Abuse Prevention) has helped develop a sizable group of competent active scientists specializing in such studies of substance use and abuse. The names and affiliations of these researchers are available along with descriptions of their projects and in many cases publications resulting from their work. One whom you may know about is Dr. Lee Robins of Washington University in St. Louis, who conducted the followup study of Vietnam veterans. Others include: Dr. John O'Donnell, University of Kentucky; Dr. Ira Cisin, George Washington University; Dr. William McGlothlin, University of California at Los Angeles; and Dr. Lloyd Johnston, University of Michigan.

You should be aware also that the National Institute on Drug Abuse has undertaken research on the effects of drugs on complex human performance which may have relevance to military tasks, such as driving and other psychomotor tasks. The individuals performing this research are: Dr. Herbert Moskowitz, Southern California Research Institute, Los Angeles, Calif., and Dr. Everett Ellinwood, Duke University, Department of Psychiatry, Durham, N.C.

It would be helpful if you would let us know when you can meet with us to discuss your needs for this kind of information. You or your designated representatives may wish to meet with members of NIDA's research staff to begin to establish a working relationship. Please let me or Dr. William Pollin, Director of the Division of Research, know when you would like to hold such a meeting. The telephone numbers are, respectively: 443-6480 and 443-1887.

Sincerely yours,

KARST J. BESTEMAN,
Acting Director.

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12. The offense being among those traditionally prosecuted in civilian courts.

Because *Relford* had committed his offenses on a military installation, his conviction was affirmed. The court stressed that the military has an essential and obvious interest in the security of persons and of property on the military enclave. It also stressed the responsibility of the military Commander for maintenance of order in his command and his authority to maintain that order. The court recognized the impact and adverse effect that a crime committed against a person or property on a military base, thus violating the base's very security, has upon morale, discipline, reputation and integrity of the base itself, upon its personnel and upon the military operation and the military mission. Interestingly enough, the court also stated that it recognized "the distinct possibility that civil courts, particularly non-Federal courts, will have less than complete interest, concern, and capacity for all the cases that vindicate the military's disciplinary authority within its own community." The court also recognized its inability to meaningfully draw any line between a post's strictly military areas and its non-military areas, or between a serviceman's on-duty and off-duty activities and hours on the post.

APPENDIX H

RECENT CORRESPONDENCE FROM NIDA TO DOD

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
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