PREPARED STATEMENT OF BRIG. GEN. JOHN H. JOHNS, DIRECTOR OF HUMAN RESOURCES DEVELOPMENT, OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL, U.S. ARMY

BIOGRAPHY
BRIGADIER GENERAL JOHN H. JOHNS
DIRECTOR OF HUMAN RESOURCES DEVELOPMENT

Brigadier General John H. Johns was born in Cordova, Alabama on 11 July 1928. He graduated from Cordova High School in 1946 and attended Walker College for one year. He enlisted in the Army in June 1947 and after completing training, served as a platoon sergeant in the Medical Field Service School at Ft. Sam Houston, Texas. After discharge from the Army in late 1948, he attended the University of Alabama, where he majored in political science and economics before accepting a regular commission as a Distinguished Military Graduate of ROTC.

As a 2d Lieutenant, he was assigned to the 77th AAA Gun Battalion, where he served as a platoon leader and Battery Commander. He was reassigned to the 28th Infantry Division (later the 9th) in Germany in 1953. He served as a platoon leader in the 899th AAA (AW) Bn from 1953-1954 and as a platoon leader in the 28th/9th QM Company. In 1955, he was assigned as Assistant G1 of the 9th Infantry Division and served in that position for two years before being assigned as Assistant S3, 84th FA Battalion. The division gyroscoped to Fort Carson, Colorado in 1956.

General Johns was on the faculty of the Special Warfare School from 1960-1962. He served as instructor in the Psychological Operations and Counterinsurgency Branches. He was assigned to Vietnam in 1962 and was the Senior Advisor, Political Warfare School.

After completing Command & General Staff College in 1964, General Johns was assigned to the Office, Chief of Research and Development, DA. He was an action officer in the field of research on politico-military affairs. He continued his work in politico-military affairs as a staff officer in the International Security Affairs Directorate, Office, Deputy Chief of Staff for Operations, from 1966-68.

During the period 1968-70, General Johns was an instructor and Associate Professor, Office of Military Psychology and Leadership, U.S. Military Academy. From West Point, he moved to Ft. Bliss, Texas, where he commanded the 6/61st Bn (HAWK). From Ft. Bliss, he went to the Office, Chief of Staff, Army, for the period 1971-73, first as an Assistant to the Secretary, General Staff (Coordinations and Reports) and then as Deputy to the Special Assistant for Training. During this period, he was involved in the establishment of an Armywide effort designed to test techniques for improving organizational effectiveness.

After graduation from the National War College, in August 1974, General Johns was assigned as Chief, Leadership and Behavior Division, Office, Deputy Chief of Staff for Personnel and on 2 June 1975, assumed the duties as Director, Human Resources Development Directorate. From September 1975 to July 1977, he was Assistant Division Commander, 1st Infantry Division. In July 1977 he again assumed the duties of Director of Human Resources Development.

Introductory Remarks.

Mr. Chairman and Members of the Committee:

I am Brigadier General John H. Johns, Director of Human Resources Development in the Office of the Deputy Chief of Staff for Personnel, Department of the Army. The Army Alcohol and Drug Abuse Prevention and Control Program is a responsibility of my Directorate and the Department of the Army has designated me to be the Principal Witness for this Hearing. Accompanying me today is Brigadier General William Fitts, Deputy Chief of Staff for Personnel, Headquarters, U.S. Army Europe, who will also have some brief remarks and will respond to any questions you may have which refer specifically to the drug problem in Europe. Mrs. Helen D. Gouin, a member of the Drug Policy Branch, Lt. Col. David H. Karney, Alcohol and Drug Abuse Consultant to the Surgeon General, and Lt. Col. David B. Reed who is a member of our Law Enforcement Division will provide additional assistance.

I appreciate the opportunity to appear before this Committee and discuss the concern that we share in regard to alcohol and drug abuse in the United States Army. Members of my staff have been working with the staff of the Select Committee on Narcotics Abuse and Control for more than a year now and on behalf of the

Department of the Army, I would like to express our appreciation for the manner in which your investigation has been conducted. We appreciate the lengths to which you have gone to become familiar with problems in the Army, and the amount of time you have taken to observe and to talk to our people. The sincerity of your members and staff has been evident.

I have a brief prepared statement which I would like to present to the Committee. The purpose of the statement is (1) to discuss the nature of the problem as we see it, (2) to summarize briefly the Army's alcohol and drug program; and (3) to discuss some specific initiatives the Army has taken to deal with the problem. After my prepared remarks, I will respond to specific questions from the Committee.

Nature of the Problem.

Alcohol and drug abuse were brought to our attention very vividly during the period of the Vietnam War. Drugs of all types were readily available, particularly the opiates and opiate derivitives. For many soldiers, alcohol and drug abuse became an accepted way to either cope with stress or to provide "pleasure" in social situations.

The fact that heroin and opiate derivities were so available and indeed "pushed" as a part of the "economy" in Vietnam served to exacerbate the problem of service members who either came into the Army with a drug problem or who had become users before they were sent to Vietnam. The availability caused many casual abusers to

become drug dependent and many who were formerly non-users to succumb to both peer pressure and availability and become at least casual abusers. However, we have not seen large numbers of hard core drug addicts in the Army since the Vietnam era.

During the past four years, we have developed a data base on drug and alcohol abuse by Army personnel. Based on self-reported data, there has been an overall decrease in the rate of hard drug abuse and there has been no significant change in the rate of marihuana and alcohol abuse. Our caseload data do show an increase in the number of personnel being treated for alcohol. However, this is probably a function of increased acceptability of treatment for alcohol problems, i.e., more volunteering for assistance.

Alcohol and drug abuse in the Army have established patterns, and we know that poly drug abuse has increased - just as it has in society. Additionally, the periodic fluctuation of high grade heroin in certain areas, such as Berlin, has shown that we must have the flexibility to deal with a potential increase in drug abuse during times of increased drug trafficking in a specific area.

Measuring the Problem.

Before describing our alcohol and drug abuse program, I would like to explain our approach to assessing the extent of abuse in the Army. We are aware of your concern over the apparent lack of reliability in statistics purporting to measure the magnitude of

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the problem and I would like to briefly review how we obtain our measures and how we interpret the data.

The Army uses several measures to diagnose the drug and alcohol abuse problem. One method is personal observations made by leaders and other authorities. This lacks consistency, however, is highly subjective, and observed abuses are not always reported. Command-directed urinalysis does provide us with a useful measure of abuse, because most leaders will take this action if the behavior of an individual is such that it adversely impacts on his performance of duty and I can assure you that in units with tough physical demands, it shows.

Perhaps the most accurate measure we have is a personnel opinion survey which is administered anonymously to a random sample of our soldiers on a quarterly basis. The sample, while it is random, is large enough to enable us to do analysis by grade, age, sex, and other relevant variables. The survey is scientifically designed and we have over four years of reliability and validity analysis. We have a great deal of confidence that this gives us a valid assessment of the approximate magnitude of the problem. We compare the results of the survey with law enforcement apprehension data, alcohol and drug program admissions, and command-directed urinalysis data. Using these various measures, we develop trend data that has proven to be highly consistent.

Current Assessment.

The data that have been collected and validated over the past four years indicate that marihuana use is stable and abuse of hard drugs is decreasing on a world-wide basis. These trends correspond with trend data from our rehabilitation program, which lists the drugs of choice of participants. Figure 1 is a table depicting results of our Aug 77 survey concerning self-reported use of hard drugs. Figure 2 is a table concerning self-reported use of marihuana as of August 1977.

Our law enforcement and indiscipline data trend lines parallel the personnel survey. The number of apprehensions for marihuana use and possession are stable but slightly down in the last three quarters of 1977; apprehension for other drug offenses has steadily declined over the past two years. The decline is true in spite of the fact that the number of investigations is increasing. Figure 3 is a chart which compares trends obtained from our survey data with military police apprehension for hard drugs and figure 4 is a comparison for marihuana. You will note that the trends obtained from both sources are similar and tend to validate each other.

World-wide Alcohol and Drug Abuse Program data are kept, with names removed, by the Patient Administration Systems and Biostatistics, Activity, Health Services Command, Ft. Sam Houston, Texas. These data indicate that world-wide, cannabis products continue to lead as the most widely abused drug reported among Army personnel, followed by opiates, amphetamines, methaqualone, other detectable

Figure: 1

ENLISTED SELF-REPORTED USE (PERCENTAGE)
*(HARD DRUGS) AUG 77

		FIRST TERM SOLDIERS	CAREER SOLDIERS	ALL SOLDIERS
SINGLE	OCCASIONAL	8.3	4.7	7.9
	FREQUENT	2.0	2.3	2.2
		10.3	7.0	10.1
MARRIED	OCCASIONAL	5.4	2.4	3.6
	FREQUENT	1.3	.5	.9
		6.7	2.9	4.5
ALL	OCCASIONAL	7.4	2.9	5.7
	FREQUENT	1.8	.9	1.6
		9.2	3.8	7.3

* Opiates, amphetamines, barbiturates, methaqualone, etc.

Figure: 2 ENLISTED SELF-REPORTED USE (Percentage)
(MARIJUANA) (AUG 77)

		First Term Soldiers	Career Soldiers	All Soldiers
SINGLE	Occasional	25.2	19.8	24.2
	Frequent	19.9	10.0	18.2
		45.1	29.8	42.4
MARRIED	Occasional	20.6	9.0	13.1
	Frequent	12.6	3.9	7.0
		33.2	12.9	20.1
ALL	Occasional	23.8	11.4	18.6
	Frequent	17.7	5.3	12.6
		41.5	16.7	31.2

Figure: 3 COMPARISON OF SURVEY AND MILITARY POLICE HARD DRUG DATA

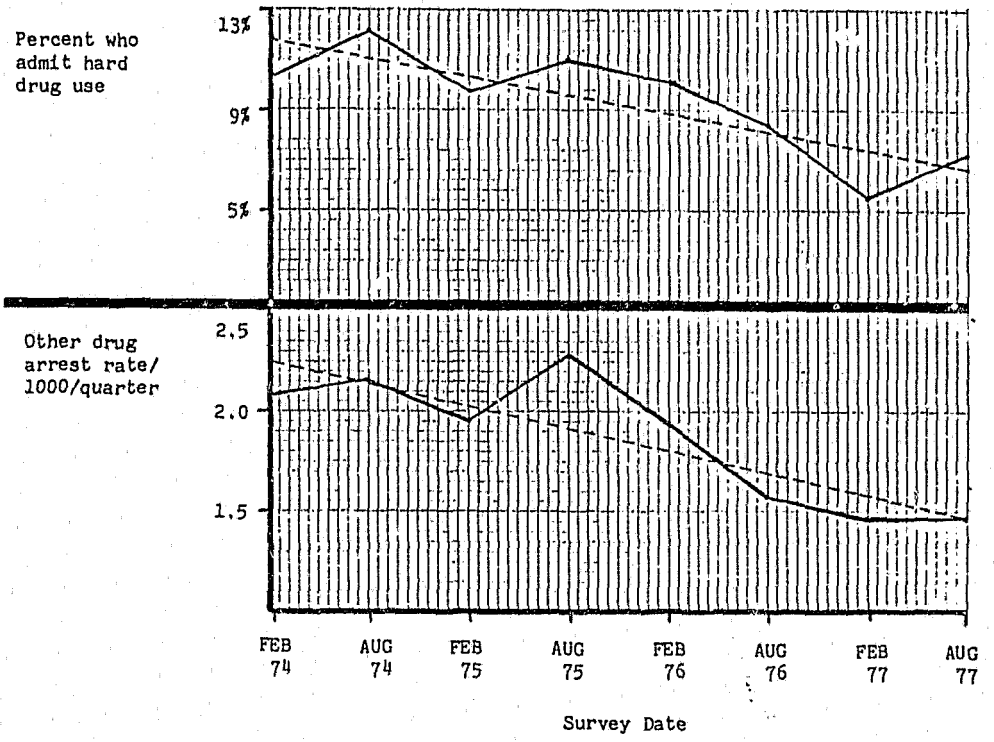
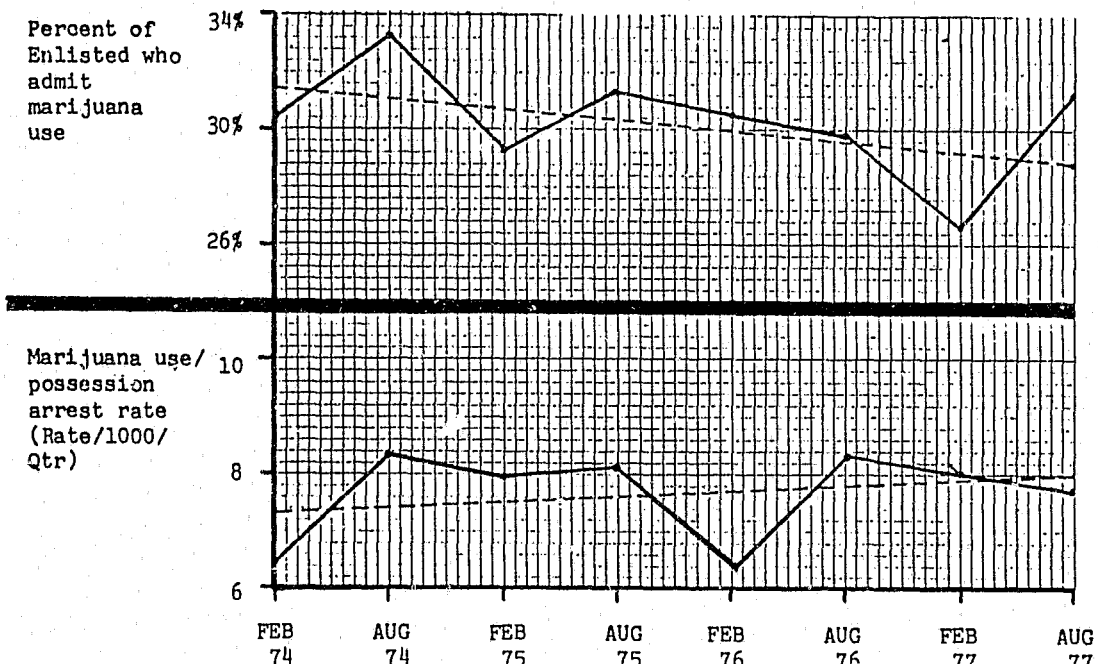


Figure: 4 COMPARISON OF SURVEY AND MILITARY POLICE MARIJUANA DATA



drugs, barbiturates, and cocaine as the least abused drug. Figure 5 is a graphic portrayal of our caseload trends over the past four years.

However, the number of persons clinically confirmed and entered into the program for cannabis abuse was relatively stable during all four quarters of 1977 and is down 1.5 points in the 1st quarter 1978 world-wide. In Europe, cannabis is down 5.2 points. Opiates are down 0.4 points in the 1st quarter of 1978 world-wide and down 1.1 points in Europe for the same period.

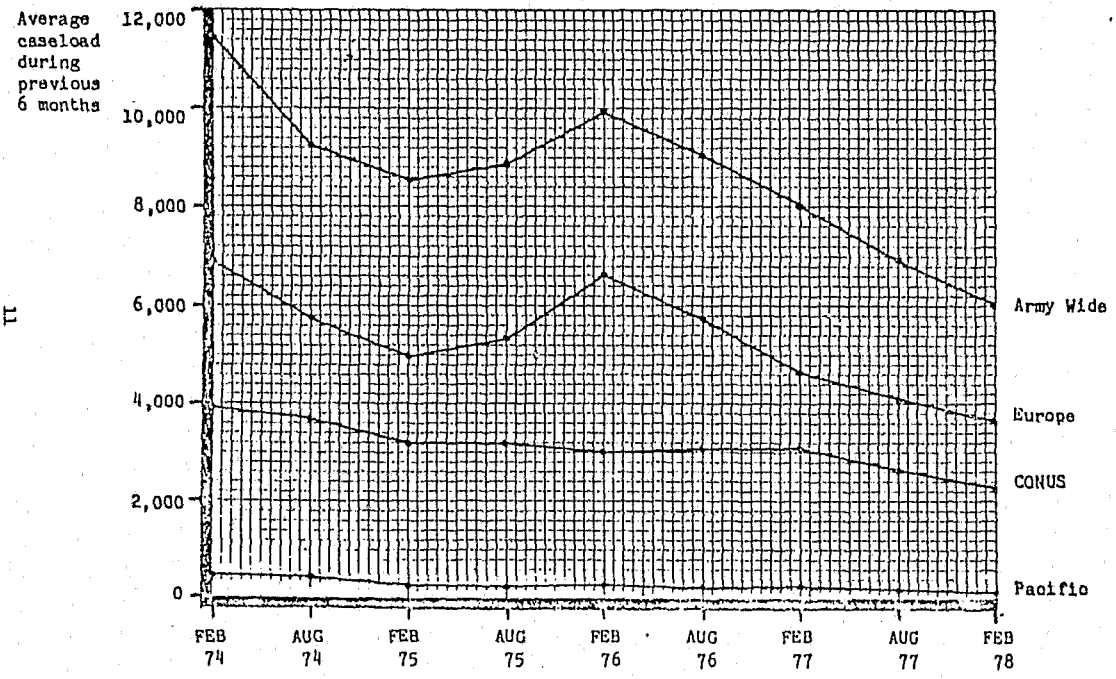
During the 2nd Quarter FY 78 the drug abuse confirmation rate for commander-directed urinalysis increased to 57.0% of all laboratory positives from the previous quarter's rate of 50.9%. Europe's confirmation rate for command-directed urinalysis increased to 62.0 percent from the previous quarter's rate of 55.9%. In the 2nd quarter FY 78, there were 29,504 command-directed urine tests Army-wide.

Interpretation of Data.

Given the data shown above, how does the Army view its drug abuse problems? While the current problems are in no manner comparable to those of several years ago, they are serious and cause us concern. Even small percentages of abusers amount to thousands of soldiers. Does this suggest there is something drastically wrong with the Army? The answer to this latter question must be given in the context of a broader demographic analysis.

Figure: 5

TRENDS IN ADAPCP CASELOADS (OTHER DRUG CASES)*
(BY GEOGRAPHIC AREA)



*including marijuana

To do this, we must first compare the composition of the Army with the composition of society as a whole. There has been much research to determine those elements of society which seem to present high risk for indulging in drug abuse. For instance, studies have shown that the 18-25 year old group is the segment of our population in which there is the greatest incidence of drug abuse. Within this age group there is greater incidence among males than females. The Army has a higher concentration of 18-25 year olds than society in general, and they are predominately male. Studies have shown that within the age group 25 to 30 and over, alcohol is most frequently chosen as the drug of abuse; however, both groups show a high propensity for poly drug abuse. (Poly drug abuse is usually the combination of alcohol with other drugs such as barbiturates or amphetamines.) Our data substantiate these studies. This information tells us that before alcohol and drug abuse trends in the Army can be related to those in society, the samples must be weighted to take into account the fact that the composition of the Army presents a sample that contains all those groups known to have the highest incidence of abuse.

Secondly, it is very difficult to compare the drug problem in European cities with the drug problem in U.S. cities. Availability of drugs, enforcement, laws, attitudes toward drug abuse, economic conditions and so on are all different.

Answered in the context of the above analysis, the Army views its drug abuse problems as serious, but not of epidemic proportions. The abuse does have some degree of adverse impact on combat readiness, but it is difficult, if not impossible, to establish a definitive causal relationship that can be quantified. As your Committee survey indicated, most personnel consider that it does have some impact.

The Army Program

The Army views the problem of alcohol and drug abuse as a personnel problem. The Deputy Chief of Staff for Personnel has the proponency for the program and places the day to day responsibility for operation upon individual commanders at the grass-roots. This is the basis for our referring to the program as a "Command" program. Commanders are responsible for the men and women in their units and the involvement of leaders at the grass roots is the key to the program.

The Deputy Chief of Staff for Personnel has general staff responsibility for plans, policies, programs, budget formulation, law enforcement and behavioral research pertaining to alcohol and other drug abuse in the Army. The Surgeon General supports the Alcohol and Drug Abuse Prevention and Control Program with clinical resources (both manpower and facilities), statistical data, technical assistance, and medical research.

The Office of the Surgeon General, provides medical consultation services to the alcohol and drug abuse program at the Headquarters, Department of the Army level. The office develops Army Medical Department

policy for the program and serves as the point of contact for all matters pertaining to Medical Department support of the alcohol and drug abuse prevention and control program; advises and assists the Army staff in the development of policies and regulations on the abuse of alcohol and other drugs; monitors the laboratory support provided on a tri-service basis for the Department of Defense drug abuse testing program; and establishes objectives and goals, specifies priorities for action, coordinates and tasks the subordinate commands on all Medical Department aspects of the program.

The Army Medical Research and Development Command conducts medical research on the impact of drug abuse on human performance in areas unique to the Army's mission.

The Academy of Health Sciences provides training in drug abuse prevention and control to physicians and other Medical Department personnel in their basic entry courses. It also conducts the US Army Drug and Alcohol Rehabilitation Training and US Army Alcohol and Drug Abuse Team Training courses for counselors, alcohol and drug control officers, and other persons working in the alcohol and drug program.

The Army Medical Commands (Health Services Command; Medical Command, Europe, Eighth US Army, etc.), through their Medical Centers and Medical Department Activities, provide laboratory support for the Department of Defense drug testing program, detoxification and inpatient treatment services, clinical consultants, physicans to perform clinical evaluations, and detail clinical directors, professional and paraprofessional counselors to the individual programs.

They also provide technical supervision of the professional medical aspects of rehabilitation, in-service training of the rehabilitation and counseling staff, and establish procedures for the control of abusable prescription drugs. Additionally, Health Services Command is the statistical data repository for the alcohol and drug abuse prevention and control program.

Alcohol and Drug Control Officers, who manage the program at the local level, Civilian Program Coordinators, and all other administrative and clerical personnel are assigned to the programs by commanders.

From its inception, the Army has operated the program as one which combines treatment and rehabilitation for alcohol and other drug abuse within the same facility, utilizing the same services as required. This has ensured that cases are managed on an individual basis with equal resources available. One cannot say that abusers of one substance are given preferential treatment over abusers of any other substance. This management philosophy was adopted for several reasons: (1) it is the most economical way to provide services and makes maximum use of personnel and resources, (2) the problem has always been one of poly drug abuse in which there is abuse of more than one drug or the use of alcohol with other drugs and (3) the caseload in our program is approximately 49% alcohol abuse to 51% abuse of other drugs.

As you are probably aware, the 1977 Conference Report of the House Appropriations Committee specifically instructed military

drug and alcohol programs that one-half of the $56,400,000 currently being spent on drug abuse should be shifted to alcohol abuse programs. It further stated that the resources made available by the termination of random urinalysis should be redirected to the alcohol abuse program. With a program such as the Army's, alcohol abusers had access to the same resources as drug abusers and it just amounted to keeping two sets of books on the program.

Within the Department of the Army, active duty military, U.S. citizen civilian employees, and dependents of active duty military and retirees are eligible to participate in the rehabilitation program. Civilian employees cannot be enrolled on other than a voluntary basis and in the United States, they have an option of using the existing military drug program or approved community programs.

The Army has alcohol and drug facilities and services available at all installations and activities rather than sending clients to centrally located treatment centers. The programs are operated primarily as out-patient facilities with the need for in-patient detoxification occurring in less than 1% of the cases.

In the past, many of the larger Army installations had live-in rehabilitation facilities called half-way houses. Some of these facilities were closed due to lack of cost effectiveness and we are now studying the feasibility of regional treatment facilities that would include facilities for longer term in-patient treatment. These facilities would be utilized on an individual case basis as determined by a physician.

We have stressed Prevention Education, and we provide educational models for the total family to include a Teen Involvement Program for our dependent children.

Alcohol and drug abusers are identified by commander or supervisor referral, medical referrals from treatment facilities, self-referral, law enforcement referrals, and commander directed urinalysis. We believe that in terms of today's drug problem, these methods are relatively successful. Our penetration rate is over 1.0%. In regard to random urinalysis, in 1974 and earlier years of the program when hard drug abuse was at its peak, random urinalysis was a useful tool for identification and, to some extent, it served as a deterrent. In those days the high cost of the procedure was justified because we identified large numbers of abusers. Today, however, abusers are switching to non-test-detectable drugs and out of a thousand tests, we may identify a dozen abusers. We cannot justify the resources it takes to run random urinalysis on a regular basis. In addition, we believe that Commander-Directed testing is an equal deterrent. In assessing magnitude and trends, we find that our survey data is at least equally effective as random urinalysis. Other agencies have reached the same conclusions in their efforts to judge rates and trends of drug abuse. Random urinalysis has other disadvantages. It singles out a particular age group, the effect upon morale is very bad, and it destroys many trust relationships between Commanders and their troops. I have surveyed our major commands within the last two weeks, and the majority of them are still strongly opposed to reinstatement of random urinalysis as we used it prior to October 1976. At the request of this

committee we conducted a two month pilot program at one installation to test all soldiers apprehended. Of 355 apprehensions we had seven confirmed positives.

Our Alcohol and Drug Program is subject to continual monitoring and evaluation in several ways. Staff visits are made by Headquarters DA personnel, primarily to the major commands, because we have limited resources. Assistance visits are provided to individual installations and activities as time and manpower permits. The major commands are given the primary responsibility of monitoring installations within their commands. The Office of the Inspector General routinely monitors our program at both the Headquarters and the major command levels. The Government Service Administration has evaluated our programs for several years and the Civil Service Commission monitors the civilian aspects.

Now let me address the perceptions involving what the Army can and cannot achieve in our treatment and rehabilitation programs. Given the mission of the Army and the ever increasing budget and manpower constraints, we cannot expect to rehabilitate successfully everyone who abuses alcohol and drugs. We are limited to 60 days intensive or "active" rehabilitation and 300 days followup care. We use a variety of treatment modalities, to include Alcoholics Anonymous for those who elect it. We stress early identification because we know those individuals have a better chance to recover within the limitations of the program we can offer. For those who do not appear to benefit from the active phase of our program, the commader is faced with a decision.

If clients are drug dependent and require longer term care than we can provide, we discharge them through a Veterans Administration Hospital, where they have an option to receive the treatment they need. If alcohol or drug abuse is only one of many problems for the individual and it appears that he/she cannot adjust to military life, his/her job performance is consistantly sub standard, she/he constitutes a continuing security risk, or she/he is a danger to himself/herself or others around her/him, we must also discharge her/him. Hopefully, they will avail themselves of existing community resources. We do feel a moral responsibility for our service members and their families and we are continually working to improve their environment. We try to work with the total family through our churches, through improving interpersonal relationships among those of us who work together, through improving the quality of life, improving the command climate and above all, improving the organization and management of the entire system. These improvements are not going to appear instantaneously, but we believe we are making steady progress in the right direction. We hope to make the Army more challenging as a vocation as well as a profession for our members.

Law Enforcement Activities,

A part of the total drug abuse control program in the Army is the Drug Enforcement Activity of our Law Enforcement Division and the U,S, Army Criminal Investigation Command (CID). I would like to review these activities with you briefly.

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It is Department of the Army drug enforcement policy to prevent, eliminate and suppress by every means available, within the constraints of the law, the use, possession and trafficking of illegal drugs to, or by members of the US Army, Department of the Army civilian employees and their dependents. Army law enforcement personnel consider it inherent in their daily duties to detect the use, possession and trafficking of illegal drugs and, within prescribed procedures, to report, interdict and seize all illegal drugs discovered, and apprehend the violators concerned. Army law enforcement officials at all levels are aware of the critical and important nature of the drug enforcement effort and have committed a priority allocation of resources to develop active drug enforcement programs world-wide

To assure an Army-wide coordinated drug enforcement effort, the US Army Criminal Investigation Command (CID) has been given overall responsibility for the Army drug suppression program. In order to provide maximum utilization of skilled investigative personnel and to provide Army commanders the maximum investigative support possible, enforcement responsibilities have been divided. In addition to overall responsibility of the drug enforcement effort, CID investigates all trafficking offenses and the use and possession cases of narcotic controlled substances and cocaine. The military police investigate the use and possession of non-narcotic controlled substances, primarily marihuana.

Each CID unit assigns the number of special agents to drug suppression operations needed to assure an effective accomplishment of the enforcement effort. Joint CID/MP drug suppression teams are formed wherever feasible and operate under the supervision of the CID drug suppression coordinator. All drug suppression operations are closely coordinated with DEA, state and local drug enforcement authorities and foreign police, in overseas areas. Areas of responsibility are closely coordinated with the investigative agencies of the other military services to assure full coverage. Drug suppression activities with civil and foreign authorities must, of course, be within Posse Comitatus restrictions and international agreements; however, always include to the maximum extent possible full exchange of criminal information.

Specialized drug enforcement training for Army law enforcement personnel is primarily provided by the Drug Enforcement Administration (DEA). 53 CID special agents have attended the DEA 10-week Drug Enforcement Officers Academy. Numerous other CID special agents and military police investigators receive basic drug training at the two-week DEA school annually. Additionally, all CID agents and military police investigators receive considerable drug enforcement training in their basic and advanced courses of instruction, as well as during unit or in-service training.

On Army installations within the United States, drug suppression operations are limited to semi-covert and overt activities targeted against wholesale and retail traffickers, and individual users. CONUS drug suppression operations by necessity must be limited by the

constraints imposed by the Posse Comitatus Act and restrictions which preclude the Army's investigation of non-DOD affiliated persons and organizations. On Army installations, civilian drug offenders identified by military authorities are referred to either DEA, state, or local agencies for investigation and prosecution. Outside Army controlled installations, drug enforcement activities must be limited to those situations in which persons subject to the Uniform Code of Military Justice are committing offenses in which a direct Army interest can be established. All other offenses by military persons outside Army controlled installations are the responsibility of the appropriate civilian agency.

Operations in overseas areas are basically similar to those conducted in CONUS, except they may also include covert drug suppression operations targeted at high level trafficking of illegal drugs destined for military personnel in overseas areas. All overseas drug suppression operations must conform to the international agreements providing for the stationing of US forces in the country concerned. Covert drug suppression operations are closely coordinated with DEA and the appropriate law enforcement agency of the country concerned. These operations are also coordinated and approved by both the major US forces commander being supported and the US embassy narcotic coordinator. During such operations, Army law enforcement personnel are precluded from apprehending or involuntarily restraining persons not subject to military jurisdiction, except on US installations or in immediate pursuit of persons committing offenses on US installations.

Law enforcement is a significant, but separate, part of the Army's overall drug abuse prevention effort. Although Army law enforcement utilizes information and statistics provided by other drug abuse activities to predict trends and allocate resources, law enforcement activities must be carefully executed so as not to have a negative impact on rehabilitation activities. Active informant and information gathering programs are operational at all Army installations to develop information which will subsequently result in the apprehension of drug offenders and to seizure of illegal drugs.

Joint Criminal Investigation/Military Police drug suppression teams are operational at most major Army installations. Although problems are encountered from time to time, cooperation with DEA, state, local and foreign authorities is generally excellent worldwide. CID and military police drug suppression activities seized illicit drugs in 1976 of a street value of approximately $29 million. Since January 1977, an additional $44 million of illegal drugs have been seized. Army law enforcement officials realize that they are combating a situation that is not only an Army problem, but also a national and international problem of great significance. Within the constraints of the legal restrictions provided and the resources allocated, Army law enforcement elements are committed to the maximum extent possible in the suppression effort.

Conclusion.

As you can see, a great deal of effort is expended by the Army to contain alcohol and drug abuse. We believe our program is in the full spirit and intent of Public Law 92-129, Public Law 91-616, Public Law 92-255 and the implementing directives of Department of Defense.

We do not contend that our program could not be improved. However, we are under severe resource constraints and it is a constant struggle to insure that scare resources are used wisely. In order to get an objective assessment of our program, in December 1977 we began a comprehensive contract study and evaluation of our entire program. The results of this analysis should be available in early fall.

In your assessment of the drug problem, you have traveled extensively and have made every effort to see things as they are. From your assessment have come some very constructive recommendations, and we appreciate them. The problems we deal with in the Army must be shared by all branches of the government and society. We need your support and hope that you have found a spirit of cooperation as you have visited our installations and activities.

Thank you.

ADDENDUM TO PREPARED STATEMENT OF BRIG. GEN. JOHN H. JOHNS

Mr. Chairman: On May 18, 1978, the Secretary of the Army received a letter in which you requested the Army respond to several specific issues and questions in my prepared statement. In our effort to comply with the Rules of the House of Representatives, to submit copies of the testimony to the Committee 48 hours in advance of our appearance, we had already completed the prepared statement. Therefore, I am submitting this addendum which contains answers to questions not addressed in the basic portion of my prepared statement. The response to question number four is submitted separately to the Committee as a classified Information Paper. The responses in this addendum are keyed to the May 18 letter from Congressman Wolff to Secretary Alexander.

(1) The nature and extent of the present drug problem in the Army is covered in the original statement. However, in reference to the recommendations in the 1975 Arthur D. Little Study (ADL) the following comments are submitted.

The prevalence data for drug use in the ADL study has been used as baseline for subsequent prevalence data. Prevention and control activities are targeted primarily by age-group rather than level of education because we have found that a dichotomy exists. As the data are refined, it appears that the prevalance of abuse is still higher among non-high school graduates.

Program objectives are broadly outlined in Army regulations covering drug abuse. Each major command and installation further defines these objectives in terms that fit local requirements. These are reviewed at least annually and revised as indicated.

Army regulations do provide guidelines defining the role of the installation drug policy council, including criteria for adminstrative effectiveness.

Major command, installation and unit commanders are required by regulation to express their support of the drug program via letter and/or command information media at least annually. Unit commanders are evaluated on their support of the drug program insofar as they are able to contain the problem within their own unit.

Training for middle managers is available to officers and noncommissioned officers in the US Army Alcohol and Drug Abuse Team Training Course as well as through periodic mandatory training and normal career progression schooling.

The responsibility for the dissemination of information on the exemption policy and enforcement of the policy is delegated to the unit commander. Army Regulation

600-85, which contains the details of the policies are distributed down through company level.

The Army is addressing the problem of destigmatizing drug rehabilitation through a systematic review of all personnel policies dealing with the assignment of personnel to sensitive positions. Individuals rehabilitated for alcoholism have been returned to flying status and their security clearances have been retained. However, individuals in the Personnel Reliability Program rehabilitated for alcohol abuse are less likely to be returned to their original positions. They are returned only after a thorough evaluation for required waiver action. Rehabilitated drug abusers are not currently considered for assignment or reassignment to the Personnel Reliability Program.

The Army has a drug education program in operation at installation level. Additionally drug education is required as part of basic training, we probably need more emphasis in this area.

Recommendations on urinalysis testing policies are resolved at DOD level and are currently embodied in the Commander-Directed Urinalysis Testing Program.

The Army recently reviewed its minimum requirements for program counseling personnel which resulted in an upgrading of the selection criteria for alcohol and drug abuse counselors. Furthermore, ongoing studies of the Army program are considering the possibility of counselor training for unit commanders, and a recent human resources development study has recommended development of a specific career program in that field.

(2) Tools currently employed by the Department of the Army to identify drug abusers are addressed in the basic portion of my prepared statement. Commanders of overseas commands and US Army Forces Command are authorized to conduct urinalysis screening of units on either a one-time or recurring basis, as they deem necessary, to ensure readiness of their commands. This screening is a form of commander-directed testing.

A new method under study is the Enzyme Multiplied Immunoassay Technique (EMIT). This is in essence a mobile testing kit which could be valuable for field use in small units, isolated posts or rehabilitation clinics where rapid determination of negatives are required. Within DOD, we are also considering use of the system described above for initial entry screening at Armed Forces Entrance and Examining Stations. Additional testing is awaiting funding, commercial availability of reagents and establishment of appropriate confirmatory tests. The introduction of testing for phencyclidine (PCP) and Cocaine is anticipated in the very near future. To obtain the results we desire may require a "second generation" version of the equipment. The testing and development are being coordinated by the OSD.

(3) Commander-directed urine testing provides a higher level of confirmed laboratory positives and a higher level of clinical confirmations than did the random program. We believe the reason for this is the personal selection process the unit commanders use in determining who should be tested.

Random screens are useful in assessment of use in a population to some degree but the opinion survey provides more valid information. It should be emphasized that data generated by any type of commander-directed tests should not be used to estimate incidence since the individuals are not randomly selected.

(5) Regarding the Army's response to the recommendation in the November 1977 DOD Abuse Assessment Review Group Report for the Office of Drug Abuse Policy, the Army concurred with four of the seven recommendations to retest three or four standard data elements for duug abuse tracking purposes and that DOD should establish the guidelines; we agreed that DOD should identify those areas of research which are valuable for a better understanding of drug abuse; we agreed that DOD should expand the program as it related to civilians and dependents; and we also agreed with the recommendation concerning adequate staffing and funding. In discussing the three nonconcurrences, two dealt with random urinalysis and the other was concerned with a DOD scheduled program of visits. Specifically, recommendation No. 1 was requesting Congress to consider reinstituting random urinalysis. The Army supports the DOD urinalysis program; however random urinalysis is the least desirable as indicated in my basic testimony. Recommendation No. 3 concerned random urine test sampling system along with surveys to assess alcohol and drug abuse. We believe that a spearate program strictly for drug abuse would be cumbersome to operate and probably non-productive. The Army currently provides significant data in regards to survey material, rehabilitation and law enforcement to assist in the assessment of drug and alcohol abuse. Use of urinalysis data without feedback to commanders would degrade its use as a deterrent tool. Further study is not needed.

Lastly, we partially non-concurred with recommdendation No. 6, specifically, that part dealing with establishment of a scheduled program of concentrated field visits. Army policy provides for major command field visits and reviews. My staff visits all MACOM annually to assist in program management. We do, however, suppport a greater emphasis being placed on drug abuse programs at the DOD level.

(6) Army personnel being assigned to certain sensitive areas are screened thoroughly to assure that only our best and most reliable soldiers are assigned to these areas. For examples, such procedures are in effect for Berlin in Europe and the Demilitarized Zone (DMA) area in Korea. Additionally, local commanders reassign problem soldiers.

Soldiers are given comprehensive briefings as part of their processing for overseas shipment. Where appropriate, information and education about drugs are included in these briefings. This briefing procedure is again conducted as part of in-processing by the overseas command when the soldier arrives in-country.

There are some indications that the tour length in Europe (especially Germany) for the first-term single soldier may cause morale problems and contribute to the abuse of drugs. The Army is currently studying alternatives to the current 3-year tour for single first-term soldiers. We have progressed to the point of analyzing the advantages and disadvantages of shorter tours. I do not know yet what the final decision will be. There are factors, such as cost, turbulence, and impact on stateside tours which will be considered carefully. The Army is currently studying its command climate and Quality of Life, to include Europe.

(7) When the Vietnam era passed, the Army recognized that soldiers remained involved in similar patterns of drug abuse which affect the civilian population from which they are drawn. In view of such concern about the unique life style of soldiers and 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 rather broad spectrum of information about military life and the conditions as they relate to the initiation, spread, and control of drug abuse within the environment of the Army.

A method used by WRAIR was the use of participant observers who actually live in military units. Their methods also involved intensive interviews with soldiers and their families, commanders, etc. In addition they analyzed the interface between drug abuse and various systems on post. A primary focus of their system analysis 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 finding which emerged from the Walter Reed data as it is 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 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. 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 perception, 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.

Several other findings which emerged from the WRAIR studies have already been presented to Representative English and his staff by Col. Harry Holloway, former Chief of WRAIR's Division of Neuropsychiatry. Unfortunately, the remainder of those data which attempted to assess further the nature and extent of drug use as related to the life style of the soldier are not available because the funding for the completion of that study was terminated by Congressional action in fiscal year 1976. It was terminated before the pilot phase of the study could be replicated at various installations in CONUS and at Army Posts overseas.

The drug abuse research programs of WRAIR were never directed at the development of new treatment modalities. The extent of WRAIR's involvement in treatment effect were limited to assuring that Department of the Army (DA) would have the data required to make informed choices regarding the adoption of treatment methods developed by Department of Health Education and Welfare (DHEW) for application in the civilian sector. WRAIR also provided a review of treatment program in CONUS and OCONUS to assure that these were consistent with the then state of the arts as perceived by DHEW. Frequent direct coordination with DHEW was effected during the time frame (1970–71) of these evaluations. Methadone maintenance is an example of a useful civilian treatment strategy, developed for severely addicted opiate abusers, which WRAIR studies indicated to be inappropriate for the young, largely non-addicted, soldier-user in Vietnam. Therefore, in the treatment arena, WRAIR focused efforts on assuring that the transfer of treatment technology from DHEW to DA was a rational process which took into account the uniqueness of the military drug problem,

The results of WRAIR's research efforts were presented repeatedly to military professional audiences, drug abuse conferences, military briefings and completed aspects of the study were published in scientific journals. In all cases materials were forwarded through appropriate command channels for distribution to military consumers.

With termination of 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 school.

(8) The Army has no established criteria to determine what level of drug abuse in a unit or installation constitutes a negative impact on combat readiness. Alcohol/drug abuse is not a specific criterion for measurement on the "Unit Readiness Report". This report allows commanders to provide narrative comments on factors affecting readiness. However, as far as we are able to ascertain, the "Unit Readiness Report" has not been used as a medium for reporting the impact of drug or alcohol abuse on readiness.

(9) Regarding the impact of the declining level of education, of the average recruit in the Volunteer Army on the levels of substance abuse, the Army data available tend to show that drug use is correlated to age, living conditions (in Barracks versus off-post) and environment (availability, local laws). The study conducted by the

Walter Reed Army Institute of Research (WRAIR) 1972-76 concluded that the poulation at highest risk for illicit drug use consists of soldiers under 25 serving their first tour of duty and living in the barracks; that standard descriptions like race, education, intelligence and socioeconomic status are neither significant nor reliable correlates of reported use; and that most of the population at risk had been initiated or exposed to illicit drug use before entry into military service. Data, obtained through Army surveys and urine testing, tend to confirm the earlier study as it relates to age and the soldier living in the barracks (single).

Analysis of self-reported drug use data in August 1977 indicates an inverse relationship between drug abuse and educational level. As shown in figure 6 soldiers (both first term and career) who are non-high school graduates reported a higher use of both marihuana/hashish and hard drugs than the high school graduate.

Figure 6 is an analysis of self-reported drug use data collected during the August '77 Quarterly Survey of Military Personnel (8408 enlisted respondents randomly selected) indicates inverse relationship between drug abuse and educational level.

FIGURE 6

	Frequency of use		
	Never	Sometimes	Frequently
(1) SELF-REPORTED USE OF MARIHUANA/HASHISH (BY PERCENT)			
First term soldiers:			
Nonhigh school diploma graduates	52.3	26.0	21.7
High school diploma graduates	61.1	23.0	15.9
Career soldiers:			
Nonhigh school diploma graduates	81.0	12.0	7.0
High school diploma graduates	84.3	11.1	4.6
(2) SELF-REPORTED USE OF HARD DRUGS—DEFINED AS HEROIN, LSD, ET CETERA (BY PERCENT)			
First term soldiers:			
Nonhigh school diploma graduates	86.0	10.7	3.3
High school diploma graduates	93.0	5.9	1.1
Career soldiers:			
Nonhigh school diploma graduates	95.0	3.8	1.2
High school diploma graduates	96.7	2.5	.8

We do not have data comparing mental categories to rates of drug abuse.

We need to do more researching of these areas to determine cause relationships and development of strategies to deal with them.

(10) The question concerning a general assessment of the overall problem of drug abuse as it relates to the military environment is addressed in my basic prepared statement.

(11) There is certainly a potential for DOD members and DOD transportation systems to be involved in drug trafficking and smuggling. This threat has been recognized and a number of actions have been taken to deter military members from engaging in these activities. The overseas commander has responsibility and authority for establishing a Military Customs Inspector (MCI). Programs cover the movement of:

(*a*) *Personnel and accompanied baggage:* Inspected by MCI personnel at the aerial port of embarkaton.

(*b*) *Second, third and fourth class mail:* Inspected as required by military mail and MCI personnel in accordance with postal requirements.

(*c*) *Household goods and unaccompanied baggage:* Inspected by MCI personnel under the control of local transportation officers.

(*d*) *Retrograde cargo:* Inspected by MCI personnel at retrograde collection points and cargo ports of embarkation (surface and air).

The effectiveness of these inspection programs is rated excellent. Although a number of seizures in small amounts of drugs have been made, to include hashish, marihuana, and other dangerous drugs, no commercial scale smuggling by military personnel has been identified by the US Customs Service.

Training requirements for MCI personnel are specified in the DOD Regulation regarding Customs procedures (DOD Reg 5030.49R). Training is accomplished by the following means:

(*a*) US Customs approved formal classroom instruction.

(*b*) On-the-job training under the supervision of military and US Customs Advisors.

Each MCI is issued a distinctive stamp which allows quality control audits of all inspections made by that person. Additionally, periodic inspections of MCI programs overseas are made by officers for Headquarters, Department of the Army and senior officials of the US Customs Service.

Personnel selected for duty as military customs inspectors are screened to ensure that they are properly motivated, have no record of undesirable traits, and possess the hightest standards of personal integrity.

(12) The spread of heroin use in Vietnam during 1970 became a dramatic and tragic instance of a massive epidemic of illicit drug abuse. It appears that the conditions for a true drug epidemic among soldiers are:

(*a*) A significant level of illicit drug use in the civilian population from which soldiers are drawn.

(*b*) The existence of mechanisms for the maintenance of illicit drug use in the military.

(*c*) The availability of a socially or pharmacologically highly desirable drug in large quantities at a cheap price.

(*d*) The spread of drug use through informal friendship networks created by the living circumstances and work relationships within military units.

To date it cannot be said that there is a direct relationship between availability and usage rates because: (1) usage rates, per se, are hard to assess accurately and (2) usage rate is affected by variables other than availability. It is difficult to gauge usage rate since the majority of use occurs off-duty, in private social settings and in modes which do not, generally, come to the attention of military authorities. Variables other than availability which affect usage rate are geographic location of installation, drug-related attitudes of soldiers, marital status, and locus of dwelling.

Drug abuse has become an endemic aspect of the military/barracks environment in a similar manner that it is endemic within the wider civilian sector. Army personnel, particularly younger enlisted men represent a special class of drug abusers. Because they are primarily young men, living away from home, they present differences in levels and patterns of risk, types of problems associated with drug use, and the kinds of performance required of them as compared to their civilian peers. The special ways in which the individual's behavior is organized in relation to his fellow soldiers within military units and barracks and the distribution and mobility of military members lead to contacts with an informal expertise about the use of a wide spectrum of drug agents. An hypothesis to be tested is that unit characteristics which encourage and maintain informal friendship ties which generate trust and intimacy increase the chances of high drug use. Accordingly, the better unit members know one another and the more time they spend together working and relaxing the more likely they are to abuse drugs when availability permits.

The development of group cohension or camaradarie among soldiers is a continuing goal of the Army. It may also be the crucial locus of the Army's effort to intervene in the abuse of illicit drugs. Cohension promotes peer influence. If the informal (peer) leaders of groups have values which are conducive to the control of drug abuse, such abuse will be discouraged. If their values are not conducive to such control, drug abuse will be encouraged.

(13) Concerning the number of drug abuse offenders prosecuted from 1969 to 1977 under the Uniform Code of Military Justice (UCMJ) including nonjudicial punishment and courts martial is shown below. I would like to point out that these statistics include all UCMJ case dispositions, including acquital cases.

SOLDIERS PROSECUTED BY COURTS-MARTIAL AND PUNISHED UNDER ARTICLE 15, UCMJ, FOR DRUG RELATED OFFENSES

Calendar year	Article 15's	Summary courts-martial	Special courts-martial	General courts-martial	Total courts-martial
1969	3,005	408	2,961	246	3,615
1970	3,968	406	2,796	274	3,476
1971	4,579	624	2,287	395	3,306
1972	4,186	591	1,141	333	2,065
1973	9,890	568	1,714	355	2,637
1974	13,396	519	1,944	507	2,970
1975	15,074	338	1,512	571	2,421
1976	16,323	415	1,647	592	2,654
1977	16,538	264	1,095	340	1,699

(14) Where small amounts of drugs are involved, the Drug Enforcement Administration, and State and local police, frequently decline to pursue an investigation because they are advised by civilian prosecutors that, regardless of the evidence uncovered, the case probably will not go to trial. Reluctance of Federal, State and local authorities to prosecute minor offenses is essentially a problem with no foreseeable solution. As long as civilian criminal dockets remain crowded, selective prosecution is necessary and a number of minor offenses must be pushed aside without action. The problem can be eased, if not solved, by providing more resources to all aspects of enforcement; investigative, prosecutorial, judicial and correctional.

Generally, there are no problems in detaining civilian offenders on Army installations for the purpose of turning them over to civilian police. This authority is derived from the Secretary of the Army's authority, under Section 3012, Title 10 of the United States Code, to conduct the affairs of the Army. Logically, such authority includes the power to maintain law and order on Army installations. Brief detention of civilian offenders under these circumstances has consistently been upheld in the Federal Courts, most recently in the 1976 Federal Court of Appeal's decision in United States versus Bank (539 F2d 14). Decisional law is clear that these acts by the military do not violate the Posse Comitatus Act. Any civilian offender who is detained on-post for an alleged criminal violation is released to the appropriate civilian authorities as soon as possible. If the alleged offense is a minor one and civilian authorities do not wish to pursue the matter, then further military involvement is limited. The installation commander may elect to bar the offender from reentering the installation, meaning that any subsequent reentry will result in a violation of Section 1382, Title 18 of the United States Code. Legislation—SG 2491—proposed by Senator Williams of New Jersey would ameliorate enforcement and investigation problems in cases of this type by providing arrest authority to military law enforcement personnel.

Overseas, Army drug suppression efforts are restricted by Section 2291(c), Title 22 of the United States Code, which prohibits any U.S. law enforcement personnel from engaging or participating in direct police arrest action in a foreign country with respect to narcotic control efforts by civilian authorities there. The purpose of this law is to keep U.S. personnel away from foreign civilian law enforcement activities where violence or use of force can reasonably be anticipated. It should be noted by the Committee that the Senate is presently considering a proposed amendment to the Foreign Assistance Act of 1961—S. 2846—that would restrict even further overseas efforts to control the flow of illicit drugs to U.S. forces. The proposed amendment reads as follows:

"(c)(1) notwithstanding any other provision of law no officer or employee of the United States may engage or participate in any direct police activity or operation, including any arrest action, interrogation of any person arrested, undercover surveillance, or purchase of information or evidence in any foreign country with respect to narcotics control efforts."

These proposed restrictions go far beyond the purposes of current law to avoid putting U.S. personnel in potentially violent civilian arrest situations. As for military jurisdiction to prosecute drug offenders on active duty, in O'Callahan versus Parker (395 U.S. 258 (1969)) the Supreme Court held that Courts martial possess no jurisdiction to try offenses which are not "service connected." In United States versus Beeker (18 USCMA 563, 40 CMR 275)—a 1969 military decision that followed *O'Callahan*—the Court of Military Appeals, which is composed of three civilian judges and is the military's highest appellate court, adopted the armed services' contention that drug offenses posed special dangers to the military community and held that such offenses, whether committed on or off-post, generally were service

connected. Military decisional law remained unchanged until 1976. Then, in United States versus McCarthy (2 MJ 26 (CMA)), the Court of Military Appeals altered its position and held that off-post, off-duty drug offenses by service members did not *per se* pose special dangers to the military community. Absent factors such as formation of criminal intent on post, some nexus between an accused service member's duties and the offense, or a demonstrable threat to the military community, beyond the bad effects on individual soldiers from off-post drug abuse, the Court of Military Appeals is unlikely to find the service connection that is a requisite for court-martial jursidiction over off-post possession, sale, or transfer of drugs. As a result, military prosecutions are curtailed. Our task is to try to convince the Court of Military Appeals that there is a service connection, and thus military jurisdiction, in all instances of drug abuse and drug traffic by service members.

Recommendations:

Some additional recommendations that were not discussed in answering your specific questions that would assist in strengthening the Army's efforts in drug and alcohol abuse prevention and control are as follows:

Make it clear that the Department of Defense is authorized and expected to conduct behavioral research in Alcohol and Drug Abuse. Fund the requests for behavioral research in Alcohol and Drug Abuse. Fund the requests for behavioral science research.

Comment: The unique population, living conditions and mobility of the service-member, makes military sociology distinct from sociology, in general. There are factors in the military environment which maintain and extend drug abuse. These factors can only be identified through research conducted in military organizations. They cannot be identified by research on the civilian population, at large. Additionally, we need to know more about the effect that drug abuse has on individual and unit readiness and the potential for breakdown in discipline during deployment and mobilization.

Examine the feasibility of making one committee in each the House and Senate responsible for oversight of alcohol and drug abuse in the military on a continuing basis. Possibilities are the manpower and personel subcommittees of HASC and SASC.

Such an arrangement as suggested above, would facilitate dialogue between the DOD and the military departments with Congress on a continuing basis to insure that programs are addressing current and future needs. During the past few years, there has been sporadic emphasis by different committees. For example, in 1976, HAC and SAC directed specific action with respect to funds to be used in alcohol programs. Of course, this select committee's emphasis has been on drugs, other than alcohol. This is not meant to suggest any criticism or to imply that we have been hampered in any way. The Congress has been quite liberal in the funds it has allocated. What is being suggested is that we would like to be able to communicate our progress, problems and needs on a continuous basis. This would enable us to carry out our responsibilities in a more planned and programmatic fashion and be responsive to the will of the Congress.

The recommendations the Army has made are only those which have implications for the Congress. This is not meant to imply that there is no corrective action necessary on the Army's part. The efforts of your select committee have pointed our several areas where we need additional work:

(*a*) The relationship of drug abuse to combat readiness and deployment capability. We need to develop better tools of measurement.

(*b*) The extent of the problem. While we think our surveys, law enforcement data, urinalysis program and caseload reports provide good indicators, we realize the state of the art doesn't allow us to know for certain the extensiveness of the problem.

(*c*) As indicated in my basic statement we are in the process of evaluating the entire Army alcohol/drug program. I am sure that some changes will become apparent as a result of these studies, since our program has operated virtually unchanged (with exceptions of terminating random urinalysis) for the past six years.

A major goal in the coming year will be to increase our emphasis and make more effective our efforts in the area of preventive education. We believe this is the most important area to develop commanders' and soldiers' awareness of the effects of alcohol and drug abuse. Accordingly it provides them with some of the necessary tools to make responsible decisions about such use. We will continue to pursue the goal and refine our educational modalities so that they will meet the unique needs of the Army and its personnel. Rehabilitation, treatment and identification are important parts of the Army's program. However, we believe that better inroads in controlling the drug problem can be made through preventive education.

PREPARED STATEMENT OF BRIG. GEN. WILLIAM H. FITTS, DEPUTY CHIEF OF STAFF, PERSONNEL, HEADQUARTERS, U.S. ARMY, EUROPE, AND 7TH ARMY

BIOGRAPHICAL SKETCH BRIG. GEN. WILLIAM H. FITTS DEPUTY CHIEF OF STAFF, PERSONNEL

William H. Fitts was born in Bedford, Indiana, May 30, 1928. In 1951, he was commissioned a 2LT, Adjutant General's Corps and ordered to extended active duty with the Active Army. He entered the Army from the State of Georgia.

BG Fitts is the recipient of a Bachelor's Degree in Business Administration from the University of Nebraska at Omaha and a Master of Business Administration (MBA) from George Washington University. He completed the Management Program for Executives at the University of Pittsburgh in 1973. General Fitts has completed a wide range of military schooling including courses in personnel management, postal operations, instructor training, ADP systems analysis, as well as the career course at the U.S. Army Adjutant General School. He was the honor graduate of his AG Career Course. He is a graduate of both the U.S. Army Command and General Staff College and the U.S. Army War College.

General Fitts has served in a broad spectrum of assignments at levels ranging from division to Department of the Army. His assignments include:

Instructor—U.S. Army Adjutant General School

Branch Chief—The Adjutant General's Office, HQ DA

Commander—USARPAC Data Processing Unit

Adjutant General and Assistant Chief of Staff, G1—1st Cav Div (AMBL) in RVN

Director—Headquarters, DA Military Systems Directorate, Personnel Information Systems Command, Deputy Chief of Staff for Personnel, HQ DA

Adjutant General, U.S. Army, Pacific, Honolulu, Hawaii

Commander, USAMILPERCENEUROPE and Adjutant General, HQ USAREUR & 7th Army

His current assignment is Deputy Chief of Staff, Personnel, Headquarters, United States Army, Europe and Seventh Army.

General Fitts is the recipient of more than 26 individual service and unit decorations including four awards of the Legion of Merit.

Mr. Chairman, I am pleased to be here to address the issue of drug abuse within U.S. Army, Europe, and Seventh Army, or USAREUR.

USAREUR's program of drug abuse prevention and control consists of several components. I will briefly describe each of these components as a means of providing you with our assessment of the problem and the results of our efforts to deal with it.

The first component, and the one which poses perhaps the greatest challenge, is problem assessment; that is, assessing the extent and seriousness of the drug problem within the command. To make our assessment, we track several indicators which give us trend data on such things as the availability and potency of the various drugs; sale and trafficking activity; the rate and frequency of abuse of each type drug; and the impact of drug abuse on the command. Taken together, these and other data provide us with a comprehensive assessment of the magnitude and trends of the drug problem over time. We obtain these data from various sources. For example, our principal source for estimating the rate and frequency of drug abuse is the USAREUR Personnel Opinion Survey or UPOS. This survey is administered twice yearly to a representative sample selected at random from among the USAREUR military population. Comparisons between the survey and random urinalysis data were made in 1976. On the basis of these comparisons and other research it is our judgment that this survey is a reliable tool for estimating drug abuse. Within the UPOS, we consider the data on monthly or more frequent use to be the best indicator of the extent of drug abuse.

Our current assessment of the drug problem in USAREUR is as follows:

Availability

Hashish is the drug most readily available. The availability and purity of heroin rose throughout the latter part of 1977 after a temporary shortage in the first quarter. The availability of other hard drugs remains relatively stable although we have seen attempts to enlarge the cocaine trafficking network. So called "hot spots" of availability have been identified and I can provide you with that data if desired.

Sale and trafficking

The U.S. serviceman is considered a relatively insignificant contributor in the overall drug trafficking problem in Europe. U.S. Forces involvement in sale and trafficking primarily consists of individuals who acquire relatively small amounts of drugs for their own consumption and that of fellow soldiers. Sixty percent of the military personnel apprehended by the Army CID in Germany for sale and traffick-

ing in 1977, were trafficking cannabis; on the other hand, 63 percent of the civilians apprehended were trafficking narcotics, i.e., opiates/cocaine.

Abuse

As I mentioned previously, we consider monthly or more frequent use to be the best indicator of the extent of drug abuse. All abuse figures which I will mention are based on this frequency and are expressed as a percentage of the total USAREUR population. Cannibis abuse declined from an estimated 21 percent of the force in September 1974 to 15 percent in August 1975; it rose to an estimated 19 percent in April 1977 and remains at that level in our latest survey.

I will now address the use of hard drugs. These include amphetamines, barbiturates, narcotics, hallucinogens, methaqualone, opiates, and phencyclidine or PCP. Data on PCP was first obtained in our January 1978 survey so the trend data I will give you will not include PCP. The abuse of dangerous drugs declined from 1974 (9.8 percent) through calendar year 1976 (5.2 percent), then rose in 1977 (6.7 percent) and again in January 1978 (7.1 percent). When PCP is included, the abuse estimate for January 1978 is 7.8 percent. Shifts in drug popularity over time are clearly evident. For example, opiates (heroin) have declined from one of the most popular drugs in 1974 to one of the least popular in early 1978.

Analysis of drug abuse by rank reveals that 88 percent of all cannabis abuse and 91 percent of all hard drug abuse occur within the lower enlisted (E1–E4) rank group. Strong relationships also exist between drug abuse and age, education, and ethnic groupings.

Impact

The impact of the drug abuse problem is expressed in a number of ways. For example, the impact on the individuals involved can be tragic and can range from administrative discharge, to court martial, hospitalization, and, of course, even death. These impacts on the individual have corresponding impacts on the command in terms of resources, morale, and unit effectiveness. However, the impact on the overall effectiveness or preparedness of the command is judged to be minimal.

In the interest of time, my description of the remaining aspects of our program will be much more brief.

The next element of our program is prevention. Our efforts in this area are focused on disrupting the supply of drugs, educating our people on the nature of the drug abuse problem and how to combat it, providing alternatives to drug abuse through enhanced life support programs, reducing boredom and dissatisfaction, and pursuing a vigorous program of activities which act as deterrents to drug abuse. I will touch very briefly on just a few of these efforts.

In the area of suppression, the USAREUR Provost Marshal and the Commander, Second Region, U.S. Army Criminal Investigation Command, are both represented on the Permanent Working Group (Drugs) sponsored by the FRG Bundeskriminalamt (BKA). This group serves as forum for coordinating suppression activities among the central European countries and is increasingly effective. For example, seizure statistics for 1st Qtr 1978 are slightly ahead of the 1st Qtr 1977. Combined operations with German agencies are greatly exceeding the 1977 effort.

With regard to education, we have separate programs for individual soldiers, commanders, and the people involved in operating our prevention and control program. For example, one of the difficulties in combating drug abuse is the differences among individual commanders in the way they perceive and react to the problem of abuse. We attempt to minimize these differences through a mandatory training program for commanders.

Finally, in the area of prevention, I would mention just one of the activities we consider a deterrent—urinalysis. We recently implemented procedures to perform urinalysis of all personnel in selected company-size units. These procedures provide for the testing of the entire unit when it is determined that such testing is warranted. To further improve the urinalysis program, we are investigating the possible use of a portable urinalysis device to provide the commander with a capability of more rapidly assessing drug usage levels. We anticipate that these initiatives will provide the command a valuable tool in deterring abuse as well as measuring its extent and identifying individual abusers.

The third element of our program is identifying individual abusers. Basically there are five ways in which an abuser can be identified: urinalysis, self-identification, identification by his commander/supervisor, apprehension by law enforcement authorities, and incident to medical care. Our data back to 1973 indicate that no one identification method can be singled out as being the most effective means of identification. Our overall effectiveness in identifying abusers and entering them in a program of rehabilitation cannot be precisely measured from the data available to

us. The data indicate, however, that a large proportion of individual abusers of both hard drugs and cannabis are identified and entered in a program of rehabilitation. It is also evident that a large amount of drug abuse is recreational as opposed to serious addiction. Thus many individuals constrain their abuse to periods and frequencies such that their job performance is not affected. The ability of any system to identify these recreational abusers is necessarily limited.

The final component of USAREUR's program is rehabilitation. Within USAREUR we have 80 non-resident treatment centers and five resident extended care facilities. In 1977, a total of 6,149 individuals entered a program of non-resident rehabilitation and 284 individuals were admitted into the resident facilities. Also during 1977, 3,647 USAREUR soldiers failed to successfully complete the rehabilitation program and 3,660 USAREUR soldiers were rehabilitated. Of course many of the soldiers in both these categories actually entered rehabilitation in 1976 so these figures should not be used to compute success or failure rates.

This has been a brief summary of the drug abuse prevention and control program within USAREUR. We view the drug problem in Europe with concern, particularly in view of the increase of availability of heroin, and have taken action accordingly. Our program is a balanced effort consistent with the resources available. We are confident that, to the extent these resources permit, we know the nature of the problem and are combating it.

May I have your questions please?

DRUG ABUSE IN THE MILITARY

FRIDAY, JUNE 2, 1978

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, D.C.

The Select Committee met, pursuant to notice, at 10:05 a.m., in room 2118, Rayburn House Office Building, Washington, D.C., Hon. Glenn English (acting chairman of the Select Committee) presiding.

Present: Chairman Lester L. Wolff, and Representatives James R. Mann, J. Herbert Burke, Robin L. Beard, and Charles B. Rangel.

Staff present: William G. Lawrence, chief of staff; Don Duskie, professional staff member; and Dan Stein, research assistant.

Mr. WOLFF. The meeting will come to order.

We are having hearings on drug abuse in the military, so ably chaired by my colleague and chairman of the task force, Mr. Glenn English of Oklahoma. Our objective in these hearings, gentlemen, is, as I have indicated, not an adversary one. Especially this service, which I hold in very high esteem, the blue suiters; not that I do not hold the rest of the services in high esteem as well.

Our objective is to try to find ways and means of helping you to solve the drug abuse problems which exist in the military. It presents to this Nation, to my mind, a great security threat, especially in very sensitive areas. The information we have received on our own sometimes conflicts with the information that has been given to us by official sources. It is in this vein that we act as an oversight committee in attempting to resolve the differences and attempting to find ways and means of providing the individual services with the resources they need in order to control the problem.

Drug trafficking is just as vicious a weapon in the hands of our adversaries as any other type weapon they might use upon our forces.

Unfortunately, what developed in Vietnam—the degradation that took place in the efficiency of our forces as a result of the ready availability and subsequent abuse of narcotics was one of the elements that undermined the U.S. effort in Vietnam. We certainly do not want a recurrence of those events. The problem of drug abuse continues in our country and the multidrug society we live in today is indicative of the fact we have to go far beyond the idea of just being a policeman trying to interdict every bit of the stuff which is either crossing our borders or being plied upon our people.

It reaches deeper than that. We found that with our military in Europe, it impacts upon the morale of our forces. It reaches into

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host-nation procedures causing problems for our servicemen stationed in those areas.

From what I have learned in the past, there is less abuse of narcotics in the Air Force than in other services. This may have been because of the particular recruitment policy of the Air Force and also because there is more time occupied by the personnel in a service such as the Air Force. However, we are anxious to learn from you as to what you think may be necessary in order to help us to solve this problem.

There are no simplistic answers, we know. But there certainly should not be an effort to sweep this problem under the rug. This is a very, very important problem for our Nation and the security of the American people. The problem of drug abuse is growing worldwide; drug abuse in not just limited to Americans any longer.

The fact is that various countries of Europe and as far off as Australia, have this growing problem affecting increasing numbers of its citizens. In fact it has reached pandemic proportions today. It is far beyond the epidemic category.

Drug abuse erodes the basic structure of Government and can have a disastrous effect, certainly, in such a critical service as the Air Force.

Therefore, we are happy to have you appear before us today to discuss the problem and your recommendations for solution. I now turn the meeting over to the chairman of the Task Force on Drug Abuse and the Military, Mr. Glenn English.

Mr. English [presiding]. Thank you very much, Mr. Chairman.

During the 18 months that this task force has been in existence, we have had opportunities to visit military bases around the world and to receive briefings from all services and major law enforcement groups concerning drug abuse. We are beginning to find that there are three central areas of concern relative to military drug abuse. They are:

(1) Identification and treatment of drug abusers;

(2) DOD, service, and command attitudes toward drug abuse; and finally

(3) Accurate assessment of the nature and impact of the drug abuse problem.

It is our experience at this time that no service can state with confidence that is has a reliable handle on either identification of abusers or assessment of the impact of the problem. I do not expect the Air Force to be any different in this regard.

The question of the attitude of individual base commanders varies greatly from service to service and from base to base. The attitude of the various services toward drug abuse appears to increase and decrease in cycles. The attitude of DOD toward drug abuse appears simply to decline constantly.

We heard testimony from the Army 1 week ago which indicated that their problems were increasing steadily in some areas of the world. We heard that their ability to identify drug abusers had declined for a number of reasons. Soldiers appear to be abusing drugs which are not detectable through urinalysis. Junior commanding officers often lack support from higher authorities to encourage vigorous identification practices. The signals which

everyone is receiving from DOD indicate a reduction in emphasis on this problem. I hope the Air Force is enjoying better success.

We will be especially interested to hear from the Air Force concerning its newly relaxed disciplinary practices concerning first-time marihuana abusers. We also will wish to discuss the impact of drug abuse upon the nuclear personnel reliability program.

General Davis, I am sure that we will have many questions for you after you deliver your statement, so at this time I will ask the chairman to swear you as a witness, and will ask you to deliver your prepared comments.

Mr. WOLFF. Do you swear the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

General DAVIS. I do.

TESTIMONY OF LT. GEN. B. L. DAVIS, DEPUTY CHIEF OF STAFF/PERSONNEL, U.S. AIR FORCE; ACCOMPANIED BY COL. JOHN R. ROGERS AND MAJ. FREDERICK M. BELL

General DAVIS. Thank you very much for your opening comments and your complimentary remarks, Mr. Wolff. I hope we deserve them, and I hope you will find we are very sensitive to the problem of drug abuse; it is a problem.

Also, I hope we will be able to clarify some of your questions this morning. Some of the questions we just may not have answers to, because we have not arrived at all the answers by any stretch of the imagination. I appreciate your opening comments, Mr. English. It is very nice to talk to a fellow Oklahoman again. I hope I may be able to shed some light on your questions.

I have submitted my prepared statement for the record. I have also supplied an addendum which provides answers to the 16 questions which came to Secretary Stetson through your letter, Mr. Wolff. Those will be submitted for the record.

Accompanying me today are John Rogers, consultant to the Surgeon General. He works closely with my staff in the area of drug abuse. To my right is Maj. Mike Bell, who is known to some members of the committee, to Mr. English. He has traveled with the committee, so I believe Mike is very well known to you.

I would also like to point out before I get into my other remarks that on my staff I am very fortunate to have, and I have had him since a year ago, Lt. Col. Frank Pappas, a reservist who is on mandays, who just retired, as the Special Assistant to the Deputy Administrator of DEA. He has been most helpful to us in beefing up our assessment program and especially supplying an important interface between the Air Force, my staff, DEA, and of course we have always had that close interface with our own internal office of special investigations.

Thank you for asking me to appear before this committee to discuss drug abuse in the Air Force.

Drug abuse has been one of the most difficult personnel issues to confront Air Force management since the late 1960's. During the last 7 years, we have developed a comprehensive drug abuse control program which we believe is effectively combating the adverse impact of drug abuse across the Air Force. However, we do not feel we have all the answers to the problem, and for that reason we

have welcomed your investigation and are hopeful that improved drug abuse control programs and an improved environment will result.

"The Current Drug Problem in the Air Force." Our base line for drug abuse prevalency in the Air Force has been the A. D. Little study published in 1975. Upon that foundation we have built a comprehensive trend analysis and assessment system to track abuse trends across the Air Force. In general, since our troops left Southeast Asia, hard drug use has been declining and marihuana abuse has remained relatively stable in the Air Force as a whole. However, the drug abuse trends vary geographically. For example, drug abuse among Air Force personnel in the Pacific has been declining substantially since 1974, with the exception of Guam. I believe the committee goes to Guam in July, so you will be able to get this information firsthand. On the other hand, in U.S. Air Forces, Europe, drug abuse, though above the Air Force average, has remained stable since 1974. Hard drug abuse has been increasing in Germany and, to a lesser extent, Great Britain. Hard drug abuse has declined substantially in our country since 1974, but marihuana use has remained relatively constant.

To cope with these complexities, the Air Force has designed a comprehensive drug abuse threat assessment system to enable us to judge the extent of the drug problem at each of our bases around the world. This assessment system also permits us to (1) develop countermeasures commensurate with the drug threat environment and abuse patterns and (2) monitor our drug abuse control program management.

In turning now to the Air Force drug assessment system.

Purpose: 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.

System structure: The assessment system is composed of three integrated subsystems. One subsystem functions at each base, another at major command levels, and the third at Headquarters, U.S. Air Force.

Base level subsystem: At the base level, the primary assessment system is the Drug and Alcohol Abuse Control Committee (DAACC). This DAACC is normally chaired by the commander or vice commander and consists of representatives from all agencies with responsibility for components of the drug and alcohol abuse control program. For example, members include Office of Special Investigations (OSI); security police; Surgeon General; drug/alcohol abuse control officer; Judge Advocate; personnel; the chaplain; and others. These members review all available indicators of drug abuse and recommend appropriate countermeasures. The indicators they review are incident reports, customs reports, arrest and investigation data, urine testing trends, safety reports, Inspector General reports, anecdotal reports from informed sources, drug trend advisories from higher headquarters, Drug Enforcement Administration (DEA) reports, and other sources. The countermeasures available include intensified investigations, random gate and barracks checks employing marihuana- and heroin-trained dogs, intensified commander-directed and unit-sweep urine tests, educa-

tional and public information campaigns, and a variety of other actions.

The members of the DAACC manage their areas of responsibility in drug abuse control, and provide status reports and briefings to the commander. Basically, they function as a board of advisers for drug and alcohol abuse control. They meet at least quarterly, and the minutes of their meetings are forwarded to their respective major command. The scope of their responsibility is primarily base-level assessment of the drug threat.

Major command subsystem: A Drug and Alcohol Abuse Control Committee (DAACC) also functions at this level. The scope of its responsibility is primarily regional. Membership consists of the major command counterparts to the staff agency participants named at the base level. The drug and alcohol abuse control officer coordinates the DAACC's efforts and manages the day-to-day program at this level. The drug threat assessment tools at this level are extensive and provide comprehensive indicators of patterns of abuse. These tools include DAACC meeting minutes/assessments from each subordinate base, monthly rehabilitation program statistical reports, quarterly narrative analyses of drug program developments, computerized rehabilitation program data, staff assistance visit reports, urine testing reports, OSI and security police reports, safety reports, Inspector General reports, discipline trends reports, and others. Countermeasures employed include staff visits, law enforcement/investigative actions, education/information programs, inspection visits, urine test expansion, customs search intensification, and many other management actions.

Headquarters, U.S. Air Force subsystem: The Drug Abuse Control Office is the focal point at this level. The scope of responsibility is worldwide and regional assessment and development of countermeasure policies and programs. The assessment tools available are the same as those used at the major commands, but they include worldwide information. Additionally, this office works closely with the Drug Enforcement Administration (DEA), employing their weekly and quarterly intelligence reports as well as data from their Drug Abuse Warning Network (DAWN).

This system provides a comprehensive, responsive means of assessing the drug abuse threat at all levels of command and assists commanders in managing the responses to that threat. We are confident that the assessment system enables us to accurately determine the nature and extent of the drug abuse threat, and we continually design and improve countermeasures to meet that threat.

The Air Force drug abuse control program: The Air Force program involves five basic elements: prevention, including education programs, 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 our program objectives through sound management.

The Air Force program was initiated in 1971 with the establishment of the limited privileged communication program (LPCP), analogous to the exemption program previously discussed by the Department of Defense. Urinalysis testing for drug abuse also began in 1971. The social actions career field was initiated in 1971 with the assignment of full-time drug abuse specialists at 141 Air Force installations worldwide. The focus of the program which has evolved since then has been mission support; and rehabilitation has been geared to the maintenance of standards and discipline. The programs have proven cost-effective in terms of returning trained and experienced personnel to productive service, thus reducing replacement/retraining costs. The drug abuse control program applies to all military personnel on active duty and has some application to Guard and Reserve forces as well as civilian employees and military dependents.

Education-prevention: Our primary prevention efforts revolve around the establishment of recruiting standards, effective drug abusers screening programs at the entry level, and the education programs presented to all personnel upon entry into the Air Force, while in attendance at professional military schools, and upon special events such as transferring or assuming supervisory responsibilities. As examples of recruiting standards, the majority of our recruits are mental categories I and II, and those category III and IV personnel we accept must have at least a high school diploma upon entry into the Air Force.

We disqualify for preservice drug abuse between 27,000 and 30,000 Air Force applicants a year. So there is a very stringent prescreening which helps the program. Then the fact we have a very high quality person who enters the Air Force. As a matter of fact, 52 to 53 percent are in the first two mental cateogries. We accept about one-tenth of 1 percent in mental category IV. So we have very stringent drug abuse standards.

We do not accept known drug abusers into the Air Force—any drug abuse within the immediate 6 months prior to enlistment is disqualifying; however, we do accept waivers for marihuana abusers on a case-by-case basis. We have held the line in this area, but the prevalence of drug abuse, particularly marihuana abuse, in the recruiting market, makes quality control at the accession point an increasingly difficult challenge. Our education programs have been built around the recommendations of the A. D. Little study of 1975—that is, our programs have standardized lesson plans presented by trained instructors, are provided at specified times for all personnel, and have specific focuses for specific audiences, for example, separate courses for recruits, supervisors, and general audiences.

Mr. ENGLISH. May I interrupt you for a moment. If I may, we will stop right there and make this vote.

[Recess.]

Mr. ENGLISH. Gentlemen, we are ready to resume. I am sorry for the interruption.

General DAVIS. I understand, sir.

I was talking about our education programs, which have been built around the recommendations of the Arthur D. Little study of 1975.

The following chart outlines the Air Force drug abuse education-prevention program.

All military personnel, civilian employees, and dependents are mandatorily provided special drug abuse education upon arrival at overseas bases of assignment, and again just prior to departure from overseas areas. While we cannot avoid assigning our personnel to high-risk areas, we make sure they are fully advised of the particular drug abuse problems in the areas of assignment and of resources available for assistance with those problems. Also in the area of prevention, we provide morale, welfare, and recreation programs at all installations which offer a variety of positive alternatives to drug abuse for military personnel and their dependents as well as our civilian force. We recognize boredom as an underlying factor in drug abuse and make every effort to insure our personnel have a variety of enriching alternative activities to choose from during their off-duty time.

Other prevention efforts include activities which tend to deter drug abuse. Chief among these are law enforcement, disciplinary actions, counseling programs, and the knowledge an airman has that a commander can direct urinalysis if drug abuse is suspected.

Identification: The Air Force uses basically four methods of identifying drug abusers. They are: apprehension/investigation, medical care, the Air Force exemption program, and urinalysis. The first method, apprehension/investigation, includes identification by the Air Force Office of Special Investigations (AFOSI), security police law enforcement efforts (including vehicle searches and sniffer dogs), antismuggling aircraft searches, and searches of personal property during shipments to and from overseas areas, civil apprehensions and detections by commanders and supervisors. Increasing sophistication in these investigatory capabilities causes this to be our largest source of identifications, our law enforcement. An added advantage to this form of identification is the full range of administrative and judicial options available to commanders. In addition, drugs themselves are removed from circulation in the course of searches conducted incidental to the investigation or apprehension. This is normally the only identification method by which drugs are taken out of circulation.

A second source of identification is incident to medical care. Primarily, abusers identified through this method experience a medical problem, seek medical assistance, and are found to have drug involvement. Very few persons are identified in this manner. Our exemption program, LPCP, is the third method of identification. Through LPCP, a member may seek medical and rehabilitative assistance for a drug problem without having information revealed concerning personal use or possession of drugs used for any actions under the Uniform Code of Military Justice; this information cannot be used in the processing of a less-than-honorable discharge.

The fourth method of identifying drug abusers is urinalysis. All military personnel regardless of age or rank are subject to commander-directed urinalysis. The Air Force supports an aggressive

commander-directed urinalysis program keyed to the testing of known or suspected drug abusers. This form of testing is the most cost-effective and least disruptive type. Sweep testing of entire units is also employed extensively across the Air Force with emphasis placed on testing units (or entire bases) in high-risk areas or when drug abuse appears to proliferate. These determinations are made through the assessment system previously discussed. By contrast, the random urine testing program which was terminated by Congress in October 1976 proved to be less cost-effective, and was disruptive and demoralizing. As hard-drug use declined following the Vietnam war, random urinalysis became an increasingly insensitive indicator, which was more of a burden than an asset to our program. The confirmed positive rates under random testing decreased from a high of 0.42 percent in 1971 to a low of 0.30 percent in 1976. In short, it has not been an effective indicator of drug abuse prevalency in the post-Vietnam era. However, the current system of commander-directed testing has yielded a confirmed positive rate of over 1 percent and has proven more responsive to our program needs.

The Air Force rehabilitates abusers where possible and separates those who either cannot or will not meet Air Force standards. Every substantiated drug abuser, regardless of how identified, is entered into the rehabilitation program. There is one exception to this policy having to do with certain first-time marihuana abusers. Personnel involved in a first sentence of marihuana use may be exempted from rehabilitation if the commander determines rehabilitation is not appropriate. The exception to this policy involves personnel on flying status, who must be removed from flying duties and entered into rehabilitation. This matter will be discussed in greater detail in the following section on utilization.

We believe the rehabilitation program is sound. Each individual placed in rehabilitation has a unique rehabilitation regimen geared to the individual's specific needs as determined by a rehabilitation committee. This committee is composed of the individual's commander, supervisor, appropriate medical personnel, the drug abuse rehabilitation specialist, and other consultants as appropriate, for example, chaplain, lawyer, et cetera. These individuals meet early, review the case, and design a program to fit the individual's needs. The regimen will include whatever treatment or support is needed to facilitate the individual's full return to duty at the earliest possible time. The treatment may run the gamut of medical or psychiatric care, education, and individual or group counseling. The rehabilitation committee closely monitors the individual's progress, and recommends return to full duty or discharge depending upon the progress in the case. Most rehabilitees return to full duty within 45 days following their entry into what we call behavioral reorientation, which is the treatment phase of the program. Those that cannot be returned to full duty within that time period—90 days at the outside—become candidates for separation.

During the early years of our rehabilitation experience we had a Special Treatment Center at Lackland AFB, Tex., for drug-dependent personnel, primarily those returning from Southeast Asia. Another facility at Lowry AFB, Colo., was also used for treating drug-dependent personnel. However, as the war wound down and our

personnel returned from the Far East, the caseload for the centralized programs decreased dramatically. During the same period our local base rehabilitation programs gained in experience and effectiveness and were able to handle the tough cases locally. The centralized treatment center caseload data by year follows: Calendar years 1971–72, 1,097; calendar year 1973, 853; calendar year 1974, 117; calendar year 1975, 44; and calendar year 1976, 27.

In our management of the rehabilitation program we also closely watch demographic trends. Our typical abuser is 21, white, an E–3, high school graduate, who smokes marihuana either as an experimenter or as a casual user. Relatively few addicts or dealers are identified, those few are discharged rather than retained. Drug-dependent personnel are medically detoxified and discharged to the Veterans Administration to provide continuity of treatment during their transition to civilian life.

In addition to monitoring demographics, we also monitor drug abuse in terms of career fields involved. In general, we find career-field abuse patterns reflective of the demographics of those career fields, that is, drug abusers are most frequently found in those career fields which have high percentages of first-term airmen. We have not detected any other correlation between drug abuse and career fields, per se.

To summarize, we believe our rehabilitation program is cost-effective in returning rehabilitated abusers to productive service, reducing replacement/retraining costs, and in separating abusers who cannot or will not comply with Air Force standards of performance and behavior. Assessing the actual effectiveness in terms of long-term benefits to the individual and the Air Force is quite difficult. However, to help us in this area, we have developed a system by which individuals entering rehabilitation are tracked by computer. Using the Air Force Advanced Personnel Data System allows us to monitor the abuser career patterns over time and better gage how successful the rehabilitation program really is on a long-term basis.

To illustrate how we will use it, a recent study of alcohol rehabilitees, using a similar approach, was completed. A 5-year followup study of alcohol treatment center graduates clearly indicates that a substantial number of highly trained and experienced persons who had serious alcohol problems were restored to effective duty. Their posttreatment performance improved on nearly every variable evaluated, including performance ratings, promotion eligibility, skill-level upgrade, education improvement, and lowered incidence of involvement in unfavorable incidents. We believe the same is true for drug abusers.

Utilization: Personnel identified as drug abusers are individually evaluated to determine appropriate action, administrative and/or disciplinary. Typical actions which might be involved would be discipline under the Uniform Code of Military Justice, separation, denial of security clearance, suspension from duties, placement on control roster, withholding of promotion, et cetera. Many factors are considered in determining appropriate action, including: Nature of the offense and category of abuse, for example, user, experimenter, addict, supplier, possessor; member's age and back-

ground; member's attitude and motivation; and the impact of drug abuse on the member's duty performance.

Once a person is placed in rehabilitation, we believe they should be kept in productive jobs in their own specialty area, except those in flying, gun bearing, and/or in PRP duties. Once rehabilitation is complete, the member is returned to all regular duties, unless limited for medical or other specified reasons. During 1977, 63 percent of all identified drug abusers were returned to full duty status. Of those, 78 percent were unconditionally retained in the Air Force. Of those not retained, the majority were separated for non-drug-related reasons.

In the discussions on rehabilitation, we mentioned a policy whereby commanders could waive rehabilitation for certain first-time marihuana abusers. We mentioned that the only exception to that policy concerned personnel on flying status. Our considerations for safety provide no latitude when it comes to drug abuse and flying. Officers involved in any drug abuse are normally separated; however, commands have the authority to retain officers based on consideration of the individual cases. Officers involved in abuse more serious than possession or use of marihuana would be separated and in no instance be eligible for return to flying.

I will discuss how the policy works and then provide some background on how the policy evolved and what our experience has been since it was implemented in 1976.

Incidents of first-time use or possession of marihuana: In cases where members are involved for the first time in the personal use, or possession for personal use, of marihuana, the immediate commander will evaluate each individual to determine whether rehabilitation is appropriate. When an individual is not identified for entry into rehabilitation, the commander should not normally remove the member from currently assigned duties. However, other administrative actions may apply at the commander's discretion. The point is, we have not changed the discipline policy, it is the rehabilitation aspect. Each case must be evaluated against the following criteria:

1. A urine test within 24 hours of the marihuana-related incident to determine whether any other type of drug abuse has occurred;
2. A determination of whether the member was under the influence of, or used, marihuana on duty;
3. A review of the member's record to determine whether past behavior or performance has been documented as substandard;
4. Determination of whether it is a second or subsequent incident of marihuana use or possession for use. If he has had an incident before, the youngster has given us a clear signal; and
5. An investigation, when appropriate, to determine whether the drug use extends beyond the simple use or possession of marihuana.

After review of the information obtained, the unit commander will determine whether rehabilitation is warranted. A decision whether rehabilitation is warranted in no way relieves the unit commander of the responsibility to determine whether disciplinary action is appropriate. Except as specifically provided otherwise, if an individual is not placed in rehabilitation, the unit commander should not invoke those administrative and personnel sanctions

which are normally associated with rehabilitation status. We have found that the 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.

In addition to these comments on the first-time marihuana policy itself, discussion of the identification procedures for decertification from the personnel reliability program (PRP) places the marihuana policy into perspective with regards to nuclear-weapons-related duty.

Identification procedures for decertification from the personnel reliability program (PRP). Potentially decertifying data may come from many sources, including law enforcement agencies, hospital, chaplain, the member's family, or the commander's observation. The immediate commander will remove an individual from PRP duties as soon as there is any question of reliability. The commander may decertify the individual either temporarily or permanently, depending on the facts of the case. Decertification is not punitive, nor is it a rehabilitative measure. It is designed to restrict an individual from nuclear-weapons-related duties.

We have identified those duty positions where the incumbent requires certification and have established procedures to insure individuals in those positions meet certain reliability standards. Before an individual is assigned to a PRP position, he or she is carefully screened. The personnel record, including any unfavorable information, is reviewed. Medical records are also reviewed and, if necessary, a medical interview conducted. The immediate commander then interviews the member, and based on all available information, decides whether or not the individual is acceptable. If not acceptable, the individual is disqualified.

After an individual is assigned to a PRP position, he or she is continually evaluated. PRP monitors are appointed in the personnel office, hospital, and in the unit. The unit PRP monitor assists the commander in insuring unit personnel in the program have been screened and continue to meet the reliability standards. The doctor, who serves as the medical PRP monitor, insures the medical records for all those in PRP positions are identified with a special form. Any potentially disqualifying medical information is promptly reported to the member's immediate commander.

The importance of prompt identification is continually stressed. The base director of personnel chairs a meeting of commanders and involved staff agencies to discuss program changes and requirements. A quarterly roster, identifying individuals in the program, is sent to the hospital and unit commanders. An aggressive inspection program evaluates the consistency and effectiveness of the program.

Our basic philosophy is that any drug abuse is incompatible with the requirements of the PRP. Members whose behavior or performance are affected by drug abuse should not perform in PRP positions. Once members have successfully completed rehabilitation, they should be restored to those duties for which they were trained, provided there are no medical, behavioral, or other impediments. The decision to reinstate a member in PRP status is based upon the judgment of the certifying officials.

Under ideal circumstances we would like to have no drug abusers in the Air Force, but we believe our current program is realistic and safe—and 2 years of incident-free experience supports the soundness of the policy.

I would like to make one final point in the PRP area. Although there are many personnel assigned to PRP duties, there are varying levels of access to nuclear weapons. There are relatively few individuals who could be said to have their finger on the nuclear button, and there are numerous and redundant safeguards and procedures to preclude any one individual lone access to weapons. There are two main points here: The first-time marihuana policy does not result in known drug abusers having direct access to weapons 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.

High-level interest and support for the drug abuse program has been a constant theme in the Air Force and one of the keys to the success of our program. From the earliest days of the drug abuse counteroffensive by the services and DOD, Air Force senior management has been intimately involved in the development of policy, the establishment of a career field to which our program specialists are assigned—it is not an additional duty—and the regular monitoring of drug abuse trends across the Air Force. Management of 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.

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, that is, the Chief of Chaplains office, Judge Advocate General's office, security police, Air Force Office of Special Investigations, Surgeon General staff, Directorate of Transportation (antismuggling program) and others. In addition, drug abuse impacts greatly on our personnel management system—and that is why you have me, the Deputy Chief of Personnel, before you this morning, the importance I attach to this program—and many officers in other parts of my organization work drug abuse issues and support the drug staff on a daily basis. In the early days of the program we had a larger full-time staff at the Headquarters, but as basic policy and program direction were established, we placed more of our resources in the field, where the work was.

At each of our major commands, within the office of the Deputy Chief of Staff for Personnel, exists a staff, usually 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 our

small, geographically separated units, personnel are assigned on a part-time basis. I mentioned previously that our program personnel are part of an established career field, which is a management approach unique to the Air Force. This means that our program personnel are carefully evaluated for entry into the career field; they receive professional training for their jobs; and they 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. By having a specific career field we have developed a professionalism in our program management at all levels and an extensive experience base upon which to build future policy and programs.

A key part of our management system is a quarterly written briefing which is furnished to senior management at all levels in the Air Force organization. Personnel who receive this quarterly briefing include the Secretary of the Air Force and the Chief of Staff as well as our major commanders and base-level commanders and managers. A copy of that analysis, I would like to submit for the record.

I think you will find it extensive and you will also find much valuable information, and particularly the DEA section or the section that we have added, which includes the DEA information in the back.

Mr. ENGLISH. Without objection, it will be so included in the record.

[The information referred to follows:]

USAF

SOCIAL ACTIONS PROGRAM

STATISTICAL SUMMARY

DRUG AND ALCOHOL ABUSE CONTROL

DEPUTY DIRECTOR, PERSONNEL PLANS FOR HUMAN RESOURCES DEVELOPMENT

THROUGH 31 MARCH 1978

DISTRIBUTION

Secretary of the Air Force	SAF/OS
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OVERVIEW - USAF DRUG AND ALCOHOL ABUSE CONTROL PROGRAM

- Background
  - -- Air Force policy:
    - --- to prevent drug/alcohol abuse
    - --- to rehabilitate drug/alcohol abusers and help them return to effective functioning
    - --- to assist in transitioning to civilian life those who cannot or will not be rehabilitated
  - -- drug abuse control program was initiated with implementation of Limited Privileged Communication Program (LPCP) and Urinalysis Testing in 1971
  - -- full-time social actions personnel assigned to 141 installations for drug and alcohol abuse control activities in 1971
  - -- alcohol abuse control program formally established in 1972 at base level
    - --- centralized treatment is provided at 10 Alcohol Treatment Centers (7-CONUS, 2-Europe, and 1-PACAF)
    - --- central treatment concept developed from test program initiated in 1966 at Wright-Patterson AFB, Ohio
  - -- DAF civilian employee drug and alcohol abuse control program initiated in 1972
    - --- combined services and directives provided by social actions (AFR 30-23, 16 Nov 73; AFR 30-2, 8 Nov 76 (C-1), and AFR 30-2, 22 Jul 77
    - --- Federal program guidelines implemented by AFR 40-792, 9 Jul 76
- Current Issues
  - -- the Random Urinalysis Testing Program was terminated worldwide 1 Oct 76
    - --- other methods of testing (entry screening, rehabilitation, commander-directed, individual incident, and sweep testing) continue
  - -- The Final Report of the Ad Hoc Task Group on Alcohol Abuse published in Oct 76
    - --- places increased emphasis on deglamorization of alcohol
    - --- directs elimination of practices which encourage alcohol consumption
    - --- highlights alternatives to alcohol abuse, strengthens the program overall
- Current Status
  - -- specific comments, as applicable, are contained in individual data sections

DRUG SEC L PR

IDENTIFICATION SOURCES (Thru 31 Mar 78) Data Source: AF/DPXHSD

	CY 1975		CY 1976		CY 1977		(Projected CY 78) CY 1978	
	NUMBER	RATE/1000	NUMBER	RATE/1000	NUMBER	RATE/1000	NUMBER	RATE/1000
LIMITED PRIVILEGED COMMUNICATIONS (LPCP)	1212/12%	1,98	744/11%	1,27	665/11%	1.2	185/12%	1.3
URINALYSIS TESTING	595/ 6%	,97	414/ 6%	,70	166/ 3%	.3	76/ 5%	.5
INCIDENT TO MEDICAL CARE	164/ 2%	.27	78/ 1%	,14	60/ 1%	.1	22/ 2%	.2
INVESTIGATION/APPREHENSION/ ARREST	8113/80%	13,25	5307/81%	9,10	4863/82%	8,5	1199/79%	8.3
OTHER	---	---	46/ 1%	---	166/ 3%	.3	47/ 2%	.3
TOTALS	10084/100%	16,47	6589/100%	11,21	5920/100%	10.4	1529/100%	10.6

- LPCP continued to decline from high of 56% in CY 1972 to 12% of total identification for CY 1/78
  - -- reflects increased emphasis commander/supervisor evaluation and actions on law enforcement activity reports
  - -- shifting societal/individual view of personal drug involvement with marijuana
    - --- numerous state laws changed, reducing penalties for personal use/possession of marijuana; no change in regard to hard drugs and trafficking
    - --- enforcement agency actions continue to concentrate on hard drug use/trafficking, on marijuana cases involving large quantities/personnel
- URINALYSIS TESTING identifications stabilized at 5% of total identifications thru CY 1/78 from high of 19% in CY 1973
  - -- urine detectable drugs are opiates, cocaine, codiene, methaqualone, amphetamines, and barbiturates
  - -- marijuana is not urine detectable using current lab procedures
  - -- laboratory quality control a problem in CY 1971 and 1972; quality of performance now exceeding 96%
- INVESTIGATION/APPREHENSION/ARREST continues to be largest source of abuser identifications, steady increase to 79% in CY 1/78
  - -- most investigative effort concentrated on hard drugs and trafficking in drugs; marijuana investigations generally concern large quantities or numbers of personnel although command requested investigations are supported
  - -- AFOSI/SPS liaison and cooperation with Federal, state, and local law enforcement agencies in CONUS and overseas is excellent

DRUGS OF ABUSE (Thru 31 Mar 78)

Data Source: AF/DPXHSD

	CY 1975		CY 1976		CY 1977		(Projected CY 78) CY 1978	
	NR/%	RATE/1000	NR/%	RATE/1000	NR/%	RATE/1000	NR/%	RATE/1000
CANNABIS	8345/83%	13.6	5437/82%	9.2	5157/87%	9.0	1267/83%	8.8
HALLUCINOGENS	295/ 3%	.5	194/ 3%	.3	136/ 2%	.2	59/ 4%	.4
AMPHETAMINES	354/ 4%	.6	391/ 6%	.7	289/ 5%	.5	94/ 5%	.7
BARBITURATES	229/ 2%	.4	184/ 3%	.3	86/ 1%	.2	31/ 2%	.2
METHAQUALONE	107/ 1%	.2	26/---	.1	14/---	---	15/ 1%	.1
OPIATES (Morphine, Heroin, Methadone, etc.)	659/ 6%	1.0	231/ 4%	.4	96/ 2%	.2	26/ 2%	.2
OTHER (Cocaine, PCP, etc.)	71/ 1%	.2	126/ 2%	.2	142/ 3%	.3	37/13%*	.2
TOTAL	10084/100%	16.5	6589/100%	11.2	5920/100%	10.4	1529/100%	10.6

- Cannabis use accounts for greater proportion of identifications by drug type (83% in CY 1/78)
- Amphetamine use up in CY 1976 (6%) but dropped (to 5%) in CY 1/78; coincides with Drug Enforcement Agency (DEA) trends analysis for civil sector
  - -- approximately 56% of amphetamine identifications occur in EUROPE, 34% in CONUS; negligible in other areas
  - -- DEA trends indicate increased incidence in all CONUS regions even though controls nave been strengthened
    - --- availability/price remain fairly stable in all areas
    - --- lower availability, higher price of heroin may be stimulating amphetamine use increase
- Barbiturate, other depressants, show slight decrease in use for CY 1977 and a slight increase for CY 1/78
  - -- deaths/injuries related to barbiturate, or barbiturate/alcohol combination, increasing in civil sector per DEA trends analysis
  - -- availability/price relatively stable in most areas, lower in low-risk regions
- Opiate use decline to 4% of total identifications for CY 1976 versus 6% in CYs 1974/1975; further drop to 2% for CY 1/78
  - -- PACAF/Thailand drawdown accounts for primary decrease
  - -- DEA analysis of civil sector indicates higher prices/lower availability of heroin in CONUS generally, NY/NYC and Northeast region continue to lead all other regions in deaths/injuries from heroin and methadone with Pacific/California area closely following
    - --- users apparently shifting to larger dosage/other substances to compensate
    - --- DEA civil sector trends are not evidenced in AF member drug involvement with opiates

* Includes 13 cocaine identifications for CY 1/78

MAJOR COMMAND IDENTIFICATION RATES (Thru 31 Mar 78) Data Source: AF/DPXHSD

	CY 1975		CY 1976		CY 1977		(Projected CY 78) CY 1978	
	NR	RATE/1000	NR	RATE/1000	NR	RATE/1000	NR	RATE/1000
AEROSPACE DEFENSE COMMAND	204	13.7	179	13.0	117	8.9	63	18.5
ALASKAN AIR COMMAND	105	8.9	146	12.7	127	12.3	39	15.1
TACTICAL AIR COMMAND	1484	18.9	1476	17.7	1326	14.2	340	14.6
US FORCES EUROPE	988	14.9	783	11.8	837	12.0	228	12.9
MILITARY AIRLIFT COMMAND	1179	19.5	1131	13.6	1005	12.5	208	10.3
AIR TRAINING COMMAND	1500	15.9	879	10.0	883	10.4	202	10.1
USAF LOGISTICS COMMAND	283	11.4	195	7.5	148	5.4	68	9.9
PACIFIC AIR FORCES	1427	25.2	320	8.8	236	6.3	74	8.0
STRATEGIC AIR COMMAND	2258	16.2	1111	8.2	836	6.8	235	7.6
USAF SYSTEMS COMMAND	343	14.3	199	7.8	221	10.0	40	6.4
USAF SECURITY SERVICE	93	22.6	126	12.2	139	10.0	22	6.3
USAF ACADEMY	2	.3	1	.2	2	.3	2	3.1
AIR UNIVERSITY	38	6.2	34	7.0	41	5.8	2	1.2
USAF TOTALS*	10084	16.5	6589	11.2	5920	10.4	1529	10.6

- Overall decline in Rate/1000 from 16.5 in CY 1975 to 10.6 in CY 1/78 d[illegible] first time marijuana policy (commander's option for entry of first time marijuana offender into rehabilitation.

* USAF totals include members in rehabilitation from other than the above MAJCOMs.

FATALITIES (Thru 31 Mar 78) Data Source: AF/DPMSCA

Geographic Areas	CY 1972	CY 1973	CY 1974	CY 1975	CY 1976	CY 1977	(Thru 31 Mar) CY 1978
CONUS	---	---	14	12	9	8	1
OTHER (Alaska, Canal Zone)	---	---	---	---	---	---	---
Europe	---	---	1	1	1	---	1
PACIFIC	---	---	5	2	---	1	---
USAF TOTALS	24	12	20	15	10	9	2

Primary Substance Involved	CY 1972	CY 1973	CY 1974	CY 1975	CY 1976	CY 1977	(Thru 31 Mar) CY 1978
BARBITURATES	---	---	11	4	2	4	1
AMPHETAMINES	---	---	---	---	---	1	---
NARCOTICS	---	---	8	9	7	3	---
OTHER (Codiene, Cocaine, Toxic Agents, Etc)	---	---	1	2	1	1	1
USAF TOTALS	---	---	20	15	10	9	2

- Deaths and injuries resulting from drug involvement have declined since high point of CY 1972
  - -- DEA trends for civil sector reveal continued increase in death and injuries, particularly in Northeast (NY/NYC) and West (CA)
- Most serious trend appears to be death or injuries resulting from ingestion of barbiturate/alcohol combination
  - -- complication most often resulting in death is aspiration of gastrointestinal contents
  - -- serious injuries increasing due to intoxication from alcohol or a combination of barbiturates/alcohol
- Steady decline attributed to Thailand drawdown (high risk area); and to increased education, awareness, and command emphasis/involvement

DRUG ABUSE CONTROL PROGRAM

CENTRAL TREATMENT CENTERS — Data Source: AF/DPXHSD

Dispositions	CY 1971	CY 1972	CY 1973	CY 1974*	CY 1974**	CY 1975	CY 1976***
RETURNED TO DUTY (HOME STATION)	187/38%	191/32%	476/60%	74/70%	9/82%	25/57%	20/74%
SEPARATED BY STC/STS	248/50%	254/42%	286/34%	27/25%	----	----	----
RETURNED TO HOME STATION FOR SEPARATION	36/ 7%	122/20%	40/ 5%	4/ 4%	2/18%	19/43%	7/26%
SEPARATED - TRANSFERRED TO VA	17/ 3%	22/ 4%	4/.5%	----	----	----	----
OTHER (AWOL, CIV CONFINE, ETS, DEATH, etc)	10/ 2%	10/ 2%	4/.5%	1/ 1%	----	----	----
TOTAL PARTICIPANTS	498	599	853	106	11	44	27

* SPECIAL TREATMENT CENTER - Lackland AFB, TX. Opened July 1971, closed February 1974. Operated Phase III - Medical Treatment and Evaluation (3 - 7 weeks) at Wilford Hall USAF Medical Center; Phase IV - Behavioral Reorientation (4 - 12 weeks) in student training area. Reason for closure: decreased requirement for centralized treatment of drug addicted/drug dependent cases, increased capability for effective treatment of members in local base level rehabilitation programs.

** SPECIAL TREATMENT SQUADRON - Retention of centralized treatment capability for drug rehabilitation moved to 3415th Special Treatment Squadron (STS), Lowry AFB, Colorado, in February 1974. On 1 February 1975, STS merged with 3320th Retraining Group (RTG) and provided centralized facility for confinement of prisoners in rehabilitation, AFM 39-12 separation rehabilitation, and drug abuse rehabilitation. Steady decline in number of cases requiring confinement/rehabilitation led to consolidation of all units into one facility; renamed the 3320th Correction and Rehabilitation Group (CRG) on 1 July 1976.

*** Drug rehabilitation capability terminated effective 15 November 1976. All drug abuse rehabilitation cases now managed through local base programs.

DRUG ABUSE CONTROL PROGRAM

REHABILITATION - PHASES I - IV (Thru 31 Mar 78)

	CY 1973	CY 1974	CY 1975	CY 1976	CY 1977	(Thru 31 Mar) CY 1978
PRIOR YEAR CARRYOVER	1442	1429	1751	1500	1170	962
NEW IDENTIFICATIONS	6439	9105	10084	6589	5920	1529
TOTAL PARTICIPANTS	7881	10534	11835	8089	7090	2491
DISPOSITIONS:						
ENTER FOLLOW-ON SUPPORT	3800/59%	5798/66%	7240/70%	4238/62%	3815/63%	947/66%
SEPARATIONS: (NON-DRUG RELATED)	907/14%	1559/18%	1554/15%	1136/17%	822/13%	176/13%
(NORMAL ETS)	285/ 4%	260/ 3%	269/ 3%	142/ 2%	114/ 2%	19/ 1%
(DRUG RELATED)	269/ 4%	537/ 6%	479/ 5%	649/ 9%	689/11%	135/ 9%
(TRANSFER TO VA)	29/---	127/ 2%	188/ 2%	75/ 1%	43/ 1%	18/ 1%
TRANSFER TO STC/STS	853/14%	117/ 1%	44/---	27/---	6/---	2/---
OTHER (AWOL, CIVIL CONFINEMENT, DEATH, ENTERED IN ERROR, ETC)	310/ 5%	385/ 4%	561/ 5%	592/ 9%	639/10%	136/10%
TOTAL DISPOSITIONS	6452/100%	8783/100%	10335/100%	6919/100%	6128/100%	1433/100%
NUMBER PENDING (CARRYOVER TO NEXT YEAR)	1429	1751	1500	1170	962	958

- Decline in new identifications for CY 1976/77/78 due to implementation of new policy for first-offense marijuana use/possession
- Increase in OTHER dispositions reflects improved unit commander involvement evaluation of drug involved members where rehabilitation entry is reversed following thorough evaluation
- Reporting procedures and accuracy have significantly improved

DRUG ABUSE CONTROL PROGRAM

REHABILITATION - PHASE V (Thru 31 Mar 78) Data Source: AF/DPXHSD

	CY 1973	CY 1974	CY 1975	CY 1976	CY 1977	CY 1978
PRIOR YEAR CARRYOVER	1404	2664	2180	1913	962	916
ENTRANTS FROM: PHASES I - IV	3800	5798	7240	4298	3815	946
STC/STS	516	117	44	26	2	1
TOTAL PARTICIPANTS	5720	8579	9464	6237	4779	1863
DISPOSITIONS						
SUCCESSFUL COMPLETIONS	1695/56%	4012/63%	5553/74%	4053/77%	3014/78%	758/79%
SEPARATIONS: (NON-DRUG RELATED)	779/26%	1442/23%	1137/15%	737/15%	507/13%	125/13%
(NORMAL ETS)	286/ 9%	355/ 5%	322/ 4%	175/ 3%	97/ 3%	13/ 1%
(DRUG RELATED)	260/ 7%	430/ 7%	358/ 5%	227/ 4%	146/ 4%	30/ 3%
(TRANSFER TO VA)	18/---	42/---	43/---	14/---	6/---	3/ 1%
OTHER (AWOL, CIVIL CONFINEMENT, DEATH, ENTERED IN ERROR, ETC)	18/ 2%	117/ 2%	138/ 2%	69/ 1%	93/ 2%	24/ 3%
TOTAL DISPOSITIONS	3056/100%	6399/100%	7551/100%	5275/100%	3863/100%	953/100%
NUMBER PENDING (CARRYOVER TO NEXT YEAR	2664	2180	1913	962	916	910

- Separation rate decline in CY 1976 thru 1978 highlight continued improvements in rehabilitation program/management capability

- Steadily improving successful completion rates are indicative of increased involvement of commanders/supervisors and more effective use of rehabilitation resource and evaluation processes

DEMOGRAPHIC DATA (Thru 31 Mar 78) Data Source: AF/DPXHSD

		CY 1975	CY 1976	CY 1977	(Projected CY 78) CY 1978
AVERAGE AGE		20.9	20.1	20.9	2[illegible]
GRADE	E-1	623/ 6%	306/ 5%	559/ 9%	138/ 9%
	E-2	2400/ 24%	1554/23%	1264/21%	261/17%
	E-3	3982/39%	2936/45%	2508/43%	726/47%
	E-4	2765/27%	1625/25%	1410/24%	347/23%
	E-5	269/ 3%	138/ 2%	154/ 3%	47/ 4%
	E-6	14/---	11/---	10/---	4/---
	E7 - E9	2/---	---	---	1/---
	O1 - O5	29/ 1%	19/---	15/---	5/---
RACE	WHITE	7247/72%	4912/75%	4711/80%	1244/81%
	BLACK	2462/24%	1398/21%	998/17%	221/15%
	OTHER	348/ 4%	270/ 4%	211/ 3%	54/ 4%
	TOTALS	10084/100%	6589/100%	5920/100%	1529/100%
EDUCATION	NON-HIGH SCHOOL GRADUATE	771/ 6%	325/ 5%	293/ 5%	65/ 4%
	HIGH SCHOOL GRADUATE	8240/82%	5510/83%	4931/83%	1271/83%
	COLLEGE - INCOMPLETE	1120/11%	717/11%	661/11%	183/12%
	COLLEGE GRADUATE	63/ 1%	37/ 1%	35/ 1%	10/ 1%
CATEGORY OF ABUSE	EXPERIMENTER	3364/33%	1893/29%	1379/23%	304/20%
	USER	4250/42%	2915/44%	2786/47%	753/49%
	ADDICT	63/ 1%	51/ 1%	24/---	3/---
	SUPPLIER	221/ 2%	205/ 3%	493/ 8%	41/ 3%
	POSSESSOR	2186/22%	1525/23%	1238/22%	428/28%
	TOTALS	10084/100%	6589/100%	5920/100%	1529/100%

OCCUPATIONAL DISTRIBUTION (CY 1976 thru 31 Mar 78) Data Source: AF/DPXHSD

Top 20 Enlisted AFSCs		NR IDs	RATE/1000*
60xxx	Transportation	95	6.9
57xxx	Fire Protection	37	5.8
65xxx	Fuels	33	5.3
43xxx	Aircraft Maintenance	226	4.9
90xxx	Sanitation	7	4.7
81xxx	Security Police	165	4.7
55xxx	Structural/Pavements	54	4.6
54xxx	Mechanical/Electrical	44	4.0
30xxx	Wire Communications Systems Maintenance	19	3.9
42xxx	Aircraft Systems Maintenance	146	3.7
90/91xxx	Medical	73	3.2
47xxx	Vehicle Maintenance	15	3.1
70xxx	Administration	82	2.9
44xxx	Missile Maintenance	7	2.8
27xxx	Command/Control Systems Operations	50	2.8
32xxx	Avionics Systems	78	2.7
20xxx	Intelligence	29	2.6
92xxx	Aircrew Protection	6	2.6
62xxx	Food Services	13	2.6
51xxx	Computer Systems	15	2.4
TOTAL ENLISTED IDENTIFICATIONS (TOP 20)		1194	
TOTAL USAF IDENTIFICATIONS (ALL GRADES/AFSCs)		1529	

* Based on number assigned in each AFSC

ALCOHOL ABUSE CONTROL PROGRAM

IDENTIFICATION SOURCES (Thru 31 Mar 78) Data Source: AF/DPXHSD

	CY 1975		CY 1976		CY 1977		(Projected CY 78) CY 1978	
	NUMBER	RATE/1000	NUMBER	RATE/1000	NUMBER	RATE/1000	NUMBER	RATE/1000
SELF-IDENTIFIED	1507/26%	2.46	1512/25%	2.57	1691/29%	3.0	414/31%	2.9
COMMANDER/SUPERVISOR REFERRAL	2930/50%	4.79	2400/41%	4.25	2347/39%	4.0	500/37%	3.5
MEDICAL REFERRAL	217/ 4%	.35	208/ 3%	.36	204/ 3%	.4	61/ 4%	.4
OTHER (MIL/CIV POLICE, SAFETY, ETC)	1129/20%	1.85	1854/31%	3.16	1712/29%	3.0	377/28%	2.6
TOTALS	5783/100%	9.45	6074/100%	10.34	5954/100%	10.4	1352/100%	9.4

- Substantial increase in OTHER category due to increased emphasis/commander evaluation of alcohol-related incidents (DUI/DWI, etc)

-- referrals per AFR 125-14 and from civil court actions increased during CY 1976

-- AF rehabilitation programs recognized by civil courts as effective resource for supervision of military personnel on civil court probation

ALCOHOL ABUSE CONTROL PROGRAM

IDENTIFICATION RATES (Thru 31 Mar 78)

Data Source: AF/DPXHSD

MAJCOM IDENTIFICATION RATES	CY 1975		CY 1976		CY 1977		CY 1978	
	NUMBER	RATE/1000	NUMBER	RATE/1000	NUMBER	RATE/1000	NUMBER	RATE/1000
PACIFIC AIR FORCES	615	10.9	686	18.9	765	20.4	118	12.7
TACTICAL AIR COMMAND	762	9.7	924	10.8	995	10.9	287	12.3
USAF LOGISTICS COMMAND	164	6.6	166	6.4	210	7.7	68	9.9
MILITARY AIRLIFT COMMAND	782	12.9	1411	16.9	1105	13.8	193	9.6
AEROSPACE DEFENSE COMMAND	191	12.8	126	9.1	129	9.8	30	8.8
STRATEGIC AIR COMMAND	970	7.0	1063	7.8	1064	8.7	270	8.7
AIR TRAINING COMMAND	575	6.1	700	8.0	667*	7.9	168	8.4
US FORCES EUROPE	1375	20.8	637	9.6	638	9.2	143	8.1
ALASKAN AIR COMMAND	79	7.7	86	7.5	7	7.4	21	8.1
USAF SECURITY SERVICE	21	5.1	71	6.9	1	7.3**	18	5.2
USAF SYSTEMS COMMAND	153	6.4	168	6.6	180	8.1	32	5.1
AIR UNIVERSITY	18	3.0	11	2.3	18	2.5	4	2.3
USAF ACADEMY	----	----	2	.8	6	.9	0	0
USAF TOTAL	5783	9.5	6074	10.3	5954	10.4	1352	9.4

* Air Training Command policy excludes from Identification Total/ID Rate Per 1000 all personnel completing evaluation process who do not enter rehabilitation.

** CY 1977-78 data represents total identifications/Rate Per 1000 for Security Service personnel worldwide. CY 1976 and prior year data did not include personnel identified/entering rehabilitation in European/PACAF areas.

ALCOHOL ABUSE CONTROL PROGRAM

FATALITIES (Thru 31 Mar 78) — Data Source: AF/IG (SERR), DPMSCA

PMV DEATHS	CY 1972*	CY 1973	CY 1974	CY 1975	CY 1976	CY 1977	CY 1978
CONUS	---	107	59	71	62	51	4
OTHER (Alasks, Canal Zone)	---	---	---	1	---	---	---
EUROPE	---	18	13	12	10	16	1
PACAF	---	9	5	2	2	4	---
USAF TOTALS	153	134	77	86	74	71	5

NON-PMV DEATHS	CY 1972	CY 1973	CY 1974**	CY 1975	CY 1976	CY 1977	CY 1978
MIXING ALCOHOL AND DRUGS			4	---	2	---	---
MEDICAL COMPLICATIONS (Cirrhosis, Hepatitis, etc)			1	5	3	3	---
ASPIRATION OF VOMITUS DUE TO ACUTE INTOXICATION			---	5	1	---	---
ACCIDENTIAL DEATH WHILE INTOXICATED			1	4	3	2	---
USAF TOTALS			6	14	9	5	---

	CY 1972	CY 1973	CY 1974	CY 1975	CY 1976	CY 1977	CY 1978
TOTAL ALCOHOL-RELATED DEATHS	153	134	83	100	83	76	5

* Data by Category not recorded until CY 1973

** Data by Category not recorded until CY 1974

- Overall decline in alcohol-related fatalities since CY 1971 attributed to increasing emphasis on safety and alcohol abuse prevention efforts
- Accidental deaths while intoxicated and medical complications (associated normally with prolonged excessive use) result in highest incidence of deaths

ALCOHOL ABUSE CONTROL PROGRAM

CENTRAL TREATMENT CENTERS (Thru 31 Mar 78) — Data Source: AF/SGPC

	CY 1973	CY 1974	CY 1975	CY 1976	CY 1977	CY 1978
CARRYOVER FROM PRIOR YEAR	---	17	40	28	19	9
NEW PATIENTS ENTERED	518	817	1133	1138	1194	334
TOTAL PARTICIPATION	518	834	1173	1166	1213	343
DISPOSITIONS: COMPLETED TREATMENT	486/97%	753/95%	1072/94%	1061/93%	1141/95%	237/91%
FAILED TO COMPLETE	15/ 3%	41/ 5%	73/ 6%	86/ 7%	63/ 5%	25/ 9%
TOTAL DISPOSITIONS	501/100%	794/100%	1145/100%	1147/100%	1204/100%	262/100%
NUMBER PENDING (CARRYOVER TO NEXT QUARTER)	17	40	28	19	9	81

- Centralized treatment began with a test program at Wright-Patterson AFB, Ohio, in 1966
  - -- 10 centers currently in operation: 7 in CONUS, 2 in Europe, and 1 in PACAF (8 centers operate 28-day programs, 2 centers are 14-day programs)
  - -- capacity of 10 centers is 109 beds for simultaneous treatment of inpatients
  - -- annual capacity is nominally 1,300, with a surge capability of up to 1,500 as needed
- Successful completion of centralized program is not completion of total rehabilitation; patients return to duty station for entry into Follow-on Support
- During CY 1977, 11% of active duty program entrants were "senior" people:

O6	2
O5	12
O4	17
E9	3
E8	14
E7	55
TOTAL	103

ALCOHOL ABUSE CONTROL PROGRAM

LOCAL REHABILITATION (Thru 31 May 78) — Data Source: AF/DPXHSD

	CY 1974	CY 1975	CY 1976	CY 1977	CY 1978
CARRYOVER FROM PRIOR YEAR	586	914	1675	1659	1602
NEW IDENTIFICATION/ENTRIES	3250	5786	6074	5954	1352
TOTAL PARTICIPATION	3836	6697	7749	7613	2954
DISPOSITIONS:					
ENTERED FOLLOW-ON SUPPORT	2073 (71%)	3774 (75%)	4473 (73%)	4364 (73%)	1084 (71%)
SEPARATE (NORMAL ETS)	200 (7%)	214 (4%)	188 (3%)	173 (3%)	22 (1%)
TRANSFER TO CENTRAL TREATMENT CENTER	390 (13%)	571 (11%)	626 (11%)	685 (12%)	188 (12%)
SEPARATE/FAILED TO COMPLETE	148 (5%)	321 (7%)	549 (9%)	489 (9%)	145 (10%)
OTHER (AWOL, CIVIL CONFINEMENT, DEATH, ENTERED IN ERROR, ETC)	111 (4%)	142 (3%)	254 (4%)	300 (3%)	85 (6%)
TOTAL DISPOSITIONS	2922 (100%)	5022 (100%)	6090 (100%)	6011 (100%)	1524 (100%)
NUMBER PENDING (CARRYOVER TO NEXT YEAR)	914	1675	1659	1602	1430

- Successful completion of local rehab and entry into Follow-on Support and other dispositions remain relatively stable due to
  - improvements in procedures and local program management
  - better development and application of local resources, program specialist training, and use of consultants
  - stronger support and visability of command, particularly by unit commanders/supervisors

ALCOHOL ABUSE CONTROLPROGRAM

FOLLOW-ON SUPPORT REHABILITATION (Thru 31 Mar 78) Data Source: AF/DPXHSD

	CY 1974	CY 1975	CY 1976	CY 1977	CY 1978
CARRYOVER FROM PRIOR YEAR	1092	1623	1835	1654	1962
ENTRIES FROM LOCAL/CENTRAL REHABILITATION	2397	4284	5074	4893	1255
TOTAL PARTICIPATION	3489	5907	6909	6547	3217
DISPOSITIONS					
SUCCESSFUL COMPLETION	1081 (58%)	3096 (77%)	4428 (84%)	3857 (85%)	938 (82%)
SEPARATE (NORMAL ETS)	371 (20%)	382 (9%)	247 (5%)	211 (4%)	48 (5%)
SEPARATE/FAILED TO COMPLETE	331 (18%)	352 (9%)	422 (8%)	296 (7%)	92 (7%)
OTHER (AWOL, CIVIL CONFINEMENT, DEATH, ENTERED IN ERROR, ETC)	82 (4%)	206 (5%)	158 (3%)	221 (4%)	69 (6%)
TOTAL DISPOSITIONS	1866 (100%)	4036 (100%)	5255 (100%)	4585 (100%)	1147 (100%)
NUMBER PENDING (CARRYOVER TO NEXT YEAR	1623	1835	1654	1962	2070

- Major management improvements contained in AFR 30-2 (published 1 Aug 74, revised 8 Nov 76 and 22 Jul 77) are basic factors in improvement of successful completion rates

- Separations cannot be based on alcohol abuse

-- actual number of separations for substand performance/behavior due to alcohol-related causes unknown

ALCOHOL ABUSE CONTROL PROGRAM

CONCERNED DRINKER PROGRAM (Thru 31 Mar 78) — Data Source: AF/DPXHSD

	CY 1975	CY 1976	CY 1977	CY 1978
FIRST INTERVIEW (INITIAL CONTACT)	133/100%	1566/100%	779/100%	166/100%
SECOND INTERVIEW (FOLLOW-UP)	69/---	852/---	331/---	94/---
OPTION I - ENTER REHABILITATION	26/ 20%	311/ 20%	203/ 25%	83/ 50%
OPTION II OFF BASE REFERRAL	22/ 17%	359/ 23%	62/ 8%	12/ 7%
OPTION III - TERMINATE CONTACT/ASSISTANCE	50/ 38%	557/ 36%	183/ 29%	46/ 27%

- Concerned Drinker Program policies/guidelines disseminated in May 75, optional implementation permitted at MAJCOM discretion
- Policies/guidelines revised with publication of revised AFR 30-2, 8 Nov 76
- Program designed as early intervention/assistance effort for persons concerned about their drinking habits/patterns, who voluntarily seek information or assistance before use of alcohol becomes problematic in terms of job performance and/or social behavior

CONTINUED

1 OF 3

ALCOHOL ABUSE CONTROL PROGRAM

DEMOGRAPHIC DATA (Thru 31 Mar 78) — Data Source: AF/DPXHSD

		CY 1975	CY 1976	CY 1977	(Thru 31 Mar) CY 1978
AVERAGE AGE		2.8	26.5	26.7	26.7
GRADE	E-1	109/ 2%	105/ 3%	291/ 5%	81/ 6%
	E-2	539/ 9%	590/10%	634/10%	134/10%
	E-3	1060/18%	1258/21%	1217/20%	277/20%
	E-4	1358/24%	1425/23%	1352/23%	323/24%
	E-5	1454/25%	1452/23%	1338/22%	306/23%
	E-6	719/12%	688/11%	669/12%	136/10%
	E7 - E9	349/ 6%	341/ 6%	312/ 6%	70/ 5%
	01 - 03	96/ 2%	108/ 2%	71/ 1%	13/ 1%
	04 - 05	92/ 2%	60/ 1%	65/ 1%	12/ 1%
	06 - 010	7/---	2/---	5/---	
	TOTAL	5783/100%	6074/100%	5954/100%	1352/100%
RACE	WHITE	4708/81.4%	4840/79.7%	4851/81%	1128/83%
	BLACK	865/15.0%	969/16.0%	854/15%	172/13%
	OTHER	210/ 3.6%	265/ 4.3%	249/ 4%	52/ 4%
	TOTAL	5783/100%	6074/100%	5954/100%	1352/100%
EDUCATION	NON-HIGH SCHOOL GRADUATE	280/ 6%	235/ 4%	299/ 5%	63/ 5%
	HIGH SCHOOL GRADUATE	4564/80%	4885/80%	4693/79%	1050/77%
	COLLEGE - INCOMPLETE	732/11%	744/12%	785/14%	205/15%
	COLLEGE GRADUATE	207/ 3%	210/ 4%	177/ 2%	34/ 3%
	TOTAL	5783/100%	6074/100%	5954/100%	1352/100%

ALCOHOL ABUSE CONTROL PROGRAM

OCCUPATIONAL DISTRIBUTION (CY 1977 thru 31 Mar 78) — Data Source: AF/DPXHSD

TOP 20 Enlisted AFSCs		NR IDs	RATE/1000*
40xxx	Intricate Equipment and Maintenance	7	6.2
55xxx	Structural/Pavements	55	4.7
47xxx	Vehicle Maintenance	22	4.6
62xxx	Food Services	23	4.6
36xxx	Wire Communications Systems Maintenance	21	4.3
54xxx	Mechanical/Electrical	45	4.1
60xxx	Transportation	57	4.1
56xxx	Sanitation	6	4.0
42xxx	Aircraft Systems Maintenance	155	3.9
74xxx	Morale Welfare and Recreation	8	3.9
43xxx	Aircraft Maintenance	171	3.7
64xxx	Supply	95	3.6
75xxx	Education and Training	12	3.6
46xxx	Munitions and Weapons Maintenance	68	3.2
25xxx	Weather	10	3.1
34xxx	Training devices	8	3.0
39xxx	Maintenance Management Systems	11	3.0
63xxx	Fuels	18	2.9
51xxx	Computer Systems	18	2.9
57xxx	Fire Protection	18	2.8
TOTAL ENLISTED IDENTIFICATIONS (TOP 20)		828	
TOTAL USAF IDENTIFICATIONS (ALL GRADES/AFSCs)		1352	

* Based on number assigned in each AFSC

ALCOHOL ABUSE CONTROL PROGRAM

STUDENT TRAINING WORKLOAD (Thru 31 Mar 78) — Data Source: AF/DPXHSD

TRAINING CATEGORY		JAN THRU JUN 76	JUL THRU DEC 76	JAN THRU JUN 77	JUL THRU DEC 77	JAN THRU MAR 78
DRUG ABUSE EDUCATION (2-Hour Course)*	- MIL	216,350	---	---	---	---
	CIV	44,431	---	---	---	---
	DEPS	8,733	---	---	---	---
	TOTAL	269,514	---	---	---	---
ALCOHOL ABUSE EDUCATION (2-Hour Course)**	- MIL	216,350	---	---	---	---
	CIV	44,431	---	---	---	---
	DEPS	8,733	---	---	---	---
	TOTAL	269,514	---	---	---	---
DRUG/ALCOHOL AWARENESS SEMINAR (4-Hour Course)***	- MIL	---	272,344	201,444	157,178	32,969
	CIV	---	24,779	9,264	7,062	1,261
	DEPS	---	10,596	6,309	3,894	1,428
	TOTAL	---	307,719	217,017	168,134	35,712
ALCOHOL AWARENESS SEMINAR (8-Hour Course)****	- MIL	---	3,090	3,169	1,713	1,059
	CIV	---	392	249	234	101
	TOTAL	---	3,482	3,403	1,947	1,160

* Drug abuse education began as mandatory two-hour annual requirement for military personnel Oct 71; civilians and dependents were encouraged to attend voluntarily.

** Alcohol abuse education began as mandatory two-hour annual requirement for military personnel in Jul 72; civilians and dependents were encouraged to attend voluntarily

*** Separate curricula for drug and alcohol abuse training terminated in Jul 76; consolidated drug/alcohol substance abuse seminar curricula were developed in two formats, one for supervisors and one for non-supervisory personnel. The new curricula were implemented 1 Jul 76, together with a change from annual training cycles to training based on key events (initial service entry, following PCS transfer, attendance at PME courses - AFR 30-2, Figure 4-7).

**** A special Alcohol Awareness Seminar was developed and implemented in Jan 76 in support of the Concerned Drinker Program, AFR 125-14, referrals for personnel involved in alcohol-related incidents, and community requests for in-depth education and evaluation assistance,

DAF CIVILIAN EMPLOYEE DRUG AND ALCOHOL ABUSE CONTROL PROGRAMS

DRUG ABUSE REHABILITATION (Thru 31 Mar 78) — Data Source: AF/DPXHSD

		CY 1975	CY 1976	CY 1977	CY 1978
CARRYOVER FROM PRIOR YEAR		9	13	7	10
NEW ENTRIES		20	14	15*	6*
	TOTAL PARTICIPATION	29	27	22	16
DISPOSITIONS:	COMPLETED	6/37,5%	8/40%	8	2
	DISMISSED FROM EMPLOYMENT	4/25,0%	5/25%	3	0
	OTHER (RETIRED, RESIGNED, DECEASED, ETC)	6/37,5%	7/35%	1	0
	TOTAL DISPOSITIONS	16/100%	20/100%	12	2
NUMBER PENDING (CARRYOVER TO NEXT PERIOD)		13	7	10	14

* NOTE: Data reports only those participating in Social Actions formal program. Additional persons sought help through other sources

DAF CIVILIAN EMPLOYEE DRUG AND ALCOHOL ABUSE CONTROL PROGRAMS

DRUG ABUSE REHABILITATION (Thru 31 Mar 78) — Data Source: AF/DPXHSD

		CY 1975	CY 1976	CY 1977	CY 1978
CARRYOVER FROM PRIOR YEAR		9	13	7	10
NEW ENTRIES		20	14	15*	6*
	TOTAL PARTICIPATION	29	27	22	16
DISPOSITIONS:	COMPLETED	6/37.5%	8/40%	8	2
	DISMISSED FROM EMPLOYMENT	4/25.0%	5/25%	3	0
	OTHER (RETIRED, RESIGNED, DECEASED, ETC)	6/37.5%	7/35%	1	0
	TOTAL DISPOSITIONS	16/100%	20/100%	12	2
NUMBER PENDING (CARRYOVER TO NEXT PERIOD)		13	7	10	14

* NOTE: Data reports only those participating in Social Actions formal program. Additional persons sought help through other sources

*URINALYSIS SUMMARY - FIRST QUARTER CY 78

MAJCOM	# TESTS	% COMMAND TESTED	# CONFIRMED POSITIVES	% CONFIRMED	NARC	AMPH	BARB	OTHER
AAC	239	2,3	17**	7,1	Ø	1	Ø	16**
ADC	491	3,7	Ø	Ø	Ø	Ø	Ø	Ø
AFLC	471	1,7	1	0,2	Ø	Ø	Ø	1
AFSC	427	1,9	5	1,2	1	Ø	3	1
ATC	2222	2,6	31	1,4	5	2	22	2
MAC	379	0,5	2	0,5	Ø	2	Ø	Ø
SAC	1215	1,0	11	0,9	Ø	3	6	2
TAC	5063	5,5	12	0,2	2	1	5	4
PACAF	1490	4,0	14	0,9	3	2	8	1
USAFE	569*	8,2	61	1,1	1	53	Ø	7
TOTAL	17690	3,2%	154	0,9%	12	64	44	34

* Includes commander-directed, incident-related, and unit sweeps; does not include rehabilitation or surveillance testing.

** Fifteen individuals suspected of using PCP were identified by a sweep test.

COMMENT: Urinalysis continues to be a high priority component of the Air Force drug abuse identification and assessment system. This data is being provided so that program managers can review their status in comparison with others. The key to testing effectiveness is gearing testing to the drug abuse threat environment as assessed by the Drug and Alcohol Abuse Control Committee. The goal is not high testing rates, per se, but testing rates which are commensurate with the drug threat.

DRUG TRENDS AROUND THE WORLD

Any survey of narcotics developments dealing with a great diversity of countries would be expected to show mixed results--new challenges, some progress in taking action to meet them, and unresolved problems. The country capsules presented below, taken as a whole, reflect an increased awareness among nations of their interdependence in dealing with drug trafficking: an awareness that a problem now plaguing another country may soon infect them as well as the realization that cooperation between law enforcement authorities of different countries is vital to immobilizing the fast-moving, well-heeled international trafficker.

United States

Indications of a continuing decline in heroin abuse and heroin availability in the Unites States are mounting. The Mexican-U.S. cooperative opium control effort appears to be the primary factor in declining heroin availability in the U.S. market. The indicators include:

A downturn in heroin abuse as measured by reported deaths and injuries;

A shift to narcotics substitutes, reflected in death/injury data and intelligence reporting;

An uptrend in retail pharmacy thefts;

An increase in admissions for treatment of narcotics addiction; and

Reduced supply of opium and heroin in Mexico, reflected in higher prices.

Mexico

The Goverment of Mexico continues its sustained opium eradication efforts to lower its image as the principal source for the U.S. heroin market. More opium poppy fields were destroyed during the first seven months of this year than in any previous January-July period. The Mexican Attorney General's Office reported over 27,000 fields destroyed from January 1 through May 1977, nearly all by sprayer-rigged helicopters. This year about 1,200 Mexican military personnel were also involved in interdiction and eradication.

Eradication campaigns picked up again in late August and September to prevent maturation of a late summer opium crop. As of October 23, 1977, a total of 12,433 fields were sprayed in the northern and southern zones. About 243 kilograms of heroin, 135 kilograms of opium gum, 73 kilograms of opium seed, and 12 heroin laboratories have been seized since the 1977 Mexican eradication campaign began.

South America

With abuse of cocaine in the United States widespread and increased demand anticipated, the "Cocaine Corridor" of western South American is more active than ever. Coca production is apparently increasing in Peru, while Bolivia remains an important source country. In September Customs Police in Ecuador uncovered a cocaine smuggling scheme utilizing tour buses that travel between Peru and Colombia. Colombia remains the hub of cocaine smuggling to the U.S. Colombian President Lopez has expressed dismay at the highly inflationary impact of drug trafficking profits on his country's economy.

Canada

The accelerated abuse of heroin continues to concern provincial and federal governments in Canada. The Vancouver Coroner's Office reported that during 1977, there were 139 drug-related deaths in that city alone.

In late May of this year, the Royal Canadian Mounted Police seized a private yacht in a case coordinated with DEA, and six and a half tons of marijuana, 19 pounds of hashish, and three quarts of hashish oil that had been smuggled from Colombia to Nova Scotia.

Thailand

Thailand has accorded one of its highest national priorities to the suppression of opium and heroin trafficking. On July 14, 1977, Thai authorities arrested a top level trafficker who has been active in an international drug ring for over 10 years. In a related raid, they seized over 140 kilograms of heroin and morphine, the largest single seizure ever made in Thailand.

In August 1977, the Thais publicly burned 284 kilograms of heroin seized in recent years.

A less spectacular but nonetheless potentially major development in the Thai campaign against illegal opium poppy cultivation has been the initial success of the experimental crop substitution program underway in northern Thailand since 1973. Many narcotics experts believe that cash crop replacement is the only long term solution to reducing the region's opium output.

Burma

On August 20, 1977, authorities in Burma seized 675 kilograms of narcotics, the largest such seizure ever recorded. The seizure included 430.8 kilograms of raw opium, 130 kilograms of unusually pure opium powder, 84.3 kilograms of heroin, and 29.9 kilograms of bricks of morphine base. The narcotics were seized from a general store in Tachilek, Burma, near the Thai border. It was another in a series of a government initiated narcotics suppression operations. In June, the Burmese destroyed five heroin laboratories. Most Burmese opium traffickers operate in the wild, hilltribe areas of the Shan State. The government has made significant progress against this traffic and hopes to continue doing so. Burma is not only a heroin producing country, but also a victim country with a large addict population.

Laos

There have been persistent reports that opium growing in Laos is continuing. Reports also indicate that Lao opium is appearing in the border areas for sale to opium traffickers.

Malaysia

If enforcement pressures in the Golden Triangle force traffickers to shift their bases of operation, Malaysia would be a likely target. Heroin laboratories, using morphine base produced in the Golden Triangle, have been seized in Malaysia. On August 10, 1977, for the first time, the Malaysian Narcotics Bureau seized No. 4 heroin. No. 4 heroin, as opposed to No. 3 heroin, which is smoking heroin and preferred by Oriental abusers, is injectable and could conceivably be produced for the U.S. market.

Singapore

The bulk of narcotics smuggled into Singapore is for local consumption since the country does not play a major role in the actual movement of narcotics to international markets. Singaporean nationals, however, figure prominently in international trafficking schemes. A number of the ethnic Chinese couriers have been arrested in Europe on trips originating in Bangkok, Kuala Lumpur, and Penang, Singaporeans also play a significant role as financiers of smuggling ventures.

Hong Kong

For several years, owing to vigilant customs inspections and stern prison sentences, it appeared that traffickers were avoiding Hong Kong. However, recent information suggests that Hong Kong-based financiers are involved in many heroin deals from other parts of Southeast Asia. These financiers maintain close links with the ethnic Chinese communities in both Europe and the U.S. To assist in the international effort to curb the flow of heroin throughout the world, an officer of the Royal Hong Kong Police Narcotics Bureau is stationed in Thailand.

PRELUDIN

Preludin is the trade name for phenmetrazine hydrochloride, a stimulant drug used in weight control programs. Phenmetrazine was originally included in Schedule III of the 1970 Controlled Substances Act. It was placed under Schedule II control near the end of 1971.

Phenmetrazine is marketed in the United States only by Boehringer Ingelheim, Ltd, located in Elmsford, New York. The bulk of the raw material is manufactured by Western Fher, Ltd, of Puerto Rico. It is then shipped to Ciba-Geigy in New York State where it is put into dosage form and packaged for marketing and distribution.

Preludin is available in three dosage strengths: white, square, scored tablets of 25 mg,: white, round Endurets prolonged-action tablets of 50 mg,; and pink, round Endurets-prolonged-action tablets of 75mg.

The 1977 Physicians' Desk Reference describes phenmetrazine hydrochloride as a white, water-soluble, crystalline power. Preludin's effects are similar to other drugs used to treat obesity, the amphetamines. Drugs of this class are commonly known as "anorectics" or "anorexigenics." Tolerance usually develops within a few weeks. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, and changes are also noted in sleep patterns. Manifestations of chronic intoxication with anorectic drugs include severe dematoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

Preludin as Substitute for Heroin

There is mounting evidence that Preludin, a stimulant, is being used by addicts to boost the effects of low grade heroin. In many cases, it is being used as a heroin substitute.

The precise scope of the abuse of Preludin nationwide is not known. This is because of the diverse methods by which local enfocement officials collect and maintain statistics. Compliance actions are further complicated by the large number of "prescription rings" that account for the diversion of hundreds of thousands of dosage units each year.

DEA offices in the Philadelphia and Baltimore areas have encountered the largest and best organized diversion operations, and therefore, have more complete information concerning the problem and its scope. The diversion problem encountered in these areas was created by individuals from Washington, DC, who used physicians and pharmacists in the Philadelphia area as their source of supply. So far, 45 persons, belonging to three separate organizations, have been identified. Other groups are suspected of engaging in similar activities since there is evidence of prescriptions being passed by as yet unidentified individuals.

The most common method of operation is to send carloads of overweight women from Washington to the Philadelphia area. There, they visit physicians who prescribe Preludin for weight control. Some of these women see the same doctor as many as three times in the same day. To do this, they use different names, wear different clothes, and change their wigs and make-up for each visit. The females are organized by "street pushers" from the District of Columbia. The women have the prescriptions filled in the town where the prescription was issued. Some of the women claim they were paid as much as much as $10 per prescription. Others claim that they received $50 to $70 per trip.

Forged prescriptions are usually prepared from blanks obtained at the doctors' offices. It is reported that one Washington, D.C. group leader called Philadelphia pharmacists and told them he had prescriptions for from 6,000 to 10,000 Preludin endurets and asked each pharmacists if they had enough of an inventory of Preludin to fill the prescriptions. On at least one occasion, it was reported that 200 prescriptions were filled in this manner.

Numerous variations on these methods exist. Some groups, for example, use women who reside in Philadelphia. These women visit local physicians and pharmacists to obtain Preludin. Once they obtain a previously agreed upon amount, they contact their organizer in Washington, D.C., who then travels to their location to pick up the drug.

Preludin diversion is reportedly spreading to other cities in the east. Those affected include Harrisburg, Allentown, Reading, the Philadelphia surburbs in Pennsylvania as well as cities in Delaware, Maryland, and New Jersey. The few statistics that are available indicate that over the past few years, approximately 25,000 dosage units per week of Preludin were diverted from pharmacies by groups operating in the Philadelphia area.

The average street price for this drug at the user level is about $10 per 75 milligram tablet. Preludin is available in Washington, D.C., through heroin dealers since the drug is reportedly used in that area in conjunction with heroin.

Because of the size of the diversion problem in the Philadelphia-Baltimore area, more information is available than can be obtained from other areas. However, the West and Southwest are also encountering major problems with Preludin.

A spokesman for the Fort Worth, Texas, Medical Education and Narcotic Treatment Program indicated that their research suggests many addicts used Preludin before turning to heroin. Additionally, there are indications that Preludin is gaining in popularity over other amphetamines and methamphetamines in that area as the current drug of choice.

Dallas County in Texas reported that Preludin was second only to Heroin as the most commonly encountered drug. Out of 80 patients recently admitted into maintenance treatment programs, 30 had a secondary addiction to some type of stimulant drug. Of the latter, one-third used Preludin as their primary stimulant.

The Gulf Coast Regional Narcotic Treatment Program in Galveston reported that Preludin is most commonly encountered in combination with Quaalude (methaqualone). Houston reports that Preludin was second in popularity, with Quaalude being the most popular legitimate drug of abuse.

As previously stated, the abuse of Preludin has now been encountered in some degree in all areas of the U.S. It is expected that the demand for Preludin will continue to increase as the purity level of heroin available in the U.S. continues to decrease.

(Based on a survey conducted by DEA's Office of Compliance and Regulatory Affairs, between January and April 1977.)

BACKGROUND

HQ USAF/DPX ALMAJCOM-SOA DP letter, Oct 77, Subject: Drug Abuse Assessment Guidelines, provided a Drug Abuse Level Assessment Guide to assist in gauging levels of drug abuse and in developing corresponding countermeasures strategies. In order to further assist the assessment effort, data have been collected from the Drug Enforcement Administration's Drug Abuse Warning Network (DAWN), i.e., from hospital emergency rooms, crisis centers, and medical examiners. Summaries are also provided from other intelligence reports.

The drugs are categorized by types of drugs, i.e, cocaine, opiates, barbiturates, amphetamines, PCP, LSD, other hallucinogens, and other miscellaneous substances of abuse (includes over-the-counter drugs, prescription drugs, aerosols, inhalants, and other substances that are abused).

These assessments are for individual cities; however, data from individual bases must be utilized in making definitive base and MAJCOM assessments by the Drug/Alcohol Abuse Control Committees (DAACC). For instance, information may indicate heavy drug abuse in a particular city. However, further specific analysis may conclude that abuse levels are low on a base near that city. The reverse could also be true. Thus, base and MAJCOM DAACC analyses are the keys to arriving at valid determination of local drug abuse levels.

The intent of this data is to assist in providing program managers at all levels with as complete a "Big Picture" as possible concerning drug abuse trends. These indicators should provide the MAJCOMs with timely information regarding drugs of abuse and levels of abuse in their respective areas.

DRUG ABUSE WARNING NETWORK (DAWN) DATA

OCT - DEC 77

	ATLANTA	BOSTON	BUFFALO	CHICAGO	CLEVELAND	DALLAS	DENVER	DETROIT	INDIANAPOLIS	KANSAS CITY	LOS ANGELES	MIAMI	MINNEAPOLIS	NEW ORLEANS	NEW YORK CITY	NORFOLK	OKLAHOMA CITY	PHILADELPHIA	PHOENIX	SAN ANTONIO	SAN DIEGO	SAN FRANCISCO	SEATTLE	WASH, DC	OTHER	COLUMN SUMS
COCAINE	6	9	7	14	4	1	4	17	2	3	6	59	11	2	116			6	4		9	13	7	9	12	317
OPIATES	24	126	19	174	26	9	32	450	21	9	59	207	17	3	671	3	7	87	68	1	149	70	29	85	104	2,468
BARBS	13	53	18	69	29	16	28	78	17	15	158	119	29	8	334	6	8	99	24	4	48	54	29	36	106	1,391
AMPHETS	16	22	13	21	16	15	8	31	8	11	23	14	24	10	88	6	5	43	16	8	23	33	15	10	82	564
PCP	7	19	19	83	1	2	4	21	3	9	106	7	16	3	62	2	7	50	1		28	10	2	27	16	514
LSD	4	6	12	9	5	6	6	22		3	6	26	9		48	2	3	15	3	2	9	8	2	8	19	230
HALLU-CINOGENS		9	2	1	1		2	11			6	3			6			2		18	3		10	3	12	75
OTHER	379	669	458	1231	359	309	547	1454	231	342	777	1356	427	164	1968	152	146	1305	437	206	482	413	315	645	2046	16,789
TOTAL	449	913	548	1597	440	358	631	2084	284	392	1141	1787	528	190	3293	174	176	1603	564		753	603	409	823	2397	22,348

DRUG ABUSE WARNING NETWORK (DAWN) DATA

Jan - Mar 78

	ATLANTA	BOSTON	BUFFALO	CHICAGO	CLEVELAND	DALLAS	DENVER	DETROIT	INDIANAPOLIS	KANSAS CITY	LOS ANGELES	MIAMI	MINNEAPOLIS	NEW ORLEANS	NEW YORK CITY	NORFOLD	OKLAHOMA CITY	PHILADELPHIA	PHOENIX	SAN ANTONIO	SAN DIEGO	SAN FRANCISCO	SEATTLE	WASHINGTON DC	OTHER	TOTAL
COCAINE	5	11	8	11	3		5	16	1	2	9	58	1		82	1	2	15	5	1	6	6	2	15	7	272
OPIATES	29	110	17	139	22	9	27	318	17	10	48	191	16	6	582	2	11	93	71	12	110	83	24	82	62	2,091
BARBS	17	51	22	48	25	18	18	69	10	15	132	105	26	6	319	3	6	122	30	14	64	56	27	32	95	1,330
AMPHETS	16	28	13	28	10	9	17	32	7	23	21	18	31	5	80	4	4	71	13	7	18	37	28	19	103	642
PCP	6	5	23	75	3	1	2	16	3	4	97	30	8	3	86		2	41	15		27	3	3	45	23	521
LSD	1	5	16	9	5	5	2	7	2	4	8	32	6	4	39	1	3	13	11	4	8	8	2	3	15	213
HALLU CINOGENS		8	1	5	4			8		2	1	2			6			3	1		2	2		1	3	49
OTHER	405	588	455	218	323	305	536	1449	219	344	930	293	429	140	927	136	179	1276	465	220	438	430	333	706	2027	16,771

In addition to the quarterly report, we provide additional program information and guidance on a continuing basis.

Assessing the impact of drug abuse on readiness, which is one specific question the committee asked, is very difficult, and I must address it in terms of how we monitor readiness in general. Readiness of Air Force combat and combat support units is reported through the Joint Chiefs of Staff force status and identity report (FORSTAT). Units are rated C-1 to C-4—C-1, combat ready; C-4; noncombat ready—depending on the state of their readiness to perform their assigned mission. The C ratings are determined from reports submitted through the Air Force-unique unit capability measurement system (UCMS). This system measures four separate areas—equipment, crew training, personnel, and logistics—to determine the percent of each category available for use. The C rating for a unit is equal to the lowest rating assigned for each of the four areas measured. In the personnel area we measure the percentage of key, sortie-generating-skill people available versus the number required. Personnel are reported not available for a number of reasons, such as hospitalized, undergoing medical treatment, in confinement, personnel reliability program disqualified, et cetera. There is no specific category for drug abuse, but drug abusers unavailable for duty would be reflected in the above categories listed. In addition, each unit commander makes an additional subjective narrative evaluation of unit readiness and any factor, including drug abuse, may be considered without regard to the UCMS-unique measured factors. The personnel component of the UCMS/FORSTAT is rarely the cause of a unit's readiness status dropping below fully ready (C-1). When this occurs, it is usually due to a shortage of key skills that are either hard to recruit, train, or retain; that is, in the area of fuels, weapons loaders, and precision measurement equipment specialists. Additionally, the Air Force management system insures close supervision of key personnel in the measured units. This system monitors the impact of that drug abuse we are detecting in terms of removing personnel from availability for their duties, but it does not fully address the drug abuse which has not been detected, that which has not visibly impacted on behavior and job performance. So what I am saying is we have a system which accounts for personnel, numbers of people who might not be available for any readiness, and we can detect drug abuse. What it does not assess are those whom one might not suspect of drug abuse.

However, with the close supervision we have on a daily basis for all those people, I would be greatly surprised if a great amount of drug abuse goes undetected.

Resources that are being directed to the detection of drug abuse and rehabilitation are in some measure detracting from resources that could otherwise be allocated to readiness. For those who we do detect and who are not on the job and the assets we have to devote to detection and rehabilitation, obviously if there were no drug abusers those assets could be devoted to readiness activities. So we pay a price for the drug abuse program, but the bottom line is such that we have never had a unit declared nonready for personnel, much less great numbers of personnel unqualified because of drug abuse.

Personnel identified as drug abusers and subsequently entered into the rehabilitation program represent a manning loss and, for that period, a direct or indirect impact upon the manning standard for unit readiness. In other words, the impact due to drug abuse or drug-related incidents represents a readiness cost in terms of turbulence and replacement. Readiness is being maintained, but at a significant personnel cost. However, readiness of all rated units is also tested/validated at least annually, and sometimes more often. Operational readiness inspections (ORI's) require a unit to actually demonstrate its capability to do its job, and frequent mobility exercises require units to perform simulated wartime missions at surge rates and increased work hours. If one were to say he would do his 8-hour day and then do his thing over the next 16 hours before he would have to report again, sometimes during those surge exercises we work for 12 hours, and even 16 hours.

These inspections and exercises have consistently demonstrated that our combat units are ready. In no case has it been documented or reported that an Air Force unit's readiness status was severely impacted due to drug abuse. This is an area, however, with no room for complacency, and I want to assure you that we will continue to closely watch the indicators and take corrective measures where warranted. Along those lines, we are reviewing our readiness monitoring system, the UCMS, to determine if we need to improve our accounting for drug abuse and its specific impact.

We believe our interaction and cooperation with DOD and the other services is very good. Because of the level of program management experience we have developed over the years, and because of the adequate funding support we have had for our program, we find the level of DOD support to be adequate at this time.

In commenting again, in compliance with the request of the committee as to the impact of marihuana decriminalization on the Air Force, the Uniform Code of Military Justice provides commanders with wide latitude in administering disciplinary or judicial actions with regard to marihuana. In practice, Air Force personnel identified for minor marihuana possession or use receive punishment such as a fine and/or reduction in rank. For a first offense, reduction in rank is frequently suspended to give the individual an added incentive. In this sense, our current system is fairly consistent with the proposed legislation, and I do not believe the passage of decriminalization legislation would radically alter the way we handle marihuana-abuse cases. The proposed legislation could have an adverse impact if our personnel inferred a permissive attitude about drug abuse because of the legislation. I want to hasten to add that.

We have some concerns in this area, and have heard some reports of military personnel being confused about the meaning of the decriminalization proposals. In order to address this subject we are publishing a pamphlet on marihuana to be used in our education/prevention programs to clarify the issues. I would like to furnish a copy of this pamphlet for the committee's use. I think you would find it very, very useful. It is very complete.

Mr. ENGLISH. Without objection, so ordered.

[The information referred to follows:]

MARIJUANA UPDATE

An Informational Report to Social Actions

Prepared by

Program Development and Analysis Section
Social Actions Training Branch
3290th Technical Training Group
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FOREWARD

The marijuana question is one of the more highly controversial and emotionally charged issues facing our society. The conflict surrounding this issue is commonly encountered by social actions personnel in the field. This update on the status of marijuana is provided as an information aid to help you deal with these issues. It is not intended to support either side of marijuana research, but rather, states the facts as objectively and precisely as possible. In using this information, it is important to remember that marijuana remains illegal and its use is in direct conflict with Air Force standards and regulations.

MARIJUANA

HISTORICAL PERSPECTIVE

The marijuana plant was originally named Cannabis Sativa in 1753 by Carl von Linne, a Swedish botanist. It is a single species genus which originated in the Orient and now grows worldwide. It has been grown commercially for its fibers, from which hemp rope is made.

Archaelogical evidence of its use as a hemp crop dates back around 3000 B.C. in China. However, no evidence of its use as a psychoactive substance was established until about 500 B.C. in the Mid-Asia region. It was used in India as early as 400 B.C. for religious purposes until A.D. 12 when it was used for medicinal purposes as well.

Marijuana became well known throughout the Mediterranean and Arab world by the 10th Century A.D. Social use of the plant spread to the Moslem world and North Africa by the 11th Century A.D. and by the 12th Century A.D. it was considered epidemic.

Marijuana was adopted by Europeans as a psychoactive substance at the turn of the 19th Century. With the wide acceptance of tobacco by Europeans, marijuana achieved a new form of administration--inhalation by smoking.

It was grown in Virginia as a commercial crop as early as 1611. It appears to have been used as a psychoactive substance in the United States, first in the 1850's and then in 1916.

American soldiers learned of its use when fighting Pancho Villa along the Mexican border in 1916. Also that same year, its use by American soldiers serving in the Panama Canal Zone became the subject of an official military inquiry. The military report found marijuana to be "a mild intoxicant used to alleviate monotony by primarily moronic and psychopathic soldiers, most of whom misbehaved because of marijuana."

By the 1920's, marijuana use in the United States had increased primarily among a few soldiers and sailors exposed to other cultures and by some citizens in seaport cities. In 1920, a New Orleans newspaper claimed it was being sold to school children by "vicious elements." Investigations termed it a "tempest in a tea pot," but journalistic coverage continued. Those events of the 1920's seem to be the first sensationalism over the drug and the first in which exploitation of the innocent in America was a theme.

By the late 1930's, marijuana had spread to Northern urban centers, but was confined almost entirely to Negro and Latin American slums. At that time, its use was social in nature. Mild euphoria was given as the reason for its use. This was followed by widespread journalistic interest and public anxiety. Myths concerning marijuana's dangerous nature began to emerge and a sustained campaign for punitive control was begun.

Mr Harry Anslinger, head of the Federal Bureau of Narcotics (NFB), began a campaign against marijuana in the late 1930's. It was a legislative plan to seek from Congress a new law that would place marijuana and its distribution directly under federal control. With the aid of FBN's resources, Mr Anslinger directed his campaign toward the public by way of radio network broadcasts, articles in magazines, and lectures by FBN agents to parents, educators, and social and civic leaders.

The main thrust of Mr Anslinger's attack against marijuana was to link its use with major crimes. He emphasized that major crimes are associated with the practice of smoking marijuana and that marijuana users come from the hardened criminal class. Additionally, he pointed out that the use of marijuana led to violence, aggression, anti-social behavior, and that it altered basic personality structure and caused sexual overstimulation.

The conclusions used by Mr Anslinger and his associates were obtained from Professors Paulo O. Wolff and R. J. Bouquet without benefit of clinical research. In spite of the deficiency in the data, Mr Anslinger treated the information as though it were based on empirical fact and approved it for dissemination.

Mr Anslinger's campaign was thorough; the public accepted the information as factual. Congress accepted Mr Anslinger's report as authentic and passed the Marijuana Tax Act in

August 1937. This federal law did not outlaw marijuana or its preparations. It taxed the grower, distributor, seller, and buyer. Administratively, it became almost impossible to have anything to do with marijuana. With the Marijuana Tax Act of 1937 as leverage, the Bureau of Narcotics and Dangerous Drugs prepared a uniform law that many states adopted. These laws made possession and use of marijuana illegal.

In 1938, New York Mayor Fiorello LaGuardia commissioned a team of scientists, under the auspices of the New York Academy of Medicine, with the task of assessing the marijuana problem in New York City. This was perhaps the first objective sociological study on marijuana conducted in the United States. At the completion of their report in 1944, though not denying marijuana exerted perceptible effects, it was concluded there was no evidence that major crimes were associated with smoking marijuana. The marijuana user does not come from the hardened criminal class and there was no direct relationship between the commission of crime and violence and marijuana. Second, the drug's use does not lead to aggressive or anti-social behavior. In most instances, the behavior of the smoker is that of a friendly, sociable character. Aggressiveness and belligerency are not commonly seen. Finally, it does not alter the basic personality structure or cause sexual overstimulation in the user. Marijuana itself has no specific stimulant effect in regard to sexual desires. It further

concluded that habituation to marijuana is not as strong as that associated with tobacco or alcohol. The report also suggested some possible therapeutic uses such as in the treatment of depression, loss of appetite, and even opiate addiction.

The findings of Mayor LaGuardia's committee, not issued until 1944, essentially invalidated Mr Anslinger's allegation. However, the effects of Mr Anslinger's campaign against marijuana in the late 1930's and the years that followed had a lasting impression on the American public and government officials. In 1967, when the use of marijuana by the young became rampant, a high priority Health, Education and Welfare (HEW) program to study the implications of marijuana use for Americans was started. This began a program of research to answer the questions concerning marijuana use. These studies are continuing. Each year since 1971, the Department of HEW submits the findings of the previous years to Congress in a numbered report. There are five reports to date. Although much has been learned about the pharmacologic effects of marijuana, more research is necessary.

MEDICAL HISTORY

The earliest recorded reference to the therapeutic use of marijuana is found in the Rh-Ya, a 15th Century B.C. Chinese Pharmacopea.

Marijuana was an important drug in the Indian Materia Medica at the turn of this century. It is still widely used in rural areas of the Indian Subcontinent for respiratory ailments such as asthma and bronchitis.

In Western medicine, an interest in medical usefulness of marijuana developed during the last half of the 19th Century. Winek (1977) describes various medicinal cannabis preparations which are found referenced in some of the older Materia Medica text and journals.

Well over a hundred papers appeared in medical journals of the time. O'Shaugnessey (1842) tried marijuana on patients with a variety of ailments, including tetanus, rabies, epilepsy, and rheumatism. He reported favorably on its anticonvulsant, analgesic, and muscle-relaxing properties. M'Meens (1860) considered it a sedative-hypnotic, useful in such diverse disorders as neuralgia, dysmenorrhea, asthma, and sciatica. Burch (1889) and Mattison (1891) recommended marijuana enthusiastically for the treatment of morphine, alcohol, and other addictions. Reynolds (1890) wrote of its value in senile insomnia. Moreau de Tours (1857) claimed the successful treatment of obsessive compulsives, melancholics, and patients with many other chronic psychiatric syndromes.

Despite the testimonials regarding marijuana, the drug fell into disuse at the beginning of the 20th Century. The following factors contributed to its demise:

a. The instability and large variation in the potency of marijuana-containing medications resulted in an unreliable degree of therapeutic effectiveness. Thus, some medications were weaker or stronger than others.

b. The active ingredient in marijuana was insoluble in water and poorly absorbed from the GI tract. This made the oral administration of marijuana medications much less effective.

c. Better drugs were being developed which could be used in place of marijuana and had a more stable and predictable pharmacologic action.

d. The Marijuana Tax Act of 1937 placed a penalty on the use of marijuana and classified it as being a dangerous, narcotic drug.

Even when the first synthetic THC, pyrahexyl (synhexyl), became available for clinical trials in 1950, it was not widely used. The systematic study of the clinical pharmacology of cannabis (marijuana) is less than 10 years old. A number of scientific advances and changes in legal and administrative policies were needed before it got underway, such as:

a. The total synthesis of delta-9-THC by Mechoulam (1965), permitting the manufacture of sufficient material for research.

b. The finding, by Mechoulam (1970), indicating that delta-9-THC is the active ingredient in marijuana.

c. The development of a reliable assay procedures for quantifying the content of delta-9-THC in marijuana, by the University of Mississippi group (1973).

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d. The findings of animal and human studies designed to investigate the physiologic, pharmacologic, and psychologic effects of marijuana.

e. The availability of various cannabinoids, from the National Institute of Drug Abuse (NIDA), for research purposes.

f. The development of assay methods for qualitatively identifying cannabinoids of biological fluids (1973).

Marijuana has been suggested to have potential therapeutic usefulness in a number of diverse areas (Cohen and Stillman, 1976):

a. Lowering intraocular pressure in glaucoma (Green et.al., 1973, 1975, 1976, and Hepler et.al., 1975).

b. Bronchodilation in asthma and other chronic obstructive pulmonary diseases (Vachan et.al., 1976, and Tashkin et.al., 1973).

c. Controlling and preventing convulsions due to various seizure disorders (Consroe et.al., 1973).

d. Tumor growth suppression in certain cancers (Harris et.al., 1976).

e. Sedation and hypnosis (Freeman, 1974).

f. Analgesia (Kaymakcalan et.al., 1974, and Noyes et.al., 1973).

g. Antidepressant activity and tranquilization (Kotin et.al., 1973).

h. Preanesthesia (Stoelting, 1973).

i. Control of nausea and vomiting associated with cancer chemotherapy (Rachelefsky et.al., 1975, and Sallan et.al., 1975).

Although the exact mechanism by which marijuana exerts its various pharmacologic effects remains unknown, studies into these and other possible areas of therapeutic usefulness continue.

FIELD STUDIES ON CHRONIC USERS

The following field studies of chronic marijuana users were sponsored by the National Institute on Drug Abuse (NIDA), Department of Health, Education and Welfare, to determine the effects of marijuana on chronic users. These studies were conducted on populations of frequent long-term users for possible adverse effects associated with chronic use. All the studies were concerned with users in countries where higher potency marijuana is more readily available than in the United States.

JAMAICAN STUDY

The Jamaican study (1970) was conducted on 30 subjects with an equal number of controlled subjects to evaluate the effects of chronic marijuana use on physical and psychologic functioning. It found few differences between the matched smoker and non-smoker populations. The results of Rubin and Comitus (1976) showed: 1) No evidence of malfunction in liver, kidney, and cardiovascular systems when comparing heavy marijuana smokers

with nonsmokers; 2) No differences could be determined in chromosomal abnormalities; 3) Only modest decreases were noted in lung (pulmonary) function and altered blood (hemoglobin) levels among smokers; 4) There was no evidence of the "amotivation syndrome;" 5) No increase in appetite was noted; and 6) There was no enhancement of hearing or altered sense of time.

GREEK STUDY

The Greek study (1975) arose from a clinical impression by Greek observers that Greek hashish users, because of their heavy use patterns, would make a good study population for examining the effects of unusually heavy marijuana use. Approximately 47 chronic users were compared with 40 control nonusers.

A variety of neurological, psychological, and physical measures found few changes attributed to marijuana use. Heavy emphasis was placed on possible brain damage as measured by electroencephalographic, echoencephalographic, and psychologic test procedures. Stefanis et.al. (1976) reported that none of these measures showed evidence of brain damage.

COSTA RICAN STUDY

The most recent Costa Rican study conducted by Coggins (1976) examined 80 samples of users and nonusers carefully matched on such variables as age, marital status, education, tobacco smoking, and alcohol use. Emphasis was placed on

extensive medical examinations with special attention to pulmonary and neuropsychological functioning. Although detailed results have not yet been published, initial findings indicate no evidence for a greater incidence of disease or of psychological deterioration has been found in the marijuana-using group.

While results of these studies may be an indication of the lack of grossly adverse consequences of marijuana use, these studies cannot be regarded as conclusive for several reasons. All three studies involved relatively small number of subjects. The psychological testing techniques used are less likely to show valid correlations when used with an experimental population differing markedly from the original sample population. It may also be argued that the demands of a lesser technologically oriented society are not as complex as those of the industrialized United States. Thus, the failure to find a drug-related decrement in social or work performance may reflect an unimpaired ability to meet the demands of a simpler situation. This, one might contend, would not be true under more demanding circumstances.

ARMY STUDY

A U.S. Army financed study (1974-1976) headed by Dr Jack H. Mendelson was conducted to determine whether chronic marijuana smoking affects an individual's work motivation or ability to

demonstrate a variety of Army skills (marksmanship, manual dexterity, etc), lung functioning, testosterone level, weight, cognition or neurological function, and group interpersonal behavior.

The study was conducted in a controlled setting at the McLean Hospital Alcohol and Drug Abuse Research Center in Belmont, Massachusetts, and involved 27 carefully selected subjects classified as casual (2-1/2 marijuana cigarettes per day) and heavy (approximately 6 marijuana cigarettes per day) smokers.

The study substantiated many of the conclusions drawn by the Jamaica Study (1970). The conclusions drawn were:

a. No impairment in motivation to work even when users smoked a large number of marijuana cigarettes.

b. Some decrease in work performance the day following heavy smoking, though not biologically significant.

c. Some impairment in lung function; closely related to the smoking process per se rather than to any pharmacological action of marijuana.

d. No change in plasma testosterone levels after heavy intensive marijuana use. This contradicts the findings of Kolodny et.al. (1974).

e. A significant weight gain was attributed to smoking marijuana as opposed to the Jamaican Study where there was a weight loss observed.

f. No evidence that chronic marijuana use impaired cognitive or neurological function.

g. Some changes were observed in social and psychological factors associated with interpersonal responses, but not to the point of interfering with group behavior. Casual users talked less and retreated into their own thoughts more, while no changes were observed in group behavior by the heavy users, except they seemed to laugh more.

Although tolerance was observed in the heavy user group (length of "high" shortened) and their level of use increased to 14 marijuana cigarettes per day, Mendelson explains that "tolerance does not develop to marijuana intoxication...unless rather heavy doses of delta-9-THC are administered repeatedly."

Mendelson concludes that "marijuana is rather benign, that it's a mild intoxicant in contrast to alcohol."

PHARMACOLOGY

There are numerous constituents (termed cannabinoids) comprising the crude, natural Indian hemp plant (Cannabis Sativa). As of 1973, it was reported that 29 cannabinoids had been isolated from the raw plant material and identified. In addition to the natural cannabinoids, there are also several cannabinoids of synthetic or metabolic origin. Since most cannabinoids are present in only small amounts, few have been evaluated for pharmacologic activity.

Marijuana is one of many different forms of cannabis. It is smoked or orally ingested to obtain a desired effect and is generally composed of a mixture of leaves, stems, and flowering tops from the Cannabis plant. Since THC (delta-8- and delta-9-tetrahydrocannabinoids) is the principle constituent that is both active and present in sufficient quantities in the plant, the pharmacologic effects of marijuana are largely attributed to THC. The quality or grade of the marijuana is determined by its THC content, which varies depending on the climate and geographic area of growth, manner of cultivation, plant strain, sex, and the part of the plant used. Marijuana containing 1% THC or more is considered to be good quality in relation to the pharmacologic effects produced. Most marijuana used in the United States contains roughly 0.5% to 2% THC per cigarette.

A typical, pharmacologically effective dose is roughly 5-10 mg THC inhaled via smoking. At these doses the onset of effects occurs within 30 minutes and lasts in duration for 3 to 5 hours. Marijuana is three times as potent when it is inhaled as when it is ingested orally. Thus, the route of administering marijuana is an important consideration in influencing the effective dose required, as well as the onset, degree, type, and duration of effects.

The type and degree of effects produced by marijuana are variable and are determined or partially influenced by factors such as the dose (THC) administered, the frequency and duration

of use, physiological and psychological make-up (set), the personality, mood, expectations and experience of the user, and the setting for its use.

The varied effects of marijuana encompass both physiological as well as psychological parameters and its action may be depressant or hallucinogenic depending on the THC dose. The scope of effects can be expressed in terms of three different stages of marijuana use: 1) The initial or average dose stage includes those effects produced following the typical, short-term (social) use of marijuana in normal, effective doses; 2) The acute toxicity stage depicts the adverse effects resulting from the short-term or single dose administration of excessive (overdose), toxic doses of marijuana; and 3) The chronic use stage involves the residual effects of marijuana following frequent, long-term use of normal, effective doses.

A wide range of physiological and psychological effects are possible with the initial or average dose stage use of marijuana. These effects include:

Increased heart rate (tachycardia)

Reddened or inflamed eyes (conjunctival infection)

Increased hunger - especially a craving for sweets

Dry mouth and throat irritation

Loss of "inhibitions" (disinhibition) - often interpreted as excitation of hyperactivity

Recent (immediate) short-term memory loss - not linked to impaired intellectual performance

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Mental depression and confusion

Drowsiness and sedation or

Irritability and restlessness

Heightened sensory perceptions - increased visual imagery, intensified senses of taste, touch and smell, and colors and sounds take on a new dimension

Illusions (misinterpreted sensations) rare

Delusions (false beliefs) rare

Cannabis-induced mild paranoia

Hallucinations (experiencing nonexistent sensations) rare

Intense, subjective feeling of well-being (euphoria or "high") - increased sense of sociability, awareness, involvement, detachment, suggestability, contentment, inner satisfaction, and free play of the imagination.

Impaired motor coordination and reaction time

Distorted time and space perceptions - time moves slowly and space seems enlarged or otherwise distorted

These effects include both objective (measurable) and subjective (personal) types of responses. Emphasis should be placed on the fact that at this stage of marijuana use, a variety of perceptual, cognitive, and psychomotor performance tasks are significantly impaired. These same tasks are closely associated with driving ability, flying, and other related skills.

The short-term (acute) ingestion of a lethal dose of marijuana in man is virtually impossible. Lethal dose

determinations made experimentally on animals show that for most species, the toxic or lethal dose thresholds for marijuana are quite high compared to other types of widely used drugs such as alcohol.

Inhalation or oral ingestion of excessive amounts of high quality marijuana or other potent forms of cannabis, such as hashish, can result in acute toxicity. Marijuana overdose can produce exaggerated degrees of responses to those types of effects noted in the initial or average dose stage of use (e.g., intensified perceptual distortions, greatly impaired judgement, and coordination functions).

In addition to the exaggerated degrees of responses, there are two primary phychological disorders which can result in the acute toxicity stage: 1) The acute panic anxiety reaction is probably the most common. This reaction is not necessarily due to marijuana overdose, but can occur at any dose producing a condition where the set and setting factors become threatening to the individual. The condition is most often associated with fears of "going crazy;" 2) The cannabis induced acute-brain syndrome or toxic delirium can result from overdosing, usually by the oral route of administration. The symptoms associated with this syndrome include mental clouding, disorientation, confusion, and marked memory impairment. The condition is self-limiting and not considered dangerous in itself, although accidental physical injury can result from the impaired state of mental functioning.

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Numerous adverse effects have been attributed to the long-term (chronic) use of marijuana. These alleged effects involve impaired immune response, genetic and birth defects, brain damage, endocrine (harmonal) abnormalities, respiratory complications, cancer, prolonged psychological deficits, and drug dependence. (These effects are discussed in greater detail under the Risk-to-Benefit Relationship section.)

Possible effects derived from the chronic use of marijuana include:

Chronic respiratory complication - impaired pulmonary (lung) function, bronchitis, emphysema, persistent cough, and obstructive pulmonary defects.

Hormonal changes - breast enlargement in males (gynecomastia), decreased testosterone levels, and possible male impotence and sterility.

Drug dependence - psychological (habituation), physical (addiction), tolerance, and withdrawal syndrome--on discontinuation of long-term use.

Flashbacks - spontaneous recurrences of feelings and perceptions similar to those produced by the drug (Stanton et.al., 1976).

Cannabis psychosis - psychotic reactions associated with the frequent use of high potency cannabis; psychosis can last up to six weeks or longer.

Psychological deficits (note section under Field Studies on Chronic Users) - amotivation and apathy, changes in personality and life styles, and social deterioration.

Chronic use studies indicate, with the exception of impaired pulmonary function changes, marijuana effects on physiological and psychological areas tend to be reversible following discontinued use of the drug. In many cases, where marijuana use is associated with some type of disorder, it is difficult to establish a precise cause and effect relationship.

RISK-TO-BENEFIT RELATIONSHIP

Contrary to the popular belief that certain drugs are inherently "safe" while others are "dangerous," it should be stressed that the effects produced by a drug on its user will largely depend on the conditions of the drug's use. Variables include dose, frequency, duration of use, physiological, and psychological make-up of the user. Since all drugs have a potential for both beneficial as well as detrimental effects, the risk-to-benefit relations must be considered with the use of any drug. Marijuana is no exception. The question of marijuana's "safety" or danger is widely publicized and highly controversial. During the last decade, research into marijuana has been oriented toward its social, behavioral, psychological, physiological, biochemical, genetic, and other types of effects. Findings in these areas of research have been claimed,

substantiated, and refuted time and time again. Many of the findings are still inconclusive and limited in scope.

Knowledge of the risk-to-benefit relationship can be useful in dealing with drug abusers. By making the drug abuser more aware of the risks, the relationship can be changed and a decision made that risks outweigh the benefits. Avoid scare tactics and deal with the relationship objectively. Legal risks are very important in this process. An assumption that the drug abuser is aware of these risks may be false.

In order to assess the risk-to-benefit relations associated with marijuana, it is necessary to know what risks or dangers have been implicated with marijuana use. Recent investigations have focused on adverse effects involving brain damage, impaired immune response, genetic defects, hormonal abnormalities, respiratory complications, cancer, impaired mental and motor responses, and dependence liability. The following excerpts provide insight into these investigations.

1) The Campbell Study (1971), which used air encephalography in 10 patients, claimed that chronic use of marijuana causes irreversible damage to the brain, including brain atrophy and premature aging. Findings indicated that the subject's cerebral ventricles were significantly larger than 13 controls of a similar age group. Heath (1972) using implant brain electrodes in monkeys, demonstrated recording changes in the septal region and other areas following marijuana exposure, thus tending to support Campbell's findings.

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Until recently, due to the complicated nature of the experimental techniques used in these two studies, no attempts had been made to replicate the results. Most recently, however, two separate studies, one by Co et.al. (1977) and one by Kuehnle et.al. (1977), failed to find any evidence of cerebral athophy in a sample total of 31 young males with histories of heavy cannabis smoking. Both studies used a brain scanning technique--computerized transaxial tomograph--to visualize the anatomy of the brain. This technique is more sophisticated and precise than the air encephalography technique used by Campbell. Despite these negative findings, the Sixth Marijuana and Health Report (1976) emphasizes that neither study rules out the possibility that more subtle and lasting changes of brain function may occur as a result of heavy and continued marijuana use. The report goes on to state, however, that virtually all studies completed to date (late 1976) show no evidence of impaired neuropsychologic test performance in humans at the dose levels studies.

2) Chronic marijuana use is believed to result in deterioration of mental functioning, pathological forms of thinking resembling paranoia, chronic passivity, and lack of motivation (the so-called "amotivational syndrome"). There are a number of clinical reports on the subject. Kolansky (1973) reported that moderate or heavy marijuana usage produces serious neuro-psychiatric complications. The impairment ranges from

mild ego disturbances to psychosis. The disabilities include: poor social judgement, attention span, and concentration; confusion, anxiety, depression, apathy, indifference, and suspiciousness; and a slowed, slurred speech. Powelson (1974) pointed out that users have no insight into the gradual mental impairment taking place. Powelson believes that sometimes the changes are not reversible after drug use is discontinued.

3) Studies by Nahas (1974), Zimmerman (1974), and Blevins (1976) have reported that marijuana decreases or inhibits cellular deoxyribonucleic acid (NDA), ribonucleic acid (RNA), and protein synthesis. These alterations in the basic, cellular reproduction and metabolic processes have been associated with reduced levels of white blood cells and possible impairment of the body's immune response, lowering the body's resistance to infections and cancer (Rachelefsky et.al., 1975). A UCLA group (Silverstein and Lessin, 1974), however, reported no impairment of immune response on skin testing of moderate to heavy marijuana users. According to the Sixth Marijuana and Health Report (1976), the possible impairment of the immune response remains unresolved and as yet there is no evidence that marijuana users are more susceptible to either infections or cancer.

4) No conclusive evidence exists regarding damage to human genetic functioning. Studies by Morishima (1974) and by Stenchever (1972) showed that marijuana use results in

chromosomal changes. This includes a reduction in the numbers of chromosomes and causes chromosomal deformities. However, a number of researchers have found no significant differences in chromosomes of users and nonusers: Maysuyama (1973), Dorrance (1970), Gilmore (1971), and Rubin (1973). Information on teratogenic effects (birth defects) in humans is lacking and it may take several generations to obtain reliable information. Studies by Gerber et.al. (1969) and Persuad et.al. (1975) demonstrated no teratogenic findings. The Sixth Marijuana and Health Report (1976) concludes: overall there is no convincing evidence at this time that marijuana causes any significant chromosome damage.

5) Marijuana is reported to have an adverse effect on the reproductive system of the male. A study by Kolodny (1974) showed that testosterone levels were temporarily reduced by 44 percent in young males who had used marijuana at least four days a week for at least six months. Sperm counts in 6 of 17 were reduced, falling to a level in the heavy smokers which would render them sterile. A small number of the subjects complained of impotence which improved on discontinuing marijuana use. Independent studies by Leuchtenberger (1973) and Miras (1973) found similar results in animals. The Army Study (1974), however, found no changes in testosterone levels in the male subjects studied. The biological significance of the previously reported hormonal abnormalities remains in doubt. The

Sixth Marijuana and Health Report (1976) states that it may well be that these findings will ultimately prove more significant for individuals with already impaired fertility or other evidence of marginal endocrine functioning.

6) Harmon and Adiapoulios (1975) reported on 16 young males, fairly heavy marijuana smokers, all of whom experienced enlargement of their breasts (gynecomastia). In Canada, the report was followed up by animal studies, which seemed to confirm the fact that marijuana causes proliferation of breast tissue in males.

7) There is good evidence indicating that the short-term administration of marijuana and synthetic delta-9-tetrahydrocannabinol produces an increase in the size of air passages--bronchodilation--in the lungs, which facilitates breathing in asthmatic patients (Tashkin et.al., 1973, and Vachon et.al., 1973). However, research continues to show that chronic marijuana smoking can result in impaired lung functioning. Recent work by Tasnkin et.al. (1976) has demonstrated impaired lung functioning after 6 to 8 weeks of heavy marijuana smoking. This suggests that marijuana smoking, like cigarette smoking, may lead to lung disease. Heavy marijuana smoking is believed to produce more sinusitis, pharnyngitis, emphysema, and other respiratory difficulties in a single year as compared to what 10 to 20 years of cigarette tobacco smoking could produce. A study by Tennant (1968-1972) on hashish use among soldiers in

West Germany showed frequent upper respiratory infections, and biopsies of the bronchi showed chronic inflammatory and mataphasic cnanges in the mucous membranes. A study by Leuchtenberger (1973) led him to believe that long-term inhalation of marijuana can contribute to the development of lung cancer. This is based on irregular growth patterns of human and animal cells under exposure of marijuana. The cells resemble precancerous lesions. A recent study by Novotvy (1975) claims that there is clear evidence that smoking Mexican marijuana cigarettes is more likely to cause cancer than smoking regular cigarettes. His tests indicate higher concentration of "several known carcinogens" in marijuana smoke, as compared to cigarette smoke.

8) Marijuana induced impairment of mental and motor performance is well documented. The various parameters affected, including memory, judgement, time sense, attention span, reaction time, motor coordination, and signal detection, are important in task functions such as driving and flying. Using low doses of marijuana cigarettes containing approximately 1 mg THC, Evans et.al. (1973) demonstrated a dose-related impairment in psychomotor performance, as measured by stability of stance and tracking ability; he found no measurable effects on mental performance. Kiplinger et.al. (1971) found dose-related impairment in both mental and motor performance using high dose marijuana (cigarettes containing approximately 6.3 mg THC); there was significant deterioration in flying performance.

Studies also point out that the impairment of motor skills, important in driving and flying, may persist for a considerable time after the subjective feeling of the "high" wears off; Keilholz et.al. (1973) and Meacham et.al. (1974).

9) Although psychological dependence (habituation) to marijuana is well known, tolerance phenomenon, physical dependence (addiction), and withdrawal have been suspected, but not previously observed in studies (either in the United States or abroad). Recent studies by Benowitz and Jones (1975) and Frank et.al. (1975) have demonstrated a dose-related tolerance which develops rapidly to certain behavioral, psychological, and physiological parameters. Studies conducted by Benowitz and Jones (1976) and Feinberg et.al. (1975) found that cessation of drug use following long-term, oral administration of high doses of THC (to volunteers under controlled experimental conditions) resulted in the appearance of symptoms indicative of a withdrawal syndrome (irritability, restlessness, decreased appetite, sleep disturbances, sweating, tremors, nausea, vomiting, and diarrhea). The appearance of a withdrawal syndrome in these studies was taken to indicate that physical dependence had existed prior to discontinued drug use.

The enormous amount of conflicting information that exists on the effects of marijuana and the intense controversy surrounding marijuana research contributes to the general confusion regarding the complex marijuana issue. In assessing the cause

versus effect relation between marijuana use and the potential risks or dangers implicated by the results of various studies, several factors must be considered:

a. Was the dose administered quantified by a reliable assay procedure?

b. Are the effects observed dose and/or time dependent in nature?

c. How was the (marijuana) dose administered (the route, frequency, and duration of administration)?

d. Are the criteria of measurement valid and sensitive enough to detect the drug's effects under the experimental conditions set?

e. Is the size of the test group adequate?

f. Are the effects observed attributable solely to marijuana or to another substance possibly interacting with marijuana?

g. Are the parameters of biologic variation (age, sex, genetic, state of health, set, and setting factors) between species, as well as within a species, taken into account in evaluating the effect(s)?

The documented pharmacologic effects of marijuana are numerous and varied. Certain effects, such as the alleged brain damage (Campbell 1971), are fairly controversial, while other effects, such as the impairment of mental and motor performance in driving (Kiplinger 1971), are fairly well

substantiated. Still, there are effects, such as the dose-related increase in heart rate (Weiss et.al. 1972), which are well established but of unknown consequences to the user.

MARIJUANA STATUS

The status of a drug (whether legal or illegal, therapeutic or recreational, prescription or over-the-counter) is largely determined by society's continually changing legal, social (public), and medical viewpoints concerning that drug. These various viewpoints are closely interrelated with each other and are all directly influenced by the type of effects inherent to the drug. The viewpoints expressed depend heavily on the risk-to-benefit relationship associated with the drug's use.

The status of marijuana is currently in a state of flux. A historical perspective on marijuana's use in the U.S. shows that it was grown as an important cash crop in Jamestown, Virginia, as early as 1611 and was listed in the medical formularies up until 1941. Adverse publicity toward marijuana in the 1930's (Anslinger Report, 1937) affected public opinion against it and brought about stringent legal restrictions on its use. Marijuana use has since re-emerged, first as a symbol of a youthful counter-culture in the 1960's, and now up to its present time (see Table 1).

Years of criminalizing marijuana through severe legal penalties and strong law enforcement have not been effective in detering its use. Marijuana is an illegal drug. It is

classified under the Federal Comprehensive Drug Abuse and Prevention Control Act of 1970 as a "dangerous drug" and is scheduled (the same as heroin and LSD) in the highest category (Schedule 1) for abuse potential, dependence liability, lack of safety, and unrecognized therapeutic usefulness. Most state laws follow this federal directive regarding marijuana's legal classification as well as the legal penalties imposed on its use, possession, transfer, and sale. The cost-to-benefit factors in the enforcement of anti-marijuana laws, in relation to the number of arrests, the actual crime involved, and the severe penalties imposed, have aroused social concern. The alleged inequity of the current legal system has led to a debate over whether or not marijuana should be legalized or decriminalized.

The past five years have seen a change in the character of marijuana use as well as in the social viewpoint concerning it. The Sixth Marijuana and Health Report states that about 35 million Americans have used marijuana at some time or another and that roughly 15 million are "regular" users. Although there is good evidence of a continuing increase in the number of younger people who have used marijuana, there is little indication that such use has come to involve a significant proportion of the older population (see Table 1). This may be explained, in part, by changes in personal status and responsibility such as marriage, parenthood, career, and the assumption of other

adult roles which could be jeopardized due to the criminalization and stigmatization associated with marijuana.

While the majority of marijuana users are found in the younger age groups (under 26 years), marijuana use is not confined to any one particular social-economic class level. Despite its widespread use and passive acceptance within many social circles, marijuana use is largely covert. The legal penalties and social stigma associated with marijuana still pose a threat.

The risk-to-benefit relations associated with the use of marijuana are most important in influencing the medical viewpoint toward it. Potential therapeutic uses for marijuana are beginning to emerge, but for the present time have limited applications. Although there is no evidence to prove permanent biological harm resulting from marijuana use, evidence of marijuana's short-term intoxication shows it to possess a clear and present danger with regard to driving and flying performance.

Despite the lack of conclusive scientific evidence as to the relative safety of marijuana, there is a movement to decriminalize its use in many states. Public opinion more than scientific evidence will likely be the deciding factor in the effect this movement will have on the current legal status of marijuana.

Table 1

CURRENT MARIJUANA USE* IN THE U.S.
(Percentage of the Population)

AGE GROUP	1971	1976
12-17	19	37
18-25	17	25
26-34	5	11
35 +	less than 0.5	1

Ref: Marijuana and Health, Sixth Annual Report to the U.S. Congress from the Secretary of Health, Education and Welfare, 1976

* Undefined frequency of amount of use; specified merely as having used marijuana during the last month

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MARIJUANA LAW AND LEGISLATION

FEDERAL LAW

Marijuana, as well as the other cannabis derivatives, is an illegal drug in this country. It is categorized as a Schedule I controlled substance under the Federal Controlled Substances Act of 1970. Penalties and sanctions regarding the possession, transfer, or sale of marijuana are regulated under the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970. This federal law treats possession or transfer of marijuana, not made for profit, as a misdemeanor instead of a felony. In addition, minimum mandatory penalties for these offenses have been abolished. Possession or transfer of small amounts of marijuana, without profit, may bring up to one year imprisonment and/or a $5,000 maximum fine for a first time offense. Subsequent offenses of this nature are punishable by imprisonment up to two years and/or a maximum fine of $10,000. The transfer or sale of even small amounts of marijuana to those under 21 years of age carries a penalty of imprisonment for up to 10 years and/or a $30,000 fine for a first offense. The penalty is increased up to 15 years imprisonment and/or a $45,000 fine for involvement in subsequent offenses of this sort. Many state laws provide for much more severe penalties than the federal law.

PROPOSED FEDERAL LEGISLATION

With the support of President Carter, Congress is considering legislation to decriminalize marijuana. Two bills in question, S.601 and H.R.432, essentially identical and modelled after the 1973 Oregon State statute, would make the possession of small quantities of marijuana for personal use a misdemeanor. In essence, the two proposed Congressional bills state that the possession of not more than one ounce of marijuana in a private residence or in a public area subsequent to private use, or transfer (not for profit) to another person for private use is an offense subject to a civil fine of not more than $100. The bills also state that such an offense does not constitute a crime against the U.S. and marijuana will not be considered as contraband and thus it is not subject to seizure or forfeiture by the U.S. This proposed legislation will not alter present federal law and criminal penalties attached to the sale of marijuana. Enactment of such legislation would have no effect on state or local laws. Most arrests made for possession of marijuana are not made under federal statutes. S.601 was introduced to the Senate on 3 February 1977 by Senator Jacob K. Javits and was referred to the Senate Judiciary Committee. Co-sponsors of the bill are Senators Gaylord Nelson, Edward W. Brooke, and Alan Cranston. H.R.432 was introduced to the House in February 1977 by former Representative Edward I. Koch. This bill has

been referred to the House Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce. Definitive action on either bill may occur during the second session of the 95th Congress which reconvened in February 1978.

MARIJUANA DECRIMINALIZATION

A Gallop Poll taken 17 May 1977 indicates that the majority of Americans, some 53%, believe the possession of small amounts of marijuana should not be treated as a criminal offense. This statistic reflects the tone of society regarding the decriminalization of marijuana. On its most rational level, the Director of the National Institute on Drug Abuse, Dr Robert L. DuPont, describes decriminalization as a much-needed reform that removes the marijuana user from prison or the threat of prison. It assures that the individual user's life and future prospects will not be seriously eroded or destroyed by being branded a "criminal" for behavior that may better be called "unwise." Dr DuPont emphasizes that decriminalization need not be viewed as a stepping-stone to legalization of marijuana. Rather, it is a rational step that takes into account the realities of mass use, while at the same time attempting to make clear that marijuana use is both undesirable and without social approval. He considers decriminalization as a reversible reform, which allows for readjustments in the marijuana law(s) should

research uncover some unforeseen dread effect of marijuana use, or if removal of criminal sanctions results in significant increases in marijuana use and subsequent public health risk. On the other hand, legalization is considered an irreversible reform having adverse social consequences. During March 1977, the Congress held Select Committee Hearings on the marijuana decriminalization issue. Representative Lester L. Wolff, Committee Chairman, stated that the intent of the sessions was to produce an "evenly balanced record" representing the expressed views of both decriminalization proponents and opponents. The record of the proceedings would then be submitted to the appropriate standing Committees of the House of Representatives having legislative jurisdiction over the decriminalization issue. The results of these hearings and their possible impact on pending proposed decriminalization legislation, remain to be determined. One major objection to the marijuana decriminalization issue brought out by opponents is that decriminalization at either the federal or state level will result in dramatic increases in marijuana usage.

A recent 1977 study, financed by a grant from the Law Enforcement Assistance Association and prepared for the National Governors' Conference, indicates there has been no significant increase in the eight states where decriminalization laws have been instituted. The study does point out that

although the changes in the law may not have an immediate effect, such changes may result in a gradual long-term change in public perceptions regarding the moral, social, and medical aspects of marijuana use. The study did not draw any conclusions as to whether states should change their marijuana laws.

Carter Administration spokesmen have testified during the recent Select Committee Hearings on marijuana that the Administration prefers each state to decide individually on decriminalizing marijuana, but it also favors a federal law change by Congress. Since the Nixon Presidential Committee recommended state sponsorship of marijuana decriminalization five years ago, eight states (Alaska, Oregon, California, Colorado, South Dakota, Minnesota, Ohio, and Maine) have passed such legislation. In addition, 30 more states are considering decriminalization legislation. Washington, Kansas, Wisconsin, Mississippi, Pennsylvania, New York, Massachusetts, and the District of Columbia are likely to approve such legislation.

CURRENT AIR FORCE POLICY

Air Force policy concerning marijuana and other drugs is in AFR 30-2, Chapter 4. As stated in the regulation, marijuana is a separate drug category which includes all cannabis derivatives. Persons subject to the Uniform Code of Military

Justice (UCMJ) who use, possess, sell, transfer, of introduce marijuana into a military unit, base, station, post, ship, or aircraft violate Article 134, UCMJ and are subject to punitive action by nonjudicial punishment under Article 15 or court-martial action.

Not all violators are prosecuted. However, each marijuana offender is individually evaluated to determine whether court-martial or other disciplinary action, administrative separation, denial of a security clearance or access to classified information, suspension of duties, control roster action, non-recommendation for promotion, or other action is appropriate. The severity of the offense, surrounding circumstances, the member's record, and the impact upon the service greatly influence the action(s) taken.

Consequently, punishment under Article 134 is generally reserved for those cases involving large quantities of marijuana or sale of marijuana for profit. Even under these conditions, pertinent circumstances and factors are carefully weighed before taking such action. For the majority of marijuana offenses, commanders elect to use either non-judicial punishment under Article 15 or administrative measures or a combination of both. In any case, whether the offender is tried by court-martial or receives an Article 15, maximum punishment can not exceed the limits authorized by the UCMJ.

Aside from punitive action, marijuana offenders may also be entered in the USAF Drug Rehabilitation Program (AFDRP).

The decision to enter an offender into rehabilitation is made by the unit commander and is strictly an administrative action. The commander's decision is based on a careful evaluation of the circumstances surrounding the incident, as well as consideration of other factors; for example, the number and nature of offenses, category of abuse (experimenter, user, addict, supplier, or possessor), the member's attitude, motivation, and effect of use on duty performance, etc.

For those involved in first-time marijuana incidents, involving the personal possession or use of marijuana, commanders consider the following before directing a member into the AFDRP: The results of a urine test performed within 24 hours of the marijuana-related incident; whether the member was under the influence of, or had used marijuana while on duty; a review of the member's prior performance record and behavior; whether this is a second or subsequent involvement and, the outcome of investigation, when appropriate, to determine the extent of drug involvement. If this review does not produce significant results, the commander may choose to waive rehabilitation.

An exception to the first-time marijuana incident policy applies to members on flying status. They must be temporarily removed from their duty and enrolled in rehabilitation subsequent to a first-time marijuana incident; the sensitivity of these jobs permit less latitude with respect to illegal or improper possession or drug use. In addition, first term

airmen in basic training (BMT) and those assigned from BMT to technical training courses who are determined to be substantiated drug abusers are entered into rehabilitation by their commanders. Following entry into the AFDRP, these members are normally removed from training and administratively separated from the Air Force (AFR 39-10 or AFM 39-12).

Members involved in second or subsequent marijuana offenses are subject to court-martial, Article 15 action, or administrative separation depending upon the severity of the offense and other factors previously mentioned. Normally, commanders will enter these members in the AFDRP regardless of the disciplinary or administrative actions taken.

It is important to note the outcome of the Court of Military Appeals' case, U.S. vs Alef, 3MJ 415, 11 October 1977. The court ruled the military services cannot exercise court-martial jurisdiction over a member accused of simple possession of marijuana, heroin, or LSD off-base. Jurisdiction in these cases is left to civil authority. Only if the service has an overriding interest in the prosecution of the individual or can demonstrate the military significance of the offense, can the service take court-martial action. If, however, a member is convicted by a civil court of an offense, including drug offenses which under the UCMJ would carry a maximum sentence of one year confinement or more, the service may administratively separate the member. Short of separation,

commanders may still take appropriate administrative actions such as removal from flying status, denial of security clearance, or nonrecommendation for promotion.

As the law (Article 134) stands, serious consequences can be imposed even for simple possession of small amounts of marijuana. In practice, however, use of marijuana or possession for personal use is treated as a serious minor offense. Punishment levied is commensurate with the circumstances surrounding the offense, the extent of the member's drug involvement, impact on the service and the mission, and the member's overall record. To this end, commanders have a wide variety of actions from which to choose, ranging from a letter of counseling to court-martial. In addition, commanders may enter marijuana offenders into the AFDRP for rehabilitation and restoration to full duty status.

The DAF civilian employee paid from appropriated funds presents a somewhat different disciplinary problem. The discipline policy for these employees is defined in AFR 40-750, and paragraph 25 of that regulation states that "(i)mproper possession, sale, transfer, or use of a narcotic or dangerous drug. . . may be the basis for disciplinary action." A dangerous drug is one so defined by the Attorney General of the United States, and marijuana is so defined. It is therefore clear that civilian employees may be disciplined for

offenses involving marijuana if other criteria of the civilian discipline system are met.

The civilian discipline system requires that there be a "nexus" or connection between the employee's offense and the employment relationship. If the offense occurs during the employee's duty hours or on the installation at which the employee is employed, there is no difficulty with this relationship: The mere fact of the occurrence under these conditions establishes the required nexus. So, if a civilian employee without authority sells or transfers marijuana on the premises of his/her employment or during the duty hours of either party, a disciplinary action is possible. Similarly, if an employee reports to work while under the influence of marijuana or if the employee uses marijuana during duty hours or on the premises of his/her employment, discipline is possible.

The difficult disciplinary problem arises if the offense occurs during the employee's off-duty hours and off the premises of employment. As explained in paragraph 20 of AFR 40-750, a disciplinary action "may not be effected unless there is clearly identifiable cause . . . ," and an "action based upon off-duty conduct can be supported only if management shows . . . the manner in which this conduct affected the employee's performance on the job, the manner in which it

was otherwise detrimental to the efficiency of the service." This showing must be factual, not speculative.

Whether the offense is on-duty or off-duty, there are other factors which must be considered in determining the level of penalty. The Air Force discipline policy is rehabilitative, and the penalty selected must encourage the employee to correct the errant behavior. The character and severity of the offense, the character of the employee's position, the nature and frequency of contacts with other Air Force personnel, the employee's past employment history including his/her record of achievement and prior disciplinary record, and other mitigating circumstances are all considered. Disciplinary actions could range from oral admonishments to removals from employment depending upon the results of interrelating all of these considerations. Where the employee has been confined by civil authority because of the marijuana offense, the employee may be removed based on absence from work if the absence is of sufficient length.

Civilian employees who commit marijuana offenses on an Air Force installation may be charged with a federal offense. For possession of marijuana for personal use, or use of marijuana, a civilian employee is normally charged with violating 18 U.S.C. 1382. Security Police issue a DD Form 1805 for such offenses and the offender is required to appear in U.S. Magistrate Court. For more serious marijuana offenses,

Security Police may contact the U.S. Magistrate who in turn, may issue a warrant for the individual's arrest. Those factors mentioned previously, which influence the type and severity of disciplinary or adverse action taken against a civilian employee for off-base marijuana offenses apply to on-base offenses as well.

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In summary, Mr. English, the Air Force recognizes the seriousness of the drug problem as it impacts our national security. We do not consider the problem to be solved or that we, the Air Force, have all the answers. We do believe we have a sound and effective program which is sensitive at all levels to the effect of drug abuse on our mission and our people. The program is also responsive in developing countermeasures which appropriately address levels of drug abuse worldwide. But, we need your help and look forward to your recommendations.

The best illustration of the effectiveness of the program is how it works in the field. One way we encourage professionalism and innovation in our programs is by sponsoring an annual award for the best programs worldwide. We believe it is significant that the winner for 1977 was our major command in Europe—probably the most adverse drug abuse environment our people are subjected to today.

But certainly a tribute to General Evans in his effort to make the program sensitive to the people's needs and to detect drug abuse as it occurs.

This concludes my prepared statement. I am prepared to answer your questions.

[Lieutenant General Davis' prepared statement appears on p. 366.]

Mr. ENGLISH. I notice in your statement you pointed out the Air Force is reviewing its readiness monitoring system to determine whether we need to improve the accounting of drug abuse and its impact.

To my knowledge, the Air Force is the only one of the services doing that. We want to commend you and we think that is a step in the right direction.

General DAVIS. And I think we need that.

Mr. ENGLISH. The second thing, since you referred numerous times in your statement to the situation which exists in Europe today with regard to drugs, and particularly in Germany. There is a story in the New York Times today referring to heroin abuse in Germany. And since you are a fellow Oklahoman, that story appeared in the Daily Oklahoman. Would you care to comment on that story and the facts contained in it?

General DAVIS. I have read the article. I read it the first thing this morning, along with other news clips.

Of course, we are very concerned in this area. We are concerned about our Air Force lack of ability to control the flow of hard drugs. We do work our intelligence people and our OSI people very closely with the host government police force and with, obviously, DEA. According to our information from the DEA, probably most of the heroin which enters West Germany emanates from the Turkish laborers traveling into Germany. It is no secret these workers often carry heroin back with them. As I understand it, and as I think you understand it quite well, there are no customs inspections of these workers in East Berlin, and there is no customs in West Berlin, so our problem is, where do we interdict, and of course my concern is a total concern, but I am more specifically concerned as to our Air Force efforts in this area.

The Air Force investigation conducted from 1975 to 1977 have resulted in the seizure of over 1,000 pounds of cannabis products and various and sundry seizures of very small amounts of hard drugs. The total amounts of narcotics seized, including heroin, was a little over 10 ounces.

So, it is coming. We are concerned with the interdiction of that and the methods which could be improved for interdiction.

As an aside, and based on my knowledge of these matters over several years, at least my reading of the concern by other countries in that drug trafficking only becomes an issue when it affects that country itself.

Mr. ENGLISH. I would assume you are a bit reluctant to point a finger at a foreign nation and say they are guilty of this, that, or the other.

The point I am trying to make is with regard to the information the Air Force has in that area and insofar as the information contained in the article, is it pretty much in line with that the Air Force has found?

General DAVIS. In terms of where it comes from, Turkish migrant workers, and the fact we have difficulty tracking it and interdicting it, yes.

Mr. ENGLISH. You know of no instance in which the East German Government has arrested any individual who is carrying, say, heroin in from Turkey through West Berlin and East Germany and East Berlin?

General DAVIS. We have a little over 1,000 Air Force people in West Berlin, and my sensitivity to that problem has resulted in two staff visits by people from my immediate staff, and resulted in, of course, two unit sweep tests, one in February and another one in April, of our West Berlin people, to insure that we do not have a heroin problem. Those unit sweep tests, by the way, resulted in zero confirmed positive tests.

I do not have any assurance that we do not have a problem, but I am assured we are on top of the problem.

Mr. ENGLISH. Those sweeps were made because heroin was readily available in Berlin in large quantities?

General DAVIS. We are concerned that it is available and I am concerned that we know what is going on. The same applies for the rest of West Germany.

Mr. ENGLISH. As far as the information the Air Force has, there is no disagreement with that story?

General DAVIS. Again, without examining every word, I would be reluctant to agree with any——

Mr. ENGLISH. If you have some information that conflicts with that and you have additional information you would like to add to it, we would love to have it. We are not simply trying to substantiate the story. If there is anything which the Air Force intelligence has that conflicts with that, please set the record straight.

General DAVIS. Not that I know of. My concern is that we, the Air Force, are aware of it, and we are familiar with it.

Mr. ENGLISH. Are you familiar with the surveys this committee has made both in the United States and foreign countries—this covers all military units, not only Air Force, but the other services as well—and the results of that survey?

General DAVIS. Yes, I am familiar. I have seen the survey; I did not memorize all the statistics, but I am familiar with the survey.

Mr. ENGLISH. Is there anything in that survey which is erroneous or out of line? All services were lumped together for that survey, but do you find anything within that survey that you would like to disagree with or that you would take exception with?

General DAVIS. On an opinion basis, I found your survey results fairly consistent with our own assessments in the opinion area.

In my prepared statement I indicated we had established our baselines, and principally we are talking about marihuana, and that is what I keyed most of my remarks to, although I do not forget the seriousness of the other drugs, but we say about a 27-percent use.

Now, looking at your opinion survey, we are not that far off. I can account for the difference in the fact that populationwise, in your survey, I think out of 2,120 enlisted, there were some 360 Air Force enlisteds who participated. Of the officers surveyed, about 80 of the total number of officers.

So, I can embrace the opinion aspects of it.

Mr. ENGLISH. Basically, what you are looking at is what you know about all the services combined, Army, Navy, Air Force, Marines, and from what you know as to all the services, the survey is pretty much in the ballpark and would fit within your conception; is that correct?

General DAVIS. No. As I say, I can factor out the number of Air Force that were tested, and I can embrace the opinion part of the survey as consistent with what we find.

Mr. ENGLISH. I do not understand what you mean by "the opinion portion of the survey."

General DAVIS. The question, for instance, that says, "What is your estimate of marihuana use?" I believe that is the way the question was stated, and the range of answers on an opinion basis is what I am specifically referring to.

Mr. ENGLISH. That particular questionnaire, particularly with regard to the enlisted personnel's question number 5, which says, "How many men or women in your unit use marihuana?"

Again, for the specific reason we did not feel this was that scientific a survey, after listening to the Army's scientific survey, we had a great deal more respect for our scientific survey, we decided—6 percent none, 24 percent a small number, 19 percent half, 24 percent said more than half, and 22 percent said almost all.

So, if you were looking at it from that standpoint, 19 percent plus 24 percent plus 22 percent and add those up, you will have a majority which feel there are at least half or more of men in their unit who are using marihuana.

It appears to me this is the real issue. Is this in the ballpark of what you understand?

General DAVIS. Of course I look at it as 50 percent of the enlisted folks saw marihuana prevalency at 50 percent or less. That is what I am talking about.

Mr. ENGLISH. Well, about half is about 50 percent.

General DAVIS. Yes, about half.

Mr. ENGLISH. But you still have 24 percent. That would equal out with those who say the smaller half. What do you do with the others? You have 46 percent of those who responded to the survey say more than half or about all; that is more than 50 percent.

General DAVIS. Again, as I view it, based on perception——

Mr. ENGLISH. You are figuring the Air Force section is the 24 percent and the rest of it is the other——

General DAVIS. No, no. I am figuring based on what we know, from what I do consider a very scientific survey, the Arthur D. Little Co., which took a long time to develop——

Mr. ENGLISH. Was not that survey conducted in 1974?

General DAVIS. That is right, but we have updated it with what we know from the HEW survey, which was reported to the Congress in 1976——

Mr. ENGLISH. Have you conducted any kind of survey in the Air Force since 1974.

General DAVIS. No, but that established a good base line, and with updates of the HEW survey and, of course, our next survey, and we are working with DOD to get this one, another Arthur D. Little-type——

Mr. ENGLISH. I would wholeheartedly agree that you need that, but the point I am making is what we are talking about here and what you are basing your opinion on are surveys which are 4 years old. Is that correct?

General DAVIS. That is correct. But good scientific surveys take a year to a year and a half to develop.

Mr. ENGLISH. In your addendum here, you say, "Army personnel survey data, analyses of law enforcement trends, urine testing, and drug program admissions for Army personnel also coincide with Air Force trends. The Army, too, has found marihuana use stable and abuse of hard drugs decreasing on a worldwide basis.

The Army came in here and told us that they had to admit committing a crime, and they ended up with 40 percent that would admit, "Yeah, I broke the law."

You are stating here that your trends pretty much coincide with the Army trends?

The thing I guess I am having trouble with is that 4 years is a long time. We have a whole new drug problem with PCP. If you try to gage the use of PCP from 1974 to the present time, it would be difficult. You say you have had no survey since 1974, but you are sure we have 27 percent out there using marihuana?

General DAVIS. That is a range that I think is a fairly accurate range. But as far as PCP, we have a special program.

Mr. ENGLISH. The thing I am asking you is, can you give me what you use to determine the amount of marihuana abuse that has taken place within the Air Force today? What is it that you use to determine that?

General DAVIS. Again, our detailed local assessments.

Mr. ENGLISH. What do those include, what input? Where do the numbers come from that go into that?

General DAVIS. Of course, our obvious identifications—and, again, we look at what the prevalence is in the community and what we get—and the most recent survey, the HEW report, which

included use in the civilian community, and we are talking about the 21 to 25 or 18- to 25-year-old group, a group of factors.

Mr. ENGLISH. We are going to use that and going to say that that is identical. We will come back and quote the survey which has just been completed, which points out 40 percent of the high school seniors this year say they have used marihuana in the last 30 days.

You have, when asked, an additional 40 percent of the high school seniors who say they expect to use marihuana in the very near future. These are the ones who have not used it in the last 30 days, "I plan to use it." You have 80 percent of the high school seniors who are saying, "I have used marihuana in the last 30 days, or I am going to use it in the near future." Then you are coming back, saying all of a sudden, they get sworn into the Air Force—and these are high school graduates you get into the Air Force—they get sworn into the Air Force and that figure is going to drop off to 27 percent? That is a 1977 study, by the way.

General DAVIS. But, Congressman English, there are sanctions and there is constant supervision on the job and, of course, the youngsters that we bring in, again, they are screened very thoroughly. Then we put them through a rigorous training program, at least through basic military training.

Mr. ENGLISH. Are you saying to me because they come into the Air Force and they have the supervision of their officers and everything, that they are going to suddenly change their habits and not smoke marihuana?

General DAVIS. I am not saying that, but there is also a maturing process. Whether it is 27 percent or whether it is 30 percent or 35 percent, I think those figures are soft. There is a problem and we are concerned with it.

Mr. ENGLISH. Mr. Chairman?

Mr. WOLFF. I think I would like to ask some questions of Colonel Rogers.

We are talking about marihuana. What is the appraisal of marihuana so far as its effect upon the individuals who are using or abusing the substance? What difference is there in the use or abuse in the way of the amount of marihuana that is used?

Colonel ROGERS. We haven't conducted any studies on effects of that nature. My own feeling is that the effects of marihuana are temporary in most cases. The primary risk is having someone in a key position who is at that time intoxicated with marihuana, much similar to someone intoxicated with alcohol; but once the intoxication has worn off his physical impairment has for all intents passed.

Mr. WOLFF. I take it you have seen the recent studies that have been made relative to the absorption of THC in marihuana in fatty tissue and the release of the effects over an extended period of time?

Colonel ROGERS. I am not sufficiently familiar with it to be able to comment on it.

Mr. WOLFF. I think it would be a good idea for you to get hold of the recent studies that have been made on the question of the residual effect of marihuana, that is, the THC in marihuana, there is a recent study that has indicated that there is a residual effect

that is released over a period of time, and abuse of marihuana as a substance does have a residual effect.

The point that we have had problems with here, is the classification of the data, and I am not talking about whether it is a restricted classification or not. I am talking about how you classify a person as an abuser or a user of marihuana. Is there anything in the regulations regarding this type of classification?

Here on utilization we have a user, an experimenter, an addict, supplier or possessor. How do we determine which is which?

Colonel ROGERS. Those referred to are personnel regulations.

Mr. WOLFF. Is there something we could have that would delineate whether a person is a user, or experimenter, or an addict, or is that just a determination that is made by the individual commander?

General DAVIS. Of course, a possessor or supplier—we can provide you those definitions. Those are very straightforward.

Mr. WOLFF. The point I am making is an important one. These surveys have been based upon criteria determined only by the person who answers the question and it is very difficult for us to really make an appraisal—and I should imagine as well it is difficult for you to make an appraisal—as to whether a person is an abuser or not?

General DAVIS. Yes.

Mr. WOLFF. Colonel Rogers, one aspect of marihuana use, as I understand, is the problem of spatial relations; is that correct?

Colonel ROGERS. Yes, sir.

Mr. WOLFF. We are operating very sophisticated aircraft today, and I am not talking about ground personnel. This spatial relationship that is distorted, although for perhaps a short period of time, does create a danger, does it not?

Colonel ROGERS. It does.

Mr. WOLFF. So that one of the problems that we see is, unfortunately, the question of marihuana abuse in the military as much more critical in nature than marihuana abuse in other pursuits.

It does not obtain that we are faced with similar conditions within the other services as critical as we face with the Air Force, because there are very critical judgments that have to be made in very short periods of time.

Let me come back to one other point. We have talked here about marihuana and heroin. What about pills? Is this not the big problem with the Air Force?

General DAVIS. Sure. What our latest results show, for instance, are: First quarter urinalysis in Europe—almost 6,000 tests, 8 percent of the people tested—of the 160-odd confirmed positive, the vast majority of those were amphetamines.

Mr. WOLFF. Are we building abusers into Air Force policy? I remember in the days when there were stop and go pills. Are there still stop and go pills in the Air Force?

General DAVIS. We are talking about ones to keep you awake.

Mr. WOLFF. Ones to keep you awake and ones to slow you down. Are they still used?

Colonel ROGERS. They are used, but on a very, very limited basis, just for specific contingencies, if we had to have them, a pilot in a wartime situation. There are plans to use this if necessary; but I

don't know of any operation in the peacetime mode where they are used at all.

General DAVIS. From 25 years of active flying, and in many of those cases being up 48 hours, I will give you a sample: I have never had one in my mouth.

Now, getting back to marihuana, any use is abuse in the Air Force, so I want to make that point crystal clear; and for those who would use marihuana and impair their judgment—I think that is your point—in these critical-type jobs, of course, the incidence of one being absolutely alone or no supervision, of course, I don't say it can't occur, but I say it would be very difficult to do in a very critical job.

We have had arrests of security policemen, for instance, who were using marihuana on the job, but those instances are limited in number. Again, there is a maturity factor.

I am not saying we wave the wand over anybody who dons a blue uniform and suddenly they don't use marihuana, again, but my point is, there is a very substantive responsibility factor here and a maturity for our young enlisted, for our rateds, our pilots, and navigators, and it is instant release from duty and in many cases they will probably go ahead and exit the Air Force; so it is a very serious step to take.

Mr. WOLFF. Do you have the same guidelines for any type of pill, marihuana use, that you do have on alcohol use before an air crew takes off?

General DAVIS. Oh, yes, sir.

Mr. WOLFF. In other words, you do have some restrictions on alcohol, prior to flight. And what are they basically?

General DAVIS. Traditionally, the ground rule has been no drinking within 12 hours of flying, but this is not an official Headquarters Air Force rule. Air Force Regulations 60–16, General Flight Rules, states that a person will not act or be permitted or required to act as a crew member if the individual's physical condition is suspected or known to be detrimental to safety. At the headquarters we do not specify a certain time limit because of the many variables that impact on an individual's ability to drink and for the body to eliminate the alcohol. However, in the field, commanders may make our directives more specific, for example, one major command has established a rule that crew members may not drink within 10 hours of reporting for a mission.

Mr. WOLFF. Is that specifically spelled out as well for drugs or any other type of mind-boggling substance?

General DAVIS. Of course, no drug is permitted and if one is on a controlled substance from a flight surgeon, one is grounded normally.

Mr. ENGLISH. Will the chairman yield on that point?

Mr. WOLFF. Yes.

Mr. ENGLISH. Perhaps I can cut through to save a little bit of time here.

The thing at least that troubles me, and I think some other members of the committee that are aware of it, is the point that particularly in California, for instance, which we visited, you have a situation where marihuana has been decriminalized and all the

services within that State, to our knowledge, are having problems with getting this across to enlisted personnel.

I don't want to say where the location was or identify the officer, but we were at one of the largest Air Force bases in this country where we had the executive officer tell us, "We really don't care whether our people use marihuana or not, as long as they are off base and off duty." That is what comes down. This is the thing that we are driving at and the thing that we are wondering about: Is this the attitude of the Air Force? Is this the attitude of some base commanders? And I am not saying that it would necessarily be the attitude of base commanders only in the Air Force but it does bring back a very serious question, and particularly in States and in areas that do have a decriminalization policy in effect, and if so, how serious is that type of situation?

That is what we are trying to get at. It was very disturbing to us to have that type of development.

General DAVIS. It is very disturbing to me also, Congressman English. That is not the Air Force position, not in any regard. We are concerned about it.

Now if we have an individual who has that attitude who is a commander, commander of an installation, I am very surprised because our attitude is just the opposite. We are concerned about it and, well, I am just surprised that you got that response.

Mr. ENGLISH. We were not only surprised that he had the attitude but we were also particularly surprised he would tell us; and it was made in a room full of people, no secret about it; and I might say that from what I can remember, the base commander was there as well.

General DAVIS. Again, we basically operate under UCMJ and when we are talking about our young first-termers——

Mr. ENGLISH. Excuse me. I want to set the record straight. I have just been informed that the base commander was not there, and that is the reason the executive officer was giving the briefing. Excuse me, Mr. Chairman.

Mr. WOLFF. I would like to get on to another area which I think is important and that is not drug abuse within the military but drug trafficking in the military and the use of military airlift capacity as a vehicle for the traffic. The fact is that there has been about 10 ounces of heroin that has been interdicted from the Customs Service, which seems to me to be an indication that there is less than a full measure of activity in this particular area.

We do know during the Vietnam era that there was a very substantial amount of stuff that was carried, and we do as well know that Guam today, where this committee will be holding hearings, is a very hotbed of trafficking. The reason that it is a hotbed is because it is an intermediate or transit point and it is easy to obviously get the stuff in there.

We don't know whether it is carried in by military or civilians, but there is greater military traffic in there than there is civilian traffic, and therefore it seems to me that there is a little bit that is left to be desired in the Customs activity. I know that you do have an extremely difficult problem of trying to really cover an entire aircraft where there are many, many places where material like this can be secreted. You are using dogs, as I understand it?

General DAVIS. Yes, sir.

Mr. WOLFF. Do they actually work on the incoming aircraft on a total census basis or do they do it on a random basis? Do you know?

General DAVIS. In the Far East, military narcotic detector dogs are used to inspect aircraft on a total census basis. Working drug dogs are used at the point of origin and at en route stations. In the European area, the narcotic dogs are used on a random basis. This is due to the limited number of dogs currently available; however, narcotic dog authorizations are being increased as the requirements are identified.

We conducted a worldwide conference the 5th and 6th of January right here at Andrews Air Force Base in Washington and the thrust of the conference was toward ensuring adequate procedures exist to prevent smuggling of narcotics or dangerous drugs in commercial amounts or in any organized manner aboard Air Force aircraft.

All the investigating agencies, including DEA, reported it virtually impossible to find any significant active military association in drug trafficking at the present time; however, the same agencies indicated the potential use of military aircraft or cargo for drug smuggling attempts did exist and recommended that the current effort by the services be continued.

We are very sensitive, based on our Vietnam experience, and I can assure you that with the procedures we have implemented now, sometimes our air crews are a little bit vexed by them because they are inspected by the dogs at every stop; but we have very stringent procedures and I would be very surprised if we were involved in military air with any so-called "connection."

Mr. WOLFF. Of course, there is also the ground servicing of the equipment, too——

General DAVIS. Of course.

Mr. WOLFF [continuing]. Which is one way that has been used in order to transport narcotics, using ground facilities on a foreign base and then the cache is moved on to another base?

General DAVIS. That is right, but I think we have a pretty tight inspection procedure.

Mr. WOLFF. How are the personal effects of rotated people handled? Are they handled in house now or are they handled by contract carriers?

General DAVIS. Some contract; as a matter of fact, most overseas on a contract basis—we have to do that—but all undergo a very rigorous inspection by the military customs inspectors and that program has been tightened significantly; and I think over the last year there were some 2,000 instances of discovery of contraband equipment in household goods shipments.

Mr. WOLFF. One thing I think would be advisable would be for you to furnish for the record, if you could, General, the number of customs people that you have at each critical location where we do have the question of either personal effects coming through or the aircraft themselves.

General DAVIS. It is impractical to separate the number of military customs inspectors by service or functional areas of responsibility. Within the overall DOD customs program the services inter-

change military customs inspectors to inspect aircraft, personal property, cargo, passenger and crew members. The number of DOD military customs inspectors assigned are:

Locations	Full time	Part time	Total
Pacific	479	432	911
Europe	1,190	0	1,190
South command	20	28	48
Atlantic	3	227	230
Total	1,692	687	2,379

Mr. WOLFF. Thank you very much.

General DAVIS. Yes, sir.

Mr. ENGLISH. Mr. Burke?

Mr. BURKE. Thank you, Mr. Chairman.

General, in your statement you said that during 1977, 63 percent of all identified drug abusers were returned to full duty status. Of these, 78 percent were unconditionally retained in the Air Force. Of those not retained, the majority were separated for non-drug-related reasons.

Would you please tell me what the 63 percent that you referred to as users used?

General DAVIS. Mr. Burke, 80 percent of our identifications for drug abuse rehabilitation are marihuana users; so, principally, I am talking about marihuana.

Mr. BURKE. But you have no breakdown of those that may have been used?

General DAVIS. Oh, I do, and I can provide that for the record; but it is in the data that I submitted for the record, the quarterly report.

Mr. BURKE. Could you break it down in connection with your statement, specifically?

General DAVIS. We do not track the successful completions, those returned to full duty status, by type of drug used specifically. However, I can tell you how that breaks out for personnel being entered into rehabilitation. That information is as follows:

	Percent
Marijuana	87
Opiates	2
Amphetamines	5
Barbiturates	1
Methaqualone	Negligible
All others	5

Mr. BURKE. Now, you also—as I indicated—said of those, 78 percent were unconditionally retained. Does that mean without charges, without anything on their records?

General DAVIS. Well, it means they were retained without stigma. In other words, if they successfully completed rehabilitation for the drug abuse offense, they may well have been given an article 15, or they may well have been fined, or they may well have been reduced in grade. The "unconditionally" doesn't mean that no disciplinary action was taken. The "unconditionally" merely means that they were returned to the Air Force in good standing, albeit a

charge against them for violating the Uniform Code of Military Justice.

Mr. BURKE. And then that particular charge remained as part of their military records too?

General DAVIS. Absolutely.

Mr. BURKE. If they were transferred to another command, the commander would know it?

General DAVIS. Absolutely.

Mr. BURKE. You also state that the only exception to that policy concerned personnel on flying status. Why just on flying status? I can understand why you wouldn't want a pilot perhaps if he had been involved in drug abuse of any kind—I can understand that, but what about those that are specialists who have the responsibility to make sure the aircraft is suitable for flying?

General DAVIS. Then, again, I said that was the only specific exemption. Again, it depends on the responsibility of the job and the commander makes that assessment.

Mr. BURKE. How does he make that assessment?

General DAVIS. You may have missed that point when I outlined it earlier in my remarks, but it considers how long he or she has been in the Air Force, has there been any previous problem, what is the record, what is the experience level? If there had been any problems in the past, then I am sure that commander will have them placed mandatorily into drug abuse rehabilitation.

Mr. BURKE. General, but nowhere in your statement did you say these were first offenders.

General DAVIS. No; that is the whole issue, Mr. Burke, our waiver policies for first-time marihuana use.

In the statement, that is the connective part.

Mr. BURKE. It may be connective, all right, but it doesn't say there. You say: "During 1977, 63 percent of all identified drug abusers were returned to full-duty status."

I presume that means all of them, not just——

General DAVIS. That is right.

Mr. BURKE. You mean all of them?

General DAVIS. That is right, but the second part of your question was the only people who are exempted are people on flying status, which is unrelated to the 63 percent or 78 percent.

Mr. BURKE. Yes, I understand that, sir. I understand that those on flying status get no exemptions.

General DAVIS. For the first-time marihuana use.

Mr. BURKE. Right. Well, what do you mean, "first time?" There wouldn't be any second time.

General DAVIS. That's right.

Mr. BURKE. I am talking about the mechanics, the specialists who have the responsibility not only for the plane but also for the specialization programs that are essential for combat planes to perform properly.

General DAVIS. No, I would say in those critical jobs the commander's judgment would be to mandatorily enter them into rehabilitation.

Mr. BURKE. Even though he might have had a previous problem?

General DAVIS. Oh, if he had a previous problem, then that would be grounds for an administrative discharge.

Mr. BURKE. It may be to one commander but not another?

General DAVIS. No; that is fairly standard.

Mr. BURKE. Do you have a set of rules, General, which establishes complete outlines of a man as a second offender?

General DAVIS. Yes.

Mr. BURKE. I didn't see it in the statement.

General DAVIS. No, it wasn't in my statement.

Mr. BURKE. Let me ask one other question: With regard to those who are coming into the service, the presumption, I guess, is that they come in the service and they are nonusers of marihuana or otherwise. How is it possible for you to detect anything and say they are nonusers except to have the suspicion, if the statistics are proper, with regard to those in high school who said they have used marihuana or some other drug substance prior to the time they graduated from school or get out of school?

General DAVIS. Mr. Burke, in our drug abuse screening, in our recruiting environment, we have a very detailed briefing that we give to each individual, and what one has to do to enlist in the Air Force is be marihuana-free for a period of 6 months; and even before that 6 months could never have been a frequent user; and we tell each of the young people that this information will be followed up because all of them must qualify for a security clearance, their high schools will be checked, all the references they give will be checked; and it is not a threat; "it is a fact of life that we are going to check on your story and if you have not told us the truth, you will be discharged." It is the stigma of the discharge, the very fact that they are put on notice that we are going to be checking your story.

Now that is not 100-percent foolproof but they know they are on notice and they sign the form under penalty of fraud, being discharged for fraudulent enlistment, that what they have given us is true, and we find it very effective.

Mr. BURKE. My concern is the specialization of particularly the Air Force and how disciplinary action can be so strong against a pilot and yet perhaps not so strong against one, whether it be an officer or an enlisted man, who has the responsibility for the aircraft itself before it gets into the air.

General DAVIS. That is the part of the ethics of the job, the fact that we do have mature people, that maturity comes after enlistment; but our standards for our officers—and the vast majority of our crew members are officer crew members—the standards for our officers are very stringent, the entry standards, because they have to uphold the policy; they become the commanders and they are the supervisors.

Our enlisted standards are obviously very, very stringent for people in key jobs of preparing aircraft or missiles.

I don't want to give the committee the impression that we are soft; we are not soft. What we do is temper the judgment for the first-termer. We are only talking about the tempered judgment for first-termers. We are not talking about the careerists; we tolerate no abuse there.

Mr. BURKE. I can see that, and I can see why it should be tempered for a first-termer.

The thing that puzzled me was why it was stringent for a pilot but not necessarily for those who may have the responsibility for safe flying by the pilot.

General DAVIS. Again, realizing that it is a sensitive and controversial area, I just need to reiterate that in the ideal world we would have no drug abusers. The drug abusers that we are discussing here are very, very few in number and those whose abuse is on an experimental basis as determined by that complete examination—and I am talking about first-termers—we are very stringent on air crew members because of the responsibility they have for other people.

Mr. BURKE. General, let me ask a question along just that line. Supposing there was an officer or an enlisted man in a sensitive position who had possession and that was all, just had it on him, how could you from the determination that he had it on him not say that he was a user or that he was a peddler or that he was something else other than just having something in his possession?

General DAVIS. In those cases, possession would be requirement for automatic disqualification from their sensitive position while an investigation was conducted and the facts found.

In my view, the circumstances you just outlined for a person in a rated position or in a very sensitive position, for possession, unless there was an awfully good explanation for it, they would be disqualified under (a) the personnel program, and probably their security clearance revoked.

Mr. BURKE. That is what my principal interest was. Thank you very much, General.

General DAVIS. Yes, sir.

Mr. BURKE. Major, good to see you again.

Major BELL. Thank you.

Mr. ENGLISH. Mr. Mann?

Mr. MANN. Thank you, Mr. Chairman.

General Davis, in your statement you refer to the recruiting dilemma: drug abuse, particularly marihuana, the prevalence of it in the recruiting market makes quality control at the accession point increasingly difficult.

I note that your primary basis for screening is the existence of any drug abuse within the immediate 6 months prior to enlistment. Let's face it, the law enforcement agencies in civilian life are not doing too good a job on that. The chance of them identifying these people within 6 months prior to application for enlistment is pretty slim.

Has there been any study or are any more sophisticated methods being considered for screening prior to enlistment?

General DAVIS. We find that Mr. Mann, and again having commanded the recruiting service and having been in the personnel business, this part of it, since 1974, those high school youngsters, especially after they have gone through basic military training, taking on that additional maturity, we find kids who come forward in basic military training and say, "I didn't tell you the whole story when I enlisted; I had used marihuana" because they are in a very close environment and they know somebody is going to be checking.

There is an attitude on their part that they are responsible people, and there has been no study. We find that a very, very effective method, that when a person signs his name, by and large he is accountable for what he is telling us is the truth; and in many, many instances where it is not the truth he will come forward and tell us before we find it out on a subsequent investigation.

I feel reasonably comfortable with our assessment, our drug abuse assessment, in the recruiting environment. Certainly, there are exceptions. There are people who don't come clean with us, but the vast majority do. That may sound naive, but I have been in the business a long time. The results verify what I am saying.

Mr. MANN. I can't avoid the conclusion though that what you are getting—and it is not necessarily terrible—is a valid cross section of users and nonusers from the eligible population.

General DAVIS. No, I understand that. I am not saying we get people who have never experimented one time with marihuana.

Mr. MANN. I really want to know if you are weeding out anybody, if you don't get the same share that anybody else gets?

General DAVIS. Maybe you missed that point, but we weed out on an annual basis between 27,000 and 30,000 people who won't sign the drug abuse form or won't sign the form for enlistment that says, "I certify that I have been drug free for * * * "

Mr. MANN. I didn't remember that.

General DAVIS. We screen out 27,000 to 30,000 a year.

Mr. MANN. I don't have any more sophisticated method to suggest. I hope we can rely on the basic honesty.

General DAVIS. I wish we had more sophisticated methods.

Mr. MANN. In your statement you indicated that drug abuse among Air Force personnel had been declining in the Pacific, with the exception of Guam. From that we can infer, with reference to something Mr. Wolff said, that where there is trafficking and local problems, that you are going to have a correlative problem; but what is wrong with local unit discipline in that location, rather than somewhere else?

General DAVIS. Of course, there is the local environment, but what we find—and I didn't want to give you the wrong idea at Guam—but what we find at Guam is not an increase in hard drug use, and we have targeted our commander-directed and our unit-sweep testing on Guam, and the confirmed positives for hard drugs just aren't there. In other words, our people don't reflect the presence of drugs in the local area in terms of drug abuse on Guam. It is a high-threat area. We are conscious of that high threat and as a result have increased the frequency of our preventive methods.

Mr. MANN. I think we can agree, as you indicated, that the environment and availability are certainly factors that contribute to that, which calls my attention to the amphetamine problem where in the first quarter of this year you had 54 detections. We have 7 under the other column, 53 amphetamines and 1 narcotic.

I suspect we haven't been giving enough attention to the amphetamine problem, but do you find, or is there any evidence of, and what is being done to determine whether or not there are any smuggling activities either out of or into the European theater within the amphetamine category?

General DAVIS. Unfortunately, in this area, Mr. Mann, prescription drugs are easily available. You don't have to smuggle; you can buy them.

Mr. MANN. Are the requirements over there less than they are here?

General DAVIS. Oh, absolutely; absolutely. Would that we could get an international agreement. I think Dr. Rogers would agree to that. They are easily available.

Mr. MANN. What work is being done with reference to international communication, and/or cooperation in the matter of drug prescription practices?

General DAVIS. I am out of my field of expertise.

Colonel ROGERS. I don't know either.

Mr. MANN. I was pleased to learn that we were working with some countries in South America, trying to improve them in prescribing methods and they were actually seeking help in that regard.

General DAVIS. Of course, the Air Force in Europe, General Evans and his people, have worked in the past with the German Government too, if you will, trying to get U.S.-type standards on prescribing the easy availability of prescription-type drugs, but those are very difficult things to work.

Mr. MANN. Do any of the detection methods that you use to check out heroin and other drugs work with reference to amphetamines?

General DAVIS. Oh, yes, sir.

Mr. MANN. Do dogs work with amphetamines or not?

General DAVIS. No.

Mr. MANN. So it would be the same sort of detection method that you would use on any contraband?

General DAVIS. That is right, the urine test.

Mr. MANN. I am talking about transportation and smuggling. You don't have a routine cargo check for cartons going to and from?

General DAVIS. Yes, we do.

Mr. MANN. I can see it would be very difficult to control.

General DAVIS. It is difficult, but we do it.

Mr. MANN. On your PRP program, the report included in your addendum, where you identify these high-risk categories, on the basis of decertification, the security/law enforcement personnel constitute, it looks like, about two-thirds, a little over two-thirds of all persons decertified, munitions handlers/loaders/mechanics is the next high group, and ground crew chiefs the next high group.

I guess if we try to pick out the three most critical groups, those are the ones that we would choose. That may account for the greater number of decertifications; but is there another reason, is there a lifestyle, is there a problem of some sort that causes this to come about?

General DAVIS. I believe you missed the earlier part of my remarks, where I correlated career fields where we have a higher concentration of first-term airmen, in other words, the target audience, and the particular field of security and law enforcement is about 75 percent first-termers, so we would expect the incidence of

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drug abuse to be higher in that group; and for the other career fields, a high incidence of first-term airmen in those career fields.

Mr. MANN. I certainly would agree with that, but we also find, under the report on occupational distribution, aircraft maintenance and aircraft systems maintenance. We also find security police, but aircraft maintenance and aircraft systems maintenance—these are identifications—those are generally career people, are they not?

General DAVIS. No.

Mr. MANN. They are not?

General DAVIS. No. Well, it may be 55-45, but the people we find in there who are involved in drugs are the first-term portion of that. Every career field we have, with very few exceptions, has first-term airmen in it.

Of course, the numbers, Mr. Mann, are misleading.

What we are talking about are less than 1 percent of the people assigned to the personnel reliability program—as a matter of fact, about eight-tenths of 1 percent.

Mr. MANN. Yes; but I would hope that a little more sophisticated analysis might be made of this situation. For example, well, on rates per thousand—and you would point me to that I am sure—that tends to level out the figures of the various occupations?

General DAVIS. No; and don't let me leave you with the impression that I am shrugging it off in a statistical discussion. We are very concerned with all of them; but the point is, our program finds them and weeds them out, because they are in a sensitive area.

The way we find them is through very close supervision.

Mr. MANN. I have not had an opportunity to make any relative comparisons—perhaps the committee has—between the programs being conducted by the Air Force vis-a-vis results and the programs being conducted by the Navy, and the Army in particular, vis-a-vis results. Perhaps you have; but I am interested to note that the Air Force receives—and I would hope because of the sensitivity of its mission—more than twice what the Navy and the Army receive combined, in funds for Federal drug abuse expenditures for prevention.

General DAVIS. No; I would be surprised if that were the case.

Mr. MANN. I was surprised. Here it is.

General DAVIS. We are talking about $6 million to $8 million for Air Force programs over the last 2 years.

Mr. MANN. Yes, that is probably correct. The chart is entitled, "Federal Drug Abuse Expenditures for Prevention, Fiscal Year 1977," Air Force, 18 percent, Navy, 1.8 percent; and Army, 6.3 percent.

General DAVIS. Well, if I heard you right, what that says to me is that we are spending 18 percent of our budget in that regard.

Mr. MANN. No; it is reduced to dollars.

Mr. ENGLISH. Excuse me. I believe that is with regard to the total Federal expenditures on drug prevention nationwide for all forms of government. The Air Force is receiving 18 percent of that total budget, as compared to the Navy's 1.8 and the Army's 6.3.

General DAVIS. I would be very surprised if that were so, because our budget in 1977 was $6.8 million, in 1978 was $7.3 million, and we are talking about a budgeting factor, and which pot of money

you get it out of and how one attributes it; but I would be very surprised.

Mr. MANN. We will try and resolve that because we have this information.

General DAVIS. But knowing budgeteers and how they put money in different pots, this is a straightforward matter, again, $7.3 million that we spent on drugs. That is the total Air Force budget.

Mr. ENGLISH. If I may interrupt—I believe the staff compiled that as a result of statistics furnished by all the various Government agencies that are involved in drug prevention, and this particular figure was the amount that we were supplied with regard to the Air Force, which was basically $2 million; and that totals up to be 18 percent of the total Federal budget of the Federal Government on drug prevention.

Also in that area, I notice in your statement that our primary prevention efforts revolve around the establishment of recruiting standards, effective drug abusers screening programs at the entry level, and the education programs presented to all personnel upon entry in the Air Force. So what in the heck is that $2 million being spent on, or what is 18 percent of the total Federal Government budget for drug prevention being spent on—recruitment?

General DAVIS. No, no; very little of it on recruitment, most of it on education and literature, that part of the total program.

Mr. MANN. I suspect that one of our problems may lie in the word "prevention"; that is, what is included in prevention with reference to your program and other programs?

General DAVIS. Yes.

Mr. MANN. But it is a question we need to resolve.

General DAVIS. Now our manpower, our 400-plus slots, are included in prevention. In other words, when you fund 400 people at a man-year cost——

Mr. ENGLISH. That is not treatment?

General DAVIS. That is in the prevention/educational line. We may have a budgeting anomoly that the experts can compare likes to likes; I suspect that is what you have.

Mr. ENGLISH. Mr. Lawrence, who is our chief of staff.

Mr. LAWRENCE. I may be able to clear up how it got termed what it is termed.

We asked each of the Federal agencies that have any prevention responsibility for a breakdown of their budget as it was applied to prevention. We asked the same question, however, in regard to treatment, and we asked the same question in regard to law enforcement expenditures vis-a-vis drug abuse; and the response of the Air Force was that of their total outlay for drug abuse, that section dealing with prevention received $2 million in fiscal year 1977; so that was the source, General, and that is why it is so represented.

General DAVIS. OK.

Mr. MANN. Then the conclusion may very well be that that is good?

General DAVIS. That is my conclusion; that is the way to work the problem, is to put dollars in prevention.

Mr. MANN. Maybe the others aren't putting enough—assuming that they are getting fair shares, whatever that is—of the total of the drug abuse budget.

General DAVIS. Of course, the Appropriations Committee has been very pointed in the area of alcohol and drug abuse. The Appropriations Committee's view is based on GAO reports that the alcohol problem is far worse than the drug problem, and I am sure the members of this committee have seen that and so directed that money be shifted from drug abuse prevention to alcohol prevention; so maybe there is need to talk over in this House, too.

Mr. ENGLISH. As I understand, you run a joint program though; isn't that correct?

General DAVIS. Yes.

Mr. ENGLISH. So it is all going in the same pot?

General DAVIS. No, no, not necessarily all in the same pot. If you are directed to put more funds in alcohol than drugs, that is a congressional mandate on the appropriations side and, as a matter of fact, dollars in the 1979 budget are 7.6 for drugs and 15.5 for alcohol.

Mr. ENGLISH. This is in part of your addendum here, which I have just been handed, which is a chart, social actions program—and you are stating in there the number of identifications that you have, and which is basically for 1978, for drugs, 1,529, for alcohol, 1,352. The rate per thousand is 10.6 for drugs and 9.4 for alcohol, which seems to indicate that you now believe that you have got more drug abuse than you do alcohol abuse—at least you are treating more; isn't that correct?

General DAVIS. Well, it is a function of identification.

Mr. ENGLISH. Excuse me. That is the first quarter.

General DAVIS. That is for the first quarter.

Mr. ENGLISH. And for 1977 we have had approximately the same amount. They are almost identical.

General DAVIS. But my point, Mr. English, is that that is an edict from the Appropriations Committee as to how the money will be allocated.

Mr. ENGLISH. The point I am making though is that it is not being allocated that way, if this is the way you are spending the money.

General DAVIS. You are talking about rates and I am talking about dollars in the program; the two are different.

Mr. ENGLISH. Mr. Mann, do you have any more questions?

Mr. MANN. Thank you.

Mr. ENGLISH. I would like to get into this whole issue with regard to the survey once again, particularly with regard to marihuana.

As I pointed out, we had this instance arise with regard to one military installation in which we had the executive officer and their attitude with regard to marihuana, and the thing that concerned me a great deal is, as we stated earlier, in the last scientific report that I suppose any one has, in the military at least, that we could determine or could categorize as being sceintific, would be the Little study of 1974 statistics. No one has anything since then, at least as far as we know. There is nothing. You have nothing and, as I understand it, the basis for your interpretation of the

amount of marihuana abuse taking place within the Air Force is based—you have taken that study—you have taken HEW's statistics, and then you have also tied that to drug arrests, to identifications by the dogs, urinalysis tests, and I would assume also any one who is arrested for that purpose, and that sort of thing?

General DAVIS. Trend analysis, an analysis of the trends, which is a good statistical technique, and our local assessment systems.

Mr. ENGLISH. It appears to me that you are pointing to that and saying, "We have about 27 percent, which is about the same as we had in 1974 with regard to marihuana," and obviously that comes no place even near the type of indication that we received when we asked the enlisted personnel what they know about their particular units.

The thing that disturbs us a great deal in looking at this is that you are depending upon arrests, you are depending upon discoveries, you are depending upon urinalysis tests, and there is absolutely no kind of urinalysis test that you are using for marihuana.

Would you use such a test, by the way, if you had it? If such a test were made available to the Air Force with regard to the discovery of marihuana, would it be used and actively used by the Air Force?

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

Mr. ENGLISH. It is thing where you have a great deal of some opiate-type drug available and are going ahead with your tests; and what you have in Berlin—and I assume you follow that same policy, which means about the entire United States—would be covered with that type of policy, because I don't think there is any question that marihuana is readily available in all areas of this Nation?

General DAVIS. We would look at behavior. One has to ask one's self how you would apply that, and I would say certainly we would use it; but for the record——

Mr. ENGLISH. "Would you like to have such a test?" is what I am asking.

General DAVIS. Yes.

Mr. ENGLISH. The Air Force would like it?

General DAVIS. Yes.

Mr. ENGLISH. Has the Department of Defense ever indicated to you that such a test was available and they have been approached with such a test?

General DAVIS. We have been advised that there might be such a test available.

Mr. ENGLISH. I am talking about—is there such a test in existence today?

General DAVIS. I think there is some question as to the accuracy of results. We have used it on a test basis at some Air Force bases.

Mr. ENGLISH. What test was that?

General DAVIS. The EMIT system, not the same test.

Mr. ENGLISH. We are talking about a test for THC?

General DAVIS. I am not aware of it.

Mr. ENGLISH. Not aware of it?

General DAVIS. No.

Mr. ENGLISH. In other words, no one within DOD has told you that the Department of Defense has been approached for such a test and that it has been available for the past year?

General DAVIS. You will have to tell me which test specifically and I will provide it for the record. We may have been told.

Mr. ENGLISH. It is produced by the Hoffman-La Roche Co., which is in New Jersey, and I believe it is the same company which provides the urinalysis test.

I have a picture of it, if you care to see the method used.

General DAVIS. I believe, Mr. English, there are at least six test concepts and at least six tests for marihuana available, so we would have to identify specifically.

Mr. ENGLISH. It is my understanding that this particular method—and, as I say, by the company that is furnishing the urinalysis testing and has furnished the urinalysis testing program for the Department of Defense for several years—this company advised the Department of Defense a year ago that they had this test available.

You are telling me that the Air Force was not advised that such a test was available and no inquiry was made as far as the Air Force was concerned as to whether or not you would desire such a testing?

General DAVIS. The Navy has been testing the EMIT for over a year.

Mr. ENGLISH. I am asking if you knew about this test?

General DAVIS. We are surprised to hear that the test is available because it was our understanding that the La Roche Co. is developing the test, but that it is not available at this time.

Mr. ENGLISH. I understand that the primary factor with the system that the Navy is using is that it is a portable system and therefore it can be taken on ships, and that is the reason that it is being tested. It is the same test for the same old drugs; it is the same thing. It has nothing to do with marihuana.

This is a marihuana test. But the Air Force would desire such a test if it were available?

General DAVIS. The latest data we have—which I pointed out at the outset—is that it is on a test basis, that it still has bugs.

Mr. ENGLISH. Mr. Lawrence has a point he would like to make.

Mr. LAWRENCE. General, it is a question following on this line. Many times when a unit commander, a wing commander, a squadron commander, refers an airman for urinalysis, he is referring the airman because he is acting different, he has lost his motivation. The commanding officer feels the man might be using drugs and sends him over.

Only 1 percent—according to your testimony earlier today—come back affirmed positive for drug abuse. I think it is reasonable to infer that in many more of those cases that individual who was tested may have been using a drug that urinalysis simply won't pick up, like marihuana, like PCP, like cocaine.

General DAVIS. I think PCP is a technical——

Mr. LAWRENCE. There is a special test for PCP but it is not generally done. It has to be specifically ordered. If he is just sent over for a urinalysis, there is no PCP test done. I am saying it would be much more fair to commanding officers who are relying

on urinalysis as an identification tool if that urinalysis would pick up the most important single drug abuse in the Air Force, which is marihuana, marihuana or hashish, or cannabis drugs.

General DAVIS. Yes, and the most prevalent in all the services.

Mr. LAWRENCE. And I think you would agree, General, that the commanding officer is put in a rather delicate position when he has taken the rather extreme step of referring the man for urinalysis and telling him, "I think you may be abusing drugs" but not giving that commander the backup to do a good, complete check. When that lab result comes back to the C.O. and it says, "This urinalysis is negative," it may not really be negative. Perhaps the C.O. was right.

General DAVIS. Perhaps. Your line is speculative and you may be right. I don't think I said I would deprive the commander of that tool. I am not saying that at all.

Mr. LAWRENCE. No; I understand that, General. What I am saying is, I hope you agree that it would be extremely desirable to test for THC, since that is the most commonly encountered drug.

General DAVIS. Certainly. I thought I had already agreed to that.

I would like to follow on to your comment, Mr. English, in what we look at. We look at fatalities in establishing the trend, OSI investigations, discipline trends, our program identifications, DEA data—this is to establish our rate of 27 to 30 percent—urine testing, local authorities' information, and it is assessed locally and regionally at our local level, at our Drug and Alcohol Abuse Control Committee.

Mr. ENGLISH. The point is that none of that information tells you how many abusers you have.

We had the Army here last week and they told us that kind of information is totally unreliable, that is the reason that they have gone with the questionnaire. As weak as those two questions are, they feel like that is the best they have to go on, because the type of information that you are putting forth here has absolutely nothing to do with the amount of drug abuse that is taking place.

General DAVIS. In my earlier point, Mr. English, that is why we are looking forward to the new A. D. Little-type survey.

Mr. ENGLISH. I hope you can light a fire under somebody at DOD and get that off the ground. As I understand, the first request that we have for any funding for any additional research on anything with regard to drugs is in fiscal year 1980.

General DAVIS. I would like to give you perhaps a more coherent response on the whole survey program.

Mr. ENGLISH. Here is the thing: Maybe I can try to cut corners a little bit here and tell you the thing that troubles me. I don't think that the Air Force is comfortable with the type of identification system that they have. I don't think that they feel like they have really got a good handle on this thing.

General DAVIS. And I think that I put that up front.

Mr. ENGLISH. So why doesn't somebody come in here and say this is the best we have; it isn't worth a darn?

General DAVIS. Because that is not true. In the very early days of the program, 1971–72, we experimented with surveys but were frankly disappointed with the results. We didn't feel we were getting an accurate feel for the extent of the drug problem. It was

during this period that our current assessment system began to evolve.

With our survey attempt, we found in order to get scientifically valid results a rather large-scale effort was required. Some of the ingredients of a valid survey, according to our statistical experts, are random samplings of respondents, avoidance of bias caused by administration by military personnel, internal and external validity checks, tests of reliability to insure the instrument measures results consistently, and so forth.

In short, we found to do the survey properly we would have to rely on consultants. We also found the surveys were not responsive to our management needs, that is, we needed an ongoing assessment system which relied on indicators available to us in real time versus the long waits that normally accompany surveys.

Again, the point on the 1975 A. D. Little survey, it took a while to get it.

We say the commander's judgment, the man on the scene, is our best way. They are on the firing line; they need to get the job done, and with his drug and alcohol abuse people, local, with central policy guidance, we can respond to the program on an immediate basis.

I agree that the Arthur D. Little survey, that type of technique, which will come out, which is random, the survey I think the opinion survey the committee did was good; it certainly wasn't random; it selected the target population and zeroed in on it.

Mr. ENGLISH. We selected the age group that is most likely to be abusing. I don't think that you would suggest that we come in and, starting with 50-year-old generals, expect that we have a problem in that area; I don't believe that is the case.

General DAVIS. I am not saying that at all, but the statisticians will tell you that it was not a random survey.

Mr. ENGLISH. No, it certainly is not meeting the guidelines we would like to have. The thing we cannot understand is why an Arthur D. Little-type study is not done once a year or once every 2 years, and why it isn't part of the program. You just got through saying you aren't happy with your surveys and here you go back to this information. I would like to point out, again, in the material that you provided us here, that you are getting part of your information from an investigative group that concentrates on hard drugs and the trafficking of drugs, not abusers, not on users.

General DAVIS. From an investigative group that does what? Who is that group?

Mr. ENGLISH. That is OSI?

General DAVIS. Oh, no; OSI works other programs too. So do our security police. They are part of the investigative arm.

Mr. ENGLISH. The point is that the whole thing depends on an individual's attitude toward marihuana. If you have a base commander that says, "I don't care what my guys do"——

General DAVIS. That is not the Air Force's attitude. If we find human beings who don't support the policy, we will remove them.

Mr. ENGLISH. You are still dealing with a situation that says, "Golly, I don't want to be out there and be busting my guys tonight who are smoking pot. I don't want to do it."

General DAVIS. I understand it. It is a tough decision to make.

Mr. ENGLISH. The other question it comes down to is that many company commanders don't like running dogs through the barracks,"So I am not going to do that." And that situation has existed.

General DAVIS. I would say maybe the sample size is a one, or two, or three certainly does not represent the total Air Force program.

Mr. ENGLISH. We are finding again a situation where a dog would go through there once every 6 months maybe, just maybe.

General DAVIS. And what is the size of that sample?

Mr. ENGLISH. Again, that is what I say; an Air Force enlisted man living in a barracks can expect possibly to have a dog go through there, depending on how much Cain his company commander raised, once every 6 months. You can't expect to keep these dogs in more than that, because the dogs just don't have it; you don't have that many dogs.

General DAVIS. The fundamental point we seem to be missing is the supervision that this target population gets on a daily basis. I agree that it is a problem. I agree we need to work the problem. I think we are working the problem. We have a program that I am rather proud of. We don't have all the answers.

Mr. ENGLISH. I would like to quote to you, since we both have a great deal of faith in adequate research and scientific research. Again, this is testimony that we took last week from the Army regarding a 1975 study done at Walter Reed in which they pointed out, particularly of hard drug abuse, the difficulties that——

General DAVIS. I think we are quoting to each other. We agree that surveys——

Mr. ENGLISH. Just a minute, now, because you brought up the leadership thing, and this is one of your key deterrents.

General DAVIS. You are talking about Army leadership. I am talking about Air Force leadership.

Mr. ENGLISH. So we are now down—are you going to say that the leadership of the Army isn't as vigorous against drugs?

General DAVIS. No, that is not the point. I speak for the Air Force.

Mr. ENGLISH. I recognize that, but I think that certainly any research that was done by the Army into this problem—it is a military problem; it crosses the boundaries of the different services; it is not peculiar to just one service—I think any research that is done by one certainly is worth looking at by the others.

General DAVIS. And we all use it.

Mr. ENGLISH. In 1975, Dr. David Marlow, project director for this Walter Reed study, says: "The same groups in which drugs are used also support and encourage their fellows to perform as 'good soldiers'. The 'good soldiers' made many soldiers unlikely suspects for significant drug abuse."

And he goes ahead and points out that this is the reason that it is so difficult to get a handle on the drug abuse problem. The ones you are going to catch, the ones who are going to get arrested, are probably not the smartest of the group, and any of them really smart enough and a part of this drug clique within the military and a part of peer pressure that is taking place, you are not going

to find them, because there is a tremendous amount of peer pressure to react to indeed "good soldier".

I would assume the peer pressure would be in the Air Force too. You don't cause problems; you don't call attention to yourself; you don't get caught. This is what brings on what Dr. Marlow quotes as being—and I quote: "a mantle of invisibility" and that is the thing that disturbs us, and I don't think that there is probably anything in this country that is more difficult to catch as the so-called marihuana users because of the attitude of society, because of the apparent attitude of the individuals, whether they are in the service or out of the service, regardless of what the official policy is.

It is against the law in this country to use marihuana but that doesn't bother the people who are using it a bit; and you have a whole host of attitudes as to whether that law is right or not, the same as you have a whole host of attitudes by every person from the top all the way down to the lowest enlisted man in the Air Force as to what he thinks about the Air Force's policy toward marihuana, and depending on his authority and upon his rank, you are pretty much going to get different levels of enforcement; and that is what I am talking about. This is the thing that troubles us, and I am not——

General DAVIS. It troubles me, too.

Mr. ENGLISH. That is what I say, and the thing that I am hoping for is, where do we find out information that material has been available to the Department of Defense to carry out tests with regard to marihuana? It has been available for a year and they didn't even bother to notify the Air Force or the Army or anyone else and point out to them that this equipment is available, "What do you think about it? Should we use it?"

You just stated that is the greatest problem the Air Force has in this drug area, marihuana, and that would be the one way you could get a handle on it. You haven't received the resources to do an Arthur D. Little-type study once a year.

These are the things that trouble us. This is either a problem or it is not. If it is not a problem, let's shut down this committee and forget it; but if it is, this Congress wants to help and this committee wants to help. We are here to help. I don't care what the official policy of DOD or anybody else is; you are the guys who have the responsibility for leading these people and your officers have the responsibility of going into combat, and we have had an awful lot of enlisted personnel that have just told us flat out, "I am scared to death to go into combat with the unit I am with." That is conduct that we shouldn't allow to exist and it just bothers us, and I can understand it.

We have people who come up here and they get a little bit on the defensive with us and just lay cold turkey on it: "Here is what we need to do. Here is what it is going to take to clear up this problem. Here is how much money it will take."

We will go to the Appropriations Committee and fight this thing with you all the way.

That is the end of the speech.

Mr. Lawrence has a question.

Mr. LAWRENCE. One question: General, speaking now of dependents of your active-duty personnel, what action is taken on military

installations if dependents, non-active-duty military personnel, are found to be abusing drugs?

First of all, how do you identify them? And, second, what type of counseling or rehab is available to these people, and is it sufficient in the Air Force?

General DAVIS. Essentially, it is through education, voluntary education, but we do offer a good deal of dependent assistance, but principally it would come from a sponsor, say a father who has a teenage son or daughter who has a problem. Treatment is available. Principally, of course, there is a medical evaluation which is available, and facilities are available for that. We do not have any limited resources in that area.

In terms of incidence of treatment, we provide for drug abuse counseling for dependents. I do not have a number, but I can supply it for the record. They are provided the same type rehabilitation as our military personnel.

If we are talking about real drug abusers, I am talking about real hard drug case abusers, we do not treat those in the Air Force. We transfer them. If we have a hard case dependent drug abuser, we would, of course, give the help we could, then transfer that person to another facility.

Mr. LAWRENCE. Probably if this committee worked for 10 years, we could be criticized for not having a sample size, but I think it is significant, of those people we did ask—and I am talking now of dependent care—there was almost universal criticism of availability to Air Force medical facilities. I know that on each base which has a drug program there are a certain number of slots allocated to that program. I also know those slots are used in order of priority by, first, active duty personnel.

Perhaps Major Bell can help me. How would that work?

General DAVIS. Active duty, retired, then dependents.

Mr. LAWRENCE. Dependents do have to stand in line with other groups. It is our understanding the facilities are full with military personnel and there are very few slots available for dependent or retired persons.

General DAVIS. I would find that awfully difficult to sustain. Primarily, we are not talking about inpatient treatment.

Mr. LAWRENCE. Correct.

General DAVIS. Maybe some psychiatric sections. We are not talking about those slots.

Mr. LAWRENCE. Drug abuse slots.

Colonel ROGERS. We can provide detoxification for dependents. Most facilities have outpatient care or psychiatric help. As far as formalized rehabilitation centers for addicted dependents, we would have to refer them to civilian resources under CHAMPUS, sure.

Major BELL. One of the strengths of our program is that we do have a sort of a closed community and we are more easily able to put into treatment a military member. Dependents, on the other hand, are more hard to reach, because we have to treat them on strictly a voluntary basis. Once identified, the same treatment and education programs are available. We say it is on a space-available basis, but it has never been brought to our attention that someone who needed help was unable to get it.

Mr. LAWRENCE. After the hearings are over, I will cite specific incidents.

Major BELL. I am familiar with the problem Mr. Nellis encountered, but without knowing the specific figures——

Mr. ENGLISH. The staff has a number of questions to be submitted in writing, and you may respond in writing.

One of them—and it will require some thought—how many of the recommendations made in the 1975 Arthur Little study did the Air Force implement? We know there is a large number which DOD in general did not implement. The one question which has to follow that is, given the fact that we are going to be doing this type survey, what good does it do if we do not implement the recommendations?

General DAVIS. We will submit that for the record, but again I have prefaced in my remarks the fact that our whole program is built on the Arthur D. Little survey of 1975 and the recommendations contained therein. But I will give you a bean count if you want.

Mr. ENGLISH. If you could go down, point by point by point; and also in regard to the White House assessment——

General DAVIS. My response to that assessment is in the record, point by point.

Mr. ENGLISH. Again, we appreciate your coming, and your cooperation. It has been most helpful.

This committee is adjourned, subject to call of the Chair.

[Whereupon, at 12:40 p.m., the committee adjourned, to reconvene subject to the call of the Chair.]

END