DRUG ABUSE IN THE ARMED FORCES OF THE UNITED STATES: OVERSIGHT UPDATE

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

FIRST SESSION

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WEDNESDAY, NOVEMBER 7, 1979

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

The Select Committee met, pursuant to notice, at 1:15 p.m. in room 2167, Rayburn House Office Building, Hon. Glenn English (acting chairman of the Select Committee) presiding.

Present: Represenatives Lester L. Wolff, Billy L. Evans, Stephen L. Neal, Robin L. Beard, and Benjamin A. Gilman.

Staff present: Patrick L. Carpentier, chief counsel; Daniel A. Stein and Elliott A. Brown, professional staff members; and Bonnie Robinson, executive assistant.

Mr. ENGLISH. This hearing of the Select Committee on Narcotics Abuse and Control will come to order.

Today, we will hear an update of what has taken place within the Department of Defense as well as Department of the Army with regard to the problem of narcotics abuse within our Armed Forces.

This committee has had underway for some time an effort and study to assist in this very serious problem. And we are hopeful that today, we will learn that great progress has been made over the past few months. Twelve months ago, the committee traveled to West Germany, conducted an investigation, and held a hearing during which we placed upon the record the findings of our committee.

Since that time, recommendations have been made by myself and Mr. Gilman. And, of course, we are quite interested in the follow up with regard to those recommendations.

Also of interest are the 12 points that Secretary Duncan laid before the committee in July 1978.

So without further ado, we will begin the hearings. First of all, we have Mr. W. Graham Claytor, Jr., Deputy Secretary of Defense; and Dr. John Moxley, Assistant Secretary of Defense for Health Affairs in the Department of Defense.

It is my understanding that you gentlemen would like to submit your testimony and would be open for questions from the committee; is that correct?

TESTIMONY OF W. GRAHAM CLAYTOR, JR., DEPUTY SECRETARY OF DEFENSE, DEPARTMENT OF DEFENSE, AND DR. JOHN H. MOXLEY III, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, ACCOMPANIED BY COL. PAUL F. DARNAUER MSC, USA, ACTING SPECIAL ASSISTANT FOR DRUG ABUSE

Mr. ENGLISH. Would you please begin, Mr. Claytor?

Mr. CLAYTOR. Thank you very much, Mr. Chairman.

I am pleased to appear before the committee today to discuss drug abuse in the military, along with Dr. John Moxley, the Assistant Secretary of Defense for Health Affairs, who, as you know, has principal staff responsibility for our drug abuse programs. We have with us also Col. Paul Darnauer, our Acting Director of Drug and Alcohol Abuse.

When he appeared before you last year, my predecessor, then Deputy Secretary Charles Duncan, stated that the drug abuse program in the military was one that greatly concerned him and Secretary Brown. At that time, Secretary Duncan described an innovative and aggressive program of initiatives to combat that problem.

I want to make clear at the outset that I, too, have a deep personal commitment to solving this problem and was very much involved with it in my previous assignment as Secretary of the Navy. I can assure you that, along with Secretary Brown, I shall be closely monitoring progress on the initiatives we have underway.

One action that we have just taken is to issue a clear-cut Department of Defense Policy on the use of cannabis [marijuana and hashish]. This should provide uniform guidance to all four services in this important area. A copy of this directive is attached to my statement. I would like permission to have it included in the record, Mr. Chairman.

Mr. ENGLISH. Without objection, so ordered.

[The cannabis statement follows:]

DEPARTMENT OF DEFENSE POLICY ON CANNABIS USE

PURPOSE

The purpose of this policy statement is to establish guidelines for addressing the problem of cannabis use among military personnel.

OBJECTIVES

The objective of these guidelines is to clarify Department of Defense policy regarding: (a) Pre-service use of cannabis; (b) identification of active duty cannabis users; and (c) appropriate disposition of identified cannabis users.

THE PROBLEM

Reporting on the results of its 1977 national survey, the National Institute on Drug Abuse revealed that 47 percent of 16–17-year-olds and 59 percent of 18–21-year-olds reported that they had used cannabis (marijuana or hashish); about 30 percent of both groups reported use within the past month. The pattern of cannabis use among military personnel of comparable ages is probably similar. The Department of Defense is thus faced with the high probability that many of those likely to volunteer for military service have used cannabis and may continue to use it after entering the military. Within the Department of Defense, current identification efforts and responses to identified cannabis users vary widely. In some organizations, there is active and intense effort to locate cannabis users; in others, there is minimal effort. In some units, use results in a mild reprimand. In others, the user is strongly disciplined and placed in treatment for up to one year. It is imperative that a clear and consistent policy regarding cannabis use be established that both recognize the change in our social mores regarding the use of cannabis and, at the same time, emphasizes the Department's commitment to the highest standards of discipline, health, and respect for the law. The policy established herein takes both factors into consideration and provides guidelines to the Services for addressing the problem of cannabis use.

PRE-SERVICE USE

The use of cannabis by many young people is related to the phenomenon of adolescent experimentation and use is discontinued or dramatically reduced as the user matures. To exclude such persons from military service solely because of past experience with cannabis is unnecessary as well as impractical. The following policy regarding pre-service use of cannabis is hereby established:

Limited pre-service use of cannabis will not be a disqualifier for enlistment or appointment.

Chronic cannabis use and psychological dependence, as defined in AR 40–501, Standards of Medical Fitness, are disqualifying conditions for enlistment or appointment.

Applicants for Personnel Reliability Program (PRP) positions or other job skills judged to be of a critical or sensitive nature by the Services concerned will be screened for cannabis use during the period of at least 90 days prior to application for enlistment or appointment. If the individual has used cannabis within the proscribed period, a waiver will be required to permit enlistment or appointment of such positions. The granting of this waiver will be the decision of the individual Service concerned and be based on the needs of the Service, the military specialty concerned, the degree of use, and any medical or psychological examination deemed necessary.

A waiver is permitted for judicial adjudication related to cannabis only when the conviction was for use or possession of cannabis. Waiver to permit such enlistments should be processed as are other waivers.

IDENTIFICATION OF USERS

Military personnel are expected and are required to obey the law. The use of cannabis is a violation of the Uniform Code of Military Justice, and commanders will enforce the law and take appropriate action against those who break it. The primary method of identifying cannabis users at the present time is through law enforcement and personnel security investigations. Within the foreseeable future, identification may also be practical through biochemical testing. When such techniques have been approved by the Department of Defense, they will prove to be a valuable tool for commanders. To avoid the disproportionate use of limited resources, however, biochemical testing to detect cannabis use will be employed in situations in which suspicion of drug abuse arises, e.g., return from or apprehension after an unauthorized absence; failure to obey lawful orders; deteriorating, abnormal or bizzare behavior; assault; violation of safety provisions; and apprehension or investigation for drug offenses. As technology develops, the levels of sensitivity for such tests should be calibrated to detect on-duty use, intoxication, or heavy use of cannabis.

APPROPRIATE DISPOSITION

The Department of Defense Drug and Alcohol Abuse Program provides the commander with a wide range of responses for restoring the abuser to duty. These include disciplinary actions, personnel security and other administrative actions, motivational education, nonresidential counseling, and residential treatment. The appropriate response must be tailored to the level of abuse and should be arrived at through a screening procedure which normally involves the commander, the immediate supervisor, appropriate drug/alcohol abuse prevention program personnel, and a medical, legal security, or religious representative as appropriate. In those cases where the drug of abuse is cannabis, unless there is evidence of serious involvement with the drug, or the individual involved holds a security clearance or is assigned to special access program duties, commanders should confine their response to appropriate administrative actions, disciplinary

action and motivational education. Motivational education has proven to be an effective method for assisting the nonaddicted alcohol abuser; commanders are therefore advised to use this approach rather than more lengthy treatment responses for the cannabis abuser.

In considering the disposition of the cannabis offender, as in considering the disposition of any other offender, all administrative, punitive, and nonjudicial punishment measures should be evaluated to determine which course or courses of action are appropriate. In making this determination, all the facts and circumstances surrounding the commission of the alleged offense, the length and character of his service, and all other mitigating and aggravating circumstances should be considered. Normally, for a cannabis offender who uses or possesses a minor amount and who otherwise has a good record, the use of Article 15 of the Uniform Code of Military Justice, as opposed to trial by courts-martial, is appropriate. If, however, use occurs during duty hours, stronger disciplinary and administrative actions may be more appropriate and, if so, should be taken.

Mr. CLAYTOR. In your letter of invitation for us to appear, you asked for us to report on the status of the initiative that we undertook last year and a number of other issues. In his prepared statement for the record, Dr. Moxley provides a detailed report on our progress. And in a moment, he will provide you a brief summary of that statement. We will then be pleased to answer your questions on those initiatives.

In your letter, you also asked several questions concerning the level of management visibility given to our drug abuse program efforts in the Office of the Secretary of Defense. As you know, we have modified Department of Defense directives so that the Assistant Secretary of Defense for Health Affairs reports directly to Secretary Brown and me and not through any intermediary staff position. I can assure you that this is happening in fact as well as in principle. Dr. Moxley has direct access to me and has been using that access to keep me well informed on our program status.

In addition, we have further emphasized the importance of solving our drug abuse problem by elevating the position of Special Assistant for Drug Abuse to that of Deputy Assistant Secretary of Defense. We are now seeking to fill this important post promptly with as highly qualified a person as possible.

Before turning this over to Dr. Moxley, I want to reiterate my personal concern and that of Secretary Brown for the health and readiness of our military personnel. We are determined to do everything in our power to eliminate drug abuse in the military because of its detrimental impact on the welfare of the force.

I welcome the assistance this committee has provided, and I am committed to working with you to make every effort to solve this problem.

Thank you very much.

Mr. ENGLISH. Thank you very much, Mr. Claytor.

Dr. Moxley?

Dr. MOXLEY. Mr. Chairman, thank you very much. I, to, appreciate the opportunity to appear before this Select Committee to discuss drug abuse in the Armed Forces and provide an update on the status of a broad range of DOD initiatives to improve the efficacy of our drug and alcohol abuse prevention program.

First of all, we acknowledge the endemic and complex nature of substance abuse problems as they are manifest in the military. Given this recognition, my remarks will focus on what we are doing to combat these problems and what is required to sustain a dynamic and aggressive program.

In particular, I will review the status of the initiatives to strengthen our program and the recommendations made by your committee.

I will also address our policy on cannabis abuse and biochemical testing to identify cannabis abusers.

Finally, I will discuss our goals for the coming year.

I know you are concerned about the emphasis on drug and alcohol abuse in my office. Let me address that issue first. You are aware that almost concurrent with my arrival in the Department of Defense some 6 weeks ago, Dr. John H. Johns, the special assistant for drug abuse prevention, submitted his resignation to assume a teaching position at the National Defense University. His leadership, extensive knowledge of the drug abuse area, and unique qualifications are a significant loss to our program.

In deciding about a successor, I consulted with Dr. Johns as well as with appropriate assistant secretaries of each of the services, as well as a number of people that were here at the worldwide conference held in September. It was their collective consultation that caused me to request that the position be upgraded to a Deputy Assistant Secretary of Defense for Drug and Alcohol Abuse Prevention. And Secretary Claytor has indicated that has been granted.

We are now seeking an individual with broad experience as well as an interest and background in the human resource development area. And we will move forward quickly in that regard.

During the last 16 months, the Department of Defense has pursued some 15 identified initiatives to cope with the drug and alcohol problem. A status report was submitted to you, Congressman English, in January. These initiatives are discussed in detail in my formal statement which I have submitted. In the interest of brevity, I will confine my comments to a discussion of the key elements of these initiatives.

Of major importance is the effort to improve our data base. Progress has been made in the redesign of the drug reporting system to obtain uniform trend data. A draft report which contains the key data elements of the proposed reporting system is complete and has been forwarded to the military departments.

The full implementation of this system which includes a test of the drug abuse warning network, so-called Project DAWN, operated by the Drug Enforcement Administration, is expected in 1980.

A second major effort in this area involves the design and administration of a DOD personnel survey which comprehensively assesses the prevalence, nature, and effects of drug and alcohol abuse. The survey objectives, design, and questionnaire have been carefully developed and now thoroughly reviewed. We have used experts from NIDA, NIAAA, the civilian community, and DOD to assist us.

In September, a contract was awarded through a competitive bid process, and the report is due by the fall of 1980. This initiative is now progressing well after some necessary delays to carefully refine the survey objectives, design and questionnaire.

We believe that the restructured survey instrument adequately addresses the survey objectives which are to measure not only prevalence, but consequences of drug and alcohol abuse. The initiative did not place enough emphasis on the consequences of drug and alcohol abuse, and that was the cause of the redesign.

Originally, the fieldwork was to be completed in 1979. However, the revision of the survey instrument, its review, and the contracting process lost us some time. As a result, the contract was awarded too late to complete the required preparations and the fieldwork before the Christmas/New Year holiday period.

Rather than jeopardize the integrity and credibility of the survey, I made the decision to delay the fieldwork and begin right after the holiday period and be completed sometime around March of 1980.

Mr. ENGLISH. Dr. Moxley, may I interrupt you? We do have a vote on right now. This might be a good point to break so we can complete that vote and then come back.

[Whereupon, a recess was taken.]

Mr. ENGLISH. Please continue, Dr. Moxley.

Dr. MOXLEY. I had just completed a brief discussion on the need to improve our data base and initiatives in that regard. I would like to turn now to the initiatives to strengthen our law enforcement efforts. We have established a DOD law enforcement task force on drug and alcohol abuse which has reviewed staffing levels. These levels have been substantially increased, particularly in Europe.

Other actions surfaced by this task force such as means to authorize payment of informants, proper employment of drug detector dogs, improved intelligence networking of treatment and law enforcement personnel without violation of confidentiality, amendment of DOD customs directives, are being addressed and should be well underway or resolved by the end of the year.

In addition, we established a Berlin Task Force on Drug Abuse on June 30, 1978. Recent emphasis has been on overt and covert drug suppression efforts, determining legal actions that could be taken by German authorities against known or suspected drug traffickers, and increased customs control, including the use of drug detector dogs.

German-American relationships are continuing to be strengthened, current cooperative efforts are outstanding, and the task force is enhancing drug abuse control in Berlin.

Another initiative involves research on the consequences of drug abuse on job performance and combat effectiveness. This matter is of concern because the House Appropriations Committee deleted $1 million needed to support research programs in the fields of alcohol and drug abuse, jet lag and combat fatigue in fiscal year 1980.

The House Appropriations Committee stated, the "committee does not believe that substantial increases for such research are warranted." Since all research funds are alcohol and drug abuse in DOD were eliminated by congressional action in 1976, we are already at zero base.

Therefore, to cut any of the funding in these important areas will seriously jeopardize funding for the research of impact of drug abuse on combat readiness as requested by the Congress.

The Senate Appropriations Committee, however, has recommended restoring these funds to the budget. We are awaiting a conference decision on this matter. Obtaining adequate funding of our research requirements continues to be an area of prime importance.

The army, which was directed to conduct this research, is focused on accomplishing four objectives within a 5-year program:

One: To establish the impact of drug and alcohol abuse on individual military performance;

Two: To characterize the relationships of this abuse to unit readiness;

Three: To specify the relationship of patterns and distribution of military drug use to unique attributes of the military environments;

Four: To recommend actions for maximizing efforts to reduce and control levels of drug and alcohol abuse by service members.

Since unit effectiveness is related to social and organizational factors, more than a characterization of substance abuse effects on individual performance is required for this research. Internal cohesion factors are critically important in this regard. Any threat to the functional integrity of a military unit increases the risks of sustaining higher combat casualty rates and reduced combat effectiveness.

In the past, drug use has fostered fragmentation within units by promoting divisiveness between the drug-using population and nondrug users. Unit leadership under these circumstances can be undermined to the extent that it has difficulty dealing with the problem.

We are pursuing the development of improved measures for drug abuse identification, primarily urine testing policies and practices. We no longer require a minimum level of urine testing.

The previous policy which required the services to maintain a minimum yearly rate of urine tests of 0.6 of the target population of service personnel 25 years old and younger was resulting in de facto "random" urinalysis, low confirmed positive rates in some areas, and decreased command support for the overall program.

The policy of requiring commanders to conduct urine tests when incidents occur which are likely to be drug or alcohol related has been reemphasized. We will monitor the services' compliance with the new guidance through the quarterly urinalysis reports. Commanders at all levels are also authorized to order urinalysis sweeps of entire units at their own discretion.

Another effort to improve our identification capability involves the use of portable urinalysis, equipment. The test phase of this technique should be completed and reports submitted by all four services by December 1979.

From our preliminary discussions, test site visits, and the Marine Corps report, which is already in hand, we have learned that, in general, people in the field favor the use of portable test equipment. The equipment used, however, is not sensitive enough and produced an unacceptable rate of false positives.

A technical evaluation of all available portable urinalysis equipment on the market and in development was initiated to determine which one we should use if we plan to use portable kits on a permanent basis.

To assure an adequate level of program staffing, we assessed the staffing within the Office of Drug and Alcohol Abuse Prevention in my office and each of the military services. The size of the Office of Drug and Alcohol Abuse Prevention staff has been sufficiently increased to perform its policymaking and program management functions for DOD.

Further, overall, the services appear to have an adequate quantity of total resources authorized. Personnel quality is of greater concern due to service assignment and staff training criteria.

I am also concerned about the Navy's policy of assigning junior officers as directors of the counseling and assistance centers because it insures that the directors will be inexperienced from the standpoint of line duty and in working with the Navy bureaucracy.

We intend to monitor this assignment policy carefully and will recommend action to have it changed if I find it detrimental to the Navy's program.

The committee recommendations as a result of its Europe hearings are discussed in my prepared statement and Army-specific items will be addressed by General Lutz.

Let me highlight two areas:

First: Concerning the appeal of decisions beyond the U.S. Court of Military Appeals, the administration is evaluating a proposal to provide for the review of U.S. Court of Military Appeals decisions by the Supreme Court.

Second: On the matter of transferring active-duty-drug-dependent persons to the Veterans Administration for treatment, Public Law 96–22 has, as you know, limited the circumstances under which transfer can occur. This will probably reduce the number of service members we transfer to the VA for treatment.

In regard to the new cannabis policy referred to by Secretary Claytor, we indicate some preservice use will not be a disqualifier for enlistment or appointment unless the use of cannabis is chronic or the user is psychologically dependent.

Applicants for special access programs such as personnel reliability or security will be screened for use prior to application. If use has occurred during a service-specified period, which must be 90 days or longer, a waiver will be required.

Currently, security investigations and law enforcement are the primary methods of identifying cannabis users. When the technology is adequately developed, however, urine testing will also be used as an identification tool in situations in which there is suspicion of use.

The sensitivity level for such tests must be calibrated to detect on-duty use, intoxication, or heavy use.

Commanders are advised to use disciplinary and administrative actions, along with motivational education, in dealing with identified cannabis users. The policy further advises that, for the cannabis offender who uses or possesses a small amount and who otherwise has a good record, use of article 15 of the Uniform Code of Military Justice, rather than trial by courts-martial, is appropriate.

It appears that a biochemical test for cannabis products in the human system will ultimately be available. We have found a procedure that is compatible with our equipment. It has been tested in one of our laboratories, but the complete body of technical knowledge necessary before we can use it for routine testing is still under development.

The active ingredients of cannabis are extensively metabolized in the body and multiple chemical compounds are excreted in the urine making correlation to degrees of impairment extremely difficult with the present state of the art. Furthermore, we still have not worked out a method to confirm the cannabis positives.

Concerning our goals for the coming year, we plan to continue our efforts to make the standards and policies of the services' programs more uniform where appropriate.

A second goal is to insure that the law enforcement and health care aspects of our program are in proper balance.

Our third goal is to further refine our problem assessment and program evaluation system, particularly with respect to our civilian employee program. We will address this in some depth in an action planning conference later this year.

Another goal is to develop a 5-year plan to insure drug and alcohol abuse prevention becomes more thoroughly integrated into our command and management processes.

Finally, we plan to continue to emphasize our involvement with other Federal and private agencies.

In conclusion, I have endeavored to give you an overview of the drug abuse program and situation as we see it. The Department of Defense remains fully committed to deterring drug and alcohol abuse and minimizing their adverse consequences to the individual and military preparedness. The initiatives and areas of concern I have highlighted are of vital importance to insure we possess a capability to sustain a responsive and effective program at all levels within the Armed Forces.

Again, I appreciate the interest and support of the Select Committee. At this time, we would be happy to address your questions.

Mr. ENGLISH. Thank you very much, Dr. Moxley.

What I would like to do, Mr. Claytor, is to go through the 12 points which now have been expanded by you people. While I realize Dr. Moxley has addressed some of them in his statement, we could get this thing down to a little finer language where it would be a little easier for everyone to recognize and understand.

The first initiative was to design and administer a comprehensive personnel [drug] survey. And the target date for completion of that project was May 31, 1979. That is now 5 months late.

Can you tell us for certain when this survey is going to be ready to be administered in the field? And do you think that you can assure us there will not be additional slippage beyond that point?

Dr. MOXLEY. Mr. English, we have slipped on almost all of the initiatives; there is no question about that. I am in more than a slightly personal responsibility for the slippage of this one.

Before I came to the Department, this was reviewed for me. And I became concerned, as did others in the program, that although it was a reasonable survey document, it did not completely fit what we wanted and, therefore, we did go back to redesign it.

By the time we got it redesigned and ready to go, we would have been collecting data over the Christmas/New Year holiday period. I, therefore, shortly after coming on 6 weeks ago, made the decision it would be better if we started the survey after that holiday period and completed it sometime in March.

I do not foresee circumstances that will go any further.

Mr. ENGLISH. So you are telling us that this survey is going to be in the field and in place by March?

Dr. MOXLEY. We should have most of it. The data will be collected or under collection at that point in time. We ought to be getting underway before March. We ought to be getting underway some time in early February.

Mr. ENGLISH. So you feel confident this thing will be moving, then, by March?

Dr. MOXLEY. Yes.

Mr. ENGLISH. Initiative 2 was: Use epidemiological data to assess drug abuse extent and location. The target date on that was March 31, 1979. You are 7 months late on that one. What is the current status?

Dr. MOXLEY. That is now in the implementation phase, including a test of the total DAWN system. And that should be completed within the next year. That is implemented right now, in the process of being implemented right now.

Mr. ENGLISH. The system is going to be implemented?

Dr. MOXLEY. A test of the system is going to be implemented, and then we will go from there to implementing the system.

Mr. ENGLISH. Can you give us a date, then, when the entire system is going to be implemented?

Colonel DARNAUER. That should be implemented within the next calendar year, during 1980.

Dr. MOXLEY. The system should be implemented——

Mr. ENGLISH. January 1980, or December?

Colonel DARNAUER. It will be later in 1980, because the test of the DAWN system will not be completed until 6 months from the first of November when it began. So we will be looking at that, we trust, by the end of September 1980.

Mr. GILMAN. Will the gentleman yield?

Mr. ENGLISH. Be happy to.

Mr. GILMAN. Mr. Chairman, I can't understand the extensive amount of delay that we are reading here and listening to in implementing some recommendations that were made back in November 1978, when this committee visited the West German theater, worked with some of the authorities, and thereafter, the Secretary made some recommendations.

And as I go through the committee's recommendations, and listen to the recommendations being made by the military administration, I fail to understand why it takes so long to implement such simple things such as reduction of tour. That was recommended several years ago by some of the leaders in the Pentagon. And our committee reemphasized it. And we are still beginning to start in that direction, started in October of this year, talking about new training programs and new recreational programs.

Why does it take 2 years to implement simple things of that nature when it is such a critical problem and affecting so many of our young people?

Mr. ENGLISH. If the gentleman would just wait a little bit, we still have 13 points to go through. I think you are going to have a chance to be more outraged than with this one.

Mr. GILMAN. Mr. Chairman, I recognize that, but I would hope that when the Secretary of our good administrators testifies that there is some substance for the reason for the delay. And I fail to understand 2 years of delay for simple things that could get to the heart and root of the problem here.

Thank you, Mr. Chairman.

Mr. ENGLISH. As I said, I think it is going to be important to go step by step and get this thing tied down to determine exactly where we are, how much slippage we have had. And I certainly appreciate the gentleman and his concern in that particular area.

But as I say, I think it will become apparent as we proceed, that very little has been implemented. I think this committee, without question, sang the praises of this plan well over 1 year ago, nearly 1½ years ago, to the high heavens. And we were all greatly relieved and filled with a great deal of hope.

But as you can see, so far, it appears that we may have been somewhat optimistic.

I would like to go on with initiative No. 3; to modify drug and alcohol reporting system to gather more uniform trend data. The target date on that was December 31, 1978. You are 10 months late on that one.

Dr. MOXLEY. We are late, there is no question about that. We now have the proposed reporting system which has been completed and forwarded to the military departments for review. Comments are due back by the end of this month. At that time, revisions will be made, and the final system will be developed by the end of this calendar year with implementation of the system expected during 1980.

And that again ties into the Drug Abuse Warning Network, the Project DAWN, I mentioned earlier.

Mr. ENGLISH. Is this an October 1980 date?

Dr. MOXLEY. No, this should be earlier than that. It will be implemented by the end of this year. We expect the final comment by the end of this month, and we will proceed to implementation.

If I might make just a general comment, Mr. English, that is that in reviewing these initiatives, we are late. As I look back and did review it with the people in the Department, there were many options in implementing them. And one was to push forward and get them implemented as quickly as possible, without paying too much attention on developing relationships, that would lead hopefully to a better program downstream a bit.

It was decided, that rather than try to push these into place as quickly as possible, that some time would be taken to enter into discussions with the services and with other agencies involved, so that when we did implement them, they would be implemented with some enthusiasm and with a feeling that everybody who was involved would be and that, therefore, we would get better results when they did get them imp'emented.

That, obviously, is a judgment call, but that was the one that was made. And in that regard, we have lost some time.

Mr. ENGLISH. I would like to say, Dr. Moxley, I think this committee recognized the possibility that some slippage could be expected on one or two of these points. Some are very complicated and rather technical and deadlines could be hard to meet on some of them.

But as I say, as this discussion progresses, I think the pattern certainly becomes very clear. And that is, frankly, that not a damn thing has happened since Secretary Duncan made these proposals. That is what it comes down to.

The committee is a very short-lived committee. We are going out of existence in approximately 14 months from now. We are not going

to be around any more. And we don't have the luxury of sitting around and talking about it and waiting for everybody in the country to decide it is a good idea.

We had a commitment. Secretary Duncan gave us that commitment. We expect it to be lived up to by the Department. And, quite frankly, as I said, I want to go through every darn one of these so the whole world knows just exactly where we are. And I want to tie it down once again on when you think this reporting system is going to be operational.

Again, on the initiative No. 3, are you talking about the testing is to be completed by the end of this next month or are you talking about this thing is going to be implemented and be a practical part, and the tool you are using to deal with the problem, by the first of 1980?

Dr. MOXLEY. You are talking about the drug recording?

Mr. ENGLISH. That's right.

Dr. MOXLEY. We will begin implementation by the end of this year. And sometime during the next year, it will be in place and running.

Mr. ENGLISH. Can you give us a month when we can say it is definitely going to be in place during that time?

Dr. MOXLEY. June to September.

Mr. ENGLISH. That is a third of the year. OK.

No. 4. Test portable urinalysis equipment. The target date was March 31, 1979.

Dr. MOXLEY. We have the report from the Marine Corps. The other reports will be in by the end of the year. The response to using the portable equipment has been favorable, but the portable equipment has given an unacceptable number of false positive results.

Therefore, we are going to have to go back and see if we can get some equipment that is going to deal with that technical problem. I cannot give you a specific timeframe on when we will find testing equipment that meets our needs. But when we do, we will implement it.

Mr. ENGLISH. For all you know, this thing may not be ready until one year from now; right?

Dr. MOXLEY. It depends on the development of the technical capability to do it. And I don't know when that will occur. That is not directly.

Mr. ENGLISH. Is this one that may never be implemented?

Dr. MOXLEY. No; because in using the test machinery that we have, the response has been that it would be very nice to have it. We would like to have it. But it doesn't do us a great deal of good when we get an extreme number of false positives.

By the time you unwind it, a lot of time has gone by. So we need a machine that is more reliable. We are currently surveying to see if we can find that machine. And if we can, we will use it.

Mr. BEARD. Will the gentleman yield?

Mr. ENGLISH. Yes.

Mr. BEARD. Is there no piece of equipment that has been tested that doesn't have the hang-ups that this other piece of equipment we are talking about has? I mean, there is bound to be something in our society that has this capability.

Dr. MOXLEY. The only specific report we have thus far is from the Marines. And the equipment that they used, as I say, gave inordinately high false positives.

I don't think, sir, that we are talking years, but——

Mr. BEARD. Who have we checked with, what different organizations, law enforcement agencies, or whatever we check with in the public sector or in the private sector?

Dr. MOXLEY. We have checked with them all, Mr. Beard. And it is portable equipment that we need to find. I am told that we hope we will be able to find some by early in the next calendar year.

Mr. BEARD. In your contacts with all the different laboratories, the private sector or different law enforcement agencies and cities such as New York or Chicago, whatever, none of them have a piece of equipment that they can support?

Dr. MOXLEY. Not a dependable portable piece of equipment.

Mr. CLAYTOR. Or that can be used in the field, Mr. Beard. I was Secretary of the Navy when we started the Marine test. And we pushed it very hard. I have been pushing. They selected what seemed to be the best available equipment to try the test.

You have to meet portability requirements for the field, out in the mud and rain, carrying in the truck, this type of stuff. And what they used has turned out not to produce a usable result.

So this is a research and development problem in a sense. The test we were undertaking was to move as fast as we could to find equipment that would work in the field. We got through the first phase of that with the Marines who were the first to try it. And we found that the particular equipment tested didn't work. We have to find something else and try it again. But believe me, it is a high-priority item.

Dr. MOXLEY. We are currently looking at about eight different systems and have been able to rule out five of them. So we are down to two or three that might work. And those are the two or three that we should have more definitive information on by December of this year or January.

Mr. ENGLISH. You don't know whether they would give us false positives or not?

Mr. CLAYTOR. Not until you try them in the field, Mr. Chairman.

Mr. ENGLISH. So you have only tried five?

Dr. MOXLEY. No; we have investigated through any mechanism we can with other agencies and so forth eight different systems. And on the basis of the information we have gotten, we can eliminate five. And it is down to two or three that are still being looked at.

Mr. ENGLISH. Are they giving false positives or have you yet to test them?

Dr. MOXLEY. I don't know the state of their evaluation at the present time in terms of false positives. We can probably get that for you.

Mr. ENGLISH. Also, I would like to know on the false positives, are you getting false positives on one or two drugs or false positives on all drugs?

Dr. MOXLEY. We see false positives with all drugs, but in varying degrees of severity.

Mr. ENGLISH. Can the portable units you are looking at also being used for cannabis?

Dr. MOXLEY. No. At this point in time there is no good urinalysis test for cannabis.

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Mr. ENGLISH. Initiative No. 5 was: Visit all major commands; institute mandatory seminars. The target date on that was December 31, 1978.

Dr. MOXLEY. That was accomplished as of August 31.

Mr. ENGLISH. You got around to see all the commands and made that one?

Dr. MOXLEY. Yes, sir.

Mr. ENGLISH. Whereall did you go?

Dr. MOXLEY. I went to 31 different stations throughout Germany and Italy. Colonel Darnauer has been to several of the commands. And I think, as I say, they have all been covered by one or the other.

Mr. ENGLISH. Initiative No. 6 is to measure extent of dependent drug abuse and determine necessary program changes. The target date on that—and that was as reported to the former Deputy Secretary Duncan, September 30, 1978. That was 2 months after the Secretary appeared.

Dr. MOXLEY. Provide better measures?

Mr. ENGLISH. No, this is to measure the extent of dependent drug abuse and determine necessity of the program changes.

Did we get that report?

Dr. MOXLEY. We have looked at the data from the school systems in Europe, and we have found that with the information that has been collected that in terms of drug use, including marihuana and its derivatives, that the dependent use, school-age use, in the military dependents is not running as high as it is in the civilian population in this country.

Nevertheless, there have been efforts to strengthen the educational program in those systems to make the educational program more informative. And obviously, efforts will be continued to monitor this.

Mr. ENGLISH. Well, it says to measure the extent of dependent drug abuse. What extent? We surveyed just to determine we don't think it is as bad as it is in the U.S. schools?

Colonel DARNAUER. That's correct, Mr. English.

Mr. ENGLISH. We didn't try to tie down 90 percent of the kids are smoking pot at some point or that 30 percent are using heroin or whatever?

Colonel DARNAUER. We do have that kind of information on our dependents in the school systems. We have no reason to believe that our other dependent community is different from the civilian sector usage in either drug or alcohol area.

Now, with the dependent school children, the dependent schools, particularly in Europe, have surveyed those youngsters. And the indication is that about 41 percent of young people 10 through 12 grades have used cannabis ever. A smaller percentage, as I recall it is about 10 percent——

Mr. ENGLISH. Give me that on cannabis, Colonel.

Colonel DARNAUER. Forty-one percent of these youngsters have ever used—that is—used it at some time in their life. Those who have used it one time per week or more frequently is 10 percent. And 6 percent use it more often than one time per week.

Mr. ENGLISH. Can you submit for the record the results of that survey?

Colonel DARNAUER. Yes, sir.

[The information referred to follows:]

STUDENT DRUG USE GRADES 10–12

[N=677, June 1979; in percent]

	No experience	Have used, stopped	Less than once a week	Once a week	More than once a week	Daily
Alcohol	29	8	35	12	13	3
Tobacco	66	8	7	2	2	15
Cannabis	59	13	18	4	4	2
Stimulants	88	6	5	½	1	½
Hallucinogens	97	2	1	----	(1)	----
Depressants	96½	2	1	(1)	½	----
Opiates	99	(1)	(1)	----	(1)	----

[1] Trace.

DODDSEUR, STUDENT DRUG USE GRADES 10–12, JUNE 1973–79

[In percent]

	Total experience							More than once a week						
	1973	1974	1975	1976	1977	1978	1979	1973	1974	1975	1976	1977	1978	1979
Alcohol	68	71	68	63	67	59	71	13	14	16	12	17	11	15
Tobacco	60	68	38	40	36	27	34	28	19	23	28	26	20	17
Cannabis	44	49	32	29	29	26	41	6	5	7	6	8	7	6
Depressants	12	32	18	10	3	3	3	1½	2	3	½	(1)	----	½
Stimulants	11	33	15	9	8	8	12	1	2	3	----	(1)	(1)	2
Hallucinogens	9	16	11	6	5	3	3	----	½	½	----	----	----	(1)
Opiates	1	1	5	1	1	1	1	----	----	----	----	(1)	(1)	(1)

[1] Trace.

Mr. ENGLISH. You are not making assumptions that what you find on the military side is what is going to be taking place on the dependent side?

Colonel DARNAUER. No, sir.

Mr. ENGLISH. We are going to have to make another vote so if you excuse us for about 5 minutes, we will be back.

[Whereupon, a recess was taken.]

Mr. ENGLISH. Gentlemen, on initiative No. 7, review military law enforcement efforts, the target date on that was September 30, 1978. Tell us where you are now on it.

Dr. MOXLEY. Yes. That group has met and has reviewed the situation, and the resources have been increased. We have increased by 19 criminal investigators, some 45 military police, 31 security police, and over 100 drug detector dogs. That has been done, although this is obviously an area that we continue to look at.

But the initial look and increase has been completed.

Mr. ENGLISH. How many of those slots have been filled?

Colonel DARNAUER. The number has been filled. They are all filled now.

Dr. MOXLEY. 111.

Mr. ENGLISH. In all services?

Dr. MOXLEY. These are mainly Air Force and Army in Europe.

Mr. ENGLISH. OK, initiative No. 8: review procedures concerning civilian arrests on military installations and take necessary corrective action. The target date was January 31, 1979.

Dr. MOXLEY. Yes. Two reviews have been made of that. What has been found is that the number of civilian arrests is a very small number. And it was determined that there was not a need at this point in time to change those procedures. Again, this is something that continues to be monitored, but the initial review has been completed, and no changes were made.

Mr. ENGLISH. Well, gentlemen, this is one complaint that we frequently heard from base commanders, particularly in this country. They felt extremely vulnerable to those individuals who came on post to sell drugs. Since they were civilians, there was very little they could do about it, mainly because they dealt in small quantities.

I just wonder how much depth you went into and how much discussion took place among commanders at these various military installations?

Colonel DARNAUER. This study was completed by the Air Force Office of Security Investigation.

Mr. ENGLISH. The Air Force?

Colonel DARNAUER. No, it included all bases. It addressed 107 bases, And it involved both Army and the Air Force and all services. And based on that study, it was found that there were relatively few cases that could really be identified as situations in which people have been apprehended on base. In most instances, there had been some action in court and resolution had occurred.

I suspect that you could say if there is fault it would be with the judgments rendered in those situations. But there was some judicial action, and there was some investigative and other action taken.

Mr. ENGLISH. You are saying this did include all the services—Navy, Marines, and everybody?

Colonel DARNAUER. This is an Air Force only study. I am just corrected on that.

Mr. ENGLISH. The Navy, the Army, and the Marines were not included?

Colonel DARNAUER. The task force that addressed this included the other services and examined incidents on each of their installations.

Mr. ENGLISH. Just examined the incidents?

Colonel DARNAUER. Examined the incidents, reviewed the data that were available on those incidences where people were on base.

When we got into the data, it appeared that we were dealing with a lot of anecdotes, but when it came down to getting your fingers on something hard, that was difficult.

Mr. ENGLISH. Don't you imagine that you have situations where the base commander recognizes the problem; people coming on his installation and selling drugs? But he also knows they are smart enough to sell in small amounts. So if he does catch them and turns them over to the authorities there is not a blasted thing that is going to happen to them.

Why should he go after those people? Why should he make the effort? He can't do anything about the situation. It seems to me this is the chicken and the egg thing.

Let me put it this way: What harm would it have been to actually have addressed this problem, taken action, and given those commanders some authority to deal with these people? What harm would it have done?

What you are doing here is making an assumption there is very little of that activity taking place. If there is very little activity, it wouldn't hurt to have the authority, would it?

Colonel DARNAUER. Mr. English, we don't have the capacity to do that within the Department of Defense, to give post commanders that kind of authority.

Mr. CLAYTOR. No, sir.

Mr. ENGLISH. It is my understanding that through the magistrates, you can deal with this problem. Is that not correct?

Mr. CLAYTOR. No.

Mr. ENGLISH. Federal magistrate.

Colonel DARNAUER. The local authorities have to agree to be involved in that and the U.S. attorneys and the Department of Justice.

Mr. ENGLISH. What you are saying is the Justice Department wouldn't cooperate with you?

Colonel DARNAUER. The small number of cases that we have found——

Mr. ENGLISH. Now, we are back to this small number of cases. I don't know how many cases are out there because I don't think people are even making an effort to do anything about it. We have had base commanders tell us that.

Colonel DARNAUER. The data that I have just been handed indicates that we have 500 cases across Department of Defense. That involves sales and trafficking. Of those, 150 cases were for other than marihuana. And those cases were dealt with approximately through legal channels that do exist. They were investigated, and there was legal action taken with respect to those by the U.S. attorneys.

Mr. ENGLISH. Initiative No. 9: That is the Berlin Task Force on Drug Abuse. I understand you have done that one.

Dr. MOXLEY. Yes, that's correct, sir.

Mr. ENGLISH. Completed, up tight, on that date.

Initiative No. 10: Synthesize, interpret, and extend scientific understanding of impact of different kinds of patterns of drug use on military performance. The target date on that was June 30, 1979. Where are we?

Dr. MOXLEY. That is the research program that I discussed in my overview, Mr. English; that we have requested funds to conduct it. The $1 million that was requested was removed by the House Appropriations Committee. We understand it has been suggested it be put back in by the Senate. And we are now waiting word from the conference committee.

The Army has accepted the responsibility to carry out the research should it be funded.

Mr. ENGLISH. Why in the world would we get a commitment from Secretary Duncan that this was going to be implemented by the 30th of June 1979 if we needed all that rigmarole through the Congress here to get that done?

Dr. MOXLEY. It is my understanding, sir, that at the time the initiative was begun, it was too late to get it into the budget that year. And that is why it slipped to this year.

Mr. ENGLISH. And you got $1 million?

Dr. MOXLEY. We have requested $1 million.

Mr. ENGLISH. You don't have a million bucks lying around over there anywhere?

Dr. MOXLEY. Not that I have been able to find.

Mr. CLAYTOR. No, sir, not that we are authorized to spend for this. As I understand it, the request is in the fiscal year 1980 defense budget. The House zeroed it. The Senate approved it. It is now in conference. I hope we get it. But we haven't got it yet.

Mr. ENGLISH. What was the Defense Department budget last year?

Mr. CLAYTOR. I don't remember the figure, but $120-some billion. $127 billion.

Mr. ENGLISH. $127 billion?

Mr. CLAYTOR. But we still don't have authority to spend money for things that aren't in the budget.

Mr. ENGLISH. Initiative No. 11: Develop and test program evaluation criteria. The target date on that is May 31, 1979. Can you tell us where we are?

Dr. MOXLEY. Well, we are to the point where treatment success as defined by satisfactory performance of duty at specific times after the admission of the patient to treatment. One of the difficulties, however, is that the followup time is not very long. It does not extend beyond the time the person is reassigned so the information we have usually extends from 180 to 360 days.

We have that information. We do not have information that goes beyond that at this point in time.

Mr. ENGLISH. Are you telling me you do or do not have a program of evaluation?

Dr. MOXLEY. We have a program of evaluation that still needs considerable improvement in my judgment. The improvement needs to be in the capability of longer term followup than we are now capable of.

Mr. ENGLISH. So you don't have a program.

Dr. MOXLEY. Pardon me?

Mr. ENGLISH. You don't have a program in place?

Dr. MOXLEY. No; we have a program that allows us to followup 180 to 360 days, but we don't have a program that gives us——

Mr. ENGLISH. That is the same program you had when the Secretary came forward, isn't it? That's nothing new. That is just the same old 360-day evaluation program youve had. You have had that thing for some time, haven't you?

Colonel DARNAUER. In part, that is correct. One of the requirements for our evaluation program of treatment success is an information system that allows us to track people for the extended periods of time—180 days to 360 days. One of the things that interferes with that is the individual's right to privacy and our interest in protecting him as a recovering person from either drug or alcohol abuse.

Mr. ENGLISH. But you are still telling me that the program that Secretary Duncan promised to have in place by May 31 of this year is not in place? The one you are talking about is not the one he was promising us?

Colonel DARNAUER. There were two elements to this particular evaluation. One had to do with our educational program. That portion of this evaluation has been completed. It looked at the effect of our education efforts on the force. Preventive education.

Mr. ENGLISH. Just tell me when this grandiose scheme is going to be in place. That is what I want to know. When are we going to have this program Secretary Duncan promised us? When is that thing going to be in place?

Colonel DARNAUER. I would like to be able to promise you that. We are continuing to work on it.

Mr. ENGLISH. We have already got your promise; we got that 1½ years ago. The question is when is it going to be in place?

Colonel DARNAUER. Our best estimate is within fiscal year 1980. Giving you a more definitive reply than that would be as far as I am personally concerned a dishonest one.

Mr. ENGLISH. I will put "unknown." How is that?

Colonel DARNAUER. All right.

Mr. ENGLISH. Initiative No. 12: Increase Assistant Secretary of Defense for Health Affairs drug and alcohol abuse program staff. What have we got there?

Dr. MOXLEY. That has been completed. The staff has been increased both within the office and, as I indicated earlier, staff in other areas.

Mr. ENGLISH. How many staff were added?

Dr. MOXLEY. We had four professionals. We added four new professionals, plus two secretaries.

Mr. ENGLISH. Added six people?

Dr. MOXLEY. Yes, sir.

Mr. ENGLISH. That was a heavy commitment, then. You have already lost one, haven't you? General Johns?

Dr. MOXLEY. Yes, sir.

Mr. ENGLISH. When did General Johns leave?

Dr. MOXLEY. About 6 weeks ago.

Mr. ENGLISH. Have you replaced him yet?

Dr. MOXLEY. We have not replaced him yet. We have changed the designation of that position from Special Assistant for Alcohol and Drug Abuse to Deputy Assistant Secretary and are now looking for a best qualified person we can find to fill it.

Mr. ENGLISH. When is he going to be named?

Dr. MOXLEY. I can't give you a specific date. But we will certainly——

Mr. ENGLISH. Do you want me to put down "unknown" again?

Mr. CLAYTOR. Yes. That is a high priority item for all of us, we are not going to appoint somebody in order to fill a vacancy. We have to find a person we think is the best qualified. We certainly ought to have one by the end of this year.

Mr. ENGLISH. You have added an initiative 13: Establish formal programs for civilian employees overseas. We didn't get a target date on that. Have you got anything new on that?

Dr. MOXLEY. Well, there is a program for civilian employees overseas. That program exists, and I think it has existed for some time. The question is how to improve it. And that is something that we look at regularly.

One of the mechanisms for improving it is to improve the educational component as we have referred to several times to make it a better educational program for the civilian employees, to see to it that when they do have a problem that comes to our attention that they receive proper therapy. And that is also done on a space-available basis.

But to the best of our knowledge, the space has been available to handle those problems when necessary.

Mr. ENGLISH. Have there been any major improvements made since we were given this commitment?

Dr. MOXLEY. I don't know that there have been any major changes made, Mr. English. As I say, to the best of our knowledge, the program is in place and does function at the present time and does not need any major improvements.

Mr. ENGLISH. It seems Secretary Duncan or somebody felt that or they wouldn't have given us this commitment, would they?

Dr. MOXLEY. All I can tell you is in the perspective I have had during the length of time I have been here, where there are problems with employees, there are mechanisms to deal with them. We are trying to upgrade them, but there are no major deficiencies in those programs right now.

Colonel DARNAUER. The civil program is part of a total Federal Government civilian program that is mandated by public law. And the primary office of responsibility is the Office of Personnel Management.

We have implemented within the Department of Defense, within each of the services, a civilian program. In the Army and in the Navy, that is an employee assistance program. It provides services in event of alcohol abuse, drug abuse, or other emotional problems.

In the Air Force, it is a program directed to personnel who have alcohol problems or drug abuse problems. All are occupational programs which means the focus is on the individual's performance on the job. Work decrements are noted, absenteeism is noted, as are other untold kinds of behavior. When that occurs, an individual is referred for evaluation.

One of the things that we cannot do, however, is mandate that an individual get involved in treatment like we can with a military person. There is the Privacy Act and confidentiality laws that come into play here and have to be dealt with.

What we have done is strengthen our programs, making sure that they are in place, making sure that the people have access to the outpatient programs. And it is the kind of a program that is an ongoing one rather than one I can trace and say from day to day to day it is working well.

The program, particularly on the alcohol side, but also on the drug abuse side, is under the regular surveillance of committees at the National Institute of Alcohol Abuse and Alcoholism and the National Institute of Drug Abuse.

Mr. ENGLISH. This is taking us longer than I had intended, and I want to move on very quickly. But what you are basically saying is that nothing has been done since this program was given to us. Generally, it is civilian responsibility and not yours.

Initiative No. 14: Military services assess staffing. Again, no target date. Can you give us something on that?

Dr. MOXLEY. Yes. As I mentioned in my summary earlier, this is something that is looked at on an ongoing basis. And it appears there is adequate quantity of personnel and resources.

There are some concerns in regard to the training criteria for the counselors. For some this is a program that is 10 weeks in length, and it is difficult in our judgment to take someone who is coming in and in 10 weeks acquaint them with how to deal with counseling of people who are having drug and alcohol abuse problems. That aspect of it needs to be worked on.

But in terms of the number of people that it appears that there are an adequate number to deal with it.

Mr. ENGLISH. OK. So you have completed that one.

Dr. MOXLEY. Yes.

Mr. ENGLISH. Improve drug abuse identification. Again, no target date.

Dr. MOXLEY. Yes. Because that is an ongoing program that relates to increasing the ability of commanders and supervisors to recognize the signs of drug abuse in terms of performance and other sorts of criteria, of assuring that drug abusers identified by military, medical, and law enforcement investigative activities are referred to the commander for appropriate action, assuring that the drug abusers identified by the civil authorities are referred to the individual commander, and so forth.

It is the sort of program that is ongoing and does receive attention all the time. There will not be an end date to that.

Mr. ENGLISH. But you have eliminated what was a mandating quota for urinalysis test?

Dr. MOXLEY. That is correct.

Mr. ENGLISH. How about the so-called hotspot areas such as we have identified in West Germany? Have there been substantial increases in identification efforts in these locations?

In other words, have resources that were used in areas where there is less activity been transferred? And has there been a demand that the number of tests in hotspot areas be increased?

Dr. MOXLEY. There has not been a demand that they be increased. The Army and Air Force in Europe have been for some time testing over and above the 0.6 requirements and still are.

Mr. ENGLISH. Let me move on very quickly. The other members want to ask questions.

I just want to address one additional point. If you had a commander, let's say, in West Germany who had an officer who didn't want to give the test, what action can you take to deal with that kind of a situation?

Here he is sitting in a hotspot area, particularly in an area of high heroin availability. And he doesn't want to give the test. What do you do about that situation?

Colonel DARNAUER. Mr. English, that situation would not come to our attention at OSD. That would be an issue that would be surfaced programmatically in the Army. And it would be something that the Army would take action on. I would defer on that one.

Mr. ENGLISH. You are in the Army, and you know what to do, don't you?

Colonel DARNAUER. Yes, sir.

Mr. ENGLISH. What do they do?

Colonel DARNAUER. His boss would deal with him appropriately.

Mr. ENGLISH. What is the appropriate action in dealing with him? Would you break him? Are you going to bring courtmartial charges against him? What are you going to do?

Colonel DARNAUER. I think he would evaluate the situation and determine based on that situation what was the appropriate action. I am sure if he gave the gentleman a direct order to do urine testing and he did not do that, he would take appropriation action using the nonjudicial action or courtmartial.

Mr. ENGLISH. Do you know of any cases in which a direct order has been given to such a commander?

Colonel DARNAUER. No, sir, I do not.

Mr. ENGLISH. Well, for all intents and purposes, we are talking theoretically then. In other words, we don't know of any cases where that has happened. DOD is not concerned enough about it to lay down the law and say, "Look, in these hotspot areas, we are going to be running tests whether you like it or not."

Colonel DARNAUER. The requirement is laid on in a memorandum that has been signed by the Deputy Secretary of Defense, Mr. Duncan, that lays on the requirement for testing.

Mr. ENGLISH. But you don't know of anything that has ever been done in the case of a commander who chose not to run the test?

Colonel DARNAUER. No, sir, I do not.

Mr. ENGLISH. Mr. Beard?

Mr. CLAYTOR. If we find any cases like that, Mr. Chairman, I will take them up with the Secretary of the service; that is the way we handle it. I don't know of any, but if any are brought to my attention, I will take it up with the Secretary of the Army or Secretary of the Navy, and we will see that something is done about it. That's the way we will handle it through the civil control.

Mr. BEARD. Dr. Moxley, in your statement, you have stated that serious drug and alcohol abuse problems are less extensive due in part to DOD recruiting and retention policies as well as the DOD law enforcement and drug abuse prevention efforts. What do we mean when we talk about retention and recruiting policies?

In other words, you don't feel like the reason why you don't have a real serious drug problem in the military is because of recruiting and retention policies?

Dr. MOXLEY. Well, the problem in the military reflects that problem in the community from which we recruit. That is the civilian community. And it also reflects the problems of the community in which the person is stationed after they are in the military.

There, as you know, are efforts to screen for drug and alcohol abuse at the time someone comes into the service. And we have spent the last couple of hours in reviewing some of the things that are done when such a problem surfaces within the services.

We certainly don't mean to say there is not a serious problem; it is a serious problem. It is one that we feel we are directing enough energy toward that we are keeping it within control. But I certainly don't mean to imply that it is not there.

Mr. BEARD. I guess my point is what I don't understand on the recruiting policies, as a result of the lowering of standards, continual lowering of standards, especially by the Department of Army, once you are getting a large percentage of—and not to be just too harsh, but there is a lot of fine young men—you are getting the dropouts in many cases of society that are joining the military, and the 17-year-old kids without high school degrees, the kids who in many cases have nowhere else to go.

It seems like to me if anything through the recruiting policies, having lowered these standards, would make you even more vulnerable to drug problems.

Dr. MOXLEY. Well, I cannot comment, Mr. Beard, on the recruiting side of it. I can only comment as follows: We have changed, as I have commented, the cannabis policy. The reason that was changed was because in realizing that no matter how you want to cut the group that we are recruiting from, that some 60 percent of high school seniors in this country have used cannabis at least once and lower proportions of that——

Mr. BEARD. I understand that. That is the reason I am making my point. Would it not be as a result of the recruiting policies, though, of having lowered the standard and looking at the people who are coming in and looking at their records, you are probably bringing those kids who would be most likely to use drugs than the kid who did pass, graduate from high school with top grades, goes to a good college or holds a responsible position at a Ford Motor plant or something like that?

Dr. MOXLEY. I don't know of any data that indicates that the use, particularly of marihuana, is relegated to any particular segment of our society. Perhaps it is; I am not aware of it. But I think that with academic performance, it is not necessarily affected by casual use, and it is the casual use rate that is so high.

But medically, if we can determine at the time they are coming into the service and they are examined by a physician who makes the judgment, if we determine that there is a drug problem, the person doesn't come into the service.

Mr. BEARD. Well, let me just say that I think you might find if you pursue this, and understanding the fact or sense of the fact you just barely had the opportunity to put your new hat on in your position, and knowing the tremendous responsibility that you have incurred, out of curiosity you just like to look at the situation. Because there are people who will say you will find individuals who are the dropouts, the kids who have nothing to hold onto, that will be more prone to become more heavily involved in the use of drugs.

So I would really, with some amazement, find it would be said that this would not be the case, understanding that because a kid manages to go straight, that doesn't mean he is not going to try marihuana or use it or whatever. But I think you can go and ask many sociologists and psychologists or whoever you may ask. There is a trend toward the abuse of drugs whether it be alcohol or whatever by the kids who have had a reputation or background of being dropouts.

This might be one of the reasons why in the Army they are having an increase in the use of drugs. You take a 17-year-old kid who didn't even make it through high school and send him into a situation that is totally foreign to him, whether it be in Europe or whether it be down at Camp Lejeune or Parris Island, that is a heck of a shock. And he hasn't been able to cope with things that have been halfway normal.

In other words, boot camp or Germany, there is nothing really halfway normal about that.

I just would say, I would think they would be somewhat more susceptible.

Colonel DARNAUER. I think you are right.

Mr. CLAYTOR. Mr. Beard, may I say on the basis of almost 3 years as Secretary of the Navy—I haven't had that much experience with the Army yet, I have just recently taken this job—but with the Marine Corps and the Navy, I am satisfied we have higher quality people in both those services now than we had when we had the draft.

Mr. BEARD. I wish you hadn't said that because I will tell you what, I will debate you any day of the world using the Army, the Navy, the Marine Corps, their figures. When it gets down to 3–B mental categories, when it gets down to the whole ball game, I am fed up with that. I am fed up with hearing that bunch because I will tell you when I have the commanding officers of all the units coming to me, and fearful of saying it, in front, because of the misrepresentation and the coverup the Department of Defense is participating in, coming and saying, "We are getting kids that can't read or write," the Army sits there, the Secretary of the Army, and says, "The best quality we have ever had," why is he setting up remedial reading schools in the Army bases here, there, every place?

Mr. CLAYTOR. Mr. Beard, I am limiting myself because my knowledge is limited to the Navy and Marine Corps. And I am basing this on the statements made to me by the Commanders in the Navy and Marine Corps because they believe that.

And one of the things I did as Secretary of the Navy was to insist recruiting had to put more emphasis on quality and less emphasis on numbers. We have not made the numbers, but we have steadily improved the quality over the last 2 years.

Mr. BEARD. I will give you credit for this. The Navy and the Marine Corps, and I know the Marine Corps, they did place emphasis on quality. They have taken a cutback, or have been, in not accepting the numbers just for numbers sake. They haven't lowered the standard down to the point the Army has, which I think, is an insult on a 17-year-old kid without a high school degree.

But when you compare it to the pre-All Volunteer Army days, and you look at the numbers, and you look at the MOS match up, you look at the kids, who have, as far as filling the MOS for the highly technical areas, I will debate any day of the world with anybody that they are having critical manpower problems.

And then if we want to get to the real ball game because the all-voluntary concept—you are very lucky, Dr. Moxley, Mr. Claytor brought this up. It takes the pressure off you now. But the fact of the matter is what we talked about, we talk about the All-Volunteer

Service and Active Duty Forces, the total force concept happens to include Reserves.

And if you look at the Reserves, we are going through a horrendous situation there. It is just, you know, but this is not the time or the place. And I have a feeling we will have a chance to compare notes at a later date.

Mr. CLAYTOR. I would like to.

Mr. BEARD. I think we should, rather than me screaming and hollering like that. And I apologize for that.

There was one other thing here. It says somewhere—I don't know what newspaper this is—oh, this is ours—it says, "The Navy, Air Force, and Marines make extensive use of senior NCO's as counselors for drug and alcohol problems." The Army says it is looking for high-caliber professional NCO's with proper training as a standard for human resources management counselors in Europe which deals to a large degree with drug and alcohol use.

Is this the case? Are they placing more emphasis or giving more responsibility to the NCO's?

Colonel DARNAUER. Yes, sir, they are.

Mr. BEARD. If so, what type of training do they receive as to—what do they tell a young man when he is caught using drugs and they counsel him? Is there a kind of a line, a fixed line, that has been instructed to give these young people as to why they should not, or whatever?

Colonel DARNAUER. No, sir, there is no fixed line. What they are trained to be is counselors to address the problems of the individual, looking into his situation, and dealing with the circumstances that they find.

Mr. BEARD. My point is you go out and ask almost any mother or father, what would you say to your child, your seventh or eighth grader, if you found him using marihuana, for example?

If I had not served on this Select Committee of Drug and Narcotics, I would have been just left sitting there with my mouth open and in no way, shape, or form qualified to counsel or to say—I am just wondering when a kid was brought in for the second time using marihuana or whatever, what does that NCO tell him? What tools has he been given to sit down and talk to that young kid and say, "Look, there is some medical advice, some medical reports, that have come out regarding lung damage, sperm count damage"?

Do you not think he should be given a little bit of material?

Colonel DARNAUER. Absolutely. And that is part of what we call motivational educational program for drug and alcohol abuse offenders. This kind of training is given to individuals when they are first discovered to be users. It addresses medical and pharmacological aspects of drugs and alcohol. It addresses values, the values that the individual has. It addresses such issues as what other alternatives does the individual have, the travel opportunities, the educational opportunities. And it addresses the whole issue of the individual's goal. What do you want out of life? And how do you get there? And it challenges the concept that using drugs or using alcohol will be of assistance in that.

Actually, it challenges him to avoid those in order to reach the things——

Mr. BEARD. You may have already turned it over to this committee, but so you have a little packet of information that is used in the training or in the educational guidelines of the explanation, medical type, to these kids or given to the NCO's or commanding officers that they familiarize themselves with? Do you have a package such as this?

Colonel DARNAUER. There is a curriculum guide. And the curriculum guide will be essentially the same, but vary to——

Mr. BEARD. Do we have a copy of that curriculum guide?

Colonel DARNAUER. We can certainly provide those.

Mr. BEARD. Would you provide me one personally when you do it to the committee?

Colonel DARNAUER. Yes, sir.

[The information referred to follows:]

1. "Questions and Answers About Drug Abuse—What You and Your Family Should Know About Drugs," a Benco Health and Welfare Edition, the Benjamin Company, Inc., 485 Madison Avenue, New York, N.Y. 10022, 1976.
2. "Marihuana—Some Questions and Answers," National Clearinghouse for Drug Abuse Information, U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, 1971.
3. "Marihuana—(Slang Names) "Pot," "Tea," "Grass," "Weed," "Smoke," "Mary Jane," etc.—A Scriptographic Fact Folder," by Channing L. Bete Co., Inc., Greenfield, Mass, 1977 Edition.
4. "Drug Abuse Prevention," National Institute on Drug Abuse (part of a series of seven pamphlets issued for the 1978 National Drug Abuse Prevention Campaign by the Prevention Branch, Division of Resource Development, NIDA).
5. "Drug Abuse Prevention For You and Your Friends," National Institute on Drug Abuse (same series as above).
6. "Drug Abuse Prevention For Your Family," National Institute on Drug Abuse, (same series as above).
7. "Do You Know the Facts About Drugs?" A Guide of Drug Information: Alcohol, Amphetamines, Barbiturates, Cannabis, Cocaine, Hallucinogens, Methaqualone, Opiate Narcotics, Solvents and Gases, Tobacco, Tranquilizers, produced by Health Communications, Inc., 7541 Biscayne Boulevard, Miami, Fla., 1977.
8. "Marihuana and Health," Seventh Annual Report to the U.S. Congress from the Secretary of Health, Education, and Welfare, 1977, National Institute on Drug Abuse.
9. "Health Consequences of Marijuana Use," statement of William Pollin, M.D., Director, National Institute on Drug Abuse, before the Select Committee on Narcotics Abuse and Control, House of Representatives, July 19, 1979.
10. Commanders, Supervisors, and Staff Officers Guide to the USAREUR Alcohol and Drug Abuse Prevention and Control Program (ADAPCP), USAREUR Pam 600–3, May 1, 1979.
11. Drug and Alcohol Education Instructional Guide and Learning Objectives for Supervisors of Military Personnel, Drug and Alcohol Education Instructional Guide and Learning Objectives for Non-Supervisory Military Personnel, Drug and Alcohol Education Instructional Guide and Learning Objectives for Civilian Personnel and Supervisors of Civilian Personnel, Drug and Alcohol Education Instructional Guide and Learning Objectives for Youth Dependents, and Drug and Alcohol Education Instructional Guide and Learning Objectives for Adult Dependents, Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).
12. Command Drug and Alcohol Program Guide—An Operations Manual for Developing Command Drug and Alcohol Programs, NAVPERS 15511A, Bureau of Naval Personnel, Aug. 8, 1977.
13. Navy Drug and Alcohol Abuse Prevention Education Package Overview, enclosure to OPNAV Note 5353.
14. Marijuana Update—An Informational Report to Social Actions, AFP 30–34, Sept. 8, 1978, prepared by Program Development and Analysis Section, Social Actions Training Branch, 3290th Technical Training Group, Lackland AFB, Tex.

15. Drug Alcohol Abuse Control Committee Management Guide, Department of the Air Force.
16. USAF Substance Abuse Seminar, Social Actions Instructor Supplement for the Substance Abuse Seminar, July 1, 1976 (DAE 734XOB–003 and 003S), and USAF Drug/Alcohol Awareness Seminar for Commanders/Supervisors/First Sergeants, Dec. 1, 1975.
17. Instructors Guide—Training Packages on Alcohol and Drug Abuse Awareness, U.S. Marine Corps.

Mr. BEARD. I would appreciate that.

How much emphasis is placed on the educational process? One of the things I have been a little bit disappointed in is the fact you have to ask a seventh grader what is wrong with smoking, and I have said this before in our entire hearings, the kid can tell you what is wrong with smoking because he has seen this little publication, TV ads, he has seen this and understands it.

You ask him what is wrong with marihuana, and they in many cases just see no problem with it at all.

Is there much medical input on this as to the physical damage that could be created as a result of use of marihuana?

Colonel DARNAUER. The medical information that we have that is coming out of the National Institute of Drug Abuse, and that has been developed in conjunction with this committee, is made a part of the training program.

Mr. BEARD. What is some of that information? What are some of the high points on the medical problems? What are some of the major points?

Dr. MOXLEY. Well, I can speak in general, Mr. Beard. That is, as you know, there is now increasing concern about the pulmonary complications of smoking marihuana, and certainly no reason that I know of to think that those complications aren't going to be as severe for marihuana smoking on a regular basis than they are for cigarette smoking.

There is the question of motivational problems involved. There are the ones you have mentioned that may or may not, I don't think the final word is in, have to do with reproductive capability and so forth.

So I think that they go pretty much across the board. I am not enough of an expert in this particular field of marihuana abuse to know which one of them have final answers in. I suspect not many. But there is certainly a number of people looking at this field at the present time. And as we get the information, it is incorporated into the program.

Mr. BEARD. If you could provide that to me, I would appreciate it.

Thank you, Mr. Chairman.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Chairman, I question whether we have got the right people before us to be perfectly honest. Dr. Moxley and Mr. Claytor have just come on board. We spent 2 weeks that weren't all that pleasant in Germany last year looking into all these problems, Mr. Chairman, and if I was going to take a chance on going on a trip and taking the heat from the constituents back home, it certainly wouldn't be to go to military bases unless I had a real desire and an interest in our military.

I am from Georgia, and we generally support a strong military budget and just about anything that the Military Establishment desires.

Mr. ENGLISH. If the gentleman would yield, we are simply trying to get acquainted with them and break them in right.

Mr. EVANS. Well, I understand.

Thank you, Mr. Chairman. But the point is that all of these things have been or are supposed to have been started to deal with a very serious problem which General Blanchard finally admitted with us before we left Germany. We issued a going statement at that time. Nothing has been done.

And I feel like I am wasting my time, and I am wasting these gentlemen's time by being here because if nothing is going to be done, Mr. Chairman, then we would be better off working on something else.

Now, maybe—and I am certainly hoping that maybe—these things will be dealt with. But I have about three or four questions, but I want to finish one other thing about the concept paper here. It looks to me like what we are doing is reducing the drug problem in the military by changing the terminology.

Now, we are going to downplay the illegality of drug use, and we are going to focus on behavioral consequences. We could do away with crime in this country if all we had to do was just not make it illegal to murder and rob and steal and do all of that.

Now, are you saying by—and I guess this is a question—this concept paper that what we are going to do is to deal with performance, deal with the ability to do the job in the military? And if the person can do the job, we are not worried about what he is doing as far as drugs are concerned, if he can do his job? And that is where we are going, what we are going to concentrate on?

Maybe that is an appropriate way to deal with it. I am not an expert, but what is the meaning, Dr. Moxley?

Dr. MOXLEY. I believe, Mr. Evans, that what the concept paper tries to do is provide us direction for the next 5 years to get us a step beyond what we have been involved in. I think it has been very obvious this afternoon, the sort of crises management, the trying to deal with each of these initiatives in a somewhat isolated way, the trying to make judgments, often making judgments that are either yes or no. The concept paper is a way to begin to look at the behavioral consequences of substance abuse so that we can make more informed judgments.

It certainly is not an effort to say we don't view it as a problem, and it is not something that has to be dealt with, but rather than sort of rushing to make this judgment or that, to begin to get a body of knowledge and look at the behavioral consequences and use judgment in that area rather than what I perceive we have been doing for the last 2 years which is trying frantically to get a hold on the problem for the first time.

Colonel DARNAUER. We do not intend to focus solely on work performance consequences. The military still is a total system. And we have to be involved with the effect on an individual and his health. Our concern is to still make the environment, the military environment, as healthy a place for him to be as we possibly can.

We, however, want to focus our attention on those things that impact on us as a society and on the institution of the military and, of

course, deal in different ways with those instances that breach the discipline problem or that jeopardize the military.

For example, one might deal with someone who is a cook and who is caught using marihuana to a much lesser degree than an individual who is in a personnel reliability position, for example, in a security job. What this paper is essentially trying to do is deal with the situation as the situation affects both the individual and the Military Establishment.

Mr. EVANS. It is not quite as bad as I thought it was, then, although I am not sure it is not doing a little of what I indicated.

Let me ask you some questions about possibly what has been done. There were certain recommendations made in addition to this 15- or 16-point program or whatever. And that is, has there been an offering of a reduced term of service to people going to Europe?

Dr. MOXLEY. I believe that General Lutz is going to cover that in his testimony.

Mr. EVANS. I will reserve that question.

The questions I have, have to do with the orientation, with educational programs, recreational programs, and things of this nature, in our overseas operation. Would this possibly be addressed to the next panel?

Dr. MOXLEY. I believe he is going to cover a number of those points.

Mr. EVANS. All right.

Well, I would just like to say that I am concerned about the drug problem throughout our society, but I do not believe that the armed services can afford to say because there is a high incidence of drug use among our general population that we are going to have to take a high incidence of drug use in our military.

If the All-Volunteer Army cannot provide enough quality people to do the job, then we are going to have to consider in Congress some alternatives to that. And I think that if we, to the best interest of all of us, if the people we had in your areas and in your departments would be frank and honest regardless of the consequences, because I think this thing is bigger than just keeping one's job or keeping one's good record, then I would hope that we would get honest and frank answers to the questions.

And if we can't get the kind of people we need, in an All-Voluntary Army because of the drug problem, or because of other problems incidental to that, then we who have the ability to make changes should know that.

Thank you.

Mr. ENGLISH. Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman.

One of the problems that I am concerned about is the apparent wide divergence between the statistics that our committee was able to assemble when we were in the West Germany area, and the statistics that the Army is basing their perception of the extensiveness of drug abuse.

You talk about a 7- to 15-percent range for hard drugs and 20- to 40-percent range for marihuana and hash and 15 percent for the use of alcohol. When we were over and talked with the troops, we found that it was as much as 15 to 20 percent for hard drugs and 58 percent

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of the troops surveyed admitted to using cannabis monthly, or more frequently; 12 percent admitted to using amphetamines. Nearly 17 percent admitted to using barbiturates. Nearly 87 percent reported alcohol is often mixed with illicit drugs.

Sixty-five percent of the respondents to our questionnaire talked about cannabis, daily use of cannabis, and also consuming alcohol. It seems that your perception of the problem is that there is a wide divergence between the military perception of the problem and our committee's perception of the problem.

I would like to ask you: I note that from your charts that you submitted to us that the sale and trafficking cases, the monthly average per quarter for hard drugs rose from the first quarter of 1979, to the second quarter of 1979, from 93 to 112; that the danger drugs, CID sale and trafficking cases, went from 18 to 31 from the first quarter of 1979 to the second quarter of 1979; that there has been a steady increase from the first quarter of 1978 all the way through—and I am referring to your chart that is attached to the reports here that we have received—that show a steady increase.

I note, too, that some recent arrests, there was a case reported in August 28, 1979, in the Washington Post from Oppenheim, West Germany.

Twenty-four U.S. soldiers have been arrested after West German Police and U.S. Military Police smashed a heroin smuggling ring, officials have said. All 24 soldiers were stationed at the Anderson barracks at Dexheim.

I note, too, that the Air Force has submitted statistical information showing that—and I am quoting from third quarter brushup data dated October 28, 1979, Headquarters, U.S. Air Force in Europe—they talk about in terms of potential impact, hard drugs, particularly cocaine and narcotics represent a growing threat, hard drug seizures have increased eightfold—25,177 doses versus 2,808 doses seized in the third quarter of 1978. While cannabis seizures have declined 88 percent, narcotics were up 1,000 doses, while cocaine, a relatively new phenomenon, increased over 10,000 doses.

My question is this: On what do you base your statistical data? Do you feel that you have an accurate evaluation and accurate perception of the extensiveness of the problem?

Maybe that is the cause for your undue delay in attacking the problem that you just don't perceive this as a serious problem. I would welcome some response of the panel.

Colonel DARNAUER. I think it would be—well, our response to that is—that drug use in Europe is indeed a serious problem. And I think what the statistics you have just cited show is that we have been working the problem. We have done that through increased law enforcement efforts and, as we indicated earlier, increased numbers of CID agents, Military Police, Air Force Investigators, Air Force Security Police and sniffer dogs.

The action in Europe is very aggressive. I think we can get into specific details, Mr. Gilman, when the Army makes its presentation because they have people on their panel who are specifically engaged in that on a day-to-day basis. But we are concerned about the problem, and we are working the problem.

I think our survey data is a different kind of data perhaps than the committee's data was because of the methods by which we select the sample and look at our data. Your data is probably entirely correct for the group of people you were talking with; it did not look at the total group as a random sample would select.

Mr. GILMAN. Colonel, did you examine our committee report that we submitted following our visit of November 1978? It is a report by the Select Committee on Drug Abuse Among U.S. Armed Services. Our sample, while it was random at each base covered 14 bases and over 600 interrogations by members and staff members in a concentrated period of time.

And while it may have been random to your mind, I think it was a pretty good cross section. And it was done, I think, at a time when we were able to elicit some very frank opinions from members of the armed services. And I at that time was critical of the military statistics, the wide divergency between the information we get from the troops in the field and the information we get from the Pentagon.

I am wondering if you still have this lack of perception of how extensive the problem is. Now, you are talking about getting a few CID personnel and a couple of MP's. I guess you added about 20 for the whole theater of CID people according to the report I have here and maybe a few inspectors on top of that. That certainly isn't going to resolve this kind of a problem.

This committee has long found that just adding a few more police to the roles does very little to resolve the problem. There are some very basic, root causes to the problem. And if you examined the report, you would find some pretty tough things that we found like very poor morale, the extensiveness of the tour of duty, the impact of the culture change and poor training and preparation for the culture change, very poor behavioral thrust by the team to try to overcome some of these problems and to have professionally trained people out there to prepare the troops and to meet their problems.

There is no one to turn to for adequate counseling. There are some very poorly trained guidance counselors. And in examining your response and the recommendations that have been made for the proposed program, I don't see that the military has really tried to get a handle on this and to do something about it in a meaningful manner.

Yes; you are moving in some of these directions as slow as it is, but it doesn't seem to me you really want to make a serious effort to stem the flow of narcotics among our military and to eradicate it.

Mr. ENGLISH. Would the gentleman yield?

Mr. GILMAN. I would be pleased to yield.

Mr. ENGLISH. I think the gentleman is on a very important track here. I would like to make two points. One that I think should not be overlooked is our study. Even though we admit it is not in depth and as scientific as we would like, it is the best and only thing that anybody has right now to measure drug use in the military.

Second are the findings of that study. If the mathematical probabilities are taken into consideration, they run very close to the urinalysis results obtained in that area. If a person is using heroin every day, his chances of getting picked up in a urinalysis test are 100 percent.

If he only uses once a week, the chances of catching him are less than 50–50, so on and so forth, depending on the number of times, how often he takes it, and the number of tests being administered.

It would appear on the surface that there are vast differences between the urinalysis results of the military and what the committee has come up with on the survey. Yet actually, when the mathematic probabilities are taken into account, they are very, very close.

I think our data shows the total likelihood and probability of the likelihood of drug usage taking place. The question is how regular. But the number of people who are doing it, I don't think there is much question about it.

I thank the gentleman.

Mr. GILMAN. Thank you, Mr. Chairman.

Would you care to respond to the comments that I made earlier?

Colonel DARNAUER. Mr. Gilman, I don't have any doubt but what you are saying is correct, and the findings from your survey are correct. I personally believe that we have made some very aggressive efforts to deal with drug and alcohol situations in Europe. We have added, in the law enforcement area, 111 people according to my calculations. Those are Army military policemen, Air Force security policemen, not investigative-level folks.

In addition, there have been about 40 added who are criminal investigative people. I just came back from a trip to Europe at which time it was my perception that the Army, Air Force, and Navy were aggressively pursuing through enforcement channels attempts to slow the use of narcotics and more specifically to identify and deal with people who are selling or dealing in all narcotics.

Mr. GILMAN. What are you doing on the preventive side?

Colonel DARNAUER. On the preventive side, we came out last year with a program of education that requires 4 hours' eduaction in the drug and alcohol area for each individual assigned to an overseas area. This is mandated by the Department of Defense, and all of the services have come back with educational plans and lesson plans that——

Mr. GILMAN. Colonel, how much have you spent on education last year, drug education?

Colonel DARNAUER. We have it at our fingertips here.

Mr. GILMAN. Approximately what are we talking about?

Colonel DARNAUER. I want to say in the neighborhood of $12 million. And that is across Department of Defense.

Mr. GILMAN. Is that for the entire Department, not just for the European area?

Colonel DARNAUER. That would be for the entire Department of Defense.

Mr. GILMAN. How much are we spending in the area of USAREUR, West Germany area?

Colonel DARNAUER. Sir, we do not break our data down in that way. The people whom we have in our programs have a requirement to provide a variety of services, and that includes delivery of educational programs. We can divide their time up on a table, but that becomes rather artificial.

Mr. GILMAN. How much, Colonel, did you spend on prevention? You can give us an approximate figure.

Colonel DARNAUER. May we give you that for the record? Because we have it.

Mr. GILMAN. All right. Mr. Chairman, I would ask that that information be provided and made part of the record at this point, including the amount spent for treatment and rehabilitation.

Colonel DARNAUER. Yes, sir.

[The information referred to follows:]

DOD DRUG AND ALCOHOL ABUSE PROGRAM, FISCAL YEAR 1979 ACTUAL BUDGET EXPENDITURES

[In thousands of dollars]

	Total DOD	Army		Navy	Marine Corps	Air Force
		Total	USAREUR[1]			
Education/prevention[2]	[3] 11,767	1,838	827	2,822	277	6,605
Treatment/rehabilitation	46,967	17,482	7,805	15,169	316	14,000
Training[4]	3,485	1,896	765	687	244	658

[1] Included in total Army figure.
[2] Education/prevention includes all efforts directed to nondrug program staff, including health care personnel.
[3] Does include $324,284 expended by the American Forces Information Service (AFIS) for printed and audiovisual materials and radio and TV spots announcements. These items are distributed to each of the Services for use in their prevention and education programs.
[4] Training includes those activities directed to developing or enhancing program staff skills.

Mr. GILMAN. Can you break it down for us for USAREUR as well?

Colonel DARNAUER. I don't believe we can do that.

Mr. GILMAN. Why is that difficult? Don't we know how much you spend in a theater of operations?

Colonel DARNAUER. We know the number of people we have there, and we can give you some estimate of that, those who are full-time dedicated to the drug and alcohol program. But in terms of giving you it by a theater, we don't keep it that way at the Department of Defense. I believe we can request it and probably get some ball park information for you.

Mr. GILMAN. I would welcome that information, Mr. Chairman, and ask it be made part of the record.

My time is running, and I am exceeding my time now. Mr. Chairman, with your permission, what can the panel tell us are your greatest needs? Where do you need some help from the Congress to do the kinds of things you think you should be doing in this area and are not doing?

Can you tell us what your recommendations are and what we can do to help you in those areas?

Dr. MOXLEY. The one area that I mentioned where you can be of some help is to help us get the research program going that we have outlined in the testimony so that we can begin to get a better handle on the consequences of drug abuse in the military.

And obviously, also in providing the advice and suggestions that you have which, although it is true, there has been a great deal of slippage in following through on it, Mr. Gilman, I just have to tell you that I have been in the office now for about 8 weeks. Prior to that, I had spent some time looking at the situation in Europe.

I believe that there is a significant concern and a significant effort directed toward the problems of drug and alcohol abuse in the mili-

tary. I sensed that when I was traveling through Europe talking to people in command and to soldiers. Perhaps this reflects the fact that there had been visits before me, including this committee, which have begun to focus the attention on it.

Since coming into the office in the Secretariat I have spent a major amount of my own time on this area. And it is a major concern within the office.

It has been said that nothing has been done. I would respectfully challenge that. I think we are behind schedule, but I think that there has been progress made in every one of the efforts that we have reviewed. We are committed to following through on them, and we will follow through on them.

I apologize for the fact there has been the slippage. I obviously don't know all the reasons why. But we will continue to make every effort to carry through on them. I simply have found nothing to indicate that there is a lack of concern for this problem. It is a major problem and one that we want, as much as you, to make significant progress against.

Mr. GILMAN. Doctor, you stated in your testimony that there are two major areas where external support for the drug program was needed, increased resources, to adequately sustain a viable drug abuse program and increased coordination, commitment and joint action. What is being done?

First of all, what have you asked for by way of increased resources and you did not get it?

Dr. MOXLEY. I can't answer that off the top of my head other than the most obvious thing, sir, is the research volume which I have referred to.

I think in other areas, at least in the glimpse of time that I have looked at it, resources have not been the absolute limiting factor. I may come back after looking at it harder and change that, but that has not been the major problem.

Mr. GILMAN. How much research money are you talking about?

Dr. MOXLEY. $1 million.

Mr. GILMAN. What about the increased coordination department for joint action? What is needed there to bring that about?

Colonel DARNAUER. There, we are talking about internal efforts within Department of Defense at getting our people to work more closely together. I think that is a program effort and one of the things that we are doing in that regard, as an example, is the civilian program area where we are planning an action planning conference that will identify the gaps in our programs and move ahead in that area.

Mr. GILMAN. Let me understand that. You are planning an action planning conference? When will that action planning conference take place?

Colonel DARNAUER. This conference will be held in December. And our purpose in that is to get all of our programs working together.

Mr. GILMAN. That is something we talked about in November of 1978. Why does it take so long to plan a planning conference?

Colonel DARNAUER. We have held two in the interim period of time. Both of those were directed most specifically to the military programs and pulling those programs together. This one is going to address more directly the civilian programs.

Mr. GILMAN. I don't mean to be overly critical, but I can't help but get a perception that this problem keeps being pushed on the back burner. I realize we have got a lot of urgent problems out there in the military, but I can't understand why there isn't a greater perception of the urgency for this problem when you have troops out on the front lines who tell us they are using drugs even while they are on duty.

And it is an extensive use. I fail to see why there isn't being given a greater urgency.

Mr. Chairman, I know I have exceeded my time. And I yield back the time to the Chair. Thank you, Mr. Chairman.

Mr. ENGLISH. Thank you very much, Mr. Gilman.

The chairman of the full committee, the Select Committee on Narcotics Abuse and Control, Lester Wolff, has joined us. Mr. Chairman, do you have some questions you would like to ask?

Mr. WOLFF. Thank you, Mr. Chairman.

First, I want to commend you as the chairman of the task force and the members of the task force, for their continued activity in this area. I think there is no more important work for the full committee on drug abuse and control than the work that this task force is doing. And I am somewhat disappointed at the results.

I think we have to consider the bottom line as the accomplishments. I am not talking about the accomplishments of the task force, but I am talking about the results that can be obtained.

I feel very strongly, from only a casual reference to the material that has been provided to us, that there is very little in the way of achievement of the desired results. That may be because of changes of personnel and other factors. However, I recall very vividly the meeting with the President that you requested when we found the overall parameters of this problem.

The President acted with great speed. In fact, on the same day, he called in Secretary Brown. We had movement in the area at that time.

Now, as a result of what is happening here, I ask the chairman of the task force to make a request for a further meeting with the President to analyze the results that have been obtained in the period that has been intervened since our last meeting with him. This is a matter of great concern to us. I'm sure it is of great concern to the military as well, this problem of the amount of drug abuse within the military.

I think if we consider these people who are abusing narcotics to be casualties, we would set up a casualty resolution center, and we would find ways and means of attacking this problem with much greater rapidity. If we had casualties of any other sort, I'm sure that the attention would be directed not toward conferences, but toward concrete results.

I am afraid we haven't achieved those concrete results. This committee will probably pass out of existence at the end of this Congress. That doesn't mean that the problem is going to go away. And it doesn't mean that the emphasis upon the results that we seek will be dissipated at all, because the work will be taken up legislatively by other committees or perhaps an overall commission as was recommended by the General Accounting Office.

I would like to ask a few questions here. No. 1, at the same time we found difficulties in the drug abuse area, we also found a similar, but even more important problem in the medical readiness of the armed

forces in Europe. I want to know what has been done to address this problem because with what is happening at various places of the world today, if we have a military, I think we have to be medically prepared to care for that military as well.

And I think that it is important that the overall question of medical preparedness is addressed. From what I had seen from the last report, the situation was disastrous. I am just wondering whether or not anything has been done in that area.

Dr. MOXLEY. I have begun again in the time that I have been there to look at this area. And I have not done anything definitive at this point in time, Mr. Wolff. I can only concur with you that there are very serious problems of the medical readiness and that we will move to address them.

I am at the present time still trying to probe them and catalog them and have not made any major initiatives in that area.

Within the services, there may have been initiatives that I am not aware of, but from the perspective of the office where I now sit, it has been one of education and learning what the problems are. And I would agree with you, they are serious.

Mr. WOLFF. I can appreciate, Doctor, that you have only recently been involved in this. However, I am sure the DOD has been involved in this for a much longer period. I think that to jeopardize the security of the military as a result of failure to back them up with all the resources that we possibly can is as serious dereliction as a lack of weaponry to engage in offensive capability.

And on that score, Mr. Chairman, I would like to ask if we can get a report, a classified report, that will give us an idea of the present state of medical preparedness and any changes that have occurred with particular regard to the European situation.

I had a boy in Vietnam that came back in one piece, for which I am very happy. However, I would not like to see our young people serving overseas as a first line of defense of this country and not having adequate medical resources available to them. I do not think we have those medical resources available today.

Dr. MOXLEY. We don't.

Mr. WOLFF. And that reflects itself in the drug area as well.

Now, on the question of the problem that we face with all due respect, I do not believe that there is adequate priority being given to the overall drug situation and narcotics abuse situation.

The reason I say that is because we are faced with increasing problems of domestic supply.

When I say "domestic supply," I am talking about supply and availability of drugs in the local areas in which our forces serve. That exacerbates a problem that we had before they had this ready supply of drug availability.

Therefore, the problem has grown astronomically greater, than it was before. Furthermore, we don't seem to have done very much except for putting on some extra CID people from what I read.

I think the military should direct its attention to a definition of the supply and demand side of the problem—it is one thing to have increased intelligence people, but it is also incumbent upon us to set the proper climate for those troops who have to serve overseas. I am happy to see there is some attention being paid to the whole question

of reduction of tours of duty and provision for certain outside activities for these people who are serving overseas so that we do not create a climate for drug abuse within the local areas.

I think more has to be done, and I am sure that doctors' officers are doing what they can on the political side. They feel that these countries where we are serving today have to attain a better local acceptance and do an educational job in the acceptance of our military in their areas. We are there to protect them as well as to protect ourselves. Yet, they are not doing a very good job of accepting our people.

Whether it be a question of a racial problem or it be a problem of just anti-American activity that exists abroad, I think that much more has to be done in the psychological and the political areas of creating an acceptance of our people overseas. And pressures have to be exerted upon these governments where our people are serving.

It is not just the idea of urinalysis testing. I think we place too much emphasis upon urinalysis tests and CID people and the like. We have to change the climate that exists overseas so that our people are accepted by the host nations where they are serving.

We can't get them to pay enough money to support our troops economically; the least thing that they can do is to extend receptivity to our people overseas so that we don't exacerbate this problem.

One final area I would like to deal with is this, Mr. Chairman. I believe that in much of the reporting that is done the nomenclature leaves a little bit to be desired. We talk about cannabis; people over here have a different look at cannabis abuse or use than hash or hash oil, heavy types of drugs. And hash is a heavy drug. It is not something you can smoke one joint and be able to carry on your regular duties.

I think that much of the studies that have been made refer to the use of cannabis. That is generally what we hear. Some people use cannabis, and they are not really referring to the heavy concentration of THC that is involved in the drugs that we are examining.

Therefore, I ask, Mr. Chairman, that we make a recommendation to the Defense Department to establish a liaison office with our committee in the same fashion that the other agencies have, law enforcement and the like. That they assign people to our committee to facilitate an exchange of information and a channel of communications.

This is not done at the present time, although we know that the people are available to us when we call. I think it is important for the Defense Department to understand that we are really serious in what we are talking about. And it will reflect itself in the future in our funding of various programs.

Mr. Chairman, I think I have far exceeded my time. Instead of asking questions, I have tried to propose——

Mr. CLAYTOR. I appreciate it.

Mr. WOLFF [continuing]. Some recommendations. But I do feel that with the new Secretary, we will be able to accomplish much of the desired aims that I know we both share.

Thank you, Mr. Chairman.

Mr. CLAYTOR. Mr. Chairman, we are certainly committed to do that. And I appreciate your comments very much.

Mr. ENGLISH. Without objection, the chairman's recommendations will be adopted.

Are there any further questions of the committee?

I want to thank both of you gentlemen for appearing before us today. It has been most enlightening.

[Dr. Moxley's prepared statement appears on p. 60.]

Mr. ENGLISH. I would like to suggest that we rearrange the order of appearance of today's witnesses. Dr. John Johns who is the former special assistant for drug abuse to the Assistant Secretary for Health Affairs might be appropriate to hear from at this point, given the testimony that we have just heard.

Dr. Johns, would you come forward please?

TESTIMONY OF DR. JOHN H. JOHNS, FORMER SPECIAL ASSISTANT FOR DRUG ABUSE TO THE ASSISTANT SECRETARY FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Dr. JOHNS. Thank you, Mr. Chairman.

I will keep my comments brief since I have had the benefit of previous dialog and questions, and since I have submitted a full statement. I would rather summarize what I was going to say on just a few points and then address some of the questions that have come up.

Of course I was the principal staff officer during the last year that you have just submitted to diagnosis. So I can respond, probably, better than the witnesses that were here before.

Let me first comment on the extent of drug abuse that has been hit on by Mr. Gilman and some of the rest of you. My impression from my year in that office, based on talking to troops and going to Europe with you on your trip, is that what you said is basically correct. And if you control for demographic variables between the DOD data and what you got, you are probably going to come up with 60 to 70 percent of your junior people using marihuana at some time. And you are going to find around 20 percent using hard drugs. That is my own gut assessment.

As you know, you saw our results of some surveys where we did spot, 100 percent urinalysis of company-sized units, and we ranged anywhere from half a percent to 9 percent in one unit showing up positive. And that 9 percent was all for opiates. Now, by any standard you come up with, that is a serious problem. Across the board, you don't find that, however.

Mr. Evans mentioned about the concept paper on consequences. One of the problems we have with our definition of drug abuse is that it doesn't reflect consequences. Even what we call so-called hard drugs, where 17 percent use downers, 18 percent said they used uppers, we found out that the most common upper over there in Germany was X–112 or what they call "jet fuel" because it helps you to get a take-off.

We bought a bottle of that, 100 tablets for $11.90. When you look at the ingredients on the label, it starts out with nicotine, caffeine, and a whole list of herbs. That pretty much comes down to "snake oil" medicine. One medical doctor analyzed it, and said, "This is a strong No-Doz."

Now, if a man tells me that he uses an X–112 upper once a week, I really don't have any way of evaluating how serious that is on his behavior. I honestly don't. We need to know that.

We have the same problem with a downer called Mandrax. Both of these are sold over the counter in the drugstore in Germany. And it would not be technically against the law here in the United States to use these drugs. The Mandrax is their Quaalude and I am told by the troops over there that Mandrax is used basically when drinking beer in the evening because it really puts you into a deep sleep. And I have no doubt that it does.

Opiates or PCP are bad news any way you put it. But just from a layman's standpoint and having been in that job for a year, it is difficult, almost impossible, for me to come up with an assessment in my own mind of how serious this whole thing is in Europe.

Cannabis, as Chairman Wolff said, is hashish over there. And that is about 10 times the strength of marihuana. But when I talked to the troops on that, they said, "Well, sometimes, we will sit with five or six of us in a room and pass a bowl, and I don't know how many draws we get." We simply don't know that.

One of the reasons we delayed our survey was that it didn't get that kind of information. I took over right after the testimony here in 1978. The contractor submitted a survey instrument 2 months later. Some of the questions were at the 12th grade level. We couldn't have gotten reasonable answers from the troops. It didn't get at anything about the time of use, the amount of use, and so forth. So we had to go back to the drawing board. We badly need that kind of information. Until we get better data, my gut feeling on this is that the problem is more serious than most commanders acknowledge.

I am not sure why they are reluctant to acknowledge it. I think one of the reasons is the frustration of not being able to do anything about it if they identify anyone. The Court of Military Appeals decisions have so tied their hands they can't deal with people even when they find them.

As you probably know, if you identify a man through urinalysis, the only thing you can do is give him an honorable discharge. Or if you go through in a shakedown in the barracks and find drugs, if you did not have probable cause for that single individual, the best you can do is give him an honorable discharge.

Commanders and NCO's tell me they are so frustrated with that, they say, "Hell, as long as a man is doing his job, I turn my head." That is not acceptable. But I can understand the frustration.

But on balance, I was told by the commanders they figure their company-sized units would be decremented about 2 or 3 percent in effectiveness because of drug use. When you add that to the other things, of course, that is a significant decrement. I would guess that that is probably about right.

Next let me just briefly state my views on identification—on the urinalysis policy. I believe that mandatory quotas, used indiscriminately across DOD, which would apply to units in areas where there is very little problem, is a very negative thing for the program. I believe it is bad for morale; I believe that the policy they have now, which focuses in on hot spots and focuses in on when people do something you can normally associate with drug and alcohol abuse, is much better.

Let me next comment on the possibility of us having a reagent for testing for THC. I think we better be very careful about deciding how

we want to use that. My own guess is that if we right now decided to find out every soldier, sailor, marine, and airman that had used marihuana in the last 7 days—THC stays in the system about that long—we would be confronted with a decision of what the hell do you do with 50 or 60 percent of your junior enlisted force?

And I am not sure what we would do. If you identify them that way, the only thing you can do is give an honorable discharge.

Now, I believe Mr. Evans said, "Well, if we can't man the force that way, we may have to go back to the draft." What do you do with a draftee who dosen't want to be in anyway and says, "Oh, I'll get an honorable discharge if I come out positive on THC"? He could smoke a joint at high noon in front of city hall and get a $50 fine and get an honorable discharge.

And I don't have any solution to this. But I am saying I don't know the practical solution to it. And I think when you start looking at whether something is just illicit or not, you have got a tough problem to know how to deal with it. My successor over there is going to have a tough time dealing with it.

A few words on treatment. Most of the treatment that I see is for people who are nonaddicts. We have very few addicts in the military from the standpoint of physical addiction. Those that are detected in the Air Force and Army are discharged after 15 days of treatment in the military and 15 days in the VA hospital.

The Navy sends certain people that they find who are either psychological addicts or heavy users to their center at Miramar, Calif. Of those that they send to Miramar, they only take the ones they think are the best bet to return to duty. They put them through 2 more weeks of screening, and then of those they put through, they have 44 percent return to duty; and not all of those finish their enlistment.

I seriously question the cost effectiveness of that. I am not critical of the Navy. Miramar is acknowledged to be the best drug treatment facility in the world. And perhaps it is good from a standpoint of keeping it, just from the standpoint of keeping the state of the art going. But I am not sure that I would endorse it as being cost effective.

I think the Air Force and Army is right; if you get someone who is addicted to drugs, our track record of treating them is such I would just discharge them and send them to a VA hospital.

The rest that are treated, the vast bulk of people that are being treated, are for marihuana. And they are generally casual users. I will give you one anecdote. I went to an air base, and I asked the treatment people there, "How many do you have in treatment for drug abuse?"

He said, "Fifty."

How many are for marihuana?

Thirty-nine.

Of those thirty-nine, how many were good airmen when they came in here?

Thirty.

I said, "What are you treating them for?"

We are trying to convince them that they shouldn't use marihuana.

I think that the drug abuse treatment we are giving basically is trying to get these young people to straighten up and accept the discipline of the military. I believe someone mentioned the use of senior NCO's. I believe that is the key to it. The Army simply doesn't have them to use. They don't have the senior NCO's to staff even the platoons. I would suggest they look at retired NCO's who have been platoon sergeants or first sergeants, give them civil service rating, and put some of them in counseling jobs. And for the others who are diagnosed as just immature, undisciplined, I would favor something like the retraining brigade at Fort Riley, Kans., which has been highly successful and cost effective.

Let me just briefly comment on what I think are areas for emphasis. First, quality of soldiers. I suppose I can speak as a private citizen on this issue of quality of people we are getting in the military.

In 1978, I don't believe we had the same quality we had during the draft. We get a lot of fine, dedicated people, but as Mr. Beard said, the mental category III–B has gone up to 53 percent in the Army last year. And if you look at the profile of the distribution of those III–B's, they are largely at the lower end near category IV.

I think we lack the peer leadership of college-bound, middle-class youth we had in the draft. And I think they provided a very stabilizing influence in the barracks. I think most of you have read "Boys in the Barracks." I believe the company norms in the unit is a key factor, and that is what we have to work on, on a systematic basis.

The last thing I would say is there are no quick fixes to this. I don't think you are going to get dramatic progress regardless of what you do. If you take a look at the Air Force in Europe and Army in Europe, I think you will find they have had very aggressive programs; that they have pushed as much as we could reasonably expect of our commanders.

The way the committee could help is to try to give some support when we ask for funds to do research. When we ask for money to do research on drug abuse, the Appropriations Committee cuts it. We asked for $1 million.

What was not brought out here in the testimony about research when you asked about it, is that the Army has people assigned on this research project and have had for 8 months now at a level of effort of about $600,000. They are actually doing it. They contracted out for the first phase of that research. It was due in October. I don't know if it has been delivered here. It was done by a research firm here in Washington, D.C. But the additional $1 million would give them the sources to go a lot faster at it.

I am going to stop my testimony here. I have gone 10 minutes. And I think it would be more fruitful, looking at the clock, if you have any specific questions. I will be glad to answer them.

Mr. ENGLISH. General Johns, I simply want to thank you for your statement. I think it is very frank, very honest. And I must say that given the relationship that you have had with this committee during your tenure with the Department of Defense we have always found that to be the case. The contribution that you made in that position, I think was outstanding.

The only regret that I have is that those in the Department who had the authority have failed to respond both with the degree of enthusiasm and the timely manner that should have taken place.

I think without question you provided the leadership and guidance that they have needed. And I am hopeful in the future, we will see the Department move in that direction and move in a very quick manner.

I think it should also be said that General Johns worked very closely with this committee and the degree in which he assisted in aiding us both in understanding this problem and understanding the way the military operated and understanding the problem of the military, is something that I think left us in a far different position.

So I have no questions of General Johns. And I simply want to thank you, General Johns, for appearing before us and thank you for your contribution.

Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman.

And I, too, want to join with my chairman in commending General Johns for his assistance to our committee and for helping us gain a broader insight into the problems confronting our troops overseas. I would hope that his interest in behavioral science and General Rogers' interest in behavioral science is beginning to take hold in the chain of command.

I would like to ask General Johns is the Pentagon placing an adequate number of behavioral scientists or people trained in the behavioral sciences in the chain of command today? I note that in response to my inquiry, they said they were looking toward one for every battalion. How far away from that goal are they?

Dr. JOHNS. They are now testing that concept. I believe there are 20 battalions in Europe being tested for a year in that concept. They are getting several weeks of training at Fort Ben Harrison, Ind., in organizational behavior, including drug and alcohol abuse, specifically how to create cohesion within organizations, how to influence norms. They are going to test it.

But in the meanwhile, they are training all the battalion personnel officers in that course. And then, they will make the determination if they need to add a second officer down there to give that emphasis. I have hopes they will do that.

General Lutz is going to testify and is responsible for that program. He, himself, is a behavioral scientist, so they have put a round peg in a round hole. And I think that if anyone can get it pushed through, he will.

Yes; they are testing it, and I think they are going forward pretty strongly.

Mr. GILMAN. When you say "testing," in other words, they haven't put it in place yet?

Dr. JOHNS. No.

Mr. GILMAN. Planning, talking, design stage?

Dr. JOHNS. That's right. And I would say if it is done in 4 years, you will be lucky, like the 18-month tour.

I am not criticizing any individual, but it takes so long to get something like that approved.

Mr. GILMAN. I sure hope our NATO combat effectiveness group can survive all of this planning and designing and preparation.

General Johns, did you take a look at that article that came out not too long ago called "The Boys in the Barracks"? I guess it was a book that was written.

Dr. JOHNS. Yes.

Mr. GILMAN. By Maj. Larry Ingraham who was reserve with the Army Medical Research Unit. It points out some pretty shortcomings in the life of the barracks.

And just a few comments. Much of "The Boys in the Barracks" describes and analyzes soldier drug use, delves into the barracks' pecking order, section drinking, Army system, and other aspects of military life.

The document is so strongly worded and true to life that many who read it react with shock, dismay, and disgust, according to Ingraham. The tone of barracks life is thought to be bleak and depressing, if not thoroughly repulsive and obscene. But it is well to remember that the boys in the barracks are not deviates or delinquents. And it goes on.

Do you have any comments about some of the findings with regard to what he has found to be some of the cases of drugs in his review of the life in the barracks?

Dr. JOHNS. Yes, sir. I think he might have taken some poetic license with some of his anecdotes, but I have read the entire study and I believe the basic findings are valid.

What he is saying is that the answer lies in the norms of the organizations and that the informal organizational norms are more important than the formal laws and rules and regulations.

I think behavioral sicence theory would support that in just about any organization. But what he further says is that very few NCO's and officers are able to control the informal organizational norms. We need better knowledge of how to do that.

Now, I might add here that the research study previously mentioned is being done by Walter Reed and calls for a $7 million effort over 5 years. If they get the money, it is going to zero in on organizational norms as one of the large facets.

So I think that the general statements he makes in there are valid.

Mr. GILMAN. I think one of the things that was outstanding in my mind when we visited the barracks in West Germany was the removal of the NCO's and the junior officers from the troops. There was no rapport. There was no understanding of the problems in the barracks. And there was no one to reach out to if there was a problem to really discuss it with.

And he comments: I note that Maj. Larry Ingraham also comments on the leaders who fundamentally are unconcerned by alcohol misuse, of drug abuse, by the men in the barracks.

Do you have some comment about that premise? Is there something we are doing to overcome that attitude? Are we trying to attack that problem?

Dr. JOHNS. Every Chief of Staff that I served under has been concerned about that. And there is so much concern and yet an inability to come to grips with it that I don't have the answer either. I could give you my own pet theories which I pushed for years in the Army, but the next fellow that gets up here, General Lutz, may have other pet theories about how to make people care.

General Rogers, who just left as Army Chief of Staff, always said, "We have to have leaders who give a damn." That was his phrase. And he meant that, but you can't legislate that. And there are many NCO's that do give a damn, many junior officers; others who don't.

I personally have always felt a bias toward putting more emphasis on development of people skills of our leaders than on the technical managerial skills which I think have been pushed in the military. And I think that is an institutional bias.

I made that known for years, and I believe if we get some of these trained behavioral scientists down to the battalions, that is where they can do the most good.

Mr. GILMAN. I still recall the young boy we found in a rehabilitation center in West Germany who said when he first started getting involved, he reached out to talk to his NCO, and the response was, "You better shape up or ship out." And that was the end of it. And before he knew it, he was really into it up to his ears.

I would hope there is some new program that is involving—that is giving—a better understanding among the officers, and the NCO's of the problem, and to try to deal with it when they first receive the problem.

I know you were concerned about it. I know General Rogers is concerned about that aspect. And I hope we are moving in that direction.

Do you see some movement in that direction?

Dr. JOHNS. Just before I left, we brought on board Lieutenant Colonel Schaum, who is in the back of the room. He is a specialist in organizational behavior and his job is to do precisely that in the drug/alcohol field. His charter is to come up with systematic programs where we can get at these norms in the organizations. It is much broader than just drug and alcohol use, however. It has to do with job satisfaction; it has to do with the sense of camaraderie and so forth. I share with you completely that view that there is where we have to really put some emphasis.

But it is a tough nut to crack.

Mr. GILMAN. Just one other question. General Johns, what can the Congress do to move this from the back burner up front?

Dr. JOHNS. Well, keep your interest in it. I know I told you that even when I was over there. And sometimes, I felt you were a little unfair with your criticism, but on balance, I think your interest is good because human resources management usually gets attention only if it is a crisis.

If you can help us to get rid of some of the decisions in the Court of Military Appeals, that would be useful. I think we have pretty much taken the discipline out of the services and tied the hands of the commanders. The chiefs have testified to that and I am not out of line with them, but I would say it anyway. But I think they made some very bad decisions that keep us from having discipline in the services.

Mr. GILMAN. Thank you for your comment, General Johns. I hope you will continue to advise the military to move in the direction of the behavioral science.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you, Mr. Gilman.

Doctor, you say in your prepared statement, and this is quoting you, "My own assessment is that drug abuse has a more serious impact on readiness than is generally afforded by commanders, but that it is not a crisis situation." And you base that on the fact that the highest combat readiness takes into account a 10-percent absentee rate.

Are you satisfied with that statement?

Dr. JOHNS. Yes; I am.

Mr. EVANS. When we had our hearings in Germany and concluded by issuing a joint statement to General Blanchard, there was a statement partially to the effect or to the general effect that we do not find that the forces in Europe are incapable of doing their job because of incapacity of drug use. But we do think that unless something is done quickly that it can reach those proportions.

Do you remember——

Dr. JOHNS. Yes; the discussion.

Mr. EVANS. The discussion generally to that effect?

Dr. JOHNS. Yes, sir, I was there.

Mr. EVANS. Then, we heard the testimony a year after that that very few of the things we talked about doing have been done. I guess maybe we overstated the situation or we are in trouble—which one would you think?

Dr. JOHNS. Well, I think you have overstated the situation. I think if you look in Europe, a hell of a lot has been done, a hell of a lot. They have done just about everything that I think was asked of them.

You take the 18-month tour: they fought for that tooth and nail, but the Pentagon has to make that decision. The other things, I think the 111 law enforcement people——

Mr. EVANS. Recreation—I think I missed some of the testimony. I had previously asked a question, but to the wrong panel. Have recreation programs and the leisure-time programs been approved?

Dr. JOHNS. Most of them have not been. The money asked by Europe—and I can't speak as an authority, I retired in 1978 and saw the requests come in from Europe at that time—just can't pass the budget cycle. They get scrubbed in the Pentagon.

We asked for $253 million additional for leased housing for dependents. That never surfaced even to OSD, much less to the Congress. It is just a budget crunch situation; but it is not their fault.

Mr. EVANS. Well, I don't know whether to call you General or Doctor, so either one. I think you did a fantastic job in the capacity as a general. And from your testimony today, I think that you have the attitude that we could use in trying to solve some of the problems that we have. I commend you for your statement.

And it makes it a lot easier to question because we don't have to go into so many different things because you covered it so well in your presentation.

Thank you very much for your testimony.

[Dr. John's prepared statement appears on p. 119.]

Mr. EVANS. Ms. Mathea Falco?

How do you do?

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TESTIMONY OF MATHEA FALCO, ASSISTANT SECRETARY OF STATE FOR INTERNATIONAL NARCOTICS MATTERS, DEPARTMENT OF STATE, ACCOMPANIED BY HARRY L. COBURN, DIRECTOR, OFFICE OF PROGRAM MANAGEMENT

Ms. FALCO. I am fine, Mr. Chairman.

This is Harry Coburn, Director of my program and policy office. Without objection, I would like him to be present with me.

Mr. EVANS. Surely; you may proceed and give your statement as you wish. The entire statement will be included in the record.

Ms. FALCO. Thank you, Mr. Chairman. I think perhaps in the interest of time, I could summarize very quickly the points that I have covered in my prepared statement.

You are already personally familiar with the deep concern that we have in the State Department with the situation in Western Europe, particularly as it affects our forces stationed there.

I had the opportunity to travel with you last year in connection with this committee's hearings in Germany and to see firsthand the situation which I have heard described today by earlier witnesses and discussed by the members of your committee.

In the year since those hearings, there has been substantial progress realized in our bilateral cooperation on a wide number of drug-control issues, particularly with the German Government.

We have also launched a number of initiatives to increase the responsiveness of other Western European governments to the drug-control problem, and to try to get them to work effectively with each other and with the illicit narcotics producing countries to curtail the rapidly increasing availability of heroin in Western Europe.

I would add here that there is overwhelming evidence in Western Europe now that the supply of heroin is increasing geometrically. You saw the evidence of that last year on this committee's visit there. I have just returned from our regional conference in Berlin, and the evidence this year is even more devastating.

Heroin overdose deaths in West Germany and Berlin now already exceed the total for last year. Last year's total was about the same as the number in this country, and we are about five times their population size.

A heroin epidemic really is now underway in Western Europe. Without reducing the availability of heroin supplies, particularly in West Germany, we will be unable to resolve successfully the drug-abuse problem in the military that you discussed earlier today.

Clearly, there are many things the military can and should do. Your committee found last year what is increasingly clear now 12 months later, that as long as the heroin supplies continue to increase in geometric proportions, it is very difficult to have any kind of fully effective program for the drug-abuse problem that exists.

We have experienced a similar phenomenon in the United States, as you know. We are now in a more favorable posture toward heroin addiction than we have been at any time in this decade. This is a direct result, we believe, of the reduction in heroin availability due to the Mexican Government's opium eradication program.

I could touch briefly on some of the initiatives we have undertaken in the European forum if that would interest you or I could just stop and let you ask me questions, whichever you would prefer, Mr. Chairman.

Mr. EVANS. I would like for you to cover just a few of the specific examples of initiatives that you have instituted as a result of the hearings last year.

Ms. FALCO. Fine. Perhaps the most immediate example of success has been the formation of the United States-German Central Working Group which had already had its first meeting by the time we arrived in Germany last November. Since that time the group has become a very effective vehicle for bilateral cooperation. They have developed several subcommittees to deal with specific issues. The most active one has been the law enforcement cooperation subgroup. As a result of this very close working relationship that has been built between our two governments at all levels—I am not talking just about the diplomatic or the political level, I am talking about the daily, operational level which is so necessary—we have seen dramatic progress in Germany in increased seizures, increased arrests, and in much greater political visibility for the narcotics problem.

West German Interior Minister Baum has recently given several press interviews and speeches in Germany in which he equated drug abuse problems at the same level of importance for Germany as terrorism. A similar rise in public focus has also taken place in Italy, where under the new government, the drug abuse problem has been accorded a much higher priority than in the past. An interministerial committee has been formed. The Minister of Health visited me here about a month ago. He has since personally involved himself in a review of a series of policy options for the Italian Government to take in what is for them an increasingly serious problem. In general, they talk about illicit narcotics and drug abuse in terms which a year ago, we would not have expected to hear at all.

We are urging Western European governments to undertake a number of steps. On a daily basis, we communicate with them through the State Department and DEA country attachés, concerning law enforcement efforts, increased working level cooperation, regular exchange of intelligence on trafficking networks, and improved treatment, education, and prevention techniques.

We have also spoken with them about specific U.S. diplomatic initiatives in multilateral forums which promote the kind of longer term strategic thinking which hopefully will help all of us with our domestic drug abuse problems.

For example, last June in the OECD [Organization for Economic Cooperation and Development] Ministerial meeting, Deputy Secretary Christopher proposed to the OECD that its bilateral Development Assistance Committee, which regularly reviews developed country bilateral assistance programs, include narcotics control considerations in its deliberations. The purpose would be, that, for example, when a major grant is being made by an OECD country to an illicit poppy-producing area in a supplier country, that the assisting country can be aware of the kinds of problems that sometimes are encountered in

producing areas, of the potential need for antipoppy clauses—which the German Government has now agreed to adopt—and of the usefulness of coordinating their own development assistance with that of other OECD countries, so that maximum return can be had in terms of shifting traditional poppy-growing farmers away from illicit cultivation.

Income substitution is a very long-term goal. But we believe that we must make a start somewhere and that the OECD, through the Development Assistance Committee, is a logical forum to provide this kind of coordination, which has never been attempted before.

We have also urged the OECD to serve as a forum for the development of statistically comparable data bases among member nations on quantitative measures of domestic drug abuse. One of the interesting problems I have discovered as I have talked to my European counterparts, is that we all collect a great deal of data, but we collect it in different terms. The United States collects apples, the Germans collect oranges, somebody else is collecting plums, and it becomes impossible to talk to each other directly about the type of problem that is facing us individually and collectively.

The statistical effort is again a beginning. Both the development assistance and statistical proposals are being actively discussed in various European capitals. It has been quite a first for narcotics to be raised in the OECD, which is primarily an economic forum attended by foreign ministers and financial ministers.

We believe the two OECD initiatives have been an important step in our efforts to get high-level political commitment to dealing with the problem of drug abuse that we simply must raise these issues to the highest levels of European governments in order to get them to focus beyond their own individual borders. It is in the U.S. interest to try to get other developed countries to help us and each other in working with the less developed, producing and trafficking areas of the world, to bring about a global reduction in illicit narcotics production and abuse.

In addition to the OECD, we have also raised the issue in NATO through its various working committees. Last month Senator Biden gave a very moving presentation on the drug problem to the 10th plenary session of the NATO Committee on the Challenges of Modern Society. I plan to attend the NATO ministerial meeting in December with Secretary Vance. Our hope is that narcotics issues will continue to be discussed in the NATO forum. We feel NATO is an appropriate place to raise the drug abuse problem, particularly in light of the interest that this committee and other Members of the Congress have expressed.

We have also been working bilaterally with individual Western European governments. I have already mentioned Germany. With them we have been dealing extensively with Italy as well. We just learned that in Switzerland, two-thirds of the population believes that drug abuse is the most important political and social issue facing their country in the next 4 years. I found that both astounding and encouraging.

We are also finding that along with the increasing European interest, in combating illicit narcotics, some progress in increased contributions to the U.N. Fund for Drug Abuse Control [UNFDAC] is being made. The Germans have indicated their intention of substantially increasing their contributions this year. I think it will be over $1 million. They also indicated to me in conversations in Bonn that, as appropriate projects are developed, the FRG will contribute much greater sums. They now openly recognize the need to support international efforts, which they have not previously done. The Italian Government has indicated its intention of giving $120,000 to UNFDAC. While this is not a great sum they have given nothing in the past 5 years, so the donation represents progress. The Swiss will also be giving to the U.N. Fund.

I am hoping the momentum which seems to be building in Europe will continue. We are doing everything we can through bilateral initiatives and through working with regional organizations like NATO and the OECD to stimulate activity. I must tell you, too, that the work that this committee did last year in Germany was critical in developing some momentum for U.S. proposals in what had been an extremely difficult region with which to work. As you know yourself, there was reluctance to talk about the problem; once you speak about it, you have to admit it exists. Once you admit it exists, then action becomes necessary. And it is that kind of resistance that this committee's visit to Germany broke through. The extensive discussions that you had, not only with regard to the troop issue, but also with individual German officials—some of whom I met again in Bonn and who all asked after you—really have made a difference.

In general, West German officials are taking narcotics problems seriously now in a way that I would not have thought possible a year ago. For example, I met recently with the State Secretary for Economic Cooperation, who is also a parliamentarian. He is one of the top officials, comparable to a U.S. Under Secretary. He had his whole top staff there. We met for an hour and a half. He understands the concept of using bilateral development assistance funds for narcotics control thoroughly. I was very impressed with the efficiency and the thoroughness with which they had prepared themselves. The Germans are now willing to use poppy clauses—an important breakthrough. They are considering putting substantial amounts of money into Northern Thailand, and possibly into Afghanistan as the situation cools down, both countries where there is substantial illicit poppy production. In the same meeting we also discussed development possibilities for Pakistan. I was enormously encouraged that the West Germans are treating this with the deepest seriousness and indicated to me that their commitment to put bilateral money into Asian producing regions of the world was a very strong one, that deutsche marks would be forthcoming.

Mr. EVANS. Well, I personally am encouraged by the change of attitude because when we met with the Health Minister and others, they had no drug problem.

Ms. FALCO. I know.

Mr. EVANS. And I remember very well Mr. Gilman's statement, "Well, we hope and pray that you are right because if we are right, you are going to be finding many increased problems in the near future." And apparently they have found those problems, and appar-

ently they are now working with you and other representatives of the U.S. Government to deal with the problem.

I would like to ask if any progress has been made in dealing with the border situation. As you correctly pointed out, as long as we have in Western Europe the tremendous supply of heroin and other drugs because of the free access caused by the free flow of people through the various countries, we are going to continue to have a very serious problem.

Is this being discussed in the Common Market, in other markets in other places, as far as you know?

Ms. FALCO. The border problems, of course, are very serious. I remember at much earlier hearings of this committee, the whole question of West Berlin was raised. And I think we clarified that at that time that we do not believe that is a border.

Mr. EVANS. Part of what I am discussing, though, is the fact that the people were able to go through all of the countries very easily, and there is a reluctance upon the part of the German Government and other governments to slow down this traffic. And, therefore, there is very little opportunity to find drugs being brought in because there is just no tendency to search for them.

Has there been any discussion of cooperation between various countries to deal with the smuggling of drugs into Germany and other countries?

Ms. FALCO. I do know that the German Government has increased its law enforcement resources devoted to that activity.

Harry Coburn has a comment; he works on this problem for me.

Mr. COBURN. Mr. Evans, the intelligence provided to us indicates that most of the drugs coming into central Europe enters in TIR trucks. These are the bonded trucks loaded in the Middle East which enter the Common Market.

Apparently, there is a small amount of body carry that also goes on, but I think you are correct in your assessment that the western concern for free movement of people, and the practical consideration of not congesting airports by having searches, are both impediments. Common Market countries are beginning to develop profiles, and I think we have to keep encouraging the effort to identify the likely traffickers.

But the bulk of the movement of heroin into Europe apparently is through these trucks, which are difficult to identify because of the amount of traffic that is on the roads.

Mr. EVANS. Thank you, Mr. Coburn.

Ms. Falco, are you familiar with any new organizations that are developing the cocaine traffic in Western Europe?

Ms. FALCO. I didn't hear the first part of the question.

Mr. EVANS. Are you familiar with any tendencies on new organizations which are dealing with cocaine? Is this becoming an increasing problem in the area?

Ms. FALCO. Yes, and you know, a year ago, again, nobody would have believed it. But there have been some substantial seizures of cocaine coming in through——

Mr. EVANS. What is the nature of the groups of people bringing cocaine in? And where is it coming from?

Ms. FALCO. I would have to defer to DEA's expertise on this, but

the reports I have seen show shipments of cocaine from South America, from Colombia, from Brazil, over to Spain and into—I think there have been some into—West Germany and Scandinavia. The market is there for cocaine. And the money is there.

I think it is logical to assume that the trend we have now seen in these recent seizures will increase dramatically. That is another subject I have raised with the German Government. They were surprised. The same health officials you met with last year, this year were expressing some surprise at this increase in cocaine.

Let me add that FRG Health Ministry officials still aren't sure they have as big a problem in Germany with cocaine and other drugs as other public officials now think they do. This is in spite of a great deal of very dramatic publicity in Germany on the drug problem. While we were in Berlin for the conference, there was a big cover story in one of the leading popular magazines showing a teenager dead on the floor with a needle in her arm. It was a very dramatic picture. Our conference over there on illicit narcotics got daily, extensive coverage. Some of that was reported in the New York Times a week ago Sunday in an article about the Berlin situation. The amount of publicity that is now generated in the European press around the drug issue is having an enormous impact on the political thinking.

Mr. EVANS. Do you happen to know the street value of the coke that has been seized thus far? Is that something that you leave to DEA?

Ms. FALCO. In Europe?

Mr. EVANS. Germany recently.

Ms. FALCO. I am sorry, we don't know that, Mr. Chairman. We could provide that for the record. We could get that from DEA and put it in the record.

Mr. EVANS. If you would do that.

Ms. FALCO. Yes, I will.

[The information referred to follows:]

The street value of the cocaine seized in West Germany in 1978 was $847,000 (DEA).

The cocaine is being imported to Europe by Columbians, Bolivians, and Peruvians working through the main continental ports of Europe. Since the mid-seventies, the amount of cocaine has been increasing.

Mr. EVANS. The court decisions that have been made in the military cases having to do with restriction of the use of Army personnel at the borders, has that had an effect on the amount of smuggling going on? Has it kept us from helping to enforce the laws there as far as smuggling of drugs?

Ms. FALCO. If that is a problem, Mr. Evans, it has not been brought to my attention.

Mr. EVANS. I believe these are decisions that have just been made within the last week so I don't guess it would have had an effect yet.

Mr. English, do you have any questions?

Mr. ENGLISH. Thank you very much, Mr. Chairman.

I'm sorry I wasn't here for your statement, but it is my understanding there has been a significant increase in the level of concern being expressed by the West German Government. I continue to be extremely concerned, about the increase of drugs that are flowing into West Germany.

I understand now we have evidence of increasing supplies of cocaine that has become available. This is a drug that certainly was not very predominant 1 year ago when we paid our visit to West Germany. And it seems to me that unless the West German Government is prepared to address this problem with much the same emphasis and vigor that they address the terrorist problem and are still addressing the terrorist problem, there is little chance that supply of drugs, the availability of drugs, is going to be reduced.

Would you agree with that assessment?

Ms. FALCO. Absolutely, Mr. Chairman. I was just saying to Mr. Evans that the German Government has now decided to give the drug-abuse problem the same priority as terrorism. And we hope that the indications that we have seen over the last year, their real determination to do something about this, will result in a reduced availability of heroin in Germany.

The problem, of course, is that the largest supply region of the world now—South Asia, including Afghanistan, Pakistan and Iran—is an area where it is difficult to generate any kind of real change through diplomacy. However, we have talked extensively with the German Government about the kinds of things they might do with their bilateral development assistance, as well as the need for them to raise at the highest diplomatic levels in all their relations with these countries, their real concern about illicit drug production and trafficking.

Mr. ENGLISH. Now, the point is the Ayatollah hasn't shut off the drug supply yet.

Ms. FALCO. No; although he has said he is about to, we are still waiting.

Mr. ENGLISH. Evidently, he is much more interested in dealing with oil than he is in dealing with heroin.

Ms. FALCO. The situation is extremely difficult. Estimates conservatively are now that opium production in Iran wil be about 350 tons. They used to, under the previous regime, cultivate opium to maintain the registered addicts. Indeed, Iran under the Shah was a net importer from the illicit opium market. They absorbed a great deal from the region.

Since the change in government, the controls have broken down completely, and production has increased. The Ayatollah Khomeini has pronounced on several occasions that he feels that Islamic teaching prohibits opium cultivation and use.

Mr. ENGLISH. We haven't seen anything better?

Ms. FALCO. We haven't seen anything yet. Meanwhile, that is an enormous source of supply when combined with Afghani and Pakistani production in the region. I think that the most conservative estimate I have seen this year is 1,000 tons, and some say much higher. When you compare that with the Golden Triangle, which they are predicting will yield about 200 tons, you can see the dimension of the problem.

It is a very tough one. And I must say when I make this approach to Western European governments, they really understand the connection between geometrically increasing supply and domestic heroin problems because they are seeing it unfold in their own countries.

I said earlier that the numbers of heroin overdose deaths now in West Germany this year already exceed the number from last year and will certainly exceed the number we have in this country. They are really in the grip of an epidemic the likes of which we haven't seen in this decade in the United States.

Mr. ENGLISH. What has happened to the registered dependents in Iran since the Ayatollah has taken over? Are they still registered and handled in the same manner as before?

Ms. FALCO. This is Mr. Coburn, my program director.

Mr. COBURN. Mr. Chairman, at the moment we don't have much information about what is going on in Iran. As you might be aware, the Embassy staff has been severely reduced. There has been very little reporting. Individuals in the Iranian Government who were contacts for the United States previously have all changed.

Previous to the recent events, we were trying to make contact with people and to develop more information.

Ms. FALCO. In fact, one of my deputies visited Iran about a month ago, and did have conversations with members of what is now the former government about this problem. They were very concerned about the runaway production and the fact that they have up to 1 million addicts.

We don't know what has happened to the addicts. We assume they are buying in the illicit market.

In Pakistan, General Zia banned the opium vends as contrary to Islamic teaching early in 1979. But opium is still available in large quantities there.

Mr. ENGLISH. If the supply of opium from Iran was limited, what kind of impact would that have on West Germany?

Ms. FALCO. I think it could knock down the total by about a third at best. We do not really know how much goes out in which direction. I think it would be a good start. But it would be very tough to have a significant impact on that region in the short run.

That is why it is imperative from the U.S. perspective to get all of our developed country allies into the effort with us. Before you came back from voting, I was talking about our initiatives in the OECD and NATO, and our bilateral initiatives with other developed countries. It is very clear that we are next on the list for a major onslaught from heroin from Afghanistan and Pakistan. It is very important for us to be able to develop a real response to that problem before we are awash in Middle Eastern heroin the way Europe now is.

Mr. ENGLISH. Well, I guess it could be viewed with those people that are being held hostage, and perhaps the military will have an opportunity to sufficiently or significantly reduce the supply somehow in the country.

Any further questions? Thank you very much.

Ms. FALCO. Thank you, Mr. Chairman.

[Ms. Falco's prepared statement appears on p. 123.]

Mr. ENGLISH. The next witness is Brig. Gen. Joseph Lutz, Director of Human Resources Development, U.S. Army.

General Lutz, we certainly want to welcome you. And we are very sorry that you had to wait so long. And you have been very patient. But I think this probably has lasted a bit longer than we expected.

TESTIMONY OF BRIG. GEN. JOSEPH LUTZ, DIRECTOR, HUMAN RESOURCES DEVELOPMENT, U.S. ARMY, ACCOMPANIED BY COL. JAMES M. KREBS, CHIEF, HUMAN RESOURCES DEVELOPMENT DIVISION, AND LT. COL. JOHN VALIEANT, CHIEF, DRUG SUPPRESSION OPERATIONS CENTER, BOTH OF HEADQUARTERS, U.S. ARMY EUROPE; AND MRS. HELEN D. GOUIN, CHIEF OF ALCOHOL AND DRUG POLICY, AND MAJ. JACK HACKETT, LAW ENFORCEMENT DIVISION, BOTH OF OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL

General LUTZ. Thank you very much, Mr. Chairman. You have described my title.

With me today from Europe, I have on my right Col. James Krebs. Jim heads up the Human Resources Development Division in Headquarters, U.S. Army Europe.

On my left, Lt. Col. John Valieant, Chief, Drug Suppression Operations Center, U.S. Army Headquarters.

Also with me is Mrs. Helen Gouin. She heads up the Office of Alcohol and Drug Policy in my shop.

Maj. Jack Hackett from the Law Enforcement Division, Human Resources Development Division, Office of the Deputy Chief of Staff for Personnel, is also in my shop.

Mr. Chairman, I would like to submit my written statement for the record and read an abbreviated copy of my remarks.

Mr. ENGLISH. General, before we get started, it might be well if I make this vote and came back. I am sorry to delay you again. They don't always give us a great amount of consideration over there on the floor of the House.

General LUTZ. We understand, sir.

Mr. ENGLISH. I will be back as quickly as possible.

[Whereupon a recess was taken.]

Mr. ENGLISH. General, I am terribly sorry. It seems like we have vote after vote, but I think now we will be able to have the time to get this thing complete. Please continue.

General LUTZ. Mr. Chairman, I would like to submit my written statement for the record and read an abbreviated version at this time.

Mr. ENGLISH. Without objection, so ordered.

[General Lutz's prepared statement appears on p. 127.]

General LUTZ. I appreciate the opportunity to appear before this committee and discuss the Army's initiatives in regard to alcohol and drug abuse. I share your concern in this regard, and we have made considerable progress in management of these highly complicated problems during the past year.

Although I have only served in my present position since September 28 of this year, the matter of alcohol and drug abuse in the Army has been a serious concern to me for a number of years in my capacity as a commander of troop units.

Upon my arrival in my new assignment, I was personally briefed by my predecessor, Maj. Gen. W. F. Ulmer, who assured me, and it is my own assessment, that the Army is in compliance with all the recommendations from previous hearings and those transmitted to us directly by members of this committee.

Before General Ulmer left, he made a personal trip to Europe for the purpose of making onsite evaluations of the drug and alcohol programs and initiating corrective action as he deemed necessary. The record copy of my statement summarizes his findings and actions.

I would like to address the status of Army initiatives for fiscal year 1979 in terms of the Army alcohol and drug program.

During this year, the Army has continued its all-out effort to prevent or control the abuse of alcohol and/or other drugs by soldiers, civilian employees, dependents, and retired military personnel. The Army alcohol and drug abuse prevention and control program [ADAPCP] directly supports and is an integral part of soldier readiness.

It assists in reducing personnel turbulence primarily through the rehabilitation of personnel in the military environment where substance abuse surfaces and by returning them to duty as soon as possible. When rehabilitation fails, we are making it possible to eliminate the military member or civilian employee from Government service in an expeditious manner.

We have accepted the fact that alcohol and drug abuse problems are endemic in our society. As such, we do not believe that total elimination of the abuse of alcohol and other drugs in the Army is realistic.

However, it is imperative that control of alcohol and drug abuse remains a top priority and that we continue to commit sufficient resources for a conscientious and sustained command effort to contain the problem. We cannot permit ourselves to be lulled into complacency as we were in 1976 and 1977. We believe we have learned this lesson well and that our commanders are increasingly aware of the important role that an effective alcohol and drug program can play in accomplishing their missions.

In the record copy of the testimony, I have outlined the nine most significant Army initiatives of fiscal year 1979. In addition, I would like to affirm our concern for alcoholism as well as other drug abuse.

We have responded to all recommendations from the chairman, Representatives English and Gilman; as well as the initiatives of Mr. Duncan, the former Deputy Secretary of Defense.

Additionally, the record version states our goals for the coming year.

I will take just a moment to review my recommendations wherein this committee might further assist our efforts.

First: We need greater congressional recognition of the degrees to which alcohol abuse has become a problem.

Second: Our concern that has been previously discussed is in terms of research moneys. What we have done is divert some funds to start that research, and we did program some funds from our own house and have started a research effort along the lines of $2.7 million.

The $1 million is significant to us in that research effort.

In summary, I feel confident that the Department of the Army and U.S. Army Europe have made significant progress this past year in addressing our alcohol and drug abuse problem. We have strengthened and improved law enforcement efforts, expanded both quality and quantity of the Army alcohol and drug abuse prevention and control

program staff personnel, and developed soldier readiness programs Army-wide with top priority directed at our soldiers in Germany.

We have developed more systematic and professional approaches to alcohol and drug abuse prevention, education, treatment, and rehabilitation. Our management of these programs is improving, especially through commander involvement. We know there is much to be done for civilian employees and dependents of both military and civilian employees.

I wish to assure this committee once again that the Army remains positively committed to prevention and control of the problems of alcohol and drug abuse. The areas I have discussed are important and no doubt can have some impact on combat readiness.

We anticipate the interest and support of this committee, and we are now ready to address any questions that you may have.

Thank you.

Mr. ENGLISH. Thank you very much, General.

It is my understanding that in the last few months, the Army has moved to something of a decentralized system with regard to the approach on a number of problems, giving more and more leeway to the local commanders, what they do and how they do it and that the armies up the chain of command is more in a position of simply offering guidance; is that correct?

General LUTZ. Sir, I would describe that as the Army, particularly my directorate. We are still in the policymaking business at the Department of the Army level. We want to get the commander more involved. While I think that has the connotation of decentralization, we are really talking about commander involvement. Our entire thrust is through commander involvement at the local level, the battalion and brigade commander. That is where we are directing our new regulation 600–85.

Mr. ENGLISH. Earlier, you heard me address the situation of a commander who does not want to use urinalysis tests and resists efforts even though he may be in an area where there is high availability. Do you have any comments with regard to that situation?

General LUTZ. Yes, sir. First of all, we have not had any instance of a commander doing that. And we have continued our monthly urinalysis reports although it is not required quarterly. We still monitor that centrally.

Mr. ENGLISH. General, we ran into quite a few commanders over in Europe that just flat told us they don't like urinalysis; they don't like to give tests; they don't want to mess with them. And they gave us the impression they strongly opposed using those tests unless they had to. That just doesn't seem to jibe with what you are saying here.

General LUTZ. Sir, I am saying the emphasis thrust of our program is to get the commanders involved. And in the urinalysis programs, since the 0.6 percent was deleted, we have a decrease in Conus, and we have maintained the same in Europe. Our overall percentage is somewhere around 0.68 right now.

I would defer to USAREUR on the question. However, as I previously testified—and I just left command—if I had a lower commander who didn't want to be involved in the urinalysis, I would tell him we are going to do that; but I never had that problem.

Our reports don't indicate that we have commanders doing that now. If we did see a high incidence of those kind of indicators that show that drug abuse might be prevalent, the Department of the Army can hit that particular level for that commander.

Mr. ENGLISH. Colonel, do you have something you wanted to add to that?

Colonel KREBS. Yes, sir. I was going to say that in Usareur, if we identify an area where it appears there is trouble and we have to do something, we have the authority to direct a particular unit to undergo urinalysis even if we have a recalcitrant commander who is going to drag his feet on that.

That is the way we bridge that shortfall, and we do that.

Mr. ENGLISH. I would like to commend you for the fact that apparently the Army has undertaken research without and is managing at the same time to give us some funds and has moved back into this direction even though the Congress has not acted in this area. Given the statement that we heard earlier from the Deputy Secretary indicating that Department of Defense couldn't do it, it is good to hear that the Department of the Army can do it, and is.

I think you are to be commended for that action. We certainly wholeheartedly support that.

I think this committee is on record of having given the Appropriations Committee our support with regard to that $1 million, and we certainly hope it will come through. And we will do all we can in that area.

A number of recommendations were made by Mr. Gilman and myself after we went to Germany. Can you tell us very briefly—I don't want to get into a long, drawn out thing as we did on the 15 points of Secretary Duncan—but can you tell us of any progress that is being made in regard to the Department of Defense being granted authority to appeal military court decisions to the Supreme Court?

Has there been any progress made in this area?

General LUTZ. Sir, we don't have a decision, but there was legislation before the 95th Congress. It did not pass, but I understand it has been reinitiated this year.

Mr. ENGLISH. I think so myself.

General LUTZ. That is the only thing we do not have any headway in, appealing above the Court of Military Appeals.

Mr. ENGLISH. Has there been a request from the administration to the Judiciary Committee to take that legislation?

General LUTZ. Yes, sir; we have done the initiative, and it has gone up the line. But I will defer on that. I stand corrected. It has not been introduced again in this session.

Mr. ENGLISH. The Justice Department still opposes that legislation?

General LUTZ. Yes, sir.

Mr. ENGLISH. That's where we run into trouble.

The recommendations regarding broadening the options, chapter 9 discharge, is there anything there?

General LUTZ. Yes, sir; two things that occurred there. We had a reeducation program, and we also reduced the level where the person could affect the discharge of a recalcitrant soldier. And we have

dropped that down to the lieutenant colonel level so it ties in with the Justice levels.

Mr. ENGLISH. You have still got to give a normal discharge?

General LUTZ. Sir, if it is under chapter 9; yes. Nothing has been done to change that legislation. We feel very strongly that there should be an incentive to change that legislation.

Mr. ENGLISH. Well, that is one that we strongly support, but no progress is being made in that area?

General LUTZ. No, sir; particularly if a man is self-referred or if he is discovered by urinalysis, we still have to give him an honorable discharge.

Mr. ENGLISH. Is there any effort underway to change that? Does the Department of Defense make any effort to change that?

Mrs. GOUIN. If I may, sir, the Department of Defense has rested its case more or less because the bill was not reintroduced in Congress this time.

A complicating factor for us in the Army has been the *Giles* case which has been tried in district court. And we have lost apparently on both instances, the class action portion and the individual *Giles* case.

A loss in the U.S. Court of Military Appeals is for a single instance and a single case. But when you get into district court, it is a horse of a different color. So we have lost now in district court which may negate any possibility we have unless Justice comes forth and the Congress acts to get that overturned.

It is a very significant timing for us. And that case has just occurred.

Mr. ENGLISH. As you know, one of the other recommendations was with regard to the question of creating a so-called retraining program which I think is technically known as IEA or IEC, something like that, program for retraining, as I understand it, for those people who have been convicted of some misdemeanor.

General LUTZ. Yes, sir.

Mr. ENGLISH. This particular program would not apply?

Individual effectiveness course; that is what it is called. And we strongly urge that that be made available to commanders in Europe. Is there any progress being made in that area?

General LUTZ. Sir, we have looked at that. And in my personal experience, although I was not on board, many of those units can be effective.

In a time of very limited resources, they do drain the resources from the combat units which are necessary to operate a unit like that.

It also becomes somewhat of a cesspool for those individuals who are suspected of drugs and are drug abusers. We had that experience in Vietnam. It turned out to be a disaster.

That became our single source of trafficking for the entire area when you put those units together. I have seen them, sir, where they have done some good. I saw it at Fort Bragg when I was down there in the 82d Airborne Division. We had the resources at that time to do it. We still feel that the commanders' use of pretrial confinement to create an environment within his unit will satisfy, and also, it doesn't prejudge the guy as being guilty.

We are having some legal problems with that.

Mr. ENGLISH. As I understand it, though, this is a program out of Fort Riley. There is no other unit like it in any of the services. The success ratio makes it cost effective—namely, you are saving more people, and the overall cost itself is such that it far exceeds the cost taken to replace that individual with new personnel.

It seems to me if this program is cost effective, obviously, it would have to have some success if it is cost effective, that it would be well worth giving serious consideration to. And it would be well worth certainly putting it into place in Europe.

I don't understand the reluctance of the Army to move in that direction. And as far as any legal problems, I can't understand why there would be a legal problem in Europe, but not one in Fort Riley, Kans. That simply doesn't make any sense.

Colonel KREBS. Sir, the way a person arrives at Fort Riley, as I understand it, is as the result of a court-martial conviction.

Mr. ENGLISH. No. That is the retraining program, not the individual effectiveness course. The individual effectiveness course takes place at the same location, and there is a difference in that the individual is assigned by the commander to take that course. He is not confined to quarters. He doesn't have board waiver or anything of that type, stiff lockup, at all. But it is a very strict course. And as I said, the figures that have come out of that indicate that it is cost effective.

And it is something that I feel very strongly about. And I think probably several members of the committee feel strongly about it.

In fact, I am going to urge at the first opportunity that we get some of the people not only from this committee, but from the Armed Services Committee and the Appropriations Committee to go out there and take a look at this program. It seems to me to make a lot of sense. And I don't understand why this is being fought within the Army. Why can't such a unit exist, particularly given the situation we have in your area.

We have some problems over there. Obviously, you have people who have been assigned to rehabilitation two and three times. It seems rehabilitation leaves something to be desired.

The next point is, of course, the fact that people who are handling rehabilitation programs tell us 70, 80 percent of the people in the rehabilitation program don't want to be rehabilitated. They are not interested in that at all; they are resisting it. They are not addicted, and they simply look at the program as a form of harassment. They are not seeking help, and you can't help anyone with that kind of a program who doesn't want to be helped.

Third, of course, is the fact that you have a lot of people over there who are actively seeking honorable discharges. And you know that they are seeking the drug route as a means of obtaining that honorable discharge and getting out of the service. You have tremendous resistance among NCO's and officers. And I don't know what to do about handing out those kinds of discharges.

You are not giving them an option. You have to send them to rehab or chapter 9 or sit there and live with it. And I would daresay that the individual effectiveness course would provide an additional option. It would give both the soldier and the Army the opportunity to save this person. It would be a last-ditch effort. It would be a chance and try to correct him.

I would daresay that you would have far fewer people who would see drugs as an easy way to an honorable discharge from the service before their completion of the tour of duty. And it seems to me that it is a cog that the machine is lacking in dealing with this problem and one that could be extremely helpful.

I know that it would cost some money to have resources, but as I said, this thing is a test model at Fort Riley, and it is cost effective according to their statistics. I have no reason to challenge that.

We talked with NCO's who were running that program at great length. And most of them—well, all of them—were drill sergeants. And they were very high on the program. They felt that it did do a great service. And I think that it could work for you in Europe, certainly provide a much greater deterrent than what we have now.

I am hopeful you will go back and take another look at this thing.

General LUTZ. Mr. Chairman, with your permission, we will defer that and take another look at it in terms of what kind of analysis was done and take a look at its cost effectiveness.

Mr. ENGLISH. I would appreciate that.

Mr. Evans?

Mr. EVANS. I think you have clarified that as well as some of my questions.

With that, General, I want to thank you very much for appearing before us and being kind enough to give us your testimony.

As I said, I think without question, the Army is making a greater effort than it was 4 months ago and certainly 18 months ago. I am hopeful you will continue to go in this direction and that you will continue to keep this committee advised as to what we can do to assist.

We do want to assist. Though we are not here in the business to harass, sometimes, it seems as if that is what we are after. But it is not the case at all. And we want to see this problem solved, if not solved, at least controlled.

And we think that you are going to have to have far better tools than what you have got now in order to do that.

General LUTZ. Thank you, Mr. Chairman.

Mr. ENGLISH. With that, this hearing is adjourned subject to the call of the Chair.

[Whereupon, at 5:57 p.m., the hearing was adjourned.]

PREPARED STATEMENT OF HONORABLE JOHN H. MOXLEY III, M.D., ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

I appreciate the opportunity to appear before this Select Committee to discuss drug abuse in the Armed Forces and provide an update on the status of a broad range of Department of Defense (DoD) initiatives to improve the efficacy of our drug and alcohol abuse prevention (DAAP) program.

Substance abuse problems continue to be a national issue, which has progressively assumed chronic and costly dimensions in the military. Estimates of the use of mood-altering substances within the enlisted force alone range from 7–15 percent for hard drugs, to 20–40 percent for marijuana and hashish, and 15 per cent for the abuse of alcohol. Prevalence statistics obtained through surveys during the last several years indicate that alcohol, marijuana, and hashish are the predominant problems. This pattern is borne out by caseloads. Hard drugs remain a major concern, especially with the increased availability of Middle East heroin in Europe. Our commanders in that theatre are directing comprehensive programs to minimize the potential impact of that drug on our forces. (Additional information on our assessment of recent trends is at Appendix 1).

Although substance abuse in the military tends to be concentrated in the age group 17–25 years, it affects all Service members and their dependents. Patterns of abuse of legal and illegal substances generally parallel those experienced in our society at large with a few exceptions. The tendency toward substance abuse is somewhat exacerbated in the military by factors such as overseas tours and family separations. Serious drug and alcohol dependency problems are less extensive due, in part, to DoD recruiting and retention policies as well as the DoD law enforcement and drug abuse prevention efforts.

The affects of family influences and the immediate work environment in which military duties are performed are substantial but perhaps the least understood. We are increasingly aware of the importance of social and organization factors which promote the deterrence and prevention of substance abuse—on the job and in military communities. Sound leadership and management practices which provide a challenging work environment and daily reflect a sensitivity and understanding of human behavior act as a buffer against the negative consequences of substance abuse.

Specifically my remarks will focus on what we are doing to combat drug and alcohol abuse and what is required to sustain a dynamic and aggressive program. In particular I will review the status of fifteen DoD initiatives to strengthen our program and the eight recommendations made by Representative English last January. I will also address our policy on cannabis use and biochemical testing to identify cannabis users. Finally, I will discuss our goals for the coming year.

Since assuming the position of Assistant Secretary of Defense for Health Affairs (ASD(HA)) in September, I am impressed with the professionalism and dedication of the drug and alcohol abuse prevention staffs. On the whole, I am pleased with our progress. My office and the Services are working well together and we have fundamental agreement on our direction. There is increased awareness of the drug/alcohol problem by top members of the Services, and the staffs generally appear to be getting the support they request. The interest and support of the Select Committee's Task Force on Drug Abuse in the Military, chaired by Mr. English, are extremely beneficial to our efforts.

I know you are concerned about the emphasis on drug and alcohol abuse in my office. Let me address that issue first. You are aware that almost concurrent with my arrival in the Department of Defense, Dr. John H. Johns, the Special Assistant for Drug Abuse Prevention, submitted his resignation to assume a teaching position at the National Defense University. His leadership, extensive knowledge of the drug abuse area, and unique qualifications are a significant loss to our program. In deciding about a successor, I consulted with Dr. Johns, as well as the appropriate Assistant Secretaries of each of the Services. It was their collective consultation that caused me to request that the position be upgraded to a Deputy Assistant Secretary of Defense for Drug and Alcohol Abuse Prevention. I am seeking an individual with broad experience, as well as an interest and background in the Human Resource Development area.

DOD INITIATIVES

The first major topic is what DoD is doing to combat substance abuse problems and improve the efficacy of program management. In testimony before this Select Committee, former Deputy Secretary of Defense Duncan announced a number of initiatives DoD was taking to cope with the drug/alcohol problem. The original twelve initiatives were expanded to fifteeen and a status report was submitted to Congressman English on 30 January 1979. I will, therefore, briefly highlight the status of each initiative. (A more complete report on each initiative is at Appendix 2.)

Drug assessment and reporting

Initiative No. 1 involves the design and administration of a DoD personnel survey which comprehensively assesses the prevalence, nature, and effects of drug and alcohol abuse. The survey objectives, design, and questionnaire have been carefully developed and thoroughly reviewed. We have used experts from NIDA, NIAAA, the civilian community, and DoD to assist in the development of this survey. A contract was awarded through a competitive bid process to Burt Associates, Inc., in September. The contractor will complete the planning, administer the survey in February-March 1980, analyze the data, and prepare

reports by the fall of 1980. This initiative is progressing well after some necessary delays to carefully refine the survey objectives, design, and questionnaire. The survey instrument we originally intended to use did not adequately address the survey objectives. We planned to complete the fieldwork in 1979; however, the revision of the survey instrument, its review, and the contracting process took longer than anticipated. As a result, the contract was awarded too late to complete the required preparations and the fieldwork before the Christmas/New Year holiday period. Rather than jeopardize the integrity and credibility of the survey, we decided to delay the completion of the fieldwork until March 1980.

Initiative No. 2 involves the use of epidemiological data to assess the extent and location of drug abuse. This system will employ the DoD personnel survey to provide point prevalence assessment data on drug and alcohol use and abuse patterns. It will also supply management-oriented data during the periods between surveys. This includes information such as urine testing results, hospital emergency room admissions for drug and alcohol-related reasons, law enforcement trends, treatment and rehabilitation information and fatalities.

The proposed system has been outlined in a concept paper which is currently being staffed with the Services. We expect to receive all comments by the end of November. A data book employing the epidemiological concept was published in August. We are progressively refining and implementing the elements of the system and will complete the task during 1980.

Initiative No. 3 is the redesign of the drug reporting system to obtain uniform trend data. A draft report which contains the key data elements of the proposed reporting system is complete and has been forwarded to the Military Departments. The full implementation of this system, which includes a test of the Drug Abuse Warning Network (Project DAWN), operated by the Drug Enforcement Administration (DEA), is expected in 1980. (New statistical summaries are at Appendix 3.)

Portable urinalysis equipment

Initiative No. 4 is the test of portable urinalysis equipment. The test phase should be completed and the reports submitted by all four Services by December 1979. From our preliminary discussions, test site visits and the Marine Corps report we have learned that, in general, people in the field favor the use of portable test equipment. However, the equipment used is not optimum. It is not sensitive enough and produces an unacceptable rate of false positives. A technical evaluation of all available portable urinalysis equipment on the market and in development has been initiated. We will determine which one we should use if we plan to use portable kits on a permanent basis.

Staff visits and education

Initiative No. 5 involves reemphasizing drug abuse control through increased staff visits to all major commands and improved education, especially for commanders and supervisors. As of 31 August 1979, all major commands have been visited at least once and areas with more significant problems, such as Europe and the Far East, have been visited more frequently. My recent orientation trip to Europe and Mr. Dogoloff's visit to Europe in October have reinforced emphasis for our program. (More information on our efforts in Europe is at Appendix 4.)

The revitalization of the DoD education program is progressing well. A task force on education will complete its revision of our program and forward its recommendations by the end of the year. Additionally, this past September the Office of the Assistant Secretary of Defense for Health Affairs, OASD(HA), sponsored the first worldwide Department of Defense Drug/Alcohol Conference. The conference was attended by representatives from each of the military Services (both command and program personnel), other Government agencies, White House Domestic Policy Staff, the private sector, and Congressman English from this Committee. The feedback generated by this conference is still being analyzed; however, it is apparent that our first attempt at sponsoring a conference of this magnitude was a success. Plans are already underway to conduct another conference in the early fall of 1980. The worldwide DoD Drug/Alcohol Conference provided the 250 attendees with a clear appreciation for top level (Congressional, White House, and OASD) perspectives on drug and alcohol issues facing the Department of Defense. Specifically, 99 percent of all participants agreed the conference provided a meaningful forum for intra-DoD drug/alcohol

program information exchange. Many attendees commented on the positive benefits derived from sharing program successes and failures with members of other military Services. Approximately 90 percent of the participants agreed that the conference assisted them in developing a better understanding of Congressional and White House perspectives. It also served to recognize those people and programs that have made significant contributions to our drug and alcohol effort by featuring them in presentations for the benefit of all attendees. Lastly, the most significant benefit was that the image of OASD(HA) and the military Service headquarters was considerably enhanced, not only by the professional quality of the conference but also by publicly displaying genuine concern and interest in drug and alcohol problems.

Assessment of DOD employees and dependents

Initiative No. 6 involves measuring the extent of drug/alcohol abuse among three separate groups—adolescent dependents, adult dependents, and DoD civilian employees. Procedures to collect the required information for each group varies greatly and cannot be accomplished simultaneously with existing resources; however, actions are being taken to obtain accurate measurements of drug/alcohol abuse within each category.

Discussions are underway with the National Institute on Drug Abuse (NIDA) to include DoD adolescent dependents in the prevalance studies being conducted under current NIDA research grants. If this is not feasible, a survey instrument has been drafted by the Office of Drug and Alcohol Abuse Prevention (ODAAP) and can be used. The administrative process involving the Office of Management and Budget approval, obtaining computer support, and funding authorizations would delay data collection if the ODAAP survey is used. Adult dependent data are now projected to be collected as a part of the fiscal year 1982 military survey and will be compatible with that effort.

Efforts to develop a study which measures the extent of drug/alcohol abuse among DoD civilian personnel has been and continues to be coordinated with the Office of Personnel Management (OPM), NIDA, and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). A statement of work is being developed by OPM. This could lead to a contract which would survey all Federal agencies. The Air Force has recently completed an Alcohol Prevalence Survey which could be modified for a broader application should the joint effort with OPM, NIDA, and NIAAA not materialize.

Another part of this initiative involves assessing how well our existing drug/alcohol programs respond to the needs of dependents and whether changes in the space-available policy should be made. Current military regulations provide authority to deliver drug/alcohol services (including rehabilitation) to DoD employees and dependents residing overseas.

There have been no indications that existing programs are not adequately responding to the needs of both civilian employees and dependents. We anticipate, however, a need for an active community-based program which encourages self-identification and extensive prevention/education programs. DoD Directive 1010.2 (Alcohol Abuse and Alcoholism) has been rewritten to accommodate civilian employees and dependents. Final staffing of that directive will occur by December.

Law enforcement

Initiative No. 7 focuses on a review of military law enforcement efforts. A DoD Law Enforcement Task Force on Drug and Alcohol Abuse has been instrumental in reviewing staffing levels, which have been substantially increased, particularly in Europe. Other actions surfaced by this Task Force such as means to authorize payment of informants, proper employment of drug detector dogs, improved intelligence networking of treatment and law enforcement personnel without violation of confidentiality, and amendment of DoD customs directives are being addressed and will be well underway or resolved by the end of the year.

Initiative No. 8 was a review of procedures concerning civilian arrests on military installations. The DoD Law Enforcement Task Force looked at this problem and determined in September 1978 that it was neither of sufficient magnitude to warrant a request for assistance from Department of Justice nor did it merit extraordinary action by the Military Departments. This situation was subsequently reviewed again this summer and the extent of the problem re-

mains relatively small. Nearly 90 percent of civilian drug arrests were for use or possession of marijuana. Fewer than 500 sale and trafficking arrests of civilians were made worldwide in calendar year 1978, and only about 150 of these involved the sale or transfer by a civilian of a substance other than marijuana. The Services are continuing to monitor the situation.

Initiative No. 9 established a Berlin Task Force on Drug Abuse on 30 June 1978. Recent emphasis has been on overt and covert drug suppression efforts, determining legal actions that could be taken by German authorities against known or suspected drug traffickers, and increased customs control including the use of drug detector dogs. German-American relationships are continuing to be strengthened, current cooperative efforts are outstanding, and the task force is enhancing drug abuse control in Berlin.

Research

Initiative No. 10 involves research of the military consequences of drug use on job performance and combat effectiveness. This initiative is of concern since the House Appropriations Committee (HAC) deleted the $1M needed to support our research program in fiscal year 1980 and indicated that drug and alcohol abuse research by DoD is unwarranted. However, the Senate Appropriations Committee (SAC) recommended restoring these funds to the budget. We are awaiting the Conference Committee's decision on this matter. Obtaining adequate funding of our research requirements continues to be an area of prime importance.

The Army, which was directed to conduct this research, is focused on accomplishing four objectives within a five year program: (1) establish the impact of drug and alcohol abuse on individual military performance, (2) characterize the relationships of this abuse to unit readiness, (3) specify the relationship of patterns and distribution of military drug use to unique attributes of the military environments and (4) recommend actions for maximizing efforts to reduce and control levels of drug and alcohol abuse by service members.

Since unit effectiveness is related to social and organizational factors, more than a characterization of substance abuse effects on individual performance is required for this research. Internal cohesion factors are critically important in this regard. Any threat to the functional integrity of a military unit increases the risks of sustaining higher combat casualty rates (to include psychiatric breakdown) and reduced combat effectiveness. In the past, drug use has fostered fragmentation within military units by promoting divisiveness between the drug using population and nondrug users. Unit leadership under these circumstances can be undermined to the extent that it cannot deal with the problem.

The conduct of basic research, which is not peculiar to the military, remains a responsibility of other agencies, such as HEW, NIDA, and NIAAA. This policy conforms to Congressional guidance we received in fiscal year 1976. These shared responsibilities underscore the importance of interservice and interagency research coordination. This coordination is improving through direct liaison with these agencies and joint participation in research advisory committees. As a result we are in a better position to fully capitalize on new technology and research findings as they emerge.

Program evaluation

Initiative No. 11 will develop and test program evaluation criteria primarily in the areas of education and treatment. Education evaluation criteria emphasize knowledge of drug/alcohol abuse subjects and behavior change. The required lesson plans for supervisors, nonsupervisors, DoD civilian employees and DoD dependents in overseas locations have been reviewed. Learning objectives are currently being drafted to focus on new enlisted and officer accessions and people enrolled in professional military education courses. An evaluation of these revised education programs is planned for late 1980.

Determining what constitutes "successful" treatment is also of major importance. It is heavily dependent on the design and staffing of residential and nonresidential programs and subject to a wide variety of interpretations. DoD has defined treatment success as the satisfactory performance of duty at specified points in time after admittance to treatment, specifically at 180 and 360 days after entry into the program. Treatment includes those activities that are medically supervised or carried out by designated treatment staffs in either a residential or nonresidential program. Satisfactory performance is determined by whether the individual is on active duty at the designated time or, if separated,

whether the separation occurred at the normal expiration of service with a separation designation code that does not prevent reenlistment because of behavioral, drug abuse, or alcohol abuse reasons. We are also reviewing an unsolicited proposal from Rand Corporation to evaluate existing treatment modalities. We believe our efforts in this area are at a state-of-the-art level.

Program staffing

Initiatives No. 12 and No. 14 are assessments of staffing levels within the Office of Drug and Alcohol Abuse Prevention (ODAAP) in OASD(HA) and each of the Military Services. The size of the ODAAP staff has been sufficiently increased to perform its policymaking and program management functions for DoD.

Overall, the Services appear to have an adequate quantity of total resources authorized. Personnel quality is of greater concern due to Service assignment and staff training criteria. The Army has authorized additional clinical directors in Germany and upgraded the quality of its counselors to some degree. This is a long-term project due to the shortage of Noncommissioned Officers in the Army. I am also concerned about the Navy's policy of assigning junior officers as Directors of the Counseling and Assistance Centers because it insures that the directors will be inexperienced from the standpoint of line duty and in working with the Navy bureaucracy. I will monitor this assignment policy carefully and recommend action to have it changed if I find it detrimental to the Navy program.

DOD employee programs

Initiative No. 13 is designed to establish formal programs for civilian employees overseas. A variety of formal programs now exist including education, outpatient and inpatient rehabilitation; however, more uniform standards for these programs are necessary. As an initial step the DoD Directive on alcohol abuse, which addresses the more serious problem among civilian employees, has been revised and staffed. Final staffing and promulgation of the Directive should begin no later than December.

An Action Planning Conference involving people who are responsible for civilian programs in each of the military Services and Defense Agencies, as well as Dependents Schools and NIAAA, is planned for 12–14 December 1979. This conference will develop a detailed action plan for civilian programs, which will be used by ODAAP and a representative committee of conference participants to monitor progress. Field trips to assess civilian programs are being planned with emphasis on overseas activities. DoD is also an active participant in meetings convened by OPM to develop a prevalence survey for Federal civilian employees.

Drug abuse identification

Initiative No. 15 involves the development of improved measures for drug abuse identification, primarily urine testing policies and practices. We no longer require a minimum level of urine testing. The previous policy, which required the Services to maintain a minimum yearly rate of urine tests of .6 of the target population of service personnel 25 years old and younger, was resulting in a de-facto "random" urinalysis, low confirmed positive rates in some areas, and decreased command support for the overall DAAP program. The policy of requiring commanders to conduct urine tests when incidents occur which are likely to be drug or alcohol related has been reemphasized. We will monitor the Services' compliance with the new guidance through the quarterly urinalysis reports and through the quantities of reagent ordered by the laboratories. Commanders at all levels are also authorized to order urinalysis sweeps of entire units at their own discretion. The only limitation placed on this authority is that the commander must schedule the sweep in consultation with his servicing laboratory when it involves 500 or more persons. (See Appendix 5, DEPSECDEF Ltr, Subject: Improved measures for Drug Abuse Identification, dated 24 Jul 1979.)

Collectively, these fifteen initiatives provide a clear message to the Services for stimulating needed improvement and constructive change and reinforcing program effectiveness and emphasis at the highest levels of authority. Individual initiatives are designed to strengthen each of the seven major functions of the DAAP program: Prevention (Law Enforcement and Education), Identification, Training, Treatment/Rehabilitation, Research, Evaluation and Planning/Coordination. Although we are striving to upgrade the quality and effectiveness

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of the program internally, there are two major areas where external support is vitally needed.

First, increased resources are required to adequately sustain a viable drug abuse program in the near and long term. The House Appropriations Committee's deletion of fiscal year 1980 research funds heightens our concern in this area.

Second, coordination, commitment and joint action with other Federal agencies must be strongly emphasized and facilitated. Initiatives concerning DoD civilian employees, dependents, identification and disposition of drug and alcohol abusers, and research are of immediate concern.

SELECT COMMITTEE MILITARY TASK FORCE RECOMMENDATIONS

In a letter to the Secretary of Defense last January, Representative English made eight recommendations to improve the DoD effort to counter drug and alcohol abuse and asked for DoD views. An interim response was submitted in January and a final reply was forwarded in May. Since then there have been some changes and progress which I will highlight. A complete summary is at Appendix 6. General Lutz will address Mr. Gilman's recommendations.

First there is evidence that the West German government has increased its efforts to reduce the availability of drugs. The Central Working Group, composed of German and U.S. members (including a military member from the U.S. European Command), is meeting regularly. The last meeting was on 22 June. Subcommittees have been formed and have begun to work. I am convinced the West Germans are aware of the drug availability problem and are taking positive steps to combat it.

The second recommendation concerns obtaining authority for the Department of Defense to appeal court decisions beyond the U.S. Court of Military Appeals. A proposal to provide for review of decisions of the U.S. Court of Military Appeals by the Supreme Court is under consideration by the Administration at this time.

The third recommendation concerns shortening the tour length in Europe. The Army has studied this problem and Brigadier General Lutz will cover this subject in his testimony.

The fourth recommendation had a number of facets to it, one of which dealt with transferring individuals with a physical or psychological dependence to the Veterans Administration. Public Law 96-22 has modified the circumstances under which we can transfer active duty personnel to the VA for drug or alcohol dependency or disability. That law provides that we may transfer an individual only during the last thirty days of his enlistment or tour of duty, and then only if the servicemember requests such a transfer in writing and specifies the period of time of treatment. Of course the servicemember may request an extension of his treatment. We expect these legal provisions to further reduce the number of active duty servicemembers we transfer to the VA for treatment from the present average of about forty-two per quarter.

The fifth recommendation deals with legislation to broaden the opportunity to issue General instead of Honorable discharges for drug abuse; the sixth recommends removing suspected traffickers from their barracks pending court martial; the seventh recommends recruiting senior noncommissioned officers for counselors; and the eighth seeks to discourage consumption of alcohol prior to and during working hours. The DoD position on these is unchanged from that previously specified (see Appendix 6).

CANNABIS POLICY AND BIOCHEMICAL TESTING

Two other subjects are of interest—our policy on cannabis use and biochemical testing. The increase in cannabis use in our society over the past few years reported by the National Institute on Drug Abuse necessitated that the Department of Defense re-examine its policy regarding the use of cannabis by military personnel. This review has been completed and has resulted in the issuance of revised policy which establishes the Department's position on preservice use of cannabis, and on the identification and disposition of users. Preservice use will not be a disqualifier for enlistment or appointment unless it is chronic or the user is psychologically dependent. Applicants for special access programs such as Personnel Reliability or security will be screened for cannabis

use prior to application. If use has occurred during the period proscribed by the Services, a waiver will be required.

Our policy acknowledges that security investigations and law enforcement constitute the primary methods of identifying cannabis users. When the technology is adequately developed, however, we intend to use urine testing as an identification tool in situations in which there is suspicion of drug use. The sensitivity level for urine tests is to be calibrated to detect on-duty use, intoxication or heavy use.

Commanders are advised to use disciplinary and administrative actions along with motivational education in dealing with identified cannabis users. The policy further advises that, for the cannabis offender who uses or possesses a small amount and who otherwise has a good record, use of Article 15 of the UCMJ rather than trial by courts-martial is appropriate.

It appears that a biochemical test for cannabis products in the human system will ultimately be available. We have found a procedure that is compatible with our equipment. It has been tested in one of our laboratories but the complete body of technical knowledge necessary before we can use it for routine testing is still under development. The active ingredients of cannabis are extensively metabolized in the body and multiple chemical compounds are excreted in the urine making correlation to degrees of impairment extremely difficult with the present state of the art. Furthermore, we still have not worked out a method to confirm the cannabis positives.

PROGRAM GOALS

Concerning our goals for the coming year, we plan to continue our efforts to make the standards and policies of the Services' programs more uniform, where appropriate. The concept paper at Appendix 7 describes the model we intend to employ. We are progressively revising our directives to fit that model.

A second goal is to insure that the law enforcement and health care aspects of our program are in proper balance. To determine the proper balance, we are focusing more specifically on determining the impact of drug abuse on both the individual and the institution. We will then adjust our resources appropriately.

A third goal is to further refine our problem assessment and program evaluation system. We will continue to pursue this, particularly with respect to our civilian employee program and will address it in some depth in an Action Planning Conference later this year.

Our fourth goal is to develop a five-year plan to insure that drug and alcohol abuse prevention becomes more thoroughly integrated into our command and management prcesses. Experience has shown that we must avoid crisis management in our drug and alcohol programs. Substance abuse has evolved into a chronic, not an acute, problem, and it demands systematic, long-term management as part of the normal course of business.

Finally, we will continue to emphasize our involvement with other Federal and private agencies. The Department of Defense has developed comprehensive drug and alcohol abuse prevention, treatment, and rehabilitation programs on a scale never before equaled. We wish to share our experiences with other agencies confronted by this contemporary challenge.

CONCLUSION

In conclusion, I have endeavored to give you an overview of the drug abuse program as we see it. DOD remains fully committed to deterring drug and alcohol abuse and minimizing their adverse consequences to the individual and military preparedness. The initiatives and areas of concern I have highlighted are of vital importance to ensure we possess a capability to sustain a responsive and effective program at all levels within the Armed Forces.

Again, I appreciate the interest and support of the Select Committee. At this time, we would be happy to address your questions.

APPENDIX 1

ASSESSMENT OF RECENT TRENDS OF DRUG ABUSES IN THE ARMED FORCES

We no longer have the epidemic proportions of drug abuse of the Vietnam days. We do consider that we still have a serious problem, and generally the seriousness of the problem is proportional to the availability of drugs in a given area and inversely proportional to the effective attention given the problem by the local commander.

In general, the military drug abusing population is the young enlisted man or woman in the 18–25 year old age grouping. They seem to use drugs primarily for recreational purposes while off duty. The most prevalent drugs of abuse, after alcohol, are the cannabis derivatives, marijuana, hashish and hashish oil. Thereafter, the drug of choice depends on the availability in the part of the world in which the servicemember is stationed. For example, in Korea it is barbiturates; and in Germany, it is heroin and methaqualone that the Army finds available, and amphetamines on Air Force bases. We have learned also that cocaine availability is increasing in Europe and we have seen evidence of increased cocaine use by servicemembers in Europe. In the United States we see nearly everything; use of LSD seems to be down, but use of PCP and cannabis seem to be on the rise, and we see a surprising amount of cocaine in Hawaii.

There is more abuse among the military outside the United States. We find that when young servicemembers are moved to a location where drugs are cheap and readily available, where they are separated from the restraints of their families, where living conditions are difficult—and sometimes dangerous, the conditions for drug abuse are present, and in many locations outside the United States, these are the conditions that prevail.

More specifically, the number of servicemembers identified and referred for admission to our rehabilitation facilities are higher in the first half of 1979 for all services except the Army than they were in a like period of 1978 (a chart for rehabilitation facility admissions for 1975–1979 is attached—note that our figures are current through June 1979).

I judge the increases in 1979 to be due largely to the reemphasis on the drug problem which we started in late 1978 and carried over into 1979 and on the increased urinalysis in early 1979.

On the other hand, the number applying for exemption in the first half of 1979 showed a decrease over the same period of 1978 for the Army and Marine Corps but an increase for the Navy and Air Force. (A comparison chart for the first six months of 1978 and 1979 is attached)

DOD's assessment now is this: the problem is still serious enough to cause DOD and the military services continuing concern and effort. Where we see an increased availability of the more dangerous drug, the abuse rate seems to be rising and I'm afraid the use of cannabis also may be increasing.

REHABILITATION FACILITY ADMISSIONS

	1st half, 1978	1st half, 1979	1975	1976	1977	1978	1979 [1]
Army:							
Admissions	5,264	4,083	21,227	16,494	11,038	10,243	8,166
Rate per 1,000	6.8	5.4	27.6	21.2	14.2	13.3	10.8
Navy:							
Admissions	6,465	8,093	9,335	10,891	12,321	12,797	16,186
Rate per 1,000	12.3	15.4	17.5	20.8	23.5	24.3	30.8
Marine Corps:							
Admissions	3,443	4,126	4,908	7,023	6,675	7,194	8,252
Rate per 1,000	18.1	22.2	25.0	36.5	35.2	37.9	44.4
Air Force:							
Admissions	2,959	4,385	10,245	6,648	5,938	6,612	8,770
Rate per 1,000	5.2	7.8	16.7	13.3	10.2	11.6	15.6

[1] Extrapolated to full year based on first 6 months entries.

SERVICEMEMBERS APPLYING FOR ASSISTANCE UNDER THE EXEMPTION POLICY

	1st half, 1978	1st half, 1979
Army	1,013	805
Navy	499	603
Marine Corps	167	75
Air Force	374	401

APPENDIX 2

DRUG ABUSE CONTROL INITIATIVES

In his testimony before the House Select Committee on Narcotics Abuse and Control on 27 July 1978, the Deputy Secretary of Defense announced twelve initiatives DOD was taking to cope with the drug/alcohol problem. These original initiatives were expanded to fifteen, as indicated below. This appendix contains a description and status report of each initiative.

INITIATIVE AND TITLE

1—Design and Administer a Personnel Survey
2—Use Epidemiological Data to Assess Drug Abuse Extent and Location
3—Redesign Drug Reporting System for Uniform Trend Data
4—Test Portable Urinalysis Equipment
5—Reemphasize Drug Abuse Control
6—Provide Better Measures of Dependent Drug Abuse
7—Review Military Law Enforcement Efforts
8—Review Procedures Concerning Civilian Arrests on Military Installations
9—Establish a Berlin Task Force on Drug Abuse
10—Conduct Job Performance and Combat Effectiveness Research
11—Develop and Test Program Evaluation Criteria
12—Increase ASD(HA) Drug/Alcohol Staff
13—Establish Formal Programs for Civilian Employees Overseas
14—Military Services Assess staffing
15—Improve Measures for Drug Abuse Identification

Initiatives 13, 14, and 15 were established by Deputy Secretary of Defense decision in May 1978. The others were announced in his testimony in July. Prior reports to the Select Committee have included all initiatives.

Initiative No. 1: Design and Administer a Personnel Survey

A major change was required for this initiative, delaying its completion.

The original objectives of the survey, as expressed in DepSecDef memo of 25 May 1978, were to determine: (1) The prevalence of abuse; (2) characteristics of abusers; (3) reasons for abuse; (4) effectiveness of Service drug education, urinalysis, and rehabilitation programs; and (5) degree of command emphasis on abuse control prgrams. These objectives were broadened in the Deputy Secretary's testimony to the Select Committee on 27 July 1978 to include: (6) The frequency of drug use; (7) the types of drugs that are used; (8) the manner and circumstances in which drugs are taken; (9) the times of day and kinds of locations in which military personnel are under the influence of psychoactive substances; (10) the individual's professed reasons for taking drugs; (11) the nature and intensity of a servicemember's dependency (if any) on them; and (12) the member's assessment of the effects of drug use on his or her personal well-being and military job performance.

Arthur D. Little (ADL), contractor for the last DoD-wide drug survey (1974), was awarded a contract in September 1977 to develop a new instrument to include both drugs and alcohol based on the 1974 drug questionnaire and a RAND-developed questionnaire on alcohol abuse. The ADL questionnaire was pretested in March 1978 and submitted to ODAAP in November after a sequence of reviews and revisions that attempted to incorporate the broader objectives announced in the Congressional testimony.

The review of the final survey instrument submitted by ADL was made by RAND, NIDA, and relevant OSD staff elements. There was a consensus that the survey instrument did not adequately include the broadened objectives in the testimony to the Select Committee. Specifically, we needed more detailed informa-

tion on the patterns of drug abuse, to include quantity, frequency and consequences. We considered it unwise to gather the data contained in the proposed survey without the additional detailed information on drugs, principally because we would be in the position of showing general usage rates without relating usage to consequences. Moreover, without a more sophisticated understanding of the drug abuse problem, we would not be able to determine the effectiveness of our programs or improve our responses to drug abuse. The survey was unbalanced in the direction of extensive data on alcohol abuse and not enough information on drug abuse. Therefore, we decided to delay the project until we had a survey instrument that would accomplish our objectives. The survey instrument was revised by an internal task force, aided by NIDA and NIAAA, and a Request For Proposals issued.

The revised survey questionnaire is designed to estimate alcohol and drug abuse based on the definitions of abuse in a Rand study of alcohol abuse in the Air Force. The Rand questions on alcohol use and consequences were combined with a similar set of questions on drug use and its consequences. The resulting questionnaire was pretested in all four Services and a variant was administered to about five thousand personnel in the Air Force. The results of these tests indicate that the questionnaire will provide the information to satisfy the objectives with only minor modifications.

Five contractors responded to our Request For Proposals to plan, administer and analyze the drug and alcohol abuse survey of DoD. The evaluation panel was composed of one representative from OASD(HA), each Service's drug and alcohol program office, the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

A contract to plan, administer and analyze the worldwide drug and alcohol abuse survey of DoD was awarded to Burt Associates this September. The contractor is planning to conduct a pilot test this November at one installation from each Service, and complete the fieldwork by the end of March 1980. The results of the survey will be available in fall 1980. We were planning to complete the fieldwork in 1979; however, the revision of the survey instrument to address consequences as well as use, the review of the proposed survey instrument by NIDA, NIAAA, civilian consultants, and DoD, and the contracting process took longer than anticipated. As a result, the contract was awarded too late to complete the required preparations and the fieldwork before the Christmas/New Year holiday period. Rather than jeopardize the integrity and credibility of the survey, we decided to delay the completion of the fieldwork until March 1980.

The delay on this initiative may draw criticism; however, we are breaking new ground in the area of drug abuse and have encountered several problems, not the least of which are the contrasting views of how best to measure drug abuse and its consequences. Subsequent surveys should encounter no such delay.

Initiative No. 2: Use Epidemiological Data to Assess Drug Abuse Extent and Location

The basic components of an epidemiological approach to assessing drug abuse are: (1) implement a periodic personnel survey to determine prevalence of abuse at given points in time; (2) routinely gather biological specimens (e.g., urine, blood, saliva, hair, etc.) in a standard manner which is not influenced by Service policy in order to validly and reliably determine trends; (3) integrate both of these elements with other selected trend indicators.

A "straw man" epidemiological system has been developed and coordinated with the Services. In its current form, the system is expected to consist of: (1) A point prevalence assessment of drug and alcohol use and abuse patterns (this prevalence assessment is being accomplished by the personnel survey described in Initiative No. 1 above.) (2) A trend assessment system which will supply management-oriented data during the periods between personnel surveys. Specific trend indicators will be:

a. Small scale random urine tests for prevalence assessment purposes only.
b. A test of the applicability of the Drug Abuse Warning Network (Project DAWN) to the military. This element is discussed in more detail at Initiative No. 3 below.
c. Fatality data (drug/alcohol related).
d. Accident data (drug alcohol related).
e. Drug and alcohol related disciplinary actions.
f. Drug and alcohol related administrative discharges.

g. Law enforcement statistics.
h. Identification data, including commander directed urine testing information.
i. Treatment and rehabilitation data.
j. Medical information.

Some of these data currently gathered in the standard DoD reporting system. We plan to establish a requirement for the remainder of the information through redesign of the drug and alcohol reporting system. Status of this redesign effort are discussed in Initiative No. 3 below.

Initiative No. 3: Redesign Drug Reporting System for Uniform Trend Data

A draft concept paper which contains the key elements of the proposed reporting system has been completed and forwarded to the Military Departments for review. Comments are due back from the Services in November 1979. Appropriate revisions will be made, and a final system will be developed by the end of 1979. Full implementation of the redesigned system is expected during 1980.

One element of the reporting system deserves special mention. A test of the Drug Abuse Warning Network (Project DAWN), operated by the Drug Enforcement Administration (DEA), is being initiated. Briefly, the test program will consist of installing the DAWN system in 30 military hospitals. Twenty-seven will be in CONUS, two in Europe, and one in the Philippines. At each of these locations, emergency room technicians will fill out a brief report form reflecting anonymous information on all emergency room episodes which are caused by drug or alcohol-related problems. These forms will be mailed to the DEA contractor, where they will be audited, coded, and entered into the DAWN data base. The contractor will produce computer data tapes and provide them to DoD for analysis. DEA will provide computer programs to assist in the analyses. Trends will be incorporated into the reporting system. Training of emergency room personnel was accomplished in October 1979.

Implementation began 1 November 1979, and data will be collected for six months. At the end of this period, a determination will be made whether or not DAWN provides sufficient information to warrant full-scale implementation of the system.

Initiative No. 4: Test Portable Urinalysis Equipment

The purpose of this initiative is to determine whether or not the concept of using portable urinalysis kits on site to test for drugs of abuse is feasible and desirable. All military services participated in the test using an available portable test kit as the test instrument.

The Army deployed two sets of portable equipment to Armed Forces Examining and Entrance Stations to test the concept of using on-site equipment to screen potential recruits for the purpose of denying entrance to the Armed Forces of drug abusers.

The Navy procured two sets of equipment to test the concept of using them in a drug rehabilitation facility and in a shipboard environment.

The Marine Corps sent one set of equipment to Okinawa, a high risk area, in which there is located a relatively large number of Marines to test the concept of using the equipment in a deployed troop setting.

The Air Force deployed two sets of equipment to test the concept of using them in remote or isolated areas.

All Military Departments deployed two sets of equipment each in Europe to test the concept of using the kits in a deployed troop setting in a high risk area.

There were some delays in obtaining the equipment and beginning the field tests but the field phase has now been completed by all the services. There has also been some slippage in submission of the final reports. The Marine Corps report was submitted in October. The Army and Air Force reports were due to our office in September but they have not yet arrived—we have been assured that they will be submitted very soon. The Navy report is due in December.

From our preliminary discussions and visits to the test sites, we have learned that, in general, the users in the field favor the use of portable equipment. It gives them a quick indication of who is using drugs even though the portable kit results are presumptive only and must be verified by more sophisticated testing. Nonetheless, while the verification process is being carried out—and it is done in an expedited fashion—the commander involved can begin the processing of the suspect drug abuser.

The equipment used for the concept testing is not considered the optimum. It was satisfactory for use in testing the idea, and it was quickly available, but it is not sensitive enough for our purposes. Further, it produced an unacceptably high rate of false positives—thus the need for independent verification. Therefore, we are researching all portable kits on the market and in development to determine which one or ones we can use if we plan to use portable equipment on a permanent basis.

Initiative No. 5: Reemphasize Drug Abuse Control

This initiative consists of two continuing elements: Staff visits to all major commands, and improved education. As of 31 August 1979, all major commands have been visited at least once. Areas with more significant problems, (e.g., Europe and the Far East) have been visited more frequently. Dr. Moxley, the new Assistant Secretary of Defense (Health Affairs), has just returned from an orientation in Europe that included review of alcohol and drug abuse activities. A special series of visits addressed biochemical testing facilities, procedures, and capabilities. This initiative is progressing well and will receive continuing emphasis as a mechanism for communicating departmental intent.

To revitalize the Department's education program, the Deputy Secretary of Defense directed that drug abuse education be given to commanders and supervisors, to nonsupervisors and to DoD civilian employees and to DoD dependents in overseas locations. All of the Services have submitted the three required lesson plans to the Office of the Assistant Secretary of Defense (Health Affairs). Implementing instructions have been issued by the Air Force; the Marine Corps and the Navy are expected to forward their implementing instructions to the field in November 1979. The Army expects to forward its lesson plans to the field with implementing instructions during the fall of 1979. The Army, however, will issue the lesson plans as guides rather than as requirements and will not require the specified minimum number of hours of education or mandatory attendance at these classes. The Army staff believes the intent of the education requirements is being followed. The major difference between the Army's approach and the approach being followed by the other Services is the amount of flexibility being given to local commanders for implementing the education policy. The Army's approach will be carefully monitored by my staff during the next several months to determine if local commanders are complying with the intent of the OSD directive.

Initiative No. 6: Provide Better Measures of Dependent Drug Abuse

This initiative involves measuring the extent of drug/alcohol abuse among three separate groups (adolescent dependents, adult dependents, and DoD civilian employees). Procedures to collect the required information for each group varies greatly and cannot be accomplished simultaneously with existing resources; however, methods to obtain accurate measurements of drug/alcohol abuse among each category is ongoing at this time.

Discussions are under way with the National Institute on Drug Abuse (NIDA) to include DoD adolescent dependents in the prevalence studies being conducted under current NIDA research grants. In the event that this is not feasible, a survey instrument has been drafted by the Office of Drug and Alcohol Abuse Prevention and can be used; however, the process involving the Office of Management and Budget approval, obtaining, computer support, funding authorizations, etc., would delay the data collection.

Adult dependent data is now projected as a part of the fiscal year 1982 military survey and will be compatible with that effort.

Efforts to develop a study which measures the extent of drug/alcohol abuse among DoD civilian personnel has been and continues to be coordinated with the Office of Personnel Management, NIDA, and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). A statement of work is being developed by OPM which could lead to a contract which would survey all Federal Agencies. Air Force has recently completed an Alcohol Prevalance Survey and could be modified for a broader application should the joint effort with OPM, NIDA, and NIAA fail.

Part II of this initiative involves obtaining some sense of how well our existing drug/alcohol programs respond to the needs of dependents and whether changes in the space-available policy should be made.

Current military regulations provide authority to deliver drug/alcohol services (including rehabilitation) to DoD employees and dependents residing overseas. There have been no indications to suggest that existing programs are not adequately responding to the needs of both civilian employees and dependents. We anticipate, however, a need for a proactive community-based program which encourages self-identification and extensive prevention/education programs. DoD Directive 1010.2 (Alcohol Abuse and Alcoholism) has been rewritten to accommodate civilian employees and dependents. Final staffing of that Directive will occur by December.

Initiative No. 7: Review Military Law Enforcement Efforts

This initiative established a DoD Task Force to review investigative procedures, criminal intelligence, interdiction techniques, and staffing levels to determine whether (and where) we need more—and different types of—law enforcement personnel.

The DoD Law Enforcement Task Force on Drug and Alcohol Abuse chaired by James Lacy of OASD (MRA&L) continues ot review and coordinate law enforcement actions among the Services. During March 1979, the Task Force met with the Police Foundation to examine techniques for measuring law enforcement productivity. The meeting reemphasized that this is a very difficult task to accomplish well, and civilian agencies have not developed any more effective measures of productivity than those employed by the Services.

In order to review manpower levels, status reports were obtained from all of the Services which reported the number of authorizations allocated to law enforcement. A review revealed that there have been substantial increases in the numbers of persons dedicated to drug law enforcement, particularly in Europe, where the drug threat is most severe. The new staffing there appears to be adequate.

A work plan was developed which assigns responsibility for addressing the remainder of the law enforcement actions which have not yet been resolved by the Task Force. All identified issues such as means to authorize payment to informants, proper employment of drug detection dogs, improved intelligence networking of treatment and law enforcement personnel without violation of confidentiality, amendment of customs directives, and others will be resolved or in the process of being resolved by the end of the year.

Initiative No. 8: Review Procedures Concerning Civilian Arrests on Military Installations

In his testimony on drug abuse before the House Select Committee on Narcotics, Deputy Secretary Duncan indicated that DoD would examine the investigative and prosecutive follow-through of civilians arrested for drug offenses on military installations. The DoD Law Enforcement Task Force looked at this problem and determined last September that the problem was neither of sufficient size to warrant a request for assistance from Justice nor did it merit extraordinary action within the Military Departments. The numbers of cases of civilians apprehended were relatively small and normally involved possession of marijuana. Regular law enforcement procedures appeared adequate. However, the Task Force resolved to again review the situation this summer. That review has been accomplished, and the extent of the problem remains relatively small.

Current data again confirm that most civilian arrests involve use and possession of small amounts of marijuana. Nearly 90% of civilian drug arrests were for use or possession of marijuana. Fewer than 500 sale and trafficking arrests of civilians were made worldwide in CY 1978, and only about 150 of these involved the sale or transfer by a civilian of a substance other than marijuana. Additionally, the Air Force Office of Special Investigations (AFOSI) surveyed all 107 of its operating locations concerning referral of cases to, and the acceptance of cases by, local U.S. Attorneys. That survey disclosed no serious problems regarding the acceptance of narcotics cases by local U.S. Attorneys anywhere. Generally, the acceptance and prosecution of cases involving civilians apprehended on base reflects the local state attitude toward prosecution for similar offenses within the local community. Thus, prosecution is less frequent in such states as Alaska, California, and others with more liberal drug laws, while it is more frequent in states like Alabama and Texas. On the whole, AFOSI found that U.S. Attorney declination of narcotic cases does not appear to be a serious problem.

At this time, there is no need to continue close scrutiny of this situation. Military law enforcement agencies are now sensitive to the issue and can provide adequate oversight.

Initiative No. 9: Establish a Berlin Task Force on Drug Abuse

This initiative responded to what was then perceived to be a crisis situation in Berlin. On 30 June 1978, a task force consisting of representatives of the Berlin Command, DEA, and the Berlin Police, was established to focus on the singular problems of that free port.

The Berlin Task Force continued its information-sharing and coordination of drug program efforts in the city of Berlin. In the most recent quarter, emphasis was on overt and covert drug suppression efforts, and on determining legal actions that could be taken by German authorities against known or suspected drug traffickers. Another thrust was on increased customs control, particularly using drug-detection dogs. The Task Force membership was expanded to include members of the Prosecutor's office and the Secretary of the Interior. Emphasis on street level arrests declined due to intensification of efforts to arrest major drug traffickers.

German-American relationships are continuing to be strengthened, and the Task Force is enhancing drug abuse control in Berlin.

Initiative No. 10: Conduct Job Performance and Combat Effectiveness Research

This initiative involves research by the Army of the military consequences of drug use on job performance and combat effectiveness. This initiative is of concern since the House Appropriations Committee (HAC) deleted the $1M needed to support our research program in fiscal year 1980 and indicated that drug and alcohol abuse research is unwarranted. Although the Senate Appropriations Committee (SAC) recommended restoring these funds to the Army budget, a final decision has not been announced. Obtaining adequate funding of our research requirements continues to be an area of prime importance since without this support our capability to pursue even a modest level of effort is in jeopardy.

A comprehensive research plan to accomplish this tasking has been developed and Phase I started (a review of work done to date by civilian and military researchers on individual performance consequences of drug use). The overall effort calls for a five-year program at a total cost of approximately $8M. The current level of effort is approximately $500K–$600K.

The Army, which was directed to conduct this research as the lead Service, is focused on accomplishing four objectives: (1) establish the impact of drug and alcohol abuse on individual military performance, (2) characterize the relationships of this abuse to unit readiness, (3) specify the relationship of patterns and distribution of military drug use to unique attributes of the military environment, and (4) recommend actions for maximizing efforts to reduce and control levels of drug and alcohol abuse by servicemembers.

Since unit effectiveness is related to social and organizational factors, more than a characterization of substance abuse effects on individual performance is required for this research. Internal cohesion factors are critically important in this regard. Any threat to the functional integrity of a military unit increases the risks of sustaining higher combat casualty rates (to include psychiatric breakdown) and reduced combat effectiveness. In the past, drug use has fostered dysfunctional forms of cohesion and fragmentation within units. Drug use promotes divisive patterns of cohesion among the drug using population while isolating this same group from nondrug users. Unit leadership under these circumstances can be undermined to the extent that it is rendered impotent to deal with the problem.

The conduct of basic research remains a responsibility of other agencies, such as HEW, NIDA, and NIAAA. This policy conforms to Congressional guidance we received in fiscal year 1976 when the HAC deleted all DoD drug and alcohol research funds and asserted that HEW should do research not peculiar to the military. These shared responsibilities underscore the importance of inter-service and interagency research coordination. This coordination is improving through direct liaison with these agencies and joint participation in research advisory committees. As a result we are in a better position to fully capitalize on new technology and research findings as they emerge.

Initiative No. 11: Develop and Test Program Evaluation Criteria

This initiative is designed to provide a more systematic evaluation of all aspects of the DoD drug/alcohol program. The current effort focuses on two elements of the program: Education and Treatment.

EDUCATION

The evaluation of education programs will be based on two criteria: Knowledge of drug/alcohol abuse subjects, and behavioral change. The original plan called for this effort to be based on studies of education and prevention programs conducted by NIDA, the Center for Disease Control (CDC) and a RAND study of the Air Force's education program. Only the RAND study was found useful for our analysis. The RAND study itself was not definitive, but it did raise doubts as to the effectiveness of frequent lectures (i.e., four hours at each permanent change of station). Based on the findings of the RAND study, ODAAP formed an Education Task Force to develop a more effective concept of education.

The task force completed its review of the drug and alcohol abuse education requirements for supervisors, nonsupervisors, and DoD civilian employees and DoD dependents in overseas locations in June 1979. The task force is presently identifying each target group within the DoD to receive education, and is developing general learning objectives for each group. Objectives have been completed for all military target groups: Enlisted personnel entering the military, officers entering the military, and personnel enrolled in professional military education courses. Objectives for civilian target groups will be completed by December 1979. On completion of this task, the revised education program will be coordinated with the Services and then issued as part of a DoD Directive. The Services will revise their current programs if necessary to meet the new objectives. The DoD education programs will then be evaluated using an approach similar to the RAND study of the Air Force education program. The evaluation is planned for late 1980.

The DoD has been able to evaluate its recently produced 26 television drug abuse spot announcements by using the NIDA Pretest Service. The spots were pilot tested using military audiences. Because of unfavorable evaluations, five of the spots will not be shown. Thirteen were rated good to excellent; the remainder received mixed reviews. NIDA has requested authority to use some of these spots in their national program. The NIDA Pretest Service will be used to evaluate all future DoD produced drug and alcohol abuse education materials.

TREATMENT

Treatment success has been defined as the satisfactory performance of duty as measured at specific times subsequent to admittance to treatment (180 and 360 days). Treatment includes those activities that are (1) medically supervised, or (2) carried out by designated treatment staff in a residential or nonresidential program designed to deal with drug or alcohol abuse. Satisfactory performance is defined as the individual who is on active duty at the designated time intervals *or*, if earlier separated, separation was at the normal expiration of service with a separation designation code that does not prevent reenlistment because of behavioral, drug abuse, or alcohol abuse reasons.

The ODAAP staff is working with the Services to incorporate the revised definition into our reporting system.

Initiative No. 12: Increase ASD(HA) Drug/Alcohol Staff

Action completed.

Initiative No. 13: Establish Formal Programs for Civilian Employees Overseas

A variety of formal programs now exists for civilian employees overseas, but more uniform standards are necessary. As an initial step, the DoD Directive on alcohol abuse, which is the more serious problem among civilian employees, has been revised and staffed. Final staffing and promulgation of the Directive should begin not later than December 1979.

An Action Planning Conference involving personnel responsible for civilian programs in each of the military Services and Defense Agencies, as well as Dependents Schools and NIAAA, is planned for 12–14 December 1979. This conference will develop a detailed action plan for civilian programs, the progress of which will be monitored by ODAAP and a representative committee of conference participants. Additionally, field trips to assess various civilian programs are currently being planned with emphasis placed on those activities overseas. DoD is also an active participant in meetings convened by OPM to develop a prevalence survey for Federal civilian employees.

Initiative No. 14: Military Services Assess Staffing

Both the Army and Air Force have significantly increased their resources in Germany, where the most serious drug problem appears to exist. The CINCEUR also asked for seven additional spaces for NAVEUR, but the Navy did not provide them. An ODAAP staff visit to Europe this fall will examine the NAVEUR staffing and evaluate its adequacy. ODAAP also considers the OPNAV drug/alcohol element to be understaffed. One billet will be added to the OPNAV staff in FY 81, but that will still leave the Navy staff as the smallest of the four services. We do not believe it is adequate to make the necessary field visits to monitor the program.

Overall, the services appear to have an adequate quantity of total resources authorized. The quality of personnel is of greater concern. The Army appears to have the most serious problem in this regard, but has several initiatives underway. The Army has authorized additional clinical directors in Germany and has upgraded the quality of its counselors to some degree. This is a long-time project, however, and will be difficult to achieve because of the shortage of senior NCOs in the Army.

We are also concerned about the current Navy policy regarding assignment of officers to the position of Director, Counseling and Assistance Center (CAAC), which is designated as an 01–02 billet. Since Navy's policy also has line officers spending the first 4–6 years in their primary specialty, there has been a disproportionate assignment of junior female officers to the CAAC director positions. This bothers us on two counts. First, limiting the billet to 01–02 ranks insures that the directors will be inexperienced from the standpoint of line duty. Secondly, the general impression gained by ODAAP field visits is that the position is becoming identified as a "female" billet. We believe this is detrimental to the Navy's program and represents a low priority being given these critical positions. We will continue to monitor this situation and if our impressions are verified, will recommend action to have the Navy modify its policy. The Navy's position with respect to this issue is attached.

We will request a personnel profile from each of the services as of January 31, 1980, and annually thereafter in conjunction with the budget submission. This will provide an improved perspective regarding program staff and permit management intervention, as appropriate.

DEPARTMENT OF THE NAVY,
OFFICE OF THE CHIEF OF NAVAL OPERATIONS,
Washington, D.C.

MEMORANDUM FOR SPECIAL ASSISTANT FOR DRUG ABUSE TO THE ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

Subject: Status report to the Deputy Secretary of Defense.
Reference: (a) ASD(HA) memo dtd 29 Aug 79.
Enclosure: (1) CAAC Officer Assignment Statistics

1. As requested by reference (a), an informal review has been conducted of the latest status report on the Duncan Initiatives concerned with drug and alcohol abuse among military personnel. The comments in Initiative No. 14 concerning adequacy of Navy program staff and disproportionate assignment of junior female officers to Counseling and Assistant Centers (CAACs) have been noted. Enclosure (1) provides current CAAC officer manning statistics. This memorandum clarifies Navy policy and practices regarding the assignment of officers to CAACs.

2. The Navy position concerning the assignment of officers to CAACs is not one of low priority, but rather it reflects the availability of quality personnel at grade levels commensurate with the primary CAAC mission, namely screening and referral of personnel evidencing various behavioral problems. There is no written or "understood" policy requiring assignment of junior female officers as stated. The higher proportion of female officers assigned to CAACs results in large part from the fact that presently most male line officers spend their initial 4–6 years pursuing their primary warfare specialty (i.e., at sea in ships, submarines, or in a flying billet). These reasons, coupled with legislative restrictions limiting assignment of women in combat billets and the greater availability of women line officers for shore duty tours of all types, provide a natural rationale to assign junior women officers to CAAC duty where they have demonstrated marked capability and have proved most effective in the Navy's drug program.

3. As with all the services, the Navy has a short fall of 03 male line officers that are assignable to these billets. Whenever possible detailers make every effort to assign such officers as CAAC Directors (which are mostly 03 billets) and attempt to maintain at least a 50 percent balance of male/female officers. Because of constraints outlined herein, there is little prospect for any significant changes in personnel assignments to CAACs in the near future. Within these considerations, the Navy's drug program is carefully monitored to ensure its continued effectiveness.

_____ _____,
Rear Admiral, U.S. Navy, Director, Human Resource Management.

CAAC OFFICERS

Rank	Male	Female	Total
0–1	1	[1] 7	8
0–2	3	8	11
0–3	8	12	20
0–4	1	0	1
Total	13	27	40

[1] 3 are assistant director.

Initiative No. 15. Improve Measures for Drug Abuse Identification

The purpose of this initiative is to increase the effectiveness of the means by which drug abusers are identified. Specifically, it prescribes:

Increasing the ability of commanders and supervisors to recognize the signs of drug abuse.

Assuring that drug abusers identified by military medical, law enforcement and investigative agency activity are referred to the individual's commander for appropriate action.

Assuring that drug abusers identified by civil authorities are referred to the individual's commander.

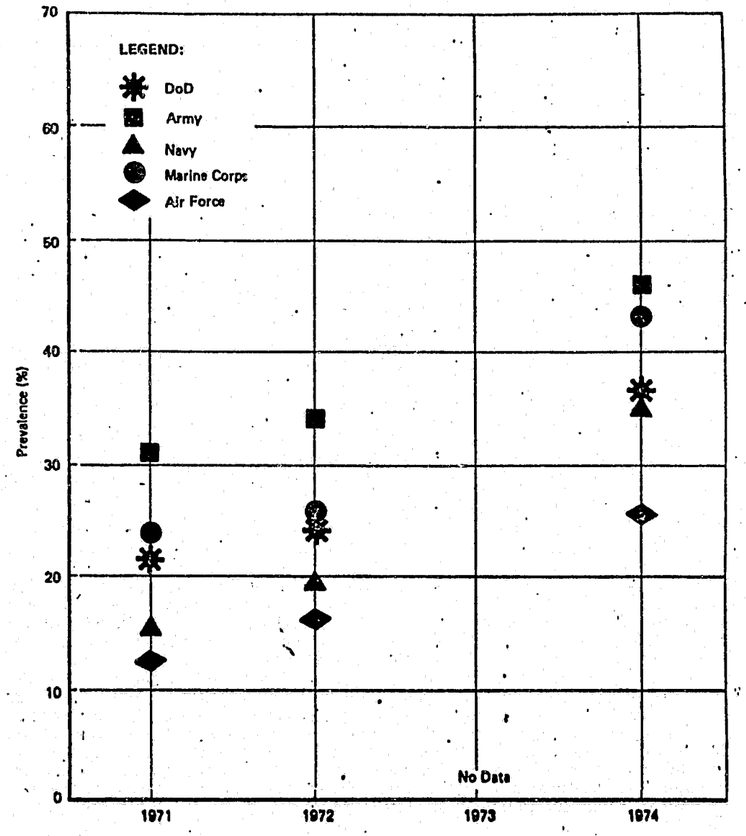
Increasing the awareness of the servicemember to the exemption policy whereby he may seek help without fear of punitive action.

Increasing the use of urinalysis by conducting unit sweeps and by ordering urinalysis in instances whereby a servicemember exhibits bizarre behavior or is involved in drug trafficking, crimes of violence, or serious incidents or accidents. In addition, the services were directed to maintain a minimum goal of urinalysis of .60 tests per individual per year for the target group population of individuals 25 years old and younger.

Instructions to accomplish these improved measures were issued by the Deputy Secretary of Defense in July 1978. In July 1979, the Special Assistant for Drug Abuse to the Assistant Secretary of Defense (Health Affairs) concluded that the requirement to maintain .60 urinalysis goal should be recinded and so recommended to the Deputy Secretary of Defense. It was felt that the minimum level requirement was resulting in de facto random urinalysis, confirmed drug abuse rates were low in some areas, and the policy was detrimental to command support of the overall drug and alcohol abuse control program. The Deputy Secretary of Defense approved the recommendation and so the .60 urinalysis goal was deleted while, at the same time, the requirement to test upon exhibition of bizarre behavior or in cases of apprehension for drug offenses, other crimes, incidents and accidents was reiterated. We will monitor the services' compliance with the new guidance through the quarterly urinalysis reports.

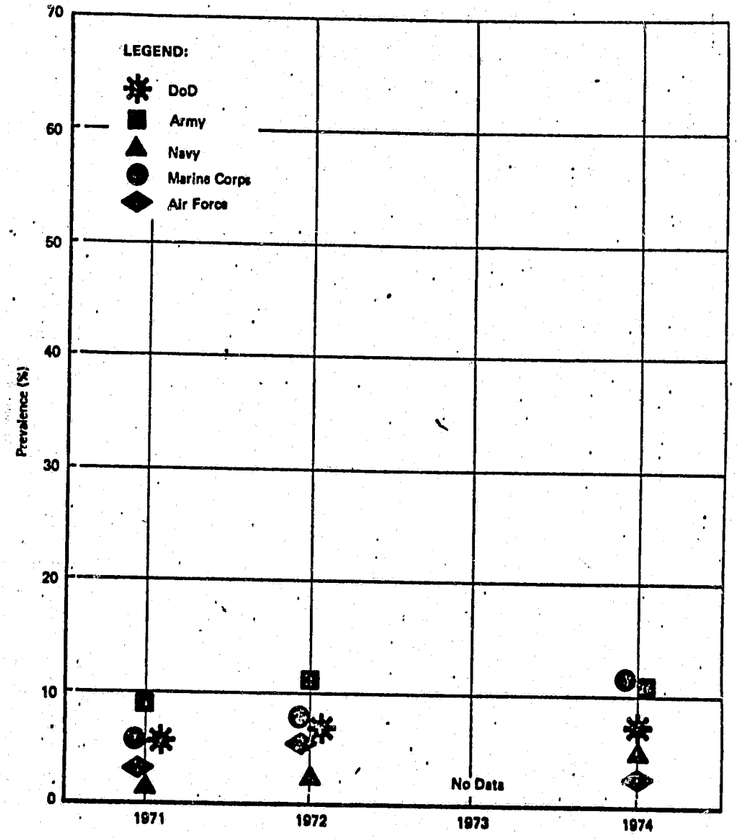
Appendix 3

Statistical Summaries



	1971	1972	1973	1974
DoD	21.7%	24.5%	–	38.5%
Army	31.2%	33.9%	–	45.9%
Navy	18.3%	19.5%	–	35.0%
Marine Corps	24.0%	26.4%	–	43.3%
Air Force	12.4%	16.5%	–	26.0%

TOTAL
CURRENT CANNABIS DERIVATIVE USE
JUNIOR ENLISTED PERSONNEL
1971–1974



	1971	1972	1973	1974
DoD	5.4%	6.9%	–	7.0%
Army	9.6%	11.0%	–	11.0%
Navy	1.8%	2.5%	–	5.1%
Marine Corps	5.4%	7.2%	–	11.3%
Air Force	2.4%	5.3%	–	2.9%

TOTAL
CURRENT NARCOTIC USE
JUNIOR ENLISTED PERSONNEL
1971–1974

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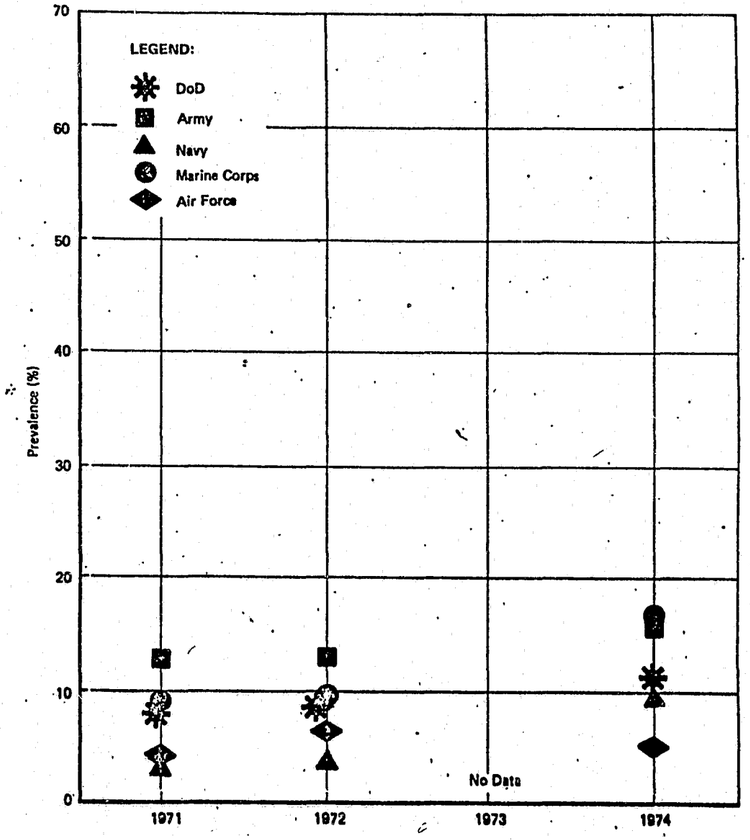
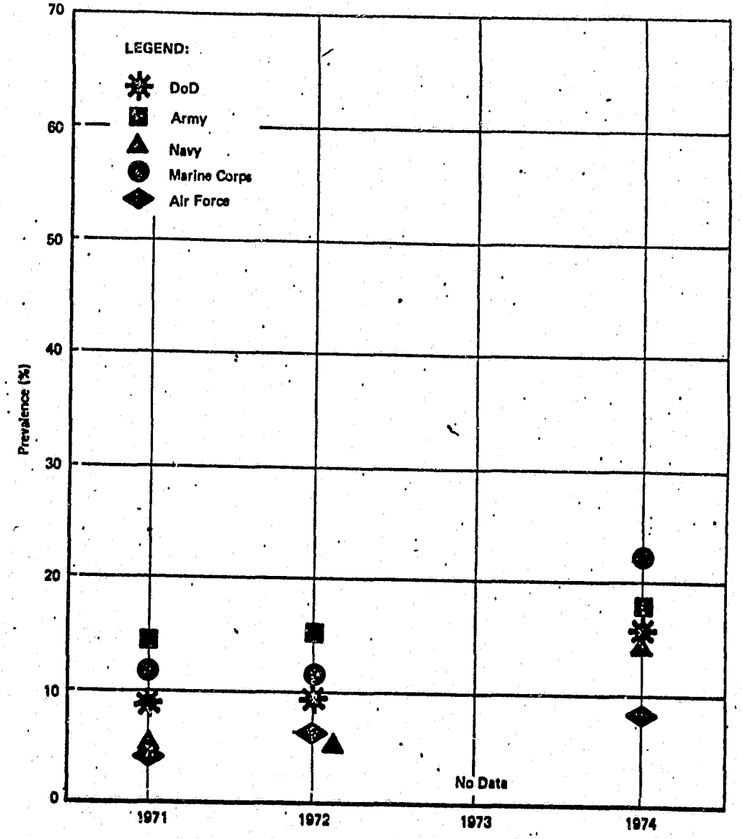


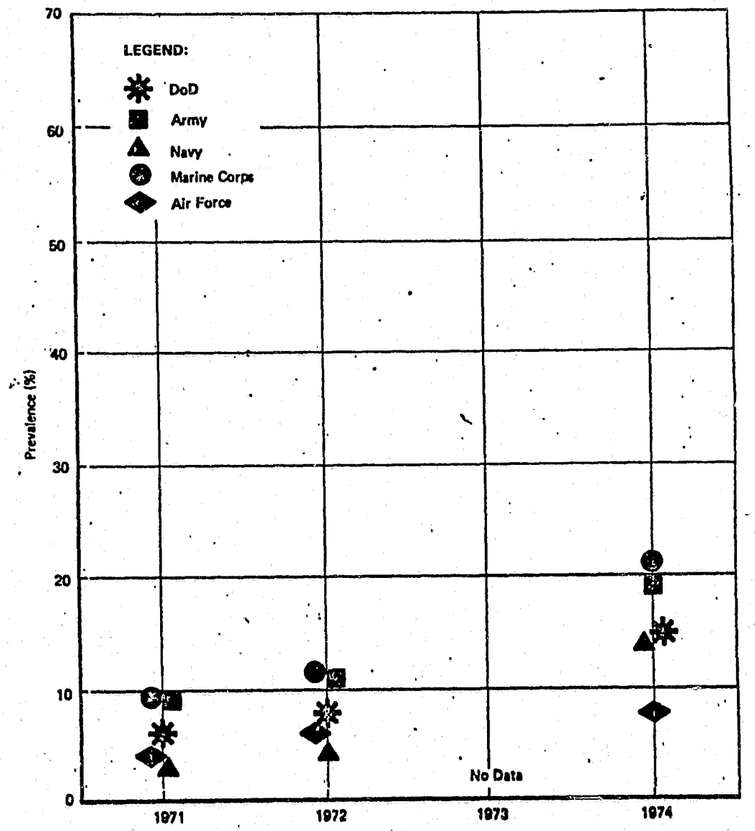
	1971	1972	1973	1974
DoD	7.8%	8.2%	–	11.1%
Army	13.3%	12.7%	–	16.1%
Navy	2.9%	3.6%	–	9.6%
Marine Corps	8.9%	9.2%	–	16.9%
Air Force	3.5%	6.3%	–	5.4%

TOTAL
CURRENT DEPRESSANT USE
JUNIOR ENLISTED PERSONNEL
1971–1974



	1971	1972	1973	1974
DoD	9.0%	9.7%	–	14.6%
Army	14.0%	14.3%	–	18.3%
Navy	5.0%	5.8%	–	14.6%
Marine Corps	12.4%	12.3%	–	22.7%
Air Force	3.9%	6.8%	–	8.4%

TOTAL
CURRENT STIMULANT USE
JUNIOR ENLISTED PERSONNEL
1971–1974



	1971	1972	1973	1974
DoD	6.1%	7.9%	–	14.3%
Army	9.2%	10.6%	–	19.3%
Navy	2.4%	4.1%	–	13.6%
Marine Corps	9.5%	11.4%	–	21.0%
Air Force	3.6%	6.9%	–	7.4%

TOTAL
CURRENT HALLUCINOGEN USE
JUNIOR ENLISTED PERSONNEL
1971–1974

ARMY HARD DRUG USE BY ENLISTED PERSONNEL, BY TERM OF SERVICE, BY GEOGRAPHICAL AREA

Question: Which of the following best describes your use of hard drugs such as heroin, LSD, etc., during the lasst 6 months? (Percent who answered sometimes or frequently.)

	Feb. 1974	Aug. 1974	Feb. 1975	Aug. 1975	Feb. 1976	Aug. 1976	Feb. 1977	Aug. 1977	Feb. 1978	Aug. 1978	Feb. 1979
First term:											
CONUS	13.7	14.1	10.9	11.3	12.7	11.1	7.3	8.7	8.2	10.8	10.1
Europe	14.8	17.5	15.4	21.9	15.1	12.6	10.4	13.3	12.3	14.7	10.1
Pacific	16.1	19.1	19.1	15.9	15.2	13.6	3.0	5.7	10.0	10.5	11.7
Armywide	14.3	15.6	12.9	14.4	13.7	11.6	8.0	9.6	9.5	11.8	10.2
Career:											
CONUS	4.0	4.3	3.8	5.5	6.8	3.7	3.2	4.3	2.8	4.6	5.5
Europe	5.8	9.6	5.0	8.7	6.6	4.5	3.2	4.2	4.1	4.8	5.5
Pacific	3.6	7.3	13.5	4.4	6.9	7.1	2.5	1.6	2.3	5.2	6.0
Armywide	4.4	6.2	5.1	6.3	6.7	4.5	3.2	4.0	3.0	4.7	5.6
All enlisted:											
CONUS	9.7	10.1	7.7	9.0	10.4	8.2	5.8	6.8	5.8	7.9	7.9
Europe	11.4	14.4	11.3	16.2	11.3	8.8	7.2	9.6	9.0	9.9	8.1
Pacific	10.3	13.5	16.6	9.8	11.0	10.3	2.8	3.7	6.6	7.7	8.6
Armywide	10.2	11.7	9.6	10.9	10.8	8.6	6.1	8.3	6.7	8.5	8.1

Source: HQDA "Quarterly Sample Surveys of Military Personnel."

ARMY MARIHUANA/HASHISH USE BY ENLISTED PERSONNEL, BY TERM OF SERVICE, BY GEOGRAPHIC AREA

Question: Which of the following best describes your use of marihuana or hashish during the last 6 months? (Percent who answered sometimes or frequently.)

	Feb. 1974	Aug. 1974	Feb. 1975	Aug. 1975	Feb. 1976	Aug. 1976	Feb. 1977	Aug. 1977	Feb. 1978	Aug. 1978	Feb. 1979
First term:											
CONUS	42.6	44.3	38.2	41.7	42.7	42.7	38.1	42.2	40.9	40.6	37.7
Europe	41.7	43.7	41.0	41.7	39.1	36.6	34.9	38.9	40.2	40.3	38.0
Pacific	50.1	53.3	46.4	47.6	47.2	53.9	37.6	45.3	39.5	36.4	40.0
Armywide	43.0	45.0	39.7	42.0	42.0	42.6	37.1	41.6	40.6	40.4	37.9
Career:											
CONUS	12.6	13.8	14.1	16.5	17.0	16.1	16.8	17.5	16.2	16.3	16.7
Europe	13.2	16.5	12.8	16.6	13.7	11.5	12.1	14.4	14.0	13.9	13.7
Pacific	13.1	21.4	26.9	18.6	22.8	24.5	16.0	18.5	15.7	15.8	13.2
Armywide	12.8	15.4	15.0	16.7	16.7	16.0	15.0	16.9	15.8	15.6	15.8
All enlisted:											
CONUS	30.1	31.9	27.8	31.4	32.7	32.7	29.9	32.0	30.2	29.3	28.0
Europe	31.0	33.3	29.7	30.9	27.9	24.9	24.6	28.6	29.8	27.6	27.2
Pacific	32.9	28.1	37.5	32.2	34.8	38.7	26.7	32.4	29.1	25.4	25.9
Armywide	30.6	33.1	29.3	31.1	31.5	31.7	27.9	31.2	31.1	28.7	27.7

Source: HQDA "Quarterly Sample Surveys of Military Personnel."

DOD WORLDWIDE URINALYSIS SCREENING, 1979

	1st quarter, 1979	2nd quarter, 1979	3rd quarter, 1979	4fth quarter 1979
Unannounced urinalysis screening rate per 1,000 personnel:				
DOD	96.7	104.4		
Army	88.4	108.3		
Navy	81.5	96.8		
Marine Corps	159.9	117.7		
Air Force	101.3	101.9		
Laboratory positive rate per 1,000 screened: [1]				
DOD	21.9	21.2		
Army	25.9	22.9		
Navy	19.9	21.2		
Marine Corps	20.2	23.1		
Air Force	19.6	17.8		
Clinical confirmation rate per 1,000 screened: [1]				
DOD	8.1	8.1		
Army	12.3	10.1		
Navy	5.6	7.5		
Marine Corps	9.0	13.5		
Air Force	4.6	3.9		

[1] Number shown are rates per 1,000 persons whose urine were screened. not rates per 1,000 persons in the force.

DOD CONUS URINALYSIS SCREENING, 1979

	1st quarter, 1979	2nd quarter, 1979	3rd quarter, 1979	4th quarter 1979
Unannounced urinalysis screening rate per 1,000 personnel:				
DOD	70.0	75.6		
Army	24.9	43.2		
Navy	41.5	63.4		
Marine Corps	132.1	101.7		
Air Force	98.0	84.4		
Laboratory positive rate per 1,000 screened:				
DOD	22.3	22.7		
Army	31.5	28.6		
Navy	21.8	21.1		
Marine Corps	20.3	23.9		
Air Force	20.9	20.1		
Clinical confirmation rate per 1,000 screened:				
DOD	7.0	7.3		
Army	10.9	8.3		
Navy	6.1	6.5		
Marine Corps	10.4	13.5		
Air Force	5.2	4.7		

DOD EUROPE URINALYSIS SCREENING, 1979

	1st quarter, 1979	2d quarter, 1979	3d quarter, 1979	4th quarter, 1979
Unannounced urinalysis screening rate per 1,000 personnel:				
DOD	200.3	237.0		
Army	248.5	279.9		
Navy	65.2	90.3		
Air Force	151.7	224.8		
Laboratory positive rate per 1,000 screened:				
DOD	22.1	19.3		
Army	25.6	22.1		
Navy	6.2	10.8		
Air Force	10.7	11.4		
Clinical confirmation rate per 1,000 screened:				
DOD	10.6	9.1		
Army	13.1	11.2		
Navy	2.3	4.2		
Air Force	1.6	3.0		

DOD PACIFIC URINALYSIS SCREENING,[1] 1979

	1st quarter, 1979	2d quarter, 1979	3d quarter, 1979	4th quarter 1979
Unannounced urinalysis screening rate per 1,000 personnel:				
DOD	170.3	127.1		
Army	32.6	50.4		
Navy	350.1	267.4		
Marine Corps	363.0	185.5		
Air Force	88.6	93.0		
Laboratory positive rate per 1,000 screened:				
DOD	19.3	20.5		
Army	12.7	2.7		
Navy	13.4	24.9		
Marine Corps	20.0	18.6		
Air Force	32.4	25.3		
Clinical confirmation rate per 1,000 screened:				
DOD	4.4	6.3		
Army	2.5	1.1		
Navy	.9	8.4		
Marine Corps	6.8	3.8		
Air Force	6.2	1.2		

[1] The Pacific summary statistics are aggregates of the country/regions Guam, Japan/Okinawa, Philippines, and South Korea.

DOD OTHER PACIFIC URINALYSIS SCREENING, 1979

	1st quarter, 1979	2d quarter, 1979	3d quarter, 1979	4th quarter, 1979
Unannounced urinalysis screening rate per 1,000 personnel:				
DOD	282.2	266.6		
Army	67.6	44.8		
Navy	468.1	423.2		
Marine Corps	160.2	254.3		
Air Force	35.7	55.0		
Laboratory positive rate per 1,000 screened:				
DOD	22.9	25.2		
Army	11.1	13.1		
Navy	29.5	25.0		
Marine Corps	23.4	29.1		
Air Force	66.0	36.7		
Clinical confirmation rate per 1,000 screened:				
DOD	8.7	12.2		
Army	7.1	13.1		
Navy	7.6	10.7		
Marine Corps	21.3	22.4		
Air Force	23.6	9.2		

DOD WORLDWIDE CONFIRMED POSITIVE URINALYSIS RATE PER 1,000 SCREENED, BY DRUG TYPE

Drug type	1st quarter, 1979	2nd quarter 1979
Narcotics	2.6	2.1
Amphetamines	1.3	1.6
Barbiturates	1.7	1.7
Cocaine	.1	0
Methaqualone	.8	.6
PCP	.3	.5
Other	1.0	1.2
Polydrug	.3	.4
Total	8.1	8.1

DOD CONUS CONFIRMED POSITIVE URINALYSIS RATE PER 1,000 SCREENED, BY DRUG TYPE

Drug type	1st quarter 1979	2nd quarter 1979
Narcotics	0.7	0.6
Amphetamines	1.1	1.2
Barbiturates	2.4	2.1
Cocaine	0	0
Methaqualone	.1	.2
PCP	.6	1.2
Other	1.8	1.8
Polydrug	.3	.2
Total	7.0	7.3

DOD EUROPE CONFIRMED POSITIVE URINALYSIS RATE PER 1,000 SCREENED, BY DRUG TYPE

Drug type	1st quarter 1979	2nd quarter 1979
Narcotics	5.9	4.4
Amphetamines	1.5	1.8
Barbiturates	.6	.7
Cocaine	0	0
Methaqualone	2.3	1.7
PCP	0	0
Other	.1	.1
Polydrug	.4	.4
Total	10.7	9.1

DOD PACIFIC CONFIRMED POSITIVE URINALYSIS RATE PER 1,000 SCREENED, BY DRUG TYPE

Drug type	1st quarter, 1979	2d quarter, 1979
Narcotics	1.6	1.9
Amphetamines	.8	1.7
Barbiturates	1.8	2.2
Cocaine	.1	0
Methaqualone	.1	0
PCP	0	0
Other	.1	.3
Polydrug	.4	.2
Total	4.5	6.3

DOD OTHER PACIFIC CONFORMED POSITIVE URINALYSIS RATE PER 1,000 SCREENED, BY DRUG TYPE

Drug type	1st quarter, 1979	2d quarter, 1979
Narcotics	1.5	0.6
Amphetamines	1.7	2.7
Barbiturates	2.2	3.4
Cocaine	.3	.4
Methaqualone	.1	0
PCP	.5	0
Other	1.8	3.6
Polydrug	.6	1.4
Total	8.7	12.1

DOD WORLDWIDE ADMISSION AND TREATMENT RATES, 1979

	1st quarter, 1979	2d quarter 1979
Treatment admission rate per 1,000 personnel [1]:		
Alcohol	4.57	5.74
Drugs	5.22	4.97
Total	9.79	10.71
Medical treatment admission rate per 1,000 personnel:		
Alcohol	.82	.80
Drugs	.15	.13
Total	.97	.93
Resident treatment admission rate per 1,000 personnel:		
Alcohol	.64	1.10
Drugs	.25	.31
Total	.89	1.41
Nonresident treatment admission rate per 1,000 personnel:		
Alcohol	3.93	4.64
Drugs	4.97	4.66
Total	8.90	9.30

ARMY WORLDWIDE ADMISSION AND TREATMENT RATES, 1979

	1st quarter, 1979	2d quarter, 1979
Treatment admission rate per 1,000 personnel: [1]		
Alcohol	5.06	5.39
Drugs	2.65	2.76
Total	7.71	8.15
Medical treatment admission rate per 1,000 personnel:		
Alcohol	.03	.06
Drugs	.08	.01
Total	.11	.07
Resident treatment admission rate per 1,000 personnel:		
Alcohol	.27	.41
Drugs	.05	.09
Total	.32	.50
Nonresident treatment admission rate per 1,000 personnel:		
Alcohol	4.79	4.98
Drugs	2.60	2.67
Total	7.39	7.65

NAVY WORLDWIDE ADMISSION AND TREATMENT RATES, 1979

	1st quarter, 1979	2nd quarter, 1979
Treatment admission rate per 1, 000 personnel: [1]		
Alcohol	3.93	5.01
Drugs	7.79	6.61
Total	11.72	12.62
Medical treatment cdmission rate per 1,000 personnel:		
Alcohol	1.42	1.46
Drugs	.36	.33
Total	1.78	1.79
Resident treatment admission rate per 1,000 personnel:		
Alcohol	1.41	2.63
Drugs	.41	.44
Total	1.82	3.07
Nonresident treatment admission rate per 1,000 personnel:		
Alcohol	2.52	2.38
Drugs	7.38	7.17
Total	9.90	9.55

MARINE CORPS WORLDWIDE ADMISSION AND TREATMENT RATES, 1979

	1st quarter, 1979	2d qurater, 1979
Treatment admission rate per 1,000 personnel: [1]		
Alcohol	15.12	16.65
Drugs	11.99	10.19
Total	27.11	26.84
Medical treatment admission rate per 1,000 personnel:		
Alcohol	1.30	1.01
Drugs	.44	.42
Total	1.74	1.43
Resident treatment admission rate per 1,000 personnel:		
Alcohol	.39	1.34
Drugs	.19	.20
Total	.58	1.54
Nonresident treatment admission rate per 1,000 personnel:		
Alcohol	14.73	15.31
Drugs	11.80	9.99
Total	26.53	25.30

AIR FORCE WORLDWIDE ADMISSION AND TREATMENT RATES, 1979

	1st quarter, 1979	2d quarter, 1979
Treatment admission rate per 1,000 personnel: [1]		
Alcohol	3.19	3.29
Drugs	4.01	3.75
Total	7.20	7.04
Medical treatment admission rate per 1,000 personnel:		
Alcohol	1.09	1.10
Drugs	0	0
Total	1.09	1.10
Resident treatment admission rate per 1,000 personnel:		
Alcohol	.51	.50
Drugs	.38	.50
Total	.89	1.00
Nonresident treatment admission rate per 1,000 personnel:		
Alcohol	2.68	2.79
Drugs	3.63	3.25
Total	6.31	6.04

CONTINUED

1 OF 2

ARMY WORLDWIDE TREATMENT COMPLETION RATE PER 1,000 DISCHARGES, 1979

	1st quarter, 1979	2d quarter, 1979
Treatment completion rate per 1,000 discharges: [1]		
Alcohol	933	933
Drug	921	926
Overall	928	930
Resident completion rate per 1,000 discharges:		
Alcohol	990	982
Drug	971	1,000
Overall	987	986
Nonresident completion rate per 1,000 discharges:		
Alcohol	929	930
Drug	920	923
Overall	925	927

NAVY WORLDWIDE TREATMENT COMPLETION RATE PER 1,000 DISCHARGES, 1979

	1st quarter, 1979	2nd quarter, 1979
Treatment completion rate per 1,000 discharges: [1]		
Alcohol	887	845
Drug	943	955
Overall	925	910
Resident completion rate per 1,000 discharges:		
Alcohol	876	884
Drug	995	1,000
Overall	901	898
Nonresident completion rate per 1,000 discharges:		
Alcohol	893	816
Drug	940	952
Overall	929	914

MARINE CORPS WORLDWIDE TREATMENT COMPLETION RATE PER 1,000 DISCHARGES, 1979

	1st quarter, 1979	2d quarter, 1979
Treatment completion rate per 1,000 discharges: [2]		
Alcohol	802	815
Drug	794	860
Overall	799	832
Resident completion rate per 1,000 discharges:		
Alcohol	958	846
Drug	640	763
Overall	875	835
Nonresident completion rate per 1,000 discharges:		
Alcohol	798	812
Drug	796	862
Overall	797	832

AIR FORCE WORLDWIDE TREATMENT COMPLETION RATE PER 1,000 DISCHARGES, 1979

	1st quarter, 1979	2d quarter, 1979
Treatment completion rate per 1,000 admissions: [2]		
Alcohol	650	646
Drug	500	528
Overall	565	579
Resident completion rate per 1,000 admissions:		
Alcohol	908	939
Drug	899	833
Overall	905	886
Nonresident completion rate per 1,000 admissions:		
Alcohol	611	594
Drug	474	487
Overall	531	533

[1] Treatment admission rate=resident treatment admission rate+nonresident treatment admission rate. Medical treatment admissions constitute a separate category for purposes of this analysis.
[2] Treatment completion is defined as ". . . those whose treatment and rehabilitation is considered successful, is completed, and who are returned to duty or separated from the service."

SERVICEMEMBERS PUNISHED UNDER THE UNIFORM CODE OF MILITARY JUSTICE FOR DRUG OFFENSES WORLDWIDE

	No.	Rate per 1,000
1975	39,899	18.8
1876	42,533	20.4
1977	42,444	20.5
1978	42,736	20.7

SERVICEMEMBERS IDENTIFIED AS DRUG ABUSERS THROUGH THE EXEMPTION POLICY WORLDWIDE

	No.	Rate per 1,000
1975	7,488	3.5
1976	6,072	2.9
1977	4,207	2.0
1978	3,893	1.9
1979 [1]	3,768	1.8

[1] Estimate based on self-referrals for first half of 1979.

SUMMARY ANALYSIS OF INSTALLATIONS WITH AND WITHOUT COUNSELING ACTIVITY, BY SERVICE, FOR CIVILIAN EMPLOYEES

Agency	Total employees	Category	New cases	Penetration	Percent helped	Staff years	Staff years (thousands)	Number of installations	Percent total installations	Number of employees	Percent total employees	Penetration	Staff years (thousands)	Number of installations	Percent total installations	Number of employees	Percent total employees	Staff year (thousands)
Department of the Army	325,702	A	3,257	1.00	82	165.7	0.51	121	77	307,965	95	1.06	0.52	37	23	17,737	5	0.29
		D	331	.10	81			51	32	178,844	55	.19	.58	107	68	146,858	45	.42
		E	8,056	2.47	95			81	51	249,576	77	3.23	.47	77	49	76,126	23	.63
Department of the Navy	289,277	A	1,648	.57	73	71.9	.25	178	60	249,473	86	.66	.25	120	40	39,804	14	.21
		D	123	.04	65			41	14	109,983	38	.11	.27	257	86	179,294	62	.24
		E	1,284	.44	84			122	41	212,636	74	.60	.24	176	59	76,641	26	.28
Department of the Air Force	232,019	A	1,284	.55	83	53.6	.23	89	71	212,213	91	.61	.23	37	29	19,806	9	.22
		D	33	.01	71			15	12	93,734	40	.04	.19	111	88	138,285	60	.26
		E	0	0	0			0	0	0	0	0	0	126	100	232,019	100	.23

APPENDIX 4

DRUG ABUSE CONTROL IN EUROPE

The drug abuse control problem in Europe is considerably aggravated by the purity, cheapness, and easy availability of narcotics. Street level purity of heroin is about ten times that in the United States. This heroin is about 20 times cheaper per gram in Frankfurt than in New York City. Heroin had been expected to become more available in 1979, and we see no slackening in this trend for 1980. Drug availability appears to be increasing across most of Central Europe.

To reduce the impact of these readily available drugs on our people and our mission, Department of Defense agencies launched a comprehensive effort during 1978.

Addressing our law enforcement initiatives first, Headquarters, U.S. European Command (EUCOM) established a Special Assistant to CINCEUR on Drug Enforcement Matters (SADEM). The task of this office has been to interface between all U.S. military law enforcement activities in Europe, drug investigators and law enforcement personnel of host nations, and other U.S. activities in country, such as the Drug Enforcement Agency, Embassy Narcotics Coordinators, and U.S. Customs. SADEM has been functioning effectively and law enforcement efforts in Europe, particularly Germany, are significantly improving.

In response to the drug threat, EUCOM, the Army, and the Air Force have increased funds for programs and the number of law enforcement personnel dedicated to drug enforcement. Nineteen Criminal Investigators (CID), 45 military police, 16 Office of Special Investigations (OSI) agents, and 31 Security Policemen have been authorized. The number of drug detection dog authorizations have been increased to 103 for the Air Force and 23 for the Army military police. The capability of the military forensic laboratory for the examination of drug evidence has been improved. Production of drug intelligence, policy, and operational matters, including deployment of available assets to drug "hot spots" has been centralized and rendered more efficient.

Department of Defense components are participating actively in a number of narcotics working groups in Europe. The German Federal Criminal Police (BKA) established a permanent working group on Narcotics. This working group was followed by creation of several regional working groups. In addition to DEA and U.S. Customs, U.S. Military law enforcement and customs agencies participate in these multinational groups which deal with all aspects of drug enforcement programs.

Military members are also actively involved in the Central Working Group composed of representatives of German ministries and specialists designated by the U.S. Embassy. This body resulted from the United States-German Norcotics Control Agreement signed on 9 June 1978. Army and Air Force representatives play key roles on the Subcommittee on Prevention and Medicine, the Subcommittee on the Military, the Legal Subcommittee, and the Subcommittee for Police and Customs Enforcement Measures.

In addition to these coordination and working groups, DoD agencies are working with the State Department to involve the NATO structure in our efforts to attack the sources of supply and international transportation of drugs. Although it is too early to discuss results of this initiative, this effort to keep the drug problem visible at the highest levels of government is expected to be helpful.

In concert with these EUCOM and multi-agency initiatives, the Army and the Air Force are operating comprehensive drug abuse control programs for their own people.

HQ, US Army Europe as published and implemented a "USAREUR Action Plan for the Reduction of Drug Abuse" (19 April 1979) and a "Commanders, Supervisors, and Staff Officers Guide to the USAREUR Alcohol and Drug Abuse Prevention and Control Program" (17 May 1979). Drug suppression was em-

phasized as the number one law enforcement priority, and resources dedicated to it were nearly doubled. The Drug Suppression Operations Center (DSOC) was established to provide central management of the drug suppression effort.

The increased effort is beginning to show results. Drug sales and trafficking cases are up 100 percent in the last year. The dollar value of drugs seized in 1979 is already four times last year's total. Drug related courts-martial for April–June 1979 increased 137 percent over the previous quarter. Commander directed urine tests have been averaging 16,000 tests per month. With these intensified efforts, the number of newly identified drug abusers is decreasing, as are discharges for drug abuse.

Changes to the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) are improving critical elements of education, assistance, treatment and rehabilitation. Drug Education and Assistance Teams have been formed to assist communities in improving their programs. Thirty clinical directors and 40 civilian counselor spaces were authorized by the Army to improve rehabilitation services. Ability to assess "hot spots" has been improved. Research on drug deaths is underway, with an eye toward preventing them in the future.

HQ US Air Forces Europe implemented "Operation Counterpush" to reduce the impact of growing availability of drugs. Counterpush is a three-pronged attack covering interdiction, identification, and education. The initial action plan published in September 1978 outlined 26 initiatives in these areas.

Interdiction efforts focused on intensified law enforcement. Investigative staffs were increased 52 percent. The number of drug detector dogs was increased by 130 percent and will increase by 232 percent (103 dogs). The law enforcement efforts are orchestrated by a Narcotics Advisory Board (NAB) which monitors law enforcement activities throughout the command and insures interface with USAREUR's Drug Suppression Operations Center (DSOC) as well as with EUCOM's Special Assistant for Drug Enforcement (SADEM).

Identification initiatives focus on demand reduction. USAFE is attempting to visibly create an environment that is inhospitable to drug abuse. Law enforcement is aggressive, drug users run a high risk of getting caught, punishment is swift, consistent, and predictable. Deserving people who are caught are disciplined and given a second chance but suppliers, repeat offenders, and addicts are disciplined and separated. Urine testing levels are high. Rehabilitation programs are publicized and are run by highly trained drug and alcohol abuse control specialists. Education efforts are targeted to all elements of the community, with curricula tailored to the needs and characteristics of the audience. These efforts include annual commander-supervisor seminars, first-termers' seminars upon arrival in the theatre, cannabis experimenters' eight-hour remedial education seminars, classes detailing legal penalties encountered when traveling to other countries, briefing for CONUS units deploying to USAFE, youth involvement programs, mass media campaigns, and a spontaneously generated anti-drug abuse peer pressure movement.

Disciplinary and administrative discharge actions have increased substantially, particularly General Courts-Martial cases for serious offenders. High urine test levels have continued and the number of confirmed positives has been declining, except for cocaine. A full range of tools and resources are and will continue to be committed to combatting the drug problem in US Air Forces Europe.

The U.S. Navy in Europe has significantly fewer permanently stationed personnel in Europe than do the Army and Air Force, and most of these are based outside of Germany, the current area of highest drug availability. The Navy does not perceive a significant drug problem among their forces in Europe. Drug abuse control programs are in place and functioning, but not with the intensity evidenced by the Army and Air Force. We are presently assessing the nature of the drug problem among Navy forces in Europe and are increasing our emphasis.

The Office of the Secretary of Defense (Health Affairs) has been closely monitoring and supporting drug abuse control efforts in Europe. Visits have been frequent, program trends and developments have been closely monitored, and supportive or corrective action has been taken where necessary. This involvement and emphasis will continue.

Appendix 5

The Deputy Secretary of Defense,
Washington, D.C., July 24, 1979.

Memorandum for the Secretary of the Army, Secretary of the Navy, and Secretary of the Air Force

Subject: Improved Measures for Drug Abuse Identification

This memorandum rescinds the minimum level of urinalysis for drug abuse detection established by Enclosure 7 to my memorandum to the Secretaries of the Military Departments dated July 11, 1978.

DoD policy with respect to urinalysis for drug abuse detection is as follows:

"Urine tests will be conducted expeditiously when certain incidents occur which indicate the probable involvement of drugs or alcohol. Although the decision to test will often be a command judgment, tests normally will be conducted when behavior is bizarre or unusually aberrant and when a person has been apprehended, or is being investigated, for drug abuse, crimes of violence, serious accidents, or drunkenness. Other incidents involving repeated or serious breaches of discipline should be examined in the context of other circumstances to determine if there is a probable involvement of drug or alcohol abuse. Where such probability is determined to exist, urine tests will be conducted expeditiously.

"The intent of this revised policy is to relate urine tests to incidents which have been shown to be often associated with drug or alcohol abuse. Commanders should continue to make judicious use of command-directed urinalysis, to include unit sweeps where appropriate, especially in areas where there is a high availability of hard drugs or there is a serious problem with drug and alcohol abuse."

Services are requested to monitor the implementation of this policy closely to ensure the intent of the policy is carried out. Addresses are requested to provide the Assistant Secretary of Defense (Health Affairs) with two copies of the implementing instructions within 60 days of the date of this memorandum.

C. W. Duncan, Jr.

APPENDIX 6

THE DEPUTY SECRETARY OF DEFENSE,
Washington, D.C., May 15, 1979.

Hon. GLENN ENGLISH,
House of Representatives,
Washington, D.C.

DEAR MR. ENGLISH: This is in further reply to your letter of January 16, 1979 in which you asked for the Department of Defense views on initiatives you have suggested for our Drug and Alcohol Abuse Prevention Program. As you will note from the attached comments, the Department of Defense is in fundamental agreement with the objectives you have in mind. Our differences are based on legal/administrative reasons rather than philosophical approach.

Your continued interest in the Department of Defense Drug and Alcohol Abuse Prevention Program is appreciated, and we welcome any further suggestions you may have on how we might improve our program.

Sincerely,

C. W. DUNCAN, Jr.

Enclosures 2.

DEPARTMENT OF DEFENSE POSITION ON INITIATIVES PROPOSED BY CONGRESSMAN GLENN ENGLISH

1. The West German government must be urged in the strongest possible terms to substantially increase the priority placed on reducing the availability of drugs in West Germany.

DoD Position.—We agree that the cooperation of the West German Government in controlling the drug traffic is important and should be actively elicited by the State Department. We have seen substantial progress during the past six months and hope the momentum is maintained.

The Army has established liaison with the Office of the Assistant Secretary of State for International Narcotics Control Matters with the purpose of expressing the Army's concern for the international drug traffic in Europe and the availability of these drugs to Army personnel and to determine State Department initiatives in this area.

The State Department has provided representation on the recently instituted DA Drug and Alcohol Review Board (DARB). The State Department efforts in establishing a Central Working Group, in conjunction with the Federal Republic of Germany, to examine and develop recommendations to deal with the problem of drug abuse in Germany appear to have the possibility of being most fruitful in increasing German awareness and action on this problem. At levels where the Army interfaces with German authorities, it appears that there is an awareness of and a sincere effort to cooperate in dealing with the drug problem. This Central Working Group had its second meeting on 21 February 1979 in Bonn, Germany.

The Berlin Task Force, consisting of U.S. Military, Embassy, and Berlin officials, was established to identify and suppress drug trafficking routes into and through Berlin. Efforts to date include increased police and customs seizures, community education, and local rehabilitation program improvements.

2. Authority should be granted to the Department of Defense to appeal court decisions beyond the Court of Military Appeals.

DoD Position.—During the 95th Congress there was a proposal at committee level in the Senate which would grant the Fourth Circuit of the United States Court of Appeals appellate jurisdiction over final decisions by the U.S. Court of Military Appeals (USCMA). Whether the bill will be reintroduced is unknown.

The Code Committee, which consists of the USCMA judges, the service judge advocates general, and the General Counsel, Department of Transportation, is considering legislative proposals which would provide for review of USCMA decisions by the Supreme Court on petition for certiorari.

In addition, the General Counsel of the Department of Defense has undertaken a major study of military appellate procedures. That study, which will be completed in the near future, will consider a number of alternative proposals for obtaining review of court-martial cases in the federal courts. We shall provide you with a copy of the study upon completion.

3. Careful study should be given to the possibility of shortening the length of tours of duty in Europe for single or unaccompanied junior enlisted personnel to 18 months.

DoD Position.—The requirements for tour length in Europe differ for the Army and Air Force, which have the bulk of forces in Germany. The Air Force believes it desirable to retain the 24-month tour for its first termers. DoD believes that is a sound decision. The Army has just completed a thorough study of this issue and has recommended a shortened tour for certain personnel. We will inform you of the OSD decision. The Navy and Marine Corps do not desire to make changes in the tour length of their personnel. DoD concurs in those decisions.

4. Drug and Alcohol Abuse Boards should be created. These panels should include the units' Commanding Officer, a Medical Doctor, a Chaplain, and a representative of a military Drug and Alcohol Abuse Center. The board should have the authority and the responsibility to determine what actions should be taken to rehabilitate abusers, including the following options.

DoD Position.—We concur with the concept of an advisory board to determine the disposition of identified drug abusers, with the final decision made by the commander. Each of the Services has such an arrangement now in being, but membership on the board varies among Services. No Service requires a Chaplain to be involved in the disposition process; however, all clients have the choice of having spiritual and legal counseling by Chaplains and legal personnel if they so desire. Chaplains may be included on Air Force Rehabilitation Committees at the option of the commander (standard practice when a Chaplain was the first point of contact, when the individual is active in base religious activities, or when the individual so requests. In all Services, the Chaplains have a vital role in the drug/alcohol abuse prevention program.

(a) Enrollment in a short drug and alcohol abuse education program during off-duty hours.

DoD Position.—The Air Force, Navy, and Marines have such programs in being, although some are on-duty. Whether it is on- or off-duty is a local command perogative, as we believe it should be. There are arguments for both, and we do not wish to dictate this detail. The Army is considering a pilot program for a short course on alcohol abuse and a similar course for drug abuse. In practice, many Army installations, e.g., Ft. Bragg, already have such courses. We believe this is a sound proposal and we plan to include it in policy guidance now being revised.

(b) Enrollment in a full-time comprehensive education and counseling program at a military counseling center.

DoD Position.—All Services have such an option.

(c) Assignment to temporary duty for intensive retraining.

DoD Position.—The Army and Marine Corps have such programs at some locations for "marginal" personnel, which may include drug users. The Strategic Air Command has such a program specifically for drug abusers. There is no such facility in Europe, however. The Army examined the feasibility of establishing a facility in Germany similar to that at Ft. Riley, Kansas, but concluded that it is infeasible due to manpower shortages and insufficient resources. The Army prefers to put its resources into better trained personnel down at the battalion level and is now testing a concept to place an additional officer, trained in human resources management, in each battalion.

DoD believes the "retraining" concept has some merit as a means for increasing motivation and improved performance by building a sense of self-esteem, confidence, and discipline in trainees. The various programs run by the Services appear to do that well. We have concluded, however, that the Army should be allowed to solve this problem in its own way. The concept to strengthen the human resources management at battalion level appears sound.

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(d) Assignment to the Veterans Administration for personnel with a physical or psychological dependence.

DoD Position.—The Services nonconcur with this recommendation, prefering to conduct rehabilitation efforts within a military environment if the individual is to be returned to duty. This is consistent with psychiatric findings that treatment should be as close to the patient's everyday living environment as possible. All Services believe the current DoD facilities for treatment of both drug- and alcohol-dependent personnel are the best available. These DoD facilities employ very few medical doctors and thus are not viewed as a significant drain of medical resources.

The Navy facility at Miramar, California, generally regarded as one of the best drug rehabilitation facilities, accommodates all Navy and Marine personnel who are drug dependent and who have potential for further service. The Air Force policy is to discharge and transfer to the Veterans Administration (VA) all drug-dependent personnel after detoxification rather than return them to duty. The Army has its own treatment facilities and returns to duty those who demonstrate a potential for useful service. Most of the Army's residential patients are in the overseas areas and should be treated there rather than within CONUS, where VA facilities are located.

DoD has explored the use of VA facilities for treatment of both alcoholics and drug-dependent personnel who have potential for further service and is developing an agreement with the VA to test the use of VA facilities for treating alcoholics. Based on the results of that test, DoD will make a decision regarding a permanent relationship for a more extended treatment agreement. For the reasons cited above, we do not have a need for use of VA facilities at this time for treatment of drug-dependent personnel who are to be returned to duty.

(e) Recommendation of a Chapter IX (Drug or Alcohol Abuse) discharge for those individuals who refuse all rehabilitation assistance.

DoD Position.—The current policy is to discharge those individuals who refuse treatment or who are repeated offenders.

5. Legislative action should be taken to broaden the options for Chapter IX discharges to allow not only Honorable Discharges, but also General Discharges under Honorable conditions for drug abusers. Provision should also be made to allow Chapter IX discharges with or without Veterans benefits, depending upon the circumstances.

DoD Position.—Flexibility in the type of administrative discharge that could be given for drug abuse, to include determination of Veterans Benefits, would be useful. Many of the administrative discharges now given, however, are based on evidence that might not be available if general discharges were given. The Court of Military Appeals (CMA) ruled in United States vs. Ruiz (1974) that a soldier's statutory right against self-incrimination prohibts the involuntary taking of urine samples if the test results thereof are to be used against the soldier. If general administrative discharges were to be given based on urine tests, we could expect personnel to refuse to give samples. The flexibility would still be useful for cases other than those identified through urinalysis, but it would be more useful if the CMA decision on urine tests could be overturned.

6. Personnel who have been charged with drug trafficking violations should be removed from their regular barracks pending court-martial.

DoD Position.—We agree with the objective of this proposal, i.e., to prevent the continuation of trafficking by suspected traffickers. There are administrative problems which make such a policy infeasible in some instances, however. Also, each case must be judged on its own merits. To establish a central policy that requires all charged traffickers to be removed from their regular barracks, then, is undesirable. We believe the present policy, which permits the local commander to decide this matter, is the most judicious way to achieve the objective.

7. The military should actively recruit senior NCOs for the drug and alcohol counseling program who have demonstrated compassion and proven their ability to command respect from both junior personnel and the officer corps.

DoD Position.—The Air Force, Navy, and Marine Corps make extensive use of senior NCOs as counselors. The Army has a long-range goal to have human resources management counselors where high caliber, professional NCOs with proper training will be the standard. The Army has already identified several such individuals for assignment to USAREUR as counselors. The Office, Drug and Alcohol Abuse Prevention believes the use of such NCOs is essential to the success of the programs.

8. The Department of Defense should institute a service-wide policy prohibiting the sale of alcoholic beverages during normal duty hours.

DoD Position.—It is DoD policy to discourage the consumption of alcohol just prior to or during working hours (prudent consumption with a meal is excepted), and to encourage moderation when alcohol is used at other times.

The revision of the DoD Directive, Alcohol Abuse by Personnel of the Department of Defense (currently being staffed), will state, "Practices which tend to encourage or glamorize the use of alcohol will be avoided." The directive will include an enclosure describing specific practices that will be followed or discontinued. Enclosure two is illustrative of what the Services now have as policy.

Action beyond the above has been considered, but would adversely impact on those whose duty periods occur at times other than the normal duty day, people who are on leave or not in work status, and retired personnel. Any exemption arangement would be difficult to administer. Further, prohibition of sales during normal duty hours may encourage people to use off post outlets. Difficulty of enforcement would be compounded by the requirement for some set of waivers for special occasions (e.g., recognition luncheons and civilian/military or U.S./foreign functions where usual social and cultural practices include a cocktail period). Prohibiting the sale of alcoholic beverages during duty hours has been tried several times by local commanders. In each instance, the policy was found to be undesirable. These factors suggest that periodic reassessment and reemphasis of stated policy, coupled with an aggressive alcohol identification and rehabilitation program, is the most prudent course.

Appendix 7

Department of Defense—Substance Abuse Control Program—A Concept Paper

Note: This paper has been developed to provide a comprehensive framework for thinking about the substance abuse problem in the military. The concepts in this document will provide the basis for future policy and program development. DoD directives and instructions will be progressively revised to be in concert with this model.

Briefly stated, the concept paper focuses on consequences of abuse, systematic assessment of the extent of the problem, measured response based on the severity of the problem, continued program evaluation, and effective management.

Program Goals.—The Department of Defense (DoD) Drug and Alcohol Abuse Prevention (DAAP) program has two broad policy goals: (1) to discourage all drug abuse—including the abuse of alcohol—; and (2) to reduce to a minimum the adverse consequences to the individual, DoD, and society when abuse does occur.

Purpose of Pamphlet.—The purpose of this pamphlet is to provide a conceptual framework for the DoD DAAP program. The concepts in this document will be the basis for DoD DAAP policy.

I. INTRODUCTION

Applicability.—Most of the concepts set forth in this document generally apply to all members of DoD, military and civilian. There are some important differences, however, in the operational programs addressing the two groups. Pertinent OPM regulations should be consulted for these differences.

Principles of DoD DAAP Policy.—The DoD DAAP policy is based on the following principles:

1. *Realistic Expectations.*—The use of mood-altering substances is a chronic problem of long standing in the U.S. society. The extent of use in any given situation is a function of two general factors: (a) values and attitudes of individuals; and (b) environmental conditions such as group norms, availability of drugs, and alternative activities available. Vigorous programs to control the availability of drugs, provide alternative activities, and influence group norms will reduce abuse, but will not eliminate it. DoD draws its members from a society which widely abuses both legal and illegal drugs. Moreover, the legal view regarding specific drugs are often not reflected in the values and attitudes of individual members coming into the DoD. Consequently, it is realistic to expect that some members of DoD will use drugs that are illegal and some will use drugs in a manner that will have adverse consequences. Therefore, DoD seeks to discourage all drug abuse and minimize the adverse impact when it does occur.

2. *Balances the needs of the Department of Defense and the individual members therein.*—The Department of Defense provides the physical security of the nation. It has the right to demand sound minds and bodies unencumbered by abuse of any kind. It also requires disciplined members who conform to laws and regulations. The public confidence in the military must be maintained. The Department, in return, owes its members a healthy environment with wholesome values and norms free of undue cultural pressure to abuse drugs. It is also obligated to provide health services to members and certain dependents who become ill, want help, and show an effort to contribute to their treatment and rehabilitation. The balance between rights and obligations of the institution and individual members is delicate. DoD policy attempts to establish guidelines for determining that balance in regard to drug and alcohol use.

3. *Requires decentralized, but consistent, implementation.*—To be effective, a program must meet the needs of the local commanders and their special set

of circumstances. The demands on management's time and the allocation of resources should be based upon the seriousness of the problem rather than upon rigid criteria established centrally. At the same time, there must be sufficient consistency to give the overall program integrity and credibility. This requires clearly stated principles that provide commanders with a common frame of reference for their decisions.

4. *Focuses on the consequences, or potential consequences, of drug use.* The basic tenet of the DoD DAAP policy is that program responses to drug use should be based upon the consequences of that use rather than upon the use itself. A wide variety of consequences must be considered, including job performance, health, family, the military organization, and society at large. In the case of use of illicit drugs, the use itself has adverse consequences for the military organization and society at large inasmuch as it represents a disregard for laws and regulations. These consequences are inherently more serious for the military because of its unique mission and the special requirement for discipline, law, and order. With respect to treatment and rehabilitation decisions, however, the legality of the substance may be irrelevant.

5. *Is consistent with the national strategy for combatting drug abuse as set forth by congressional legislation, and the specific needs of DoD.*

6. *Is flexible enough to reflect changing social conditions, new scientific knowledge, and experience in managing the DoD program.* The nature of the drug problem changes over time. Policy should be established that accommodates such changes. Similarly, policy must be responsive to new knowledge about drugs and their effect on health and performance. Experience in managing the program must be systematically used to adjust policy.

7. *Provide sufficient information to OSD to enable the ODAAP, in coordination with the Military Departments, to analyze, evaluate, plan and develop policy and program guidelines.*—The management information system, supplemented by staff visits to the field, must be adequate to allow for appropriate problem assessment, evaluation, policy revision, and overall management of the DAAP program. This requires clearly stated, standardized criteria measures.

II. DEFINITIONS

To be added at a later date.

III. BACKGROUND

From all indications, the regular use of psychoactive chemical substances has become an integral part of the United States culture. According to a recent White House report:

"Drug abuse crosses racial, cultural, social, and economic ilnes and involves millions of people using hundreds of substances. Although some substances may appear to be abused more frequently in one cultural age or economic group than in another, virtually no group is entirely free of some form of substance abuse. The substances abused are as varied as the abusers. The range includes youth inhaling glue, young adults ingesting pills and injecting heroin, businessmen consuming large quantities of alcohol, and older people misusing 'over-the-counter' and prescribed medicines."

This drug use occurs on a continuum from one-time experimentation to very heavy use resulting in severe dependence. The consequences of this use vary from beneficial to harmful, to both the user and the society. These consequences are determined by a complex interaction of many factors, including the strength, purity, and pharmacology of the drug; the reaction of the individual to that drug; the setting in which the drug is taken; the frequency of ingestion; the social/occupational position of user; and other factors.

The use of chemical substances to alter physical and mental processes is thousands of years old. Chewing coca leaves has been a social ritual among certain South American Indians for more than a thousand years. They believe the practice renews their energy and endurance, reduces the need for food and water, improves the spirits, and helps them withstand climatic extremes. The chemical substance in the coca leaves does have a stimulating effect and one of the most popular soft drinks of all time was originally developed using cocaine extracts of the coca leaf. By 1906 the cocaine had been removed and caffeine substituted to provide the "pick up."

In the United States, the chemical substances most widely used to alter mental and physical processes are caffeine, alcohol, and nicotine. Caffeine is found in such common substances as coffee, tea, chocolate, soft drinks, and mild stimulants sold over-the-counter (e.g., NO-DOZ) and is consumed by many without awareness that they are ingesting stimulants. Alcohol and nicotine are normally recognized by the user as mood-altering substances. All three of these substances are legal and "abuse" is a judgment to be made based on the behavioral consequences of such use rather than the mere use of the substance itself. It is estimated that over 400,000 deaths each year are directly attributable to the abuse of tobacco and alcohol and millions more suffer less harsh consequences. HEW has estimated that 10 million Americans have alcohol problems, e.g., drunken driving, missed work, accidents, family problems. Emphysema, heart attacks, high blood pressure, etc., are often the result of nicotine abuse.

Many other substances, such as marijuana, peyote, and opium, have a long history of socially acceptable legal use in certain cultures. Legal regulation of certain substances began in the United States in 1914, and at the present time many chemical substances have been placed under strict control, and can be used only under specific medical supervision. The use of such substances under other conditions is illicit and punishable. Other chemical substances are not controlled, and can be used as one desires, with certain restrictions on sales (alcohol and tobacco) and places of use. Marijuana fell into the same category with other tobacco until 1938, when it was designated a controlled substance.

For controlled chemical substances, the simple use without a medical prescription is often defined as "abuse." Thus, one who takes a controlled dexadrine diet pill without a prescription is a "drug abuser," regardless of its consequences. Likewise, one who uses a valium or quaalude pill without prescription is an "abuser" even if it is an occasional use to handle a stressful situation. In both instances, it is possible that the use has a beneficial effect. Such use of the term "drug abuse" is a legal definition, as opposed to the behavioral and medical definitions referred to in the previous discussion of caffeine, nicotine and alcohol.

Many, perhaps the large majority of, people who use illicit chemical substances (drugs) do so without affecting their behavior to the degree the use has observable adverse consequences. In fact, it is not unreasonable to assume that a person who uses a diet pill to stay awake when driving on a long trip will actually function better than if he/she drove while drowsy. It is estimated that approximately 43 million Americans have smoked marijuana and 16 million continue to use it on a regular basis, but when not intoxicated, the vast majority function without observable behavioral changes.

The controlled substances have been so designated, however, because they are believed to have a high potential for abuse in the sense of behavioral consequences, especially if the substance has the potential for physical or psychological dependency. Thus, the user of a dexadrine pill may perform better on a specific occasion, but the danger is that he/she may use the drug frequently, becoming more and more dependent on it and eventually using high dosages that will do physical and mental harm, as well as endangering others. For example, whereas a medically prescribed dose of an amphetamine may be 2.5–15 mg per day, those on a speed binge have been know to inject as much as 1,000 mg every two or three hours. Such "speed freaks" are often bizarre and violent, and are difficult to treat. Many arrive at that condition without intending to do so.

Available information indicates that most users of illicit drugs are "recreational" users, that is, they use them on weekends or during nonworking hours to relax or get "high." Apparently, some can do this, even with the more dangerous drugs such as heroin, without becoming physically or physhologically addicted, and without any observable alteration of their behavior while at work. Many others cannot, however, and become dependent and/or their behavior suffers, their performance is degraded, and they become physically or psychologically disabled. In the case of some drugs, the adverse behavior may come unexpectedly, under stress, when it can be most damaging.

The problem in DoD

The manner in which the drug abuse problem is defined is of critical importance in developing a program to deal with that problem. Not only does the definition of the problem focus the thinking of policymakers and managers of the program; it also determines to a great extent the perception of the problem by those outside the Department of Defense. The terms "drug abuse" and "drug

problem" mean different things to different people. When statistics are published regarding the extent of "drug abuse" in the military, each individual reader interprets the figures according to his/her meaning of the term.

Some definitions of drug abuse focus on the drug use itself. The earlier definition used by DoD was of this nature: "The illegal, wrongful, or improper use of any narcotic substance, marijuana, or dangerous drug, or the illegal or wrongful possession, transfer, or the sale of the same . . ."

Definitions that focus on the mere act itself often lead to rather crude estimates of the nature of the problem. This is particularly so when the definition includes any use of an illicit substance. While such a definition may be technically correct from the legal standpoint, it ignores certain factors:

The magnitude of the drug abuse problem is related to the particular drug being used. Different drugs pose radically different threats to the behavior and health status of users.

The magnitude of the drug abuse problem is related to the frequency and quantity of consumption, particularly with intravenous administration, where users' behavior and physical condition may deteriorate rapidly.

These factors are interrelated. The likelihood of advancing to chronic, intensive levels of consumption differs from drug to drug and from individual to individual. Users of physical dependence-producing drugs such as heroin are more likely to advance to high levels of use than are users of non-physical dependence-producing drugs such as marijuana.

Other definitions of drug abuse are based on medical consequences. The most common criteria are serious adverse effects on health and psychological and/or physical dependence. Such a definition is too restrictive for use as a concept upon which to base a DoD program. Many lives may be ruined and personal reliability and job performance may suffer greatly before adverse medical effects become evident. Some definitions of drug abuse are based solely on job performance. Many industrial organizations' drug and alcohol programs are based on behavioral consequences on the job. As long as an individual performs well, there is no official "problem." Increasingly, however, organizations have realized that such a policy is not only somewhat callous to the welfare of the individual, but uneconomical as well. Intervention occurs much too late. Thus, more and more organizations are intervening earlier in the process of abuse. Few such organizations use a legal criterion, however, and most are not concerned with the "legality" issue. Moreover, some industrial organizations are not officially concerned with life problems outside the workplace, such as family problems, drunken driving, etc., unless the offender has sufficient stature to bring discredit on the organization. Such an "industrial model" is inappropriate for use by the military. DoD is a "total institution" in many respects and must concern itself with the total life conditions of its military members. Also, the unique mission of DoD requires that higher standards be demanded of its members, lest the public lose confidence in its military forces.

In March 1979 the Office of Drug Abuse Policy, the Executive Office of the President, established new guidelines for the Federal effort on drug abuse to focus concern on the negative health and social consequences to the individual and society which result from the abuse or misuse of psychoactive substances. The following definitions were established as policy guidance:

"*Drug Abuse.*—The nontherapeutic use of any psychoactive substance, to include alcohol and tobacco, in such a manner as to adversely affect some aspect of the user's life, the lives of others, or the community at large.

"*Drug Problem.*—The sum of the negative medical, social, and economic consequences of drug abuse and misuse as they affect the user, the user's family, and the community at large."

The White House policy definitions have important implications for the DoD program. They place the focus on consequences of drug use rather than on the absolute number of users. The definitions, and the supporting rationale, recognize that not all drug use is equally destructive. Different drugs pose different threats to the behavior and condition of users. Further, when drugs are used in combination or at high levels of consumption—particularly with intravenous injection—the effects are vastly increased. The implication for the military is that commanders should be most concerned with those drugs and drug use patterns which have the highest actual, or potential, adverse impact on the individual, unit readiness, and society. Priority must be given to treatment and enforcement efforts targeted toward those drugs which pose the greater risk.

This concept of the drug abuse problem does not suggest devoting all resources to the highest priority drugs, and none to lower priority drugs. All drugs are dangerous in varying degrees and should receive attention. But where resource constraints force a choice, those drugs with the potential for causing the greatest problem should receive priority attention.

The policy guidance contained in the White House review, together with Congressional guidance and legislation, serves as the foundation for DoD policy. The focus on consequences as a basis for defining drug abuse is more meaningful as a management tool than a legal definition, which classifies any use of illicit substances as "drug abuse." Shifting the basis of the definition from the legal dimension to behavioral consequences does not mean that the legal issue is of no concern, as will be discussed later.

The primary purpose of the definition of drug abuse herein is to provide a practical concept with which commanders may judge the seriousness of the drug problem and make sound management decisions regarding the execution of an appropriate program. In assessing the drug problem, commanders must consider many factors and assessment of the problem is a complex task in many instances. A conceptual framework is provided below to assist in such an assessment.

Based on the White House concept of drug abuse, the following definition of drug abuse is used to formulate the DoD Alcohol and Drug Abuse Prevention program: The nontherapeutic use of any psychoactive substance, to include alcohol, in such a manner as to affect adversely some aspect of the user's life, the lives of others, the community, or Department of Defense effectiveness. The abused substances may be licit or illicit and may be obtained from a friend, by prescription, over-the-counter, or from the illicit market.

Although the abuse of nicotine and caffeine fall within the above definition, the DoD DAAP program specifically excludes these two substances. The principal reason for the exclusion is that the two substances appear to have very little observable adverse impact on duty performance and their use is deeply ingrained in military culture. Including these substances in the DAAP program would detract substantially from the focus on the more serious drugs without potential benefit to offset that cost.

Drug Abuse and Illicit Substances

The Alcohol and Drug Abuse Prevention program is primarily concerned with the adverse effects of drug use on the individuals' health and behavior, the family, society, and the Department of Defense. Therefore, the program focuses on the consequences of substance use regardless of the legal status of the drug itself. The DoD response to drug use must, however, take into consideration the legal status of the drug. It is important to understand the legal aspect as it relates to decisions regarding classification of the use as abuse. The two are interdependent, but separate, issues.

During the early years of the DoD program to combat drug and alcohol abuse, any user of illicit drugs was by definition classified as a drug "abuser" regardless of the behavioral consequences. While such a classification was correct in a strict legal sense, it had little relevance to the treatment of the individual from a health standpoint. In practice, however, some commanders required every individual identified as a user of illegal drugs, to include first-time marijuana users, to be entered into the regular out-patient treatment and rehabilitation program for up to a year. Not only was this a waste of critical resources, but at best it had little benefit for the individual and in many cases it had an adverse impact.

With respect to the health problem of drug use, the official response should be based on the behavioral consequences, actual or potential, without regard to the legal status of the drug itself. Factors to be taken into consideration in determining this response are discussed elsewhere in this document.

The legal aspect of drug use is of critical importance in DoD and should be handled similarly to other acts of indiscipline which are nondrug related. In general, the severity of response is based on the perceived seriousness of the offense. The mere use of an illegal drug is of greater concern within DoD than in civilian communities due to the mission of DoD and the need to maintain the confidence of the public. Thus, repeated offenses, even if there are no perceived adverse effects on individual behavior, should be treated as other breaches of discipline. Nothing in this document should be interpreted to imply that DoD condones the use of illegal drugs; rather, the intent is to convey the idea

that the action taken will vary according to the seriousness of the behavior. Not all use of illegal drugs has the same consequences and thus punishment will vary. The use of a sleeping pill without a prescription during unusual stress, for example, would not call for the same response as the use of heroin, other things being equal. The time and place of use, the nature of the substance, and the circumstances attending the use—all must be taken into account.

The DoD uses techniques that no other organization uses to detect the use of drugs, e.g., urine tests. Consequently, we are able to identify users who may show no behavioral consequences and who would not be identified by any other organization in the world. We plan to continue such identification techniques, but the results must be used with prudence.

IV. ASSESSMENT FRAMEWORK

The Department of Defense must officially respond when drug use has or can be expected to have an impact on duty performance, readiness, or operational costs; or when the use involves illegal substances. The overall seriousness of the problem, which will determine the severity of the response, can be characterized on a continuum as depicted below:

Slight problem — Moderate Problem — Serious problem

The characterization of the problem is a complex matter and, in the final analysis, must be a global judgment of the commander. Some of the relevant factors which must be considered in determining the seriousness of the problem are:

(1) *The prevalence of use* of drugs and alcohol in any given unit or area of the world. This prevalence estimate constitutes the starting point for assessing the problem as it impacts on unit readiness.

(2) *Type of drug abused.* The critical factors to be considered here are (a) the potential of the drug for creating physical or psychological dependence of the user (b) the degree to which the effects of the drug tend to impair the reliability or capability of the user. These factors are discussed further in Section X, SPECIFIC SUBSTANCES, below.

(3) *Pattern of use.* The time and place of use are important variables in assessing the seriousness of drug use. Use immediately before or during duty hours can have serious consequences and cannot be tolerated if detected. Similiarly, on-post use of illicit drugs have more serious consequences than off-post use, other things being equal, because it impacts more on other military personnel and weakens discipline.

(4) *Behavior impairment.* The adverse impact of drug use on behavior is the most critical factor to be considered. On-duty performance is the most important behavior, but off-duty behavior, especially if it affects others, must be considered. In this regard, behavioral problems such as lack of motivation, inattention, and withdrawal must be considered as well as the more apparent problems of an overt aggressive nature.

(5) *The nature of the mission.* The nature of the unit's mission and the nature of the job of the drug user (i.e., criticality/sensitivity of the job) must also be considered.

(6) *The degree of involvement* with the drug. Often the degree of impairment of an individual's behavior can be reasonably well predicted by the extent of involvement with drugs. The involvement can be characterized along a continuum as illustrated below:

Experimenter — User — Heavy User — Very Heavy User (Chemically Dependent)

Obviously, the physical impairment is a function of other factors such as type of drug (e.g., heroin vs. marijuana) and manner of ingestion (e.g., intravenous vs. oral ingestion of amphetamines), but general behavior, especially motivation

and commitment to the organization, is closely related to the degree of involvement.

Evaluating these relevant factors and deriving an estimate of the seriousness of the problem requires a thorough assessment process. One effective method of assessing the seriousness of the problem at a given location is for the senior installation commander to establish a council of advisors made up of persons who have key responsibilities in the drug and alcohol abuse control program and to charge them with the responsibility for providing a thorough assessment. This advisory group should include investigative and law enforcement personnel; drug and alcohol program managers; medical personnel; chaplains; morale, welfare, and recreation officials; and others with key roles in drug/alcohol programs. Effective use of an advisory board facilitates coordination of all components of the drug and alcohol abuse control efforts at operating levels.

The response to the assessment of individuals, or organizations, should be commensurate with the seriousness of the problem, weighing all relevant factors. The relevant factors must include a clear understanding of the consequences of the problem on the institution and on the individual.

Some initial guidelines incorporating this conceptual framework are provided below. These guidelines address prevention, identification, individual evaluation, treatment, rehabilitation, separation, and program evaluation.

V. PREVENTION

Prevention of drug and alcohol abuse is obviously the most cost-effective way to reduce the impact of drug and alcohol abuse upon the Department of Defense. However, cause and effect relationships between prevention programs and changes in drug-taking behavior are very difficult to establish. Nevertheless, the Department must pursue systematic prevention programs based on the knowledge that similar activities (e.g., education) have had some results in other areas. Prevention program components should include:

a. Maintenance of high recruiting standards based on knowledge of which demographic variables correlate with drug abuse.

b. Law enforcement efforts. These efforts should be targeted at substance abuse problems which constitute the greatest threat to the institution. Resources must be applied where the greatest difference can be made. This will require sound measurement of law enforcement productivity.

c. Education. Education plays an important part in the prevention effort. In addition to education programs designed to impart knowledge about drugs, people need to learn a decision-making process and constructive means of expressing their feelings as well as how to explore and examine their values. These are essential for acquiring the ability to evaluate and choose among alternatives for solving problems and achieving a degree of fulfillment.

The major portion of the Department's education program for adults will be directed toward three target groups—nonsupervisory personnel, supervisors, and abusers who are not physically or psychologically dependent. For nonsupervisory personnel, education classes will emphasize factual information about the Department's policies and programs concerning alcohol and drug abuse and the consequences of abuse. Reminders about drug-free alternatives will also be pursued especially through media presentations. The Department of Defense acknowledges its obligation to present factual information to this target group; however, repetitious "square-filling" classes should be avoided. Education should be given on an even basis beginning with orientation on entry into the military and repeated at specified points during career progression. One of the most effective educational methods is the small group discussion in an informal manner on the job, led by the grass-roots supervisor.

Supervisors play an important role in both prevention and early identification. Education for this target group should emphasize techniques and actions that can be used to contribute to a healthy organizational climate and create an atmosphere less conducive to alcohol and drug abuse. Equal emphasis should be placed on intervention, on positive methods of confronting employees who evidence potential drug and alcohol abuse problems, and on the role of the supervisor in the post-treatment stage of those returned to duty. Education should also familiarize supervisors with current DoD and service policy regarding drug and alcohol abuse.

Education can also be used effectively as an intervention strategy for abusers whose alcohol or drug involvement has not led to dependence. Education for this target group should focus on helping the participant focus on the consequences of continued abuse. Discussions should help abusers to examine and better understand their values and to learn to take responsibility for their behavior. The primary goal of education for this target group is change in attitude and behavior. Sessions should be of sufficient duration to enable accomplishment of the primary goal.

The education program will also include special efforts aimed at general audiences to increase awareness, mobilize anti-drug pressure, and increase community involvement in combating alcohol and drug abuse. Programs which emphasize the development of the family and which encourage healthy growth and development in such areas as nutrition, safety, personality, and skills will for the most part be directed toward dependent children who are at an age when such efforts appear to be most effective. Programs will be conducted for this target group through the dependents schools supplemented by special classes for dependent children at local installations.

d. Systematic attempts to change organizational climate and cultural milieu. The use of mood altering chemicals is a cultural phenomenon. The patterns of use are largely governed by cultural or subcultural norms and expectations. Negative consequences of alcohol and drug abuse are often exacerbated by cultural conflict, unhealthy organizational climate, and other similar factors. Positive cultural and organizational changes can be effected which tend to reduce substance abuse and other negative behaviors. The technology to effect these changes currently exists and is being continually refined. It is necessary to begin to apply this technology more systematically to the substance abuse problems in the Department of Defense.

VI. IDENTIFICATION

A functional area in which the military services can combat drug and alcohol abuse is that of drug and alcohol abuse identification. Aggressively pursuing the identity of abusers has several advantages: (1) the identification program is a perceivable expression of the commander's interest in rooting out abuse; (2) a visible deterrent is afforded those who could not otherwise withstand peer pressure to use drugs or alcohol; (3) the likelihood of detecting the experimenter or occasional user early in his involvement is increased, thus easing the task of rehabilitation; and (4) by detecting and rehabilitating or disposing of abusers, morale in a unit is enhanced. Specifically, each service should:

a. Assure the awareness of the individual servicemember of the exemption policy whereby a drug abuser may seek help without fear of punitive action.

b. Assure the ability of commanders and supervisors to recognize the signs of drug and alcohol abuse in those they supervise. There are considerable educational materials available to assist in increasing this ability. Supervisor development and training programs should make active use of all available resources.

c. Assure that drug and alcohol abusers detected through the exercise of military medical, law enforcement, and investigative agency functions are brought to the attention of the abuser's commander or supervisor so that the necessary confirmatory, rehabilitative or other actions may be taken.

d. Assure that drug and alcohol abusers detected by civil authorities are referred to commanders or supervisors for appropriate action.

e. Assure the judicious, effective use of urinalysis. Consideration should be given to periodic urinalysis sweeps of entire units as well as to commander- and physician-directed urinalysis of suspect individuals. Some indicators which may signal the need for unit urinalysis sweeps are trafficker apprehensions in the area, drug seizures, drug-related deaths or emergencies, or other evidence of increased drug availability.

Urine tests will be conducted expeditiously when certain incidents occur which indicate the probable involvement of drugs or alcohol. Although the decision to test will often be a command judgment, tests normally will be conducted when behavior is bizarre or unusually aberrant and when a person has been apprehended, or is being investigated, for drug abuse, crimes of violence, serious accidents, or drunkenness. Other incidents involving repeated or serious breaches of discipline should be examined in the context of other circumstances to determine if there is a probable involvement of drug or alcohol abuse. Where such probability is determined to exist, urine tests will be conducted expeditiously.

The intent of this policy is to relate urine tests to incidents which have been shown to be often associated with drug or alcohol abuse. Commanders should continue to make judicious use of command-directed urinalysis, to include unit sweeps where appropriate, especially in areas where there is a high availability of hard drugs and/or there is a serious problem with drug and alcohol abuse.

VII. INDIVIDUAL EVALUATION AND DISPOSITION

Public Law 92–129 directed the Secretary of Defense to combat effectively drug and alcohol dependence in the Armed Forces and treat and rehabilitate members who are drug or alcohol dependent. The legislation specifies that all practical available methods and necessary facilities will be used to fulfill this mission. Implicit in that guidance is the concept that a range of activities should be considered to deter individuals from becoming dependent or, having become dependent, to overcome the dependency. The 1975 White House White Paper on Drug Abuse addressed intervention in terms of treatment costs and the need to focus treatment toward high risk users. It charged all Federal agencies with responding to drug and alcohol abuse in the most cost-effective manner. The Department of Defense can fulfill its legislative mandate by the following actions:

A. Individual Evaluation. Individual evaluation is concerned with the nature of an individual's involvement in substance abuse; the effect of that involvement on ability to perform duty, personal life, and physical well-being; and potential for rehabilitation within the constraints of the DoD programs. The extent of the evaluation is dependent upon the circumstances of the individual case.

Following an individual's identification as having a potential problem involving substance abuse, the military commander should initiate the evaluation process. When the commander's preliminary review reveals that the identification was erroneous, or that experimental use or a first-time incident is involved, command evaluation and action, alone, is usually appropriate. In instances where the commander is in doubt about the extent of an individual's involvement or where the nature of the incident requires more extensive evaluation, the commander should ask the drug and alcohol abuse program (DAAP) personnel for assistance.

The DAAP evaluative effort should include an interview conducted by an experienced drug/alcohol specialist during which there is review of the method of identification (e.g., drunk and disorderly incident, accident, self-identification, commander/supervisor referral, or medical problem), drug use pattern, military status and duty performance, and social circumstances. The DAAP evaluation should arrange, as appropriate, for medical and psychological evaluation (including urinalysis, breathalyzer, blood test, etc.), discussion with supervisory personnel, contact with the individual's family, and other necessary activities (e.g., review of previous or ongoing rehabilitation activity, assessment of legal situation, or involvement with religious activities). The DAAP review should be systematic and thorough since it will provide data for Rehabilitation Committee (see below) deliberations and subsequent commander decisions and actions.

Although assistance from the DAAP involves numerous technical assessments and is necessary, the evaluation process should make maximum use of reasonable judgment, be timely, and minimize administrative procedures.

The Rehabilitation Committee.—The basic premise of the DoD DAAP program philosophy is that the response to abuse will be tailored consistent with the needs of the individual and the impact on the institution (e.g., consider the individual's use, the nature of the substance, the sensitivity of the member's job, and resources available). Complex judgments of this kind cannot be made by rigid criteria and are usually best developed by a group representing different perspectives. Experience suggests use of a rehabilitation committee to accomplish a responsible review of the individual's situation, to design a proper response, to monitor the individual's progress, and to make recommendations regarding the individual to the commander. The rehabilitation committee is a small group of key persons in the individual's life; it normally includes the commander, at the small unit level, the immediate supervisor, a physician or mental health officer or NCO with knowledge of the case, and the drug/alcohol specialists who participated in the evaluation process. Other persons (e.g., a Chaplain, lawyer, etc.) who are involved in the rehabilitation process may participate as needed and/or desired by the individual. The unit commander should chair the rehabilitation committee and retain final decision authority. Effective staff management should minimize time demands on senior management.

In addition to providing a comprehensive review of the individual evaluation data, the rehabilitation committee mechanism facilitates communication between command/duty, DAAP, and others concerned with an individual's rehabilitation.

The rehabilitation committee should consider a range of proper responses, including awareness education, disciplinary actions, administrative actions, treatment, formal rehabilitation, separation, or others.

Awareness Education.—Alcohol Safety Action Programs across the country have shown that awareness education can be appropriate and effective means of intervention with people whose use of alcohol has led to problems. Similar education program for drug abusers whose use has not yet led to dependence seem to have as much potential for effectiveness as more traditional treatment approaches, but are far less costly. The purpose of awareness education is to intervene at the early stage of abuse before the dysfunctional pattern of drug use has progressed to the stage of dependency. Careful screening of clients is an essential element of this strategy; those who are found to be seriously involved with drug abuse should be referred for longer-term treatment.

The focus of awareness education is on the consequences of continued abuse. Courses not only provide factual information on the social, psychological, and physiological ramifications of drug abuse but also include small group discussions about values, decisionmaking and alternatives. Classes should usually be conducted during off-duty hours and be of sufficient duration (at least 20 hours) to give those attending an opportunity to examine their attitudes and behavior. It is essential that attendance be made mandatory for all course sessions.

Disciplinary actions.—These include letters of reprimand. Article 15s, courts-marital, and others. Normally, disciplinary action should not be withheld merely because of entry into educational or rehabilitation programs. Strong discipline can often convince members of the seriousness of their behavior by having them experience the realistic consequences of their actions.

Administrative actions.—Administrative actions should also be taken where appropriate. Driving priviliges may need to be suspended or revoked. Security clearances should be reviewed. Personnel Reliability Program requirements must be met. These actions are not necessarily negative in nature, but may serve to further impress upon the members that certain consequences follow decisions to abuse chemicals.

Separation.—The Military Services are limited to providing short-term rehabilitation services and must require standards of conduct that do not accommodate continued abuse of drugs. When members do not respond within the constrained rehabilitation guidelines or cannot or will not meet standards regarding substance use, separation from the Service is appropriate. Also, careful evaluation of a member may reveal characteristics that indicate, based on Department of Defense experience and substance use research, the individual is a poor risk for rehabilitation (e.g., heroin dependency). The Department of Defense may determine that the most appropriate action in these cases is detoxification, separation and transfer to the Veterans Administration for longer term treatment.

VIII. TREATMENT AND FORMAL REHABILITATION

Congressional and Presidential mandates, societal concern, and moral and ethical responsibilities to Service personnel obligate the Department of Defense to provide treatment and other rehabilitative services, as appropriate, to members who have serious substance abuse problems, specifically the compulsive use of alcohol and other drugs.

In making treatment and rehabilitation decisions, the fact of a substance's legality or illegality is immaterial; rather, the obligation of the Department of Defense is twofold: (1) to confront the individual whose use patterns suggest serious problems with that fact and with the offer of help, and (2) to persevere with individuals, within the short-term policy constraint, who demonstrate genuine interest in receiving assistance and are responding to help.

A full range of treatment and rehabilitation services should be available. These should be flexible in length; the short-term policy constraint should be tempered by review of the individual's recovery progress and potential for continued military service. Treatment programs should provide necessary medical care and evaluation, detoxification, and psychiatric/mental health services. Medical care should be provided in accordance with accepted professional standards

and be consistent with the guidance in the joint service publication, Drug Abuse (Clinical Recognition and Treatment Including the Diseases Often Associated). In-patient care or residential/day care/halfway rehabilitation may be the modality of choice. These more intensive and expensive modalities should be available alternatives. Region-serving facilities, those of another service, or those provided through interservice agreements should be considered to deal with emerging or unmet requirements for residential or similar care.

Out-client services will meet the needs of most individuals requiring rehabilitation and costs are significantly less. Services should be delivered by, or under the direct supervision of, personnel who have demonstrated skills in substance abuse and are familiar with the military setting. Programs should emphasize group processes and err in the direction of limiting individual counseling when resource prioritization requires. Programs should also provide: (1) introduction to, and encouraged involvement with, self-help groups such as Alcoholics Anonymous and Narcotics Anonymous, (2) family involvement (research indicates that involving the family in the recovery process contributes substantially to long-term success), (3) exploration of positive alternatives including planned involvement in personal growth activities, and (4) a thorough follow-up program that provides clients with a means for obtaining continued help, engages appropriate command/supervisor support, and encourages continued self-help group involvement. During the rehabilitation process, the problem of stigma associated with being treated for substance abuse must be addressed and positive means for reducing and coping with that stigma taught.

Rehabilitation program creativity and flexibility is encouraged. However, certain modalities are unacceptable because they are inconsistent with the military mission and the short-term policy. These include methadone maintenance therapy and the therapeutic community approach. Other modalities (e.g., aversion therapy and "scream" therapy) are discouraged because of their questionable validity.

Rehabilitation programs are encouraged to involve recovering individuals either as staff members or volunteers. Frequently these persons alone, or teamed with other staff members, have been highly successful. Programs are further encouraged to engage available, appropriate community resources on a voluntary or reciprocal basis. These interchanges are frequently enriching for both clients and staff and broaden program capacity. Extension of program is also possible through use of volunteers. Both the military and civilian communities may provide capacity that would otherwise be lacking. Although the utilization of volunteers requires judicious screening and involves certain risk, this potential resource should not be summarily dismissed.

Active involvement of an individual in a rehabilitation program should normally result in significant progress within 60 days. When independently sustainable progress cannot be predicted after 180 days in a rehabilitation program, an individual's potential for recovery in a military program and potential for continued service should be seriously questioned. Although relapses are an expected occurrence with substance abuse clients, more than two relapses should normally be grounds for discharge.

Rehabilitation programs and facilities should be available during off-duty as well as on-duty periods. While staff resources and administrative limitations may preclude extensive involvement of desingated program staff, alternatives (e.g., use of other personnel in a special duty capacity, volunteers, or tutors/trainers on a fee-for-service basis) may allow these flexibilities. Often rehabilitation capacity is found to exist when the management issue is "how to" rather than "why not."

IX. PROGRAM EVALUATION

Responsibility has been assigned to ODAAP for establishing DoD policy and evaluating, for the purpose of prescribing policy, the results of service programs in the areas of prevention, identification, and treatment/rehabilitation. Each of the Military Departments has established offices responsible for translating DoD policy into operational plans and procedures, developing Service-specific policy, and obtaining the resources required to operate the drug and alcohol abuse program. The operation of the program has been decentralized with responsibility at the command level within each Service. Table IV–I contains the geographical breakout used by OSD to monitor the service programs on a regular basis.

Service	*Countries*
Army	CONUS
	Europe
	Germany
	Japan/Okinawa
	Korea
	Panama Canal
Navy	CONUS
	Europe
	Guam
	Japan/Okinawa
	Philippines
	6th Fleet
Marine Corps	CONUS
	Europe
	Guam
	Japan/Okinawa
Air Force	CONUS
	Europe
	Germany
	Guam
	Japan/Okinawa
	Korea
	Philippines

Management Information System

Management of the DoD DAAP program is contingent on accurate, timely data that will permit program managers at each level to determine the nature of the drug/alcohol abuse problem and evaluate DAAP program activities. Insofar as is possible within the state-of-the-art, it is desirable to develop mathematical models which will allow cost-benefits analysis of the various program elements. Many factors cannot be meaningfully quantified, however, and are not likely to be so in the near future. Decision makers must recognize this limitation and avoid the tendency to reject outright, professional judgment based on experience and common sense. Program managers, on the other hand, must continue to develop better quantitative techniques to reduce subjective judgment where possible. Furthermore, "professional judgment" must be supported by systematic, analytical evidence.

The data to be collected and analyzed by DAAP program managers must be of sufficient specificity to permit sound judgments regarding resource allocations and program policy. Based on the conceptual framework presented above, three essential categories of information have been identified; prevalence and trends of drug use; impact of drug use on people and the institution; and information relating to program activities. Some of the data needed in each category are listed below:

a. *Prevalence and trend data.*—Several kinds of data have been used to estimate the prevalence of drug use. While each measure is subject to bias, taken as a composite they can provide a reasonable estimate of the prevalence of use. The single most valid tool now available to DoD is the anonymous personnel survey. While there are limitations to this technique (e.g., costly, slow, questionable state-of-the-art), it is the single most valid measure of drug use. Because of its limitations, however, a comprehensive DoD-wide survey should be conducted only every three or four years. More limited surveys should be conducted as suggested by other indicators of changing prevalence (see below).

Other indices of prevalence of drug use include:

(1) Urine testing of a small scientifically selected sample of persons periodically (e.g., every six months). Because of the inherent limitations of urinalysis (e.g., only certain drugs are detectable, detection is limited to recent use, etc.), this technique will systematically underestimate the prevalence of drug use. By developing an index relating urinalysis rates to survey data, however, we hope to be able to use this technique as a valid measure between surveys. This method is inexpensive, objective, and timely.

(2) Medical information. This information may consist of emergency room data collected via a system similar to the Drug Abuse Warning Network

(DAWN) operated by the Drug Enforcement Administration. A one year test of DAWN at approximately 30 bases is under consideration.

(3) Drug abuse related disciplinary action (e.g., Article 15s, courts-martial).
(4) Drug abuse related administrative discharges.
(5) Law enforcement statistics:
  (a) Number of investigations
  (b) Quantity, purity and price of drug seizures (customs and law enforcement)
  (c) Narrative intelligence reports
(6) Treatment and rehabilitation data
  (a) Number entrants
  (b) Demographic variables (e.g., age, sex, education, grade, race, occupation)
  (c) Disposition data (e.g., successful completion, separation, etc.
  (d) Narrative summary of problems, trends, and successful programs
(7) Drug abuse related fatalities
(8) Medical indicators
  (a) Cirrhosis trends
  (b) Hepatitis trends
  (c) Prescription of psycho-active drugs

b. *Impact of drug use on health, performance, and unit readiness.*—As stated previously, the absolute number of drug users is a poor indicator of the drug abuse problem in a unit. The kind of drugs used, pattern of use, etc., are more important as indicators of the problem magnitude. Moreover, it is the consequences of the drug use which are of paramount importance to DoD program managers. Therefore, more detailed kinds of data are required for analysis than have been collected and reported in the past. In addition to absolute numbers, there is a requirement for data to be collected and analyzed which will:

(1) Establish categories of drug and alcohol abuse in terms of physical damage, social disruption and work/duty impairment and the extent of physical or psychological dependency.
(2) Determine the prevalence of drug and alcohol abuse within the military by environmental, background, and behavioral factors.
(3) Compare high risk subpopulations for drug and alcohol abuse within the military to similar subpopulations of civilians.
(4) Determine the demographic characteristics of drug and alcohol abusers in the military.
(5) Assess the effects of drug and alcohol use on service members' personal well-being, military job performance, and on unit readiness.
(6) Determine the service members announced reasons for using and not using drugs and alcohol by service and abuse categories.
(7) Determine the critical organizational factors that contribute to, or discourage, drug abuse.
(8) Determine the critical sociological and psychological factors that contribute to, or discourage, drug abuse.

There are numerous sources of data for meeting the above requirements. Surveys should contain items that elicit the kind of data enumerated, but much of the data can be obtained only through long-term research. DoD must develop a comprehensive research plan that will coordinate the Services' effort with that of NIDA, NIAAA, and other research efforts. Reporting activities cited in a, above, and c, below, must also be designed to provide appropriate data to meet these requirements.

c. *Program evaluation.*—The DoD DAAP program must be subjected to evaluation based on a systematic, analytical process using objective, reliable data. Managers should be able to make better decisions about which prevention activities are most effective; what law enforcement techniques are most productive; what identification techniques are most effective; what treatment/rehabilitation modalities are most effective; etc. As mentioned previously, the process should include cost-benefits analyses wherever possible, but be based on systematic analysis in any case. The following kinds of data must be collected and analyzed:

(1) Prevention activities
  (a) Demographic correlates that can be used for developing recruiting policy.

  (b) The effects of different kinds of urinalysis as deterrents to drug use.
  (c) The effect of differing punishment policies as deterernts to drug abuse.
  (d) The relative effectiveness of different educational techniques.

(2) Identification. The five methods of identification are urinalysis, commander/supervisor referral, medical referral, self-referral, and law enforcement detection. Data for each of these methods should include number and types of drug users and the cost of the effort.

(3) Disposition of Identified Users. Data must be collected and analyzed which will show the disposition of each identified user (e.g., type punishment, type treatment/rehabilitation, subsequent behavior).

(4) Treatment/rehabilitation. The treatment/rehabilitation program element has 3 components:
  (a) Inpatient treatment,
  (b) Residential rehabilitation,
  (c) Nonresident rehabilitation.

There are two primary goals of this program element. First, return an identified drug or alcohol abuser with potential for further useful military service to useful duty performed satisfactorily through his/her term of obligated service or 360 days from the time of identification, whichever comes first. Second, provide a minimum treatment program prior to discharge for those drug or alcohol abusers without potential for further useful military service. These goals result in 2 primary evaluation criteria. The first criterion is the percentage of drug or alcohol abusers with potential for further military service that performed satisfactorily through their term of obligated service or 360 days from the time of identification. The second criterion is the percentage of identified drug and alcohol abusers without potential for further useful military service that completed the minimum treatment program prior to discharge. The application of these two criteria require the following data for each of the rehabilitation components:

(1) The number of identified abusers with potential for further useful military service for each substance category (drugs and alcohol) and each rehabilitation component (resident/nonresident);
(2) The number of identified abusers with potential for further military service returned to useful duty performed satisfactorily through their term of obligated service or 360 days from the time of identification for each substance category and each rehabilitation component;
(3) The number of identified abusers without potential for further useful military service that entered the minimum treatment program for each substance category and treatment rehabilitation component;
(4) The number of identified abusers without potential for further useful military service that completed the minimum treatment program for each substance category and treatment/rehabilitation component.

X. SPECIFIC SUBSTANCES

Management policies designed to focus primarily on types of drugs abused lack the precision necessary to identify and deal with the problem. Due to the wide variance of drug effects, no rational, consistent policies can be established which apply to all classes of drugs. The effect of even one drug varies depending upon set (i.e., the expectations of the user), setting (the environment), and the person's physiological reaction to the chemical. Controversy continues among researchers concerning the actual positive or negative impact of certain drugs. New drugs are being developed regularly and are diverted into nonprescribed use. Users who purchase "street drugs" may believe they are using one drug when in fact they have been sold an entirely different substance (e.g., PCP sold as THC). There is no comprehensive scheme yet avalibale to develop manageable politics which are based exclusively on the types of drugs abused. Therefore, the primary focus of this conceptual framework is upon the specific behavioral consequences of substances abuse, rather than upon the nature of the drug itself. However, there are some aspects of the drugs themselves which cannot be ignored in making judgments about users behavior and potential for future service. For example, the decision to use alcohol is substantively different from the decision to use LSD, and this judgment factor, as well as the nature of the drug, must be considered.

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Below are some guidelines based upon current knowledge of the drugs which are frequently used and abused. These guidelines should be considered to be preliminary statements to be validated, expanded, and made more definitive through research and evaluation. They consider (1) the potential the drug has for creating dependence; (2) the degree to which the action of the drug may be expected to impair the reliability of the user; and (3) the patterns of use of the drug. As our body of knowledge of the characteristics, effects, and consequences of use of these drugs grows, so will the sophistication of these guidelines. Current literature concerning drug actions, abuse potential, and hazards should also be maintained at medical facilities and drug/alcohol offices.

a. *Alcohol.*—Alcohol is the most widely used mood altering drug among members of the Department of Defense except for caffeine and nicotine. The vast majority of personnel drink alcoholic beverages and although most drinkers do not experience problems with their alcohol use, a substantial number do. Current conservative estimates suggest that fifteen percent of the active military force have experienced recent signficant problems related to the consumption of alcohol. Approximately five percent of the force report symptoms of alcohol dependency. The majority of drug abuse related deaths of military members involve alcohol. It appears that the greatest amount of drug abuse-related lowered productivity (e.g., absenteeism, lateness, poor work performance, hospitalization etc.) results from alcohol abuse. Alcohol is involved in many of the racial incident, violent crimes, motor vehicle accidents, and other incidents requiring law enforcement intervention. Due to the widespread use of alcohol, alcohol abuse appears to be the drug abuse problem with the greatest impact on the Department of Defense.

Because of the pervasive impact of alcohol abuse on the institution, comprehensive programs must be maintained. These programs must take into account the legality and general acceptance of the use of alcohol, and the frequent perception of many managers that alcohol abuse control policies penalize the majority who drink responsibly in order to protect the minority who cannot. Identification of persons who are having problems with alcohol continues to be delayed because many supervisors still do not perceive them to be serious drug problems requiring intervention, particularly when the person with the problem is a senior noncommissioned officer or commissioned officer. Specific emphasis should be placed on increasing the general awareness of the pervasiveness and extent of alcohol problems, as well as increasing supervisory skill in initiating the intervention process.

Alcohol has a high physical and psychological dependence potential when consumption level is high. Overdose death potential is slight unless ingestion is accompanied by other drugs or unless distilled spirits are drunk in large quantities in a short period (i.e., "chugged"). Death potential is then high and these practices, in fact, are a significant cause of fatalities in the military population. Being under the influence of alcohol is incompatible with duty performance. Physical dependence on alcohol substantially lowers the reliability of the dependent person, and appropriate detoxification, treatment, and rehabilitation is necessary.

Statistically, alcohol problems, e.g., accidents, violence, etc., tend to concentrate among males, among younger and more junior personnel, and among those unmarried or unaccompanied by spouses, although other subpopulations also experience significant problems. Alcohol addiction, on the other hand, often afflicts more senior persons. There is also a tendency for higher problem rates to occur among personnel stationed overseas. Risk appears to rise substantially when consumption exceeds six drinks per day or when heavy-drinking days (eight or more drinks) occur as often as once per month. Even more significant risk is associated with frequent intoxication and with receipt of warnings from associates about drinking too much. The onset of frequent intoxication and social warnings appears to represent an intermediate stage in alcohol problem development. This stage follows the beginning of heavy consumption and for some people eventually culminates in alcohol dependence or adverse effects. For these reasons heavy consumption, frequent intoxication, and social warnings about drinking signal a need for intervention to which supervisors must respond.

b. *Cannabis.*—Cannabis, including marijuana, hashish, hash oil, and other forms of the substance, is the second most widely used nonprescribed mood altering drug (again, excepting caffeine and nicotine). The consequences of cannabis use to the individual and institution are not as precisely known as the

consequences of alcohol use. Most studies remain controversial, but three key factors are clear. First, marijuana use is illegal and therefore violates military standards of behavior. Second, marijuana causes intoxication and must not be tolerated on the job or when driving a vehicle. Third, marijuana is often "laced" with other drugs such as opiates and PCP, frequently without the knowledge of the user.

The effects of marijuana/hashish are more difficult to detect than those of many other drugs. Some researchers and treatment experts report the frequent development of "potaholics," or persons whose adjustment to life depends upon regular use of marijuana. With continued regular use, characteristics such as loss of energy, confusion, diminished attention and span of concentration, depression, blunted emotions, and loss of memory are reported. Along with the general lethargy, hostility to authority and even paranoia are reported to occur. This is popularly referred to as being "burnt out." However, all of these symptoms are similar to certain personality disorders, and are difficult to connect scientifically with the marijuana abuse alone. Those who see the marijuana use as primary cause of these behaviors believe them to be related to the storing of psychoactive ingredients in cannabis in the fatty tissues of the brain.

Evidence is accumulating to show that the adverse impact of cannabis use on the military and on the society is substantial, largely due to its widespread use. The impact seems to include both the effects of intoxication (ranging from hazardous driving to general lethargy and caring less about personal and institutional goals) and physical health problems (including injury, chronic bronchitis, possible disruption of the immune responses, and potentially, increased risk of cancer).

Current DoD responses to marijuana use vary widely. In some units, marijuana use results in a mild reprimand. In others, the person is strongly disciplined and placed in treatment for up to one year. There is a need for developing rational, comprehensive guidelines concerning the proper response to marijuana use. These guidelines should be built upon the conceptual framework presented herein. That is, the responses targeted at prevention, identification, treatment, and rehabilitation must be based upon the seriousness of the problem.

Reporting on the results of its 1977 national survey, the National Institute on Drug Abuse revealed that 47 percent of 16–17 year olds and 59 percent of 18–21 year olds reported that they had used marijuana or hashish; about 30 percent of both groups reported use within the past month. The pattern of cannabis use among military personnel of comparable ages is probably similar. The Department of Defense is thus faced with the high probability that many, if not most, of those likely to volunteer for enlistment have used cannabis and many continue to use it after entering military service. It is imperative then that a clear policy regarding cannabis use be established that recognizes the change in our social mores regarding the use of marijuana and hashish and at the same time emphasizes the Department's commitment to the highest standards of discipline, health, and respect for the law. The policy established here takes both factors into consideration and provides guidelines to the services for addressing the problem of cannabis use.

The use of cannabis by many young people is related to the phenomenon of adolescent experimentation and use is discontinued or dramatically reduced as the user matures. To exclude such persons from military service solely because of past experience with cannabis is as impractical as it is unnecessary. It is therefore recommended that a waiver for preservice use of cannabis not be required. If however, the applicant has used cannabis within the three-month period prior to application for enlistment/appointment and he/she is enlisting for positions in the Personnel Reliability Program (PRP) or other DoD special access programs, a waiver may be appropriate. The recency, frequency and degree of use together with the applicant's stated intentions with respect to abstinence or continued use will be the criteria on which a waiver consideration will be based.

Military personnel are expected and are required to obey the law. The use of cannabis is a violation of the Uniform Code of Military Justice, and commanders will enforce the law and take appropriate action against those who break it. The primary method of identifying cannabis users at the present time is through law enforcement and personnel security investigations. Within the foreseeable future, identification may also be practicial through biochemical testing. When such techniques have been approved by the Department of Defense, they will likely prove to be a valuable tool for commanders. To avoid the disproportionate

use of limited resources, however, prudent judgment must be exercised in using this method of identification. It is therefore recommended that biochemical testing to detect cannabis use be used only on a selected basis in situations in which suspicion of drug abuse arises, e.g., return from or apprehension after an unauthorized absence; faiure to obey lawful orders; deteriorating, abnormal or bizarre behavior; assault; violation of safety provisions; and apprehension or investigation for drug offenses. The use of biochemical testing to detect cannabis use is not recommended for unit or sweep testing. Furthermore, as technology develops, the levels of sensitivity for such tests should be calibrated to detect on-duty use, intoxication, or heavy use of cannabis.

The DoD Drug and Alcohol Abuse Program provides the commander with a wide range of responses for restoring the abuser to duty. These include disciplinary actions, personnel security and other administrative actions, awareness education, nonresidential counseling, and residential treatment. The appropriate response must be tailored to the level of abuse and should be arrived at through a screening procedure which normally involves the commander, the immediate supervisor, the drug/alcohol specialist, and a medical, legal, security, or religious representative as appropriate. In those cases where the drug of abuse is cannabis, it is recommended that unless there is evidence of serious involvement with the drug, or the individual involved holds a security clearance or is assigned to special access program duties, commanders confine their response to appropriate administrative actions (e.g., removal from PRP, withdrawal of access to classified information, withdrawal of authority to bear firearms), disciplinary action and awareness education. Awareness education has proven to be an effective method for assisting the nonaddicted alcohol abuser; commanders are therefore encouraged to use this approach rather than more lengthy treatment responses for the cannabis abuser.

In considering the disposition of a first-time cannabis offender, as in considering the disposition of any other offender, all administrative, punitive, and nonjudicial punishment measures should be evaluated to determine which course or courses of action are appropriate. In making this determination, all the facts and circumstances surrounding the commission of the alleged offense, the age of the accused, the length and character of his service, and all other mitigating and aggravating circumstances should be considered. Normally, for a first-time cannabis offender who uses or possesses a minor amount and who otherwise has a good record, the use of Article 15, as opposed to trial by courts-martial, is appropriate. If, however, use occurs during duty hours, stronger disciplinary and administrative actions may be more appropriate and, if so, should be considered.

c. *Other drugs.*—1. Narcotics. Narcotics (opium, morphine, codeine, heroin, meperidine, and others) have a high physical and psychological dependence potential, tolerance develops quickly, overdose potential is high, and effects are incapacitating for work. The record for successful rehabilitation of opiate dependent individuals is poor. Separation after 30 days drug free treatment (including 15 days at a VA facility) is often warranted.

2. Depressants (barbiturates, methaqualone, chloralhydrate, tranquilizers, and other depressants). This class of drugs covers a wide range. Physical and psychological dependence varies from very high for barbiturates to moderate-to-low for tranquilizers and other depressants. Withdrawal from barbiturate dependence can be life-threatening. Overdose potential is very high, especially when used with alcohol. The continuum of use model is particularly well suited to guiding decisions concerning depressant users.

3. Stimulants (cocaine, amphetamines, Preludin, Ritalin, and other stimulants). Physical dependence is possible, but rare. Psychological dependence potential is high. The means of ingestion (i.e., oral or injected) has a strong bearing on the degree of seriousness. The continuum of use model is useful for decisions concerning use of this class of drugs, but the type drug is important. For example, mild, over-the-counter stimulants such as "NO-DOZ" are considerably less serious than high-dosage amphetamines.

4. Hallucinogens (LSD, mescaline, PCP, MPA, psilocybin, other hallucinogens). Hallucinogens have no legitimate medical uses. They create no physical dependence, but little is known about the degree of psychological dependence associated with them. The illusions and hallucinations associated with them, and the violence sometimes associated with them, especially PCP, cause them to be risky drugs to users and those around them. Use of these drugs on duty

would be incapacitating. Questions concerning "flashbacks" are not well resolved, but there is strong evidence that stress will induce "flashbacks" long after PCP has been used. Thorough medical and psychological evaluation is necessary in making decisions about the extent and consequences of use of these drugs.

5. Inhalants (Volatile anesthetic solvents: toluene, xylene, benzene, gasoline, paint thinner, lighter fluid, etc.) Inhalants produce a general nervous system depression characterized by inebriation and dizziness. These substances are most often used by young children (ages 6 to 14). Psychological dependence can occur. Use of inhalants may lead to violent behavior or accidents. Some inhalants may lead to permanent physical damage to the brain and bone marrow. Death due to suffocation has also been reported. Medical evaluation is essential in making judgments about users of inhalants. Recently, inhalant abuse appears to be relatively infrequent in the Military Services.

DRUG ABUSE CONTROL IN EUROPE

The drug abuse control problem in Europe is considerably aggravated by the purity, cheapness, and easy availability of narcotics. Street level purity of heroin is about ten times that in the United States. This heroin is about 20 times cheaper per gram in Frankfurt than in New York City. Heroin has been expected to become more available in 1979, and we see no slackening in this trend for 1980. Drug availability appears to be increasing across most of Central Europe.

To reduce the impact of these readily available drugs on our people and our mission, Department of Defense agencies launched a comprehensive effort during 1978.

Addressing our law enforcement initiatives first, Headquarters, U.S. European Command (EUCOM) established a Special Assistant to CINCEUR on Drug Enforcement Matters (SADEM). The task of this office has been to interface between all U.S. military law enforcement activities in Europe, drug investigators and law enforcement personnel of host nations, and other U.S. activities in country, such as the Drug Enforcement Administration, Embassy Narcotics Coordinators, and U.S. Customs. SADEM has been functioning effectively and law enforcement efforts in Europe, particualrly Germany, are significantly improving.

In response to the drug threat, EUCOM and the component commands have increased funds for programs and the number of law enforcement personnel dedicated to drug enforcement. Nineteen Criminal Investigators (CID), 45 military police, 16 Office of Special Investigations (OSI) agents, and 31 Security Policemen have been authorized. The number of drug detection dog authorizations have been increased to 103 for the Air Force and 23 for the Army military police. The capability of the military forensic laboratory for the examination of drug evidence has been improved. Production of drug intelligence, policy, and operational matters, including deployment of available assets to drug "hot spots" has been centralized and rendered more efficient.

Department of Defense components are participating actively in a number of narcotics working groups in Europe. The German Federal Criminal Police (BKA) established a permanent working group on Narcotics. This working group was followed by creation of several regional working groups. In addition to DEA and U.S. Customs, U.S. Military law enforcement and customs agencies participate in these multinational groups which deal with all aspects of drug enforcement programs.

Military members are also actively involved in the Central Working Group composed of representatives of German ministries and specialists designated by the U.S. Embassy. This body resulted from the U.S.-German Narcotics Control Agreement signed on 9 June 1978. Army and Air Force representatives play key roles on the Subcommittee on Prevention and Medicine, the Subcommittee on the Military, the Legal Subcommittee, and the Subcommittee for Police and Customs Enforcement Measures.

In addition to these coordination and working groups, DoD agencies are working with the State Department to involve the NATO structure in our efforts to attack the sources of supply and international transportation of drugs. Although it is too early to discuss results of this initiative, this effort to keep the drug problem visible at the highest levels of government is expected to be helpful.

In concert with these EUCOM and multi-agency initiatives, the component military commands are operating comprehensive drug abuse control programs for their own people.

HQ US Army Europe has published and implemented a "USAREUR Action Plan for the Reduction of Drug Abuse" (19 April 1979) and a "Commanders, Supervisors, and Staff Officers Guide to the USAREUR Alcohol and Drug Abuse Prevention and Control Program" (17 May 1979). Drug suppression was emphasized as the number one law enforcement priority, and resources dedicated to it were nearly doubled. The Drug Suppression Operations Center (DSOC) was established to provide central management of the drug suppression effort.

The increased effort is beginning to show results. Drug sales and trafficking cases are up 100 percent in the last year. The dollar value of drugs seized in 1979 is already four times last year's total. Drug related courts-martial for April–June 1979 increased 137 percent over the previous quarter. Commander directed urine tests have been averaging 16,000 tests per month. Despite these intensfied efforts, the number of newly identified drug abusers is decreasing as are discharges for drug abuse.

Changes to the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) are improving critical elements of education, assistance, treatment and rehabilitation. Drug Education and Assistance Teams have been formed to assist communities in improving their programs. Thirty clinical directors and 40 civilian counselor spaces were authorized by the Army to improve rehabilitation services. Ability to assess "hot spots" has been improved. Research on drug deaths is underway, with an eye toward preventing them in the future.

HQ US Air Forces Europe implemented "Operation Counterpush" to reduce the impact of growing availability of drugs. Counterpush is a three-pronged attack covering interdiction, identification, and education. The initial action plan published in September 1978 outlined 26 initiatives in these areas.

Interdiction efforts focused on intensified law enforcement. Investigative staffs were increased 52 percent. The number of drug detector dogs was increased by 130 percent and will increase by 232 percent (103 dogs). The law enforcement efforts are orchestrated by a Narcotics Advisory Board (NAB) which monitors law enforcement activities throughout the command and insures interface with USAREUR's Drug Suppression Operations Center (DSOC) as well as with EUCOM's Special Assistant for Drug Enforcement (SADEM).

Identification initiatives focus on demand reduction. USAFE is attempting to visibly create an environment that is inhospitable to drug abuse. Law enforcement is aggressive, drug users run a high risk of getting caught, punishment is swift, consistent, and predictable. Deserving people who are caught are disciplined and given a second chance but suppliers, repeat offenders, and addicts are disciplined and separated. Urine testing levels are high. Rehabilitation programs are publicized and are run by highly trained drug and alcohol abuse control specialists. Education efforts are targeted to all elements of the community, with curricula tailored to the needs and characteristics of the audience. These efforts include annual commander-supervisor seminars, first-termers' seminars upon arrival in the theatre, cannabis experimenters' eight-hour remedial education seminars, classes detailing legal penalties encountered when traveling to other countries, briefings for CONUS units deploying to USAFE, youth involvement programs, mass media campaigns, and a spontaneously generated anti-drug abuse peer pressure movement.

Disciplinary and administrative discharge actions have increased substantially, particularly General Courts-Martial cases for serious offenders. High urine test levels have continued and the number of confirmed positives has been declining, except for cocaine. A full range of tools and resources are and will continue to be committed to combating the drug problem in U.S. Air Forces Europe.

The U.S. Navy in Europe has significantly fewer permanently stationed personnel in Europe than do the Army and Air Force, and most of these are based outside of Germany, the current area of highest drug availability. The Navy does not perceive a significant drug problem among their forces in Europe. Drug abuse control programs are in place and functioning, but not with the intensity evidenced by the Army and Air Force. We are presently assessing the nature of the drug problem among Navy forces in Europe and are increasing our emphasis.

The Office of the Secretary of Defense (Health Affairs) has been closely monitoring and supporting drug abuse control efforts in Europe. Visits have been frequent, program trends and developments have been closely monitored, and supportive or corrective action has been taken where necessary. This involvement and emphasis will continue.

Prepared Statement of John H. Johns, Ph. D., Professor of Human Resources Management, Industrial College of the Armed Forces

BIOGRAPHICAL SKETCH

Dr. John H. Johns served as a commissioned officer in the Army for over 26 years, retiring in 1978. He served as a platoon sergeant in 1947–48 and then returned to the University of Alabama, where he was commissioned from ROTC as a Distinguished Military Graduate in 1952. He served in various artillery troop assignments and staff positions during his career. Dr. Johns' last assignments as an Army officer were as Assistant Division Commander, 1st Infantry Division, 1975–77; and Director, Human Resources Development, Headquarters Department of the Army, 1977–78. Upon his retirement, he was appointed by the Secretary of Defense as the Special Assistant for Drug Abuse. His academic background includes graduate degrees in international affairs, psychology, and sociology. He is currently Professor of Human Resources Management, Industrial College of the Armed Forces.

Mr. Chairman, members of the Select Committee on Narcotics Abuse and Control. I am pleased to have the opportunity to present my views on drug abuse in the military. My comments are offered as those of a private citizen, although they are based on my experiences as an Army troop commander and as the Special Assistant for Drug Abuse, Office of the Secretary of Defense during 1978–1979. My comments are for the most part impressionistic, but I've attempted to base them on systematic consideration of research data and interviews.

Before I get into the substance of my testimony, I want to express my appreciation to this Committee, the White House Staff, the Department of Defense for their cooperation and support during the year I served as the Special Assistant for Drug Abuse. Any lack of initiative on the part of OSD during the past year can be attributed to me. Congressman English and the other members of the Committee with whom I dealt offered constructive criticism, but were realistic in their demands. Secretary Duncan, who served as the Deputy Secretary during my tour, was always accessible and supported me in every effort I made. I view my work during that year as a collaborative effort with you and the White House and I'm appreciative.

We did not make the progress I would have liked. Bureaucracies are slow to react unless there is a perceived crisis. I deliberately recommended we not approach the Drug Prevention program on a crisis basis because in my judgment such efforts are short-lived and turn off the commanders. In the long run the overall effort suffers.

NATURE OF THE PROBLEM

Let me first turn to the nature of the drug abuse problem in DOD. By drug abuse I mean any use of a psychoactive substance in a manner that has an adverse impact on the individual user, other people, the community, or Department of Defense. Obviously, not all drug abuse has equal consequences and therefore we should have a variable response to the abuse according to its consequences. I'll make this point more clearly in later comments. Although nicotine and caffeine are two of the most widely abused substances, DOD does not include them in the Drug Abuse Prevention program and I will not refer to them again. Of the other drugs abused, alcohol is clearly the most serious problem in DOD. Because this Committee does not have its primary focus on alcohol, however, I will not dwell on that substance except as it relates to other drug abuse.

As the Committee knows, the precise extent of drug use is difficult to determine. Most indicators used to estimate the prevalence, such as low enforcement statistics, medical records, etc., are unreliable in that they are subject to differential policies and wide variances in policy execution. Random urinalysis could provide a reliable estimate, but that mode of measurement will always understate the prevalence for reasons known to the Committee. Surveys, with all their shortcomings represent the best tool for measuring the problem.

DOD has not conducted a DOD-wide survey on drug abuse since 1974. The Army has included items on drug abuse in a personnel survey since 1974, however, and that is the best measure DOD has. The exact figures are included in other testimony today and I'll not repeat them. Let me just say this in regard to the results reported by the Committee based on the survey you administered in Germany: I believe the results of the two surveys, when demographic variables are controlled, are not far apart. We can assume that about 60–70 percent of junior en-

listed people use cannabis at least occasionally. About 20 percent use "hard drugs" at least occasionally.

I have no basis to question the data contained in the surveys. The important question in my mind is: What are the adverse consequences of the use? Many factors have to be considered in answering that question, as the Committee has recognized in some of its reports. The kind and amount of drug use is critical as is the time the drug is used. Without going into detailed justification for my conclusions, let me offer my global judgment of the consequences of drug use in the military.

First, we all must recognize that the mere use of an illicit substance has in itself, an adverse impact in DOD. Discipline is critical in the military for obvious reasons and the deliberate violation of laws, rules, and regulations undermines discipline. In that sense, any illicit drug use is undesirable. This is not a simple issue, however, and does not warrant the emotional reaction often associated with drug use. Traffic violations, gambling and many other widespread behaviors are also illegal, but we do not get overly concerned about them unless they have serious consequences. In some states, the legal age for alcohol consumption is 21, but few commanders classify the use by teenage military personnel as "drug abuse." So the simple fact that a drug is illegal should not be weighed out of proportion.

With respect to the other drugs used, my intuitive feeling is that the use of cannabis has little observable impact on the duty performance of most personnel. For heavy users, I suspect it contributes to poor motivation, apathy, and reduced benefit from training. I'm not sure that troop leaders are sufficiently appreciative of these effects as long as an individual is not a trouble-maker. Also, it is difficult to know which is cause and effect. Poorly motivated, slow learners are likely to be the abusers. This relation is hard to sort out and many commanders don't try. As we know, heavy use of cannabis also affects judgment and psychomotor skills. For the "hard drug" abuse, we need a great deal more information before we can draw firm conclusions. For example, the most widely reported drugs used in Germany are various sorts of uppers and downers. Specifically, two over-the-counter drugs appear to be the most used. X–112, often referred to as "jet fuel," because it helps one "take off," is the most common "upper." One of my staff purchased a bottle of 100 tablets for about $11. The ingredients listed on the label include caffeine, nicotine, and a variety of herbs. One medical doctor told me that it was probably equivalent to a NO-DOZ tablet—which contains about the same stimulant effect of an average cup of coffee. The "downer" most widely used in Germany is Mandrax, another over-the-counter drug which is the German version of Quaalude. I'm told that the common method of using Mandrax is to take it with beer during the evening drinking sessions. It allegedly provides a good night's sleep. So I don't know how to interpret survey data that shows 18 percent of soldiers say they use uppers or downers once a month or more often.

I simply can't estimate how much adverse effect such drug use has on behavior. In some instances, it could be beneficial. As one tank driver told me, ". . . look, you've been on a field exercise a week, with not very much sleep. You have to drive a tank through one of these narrow streets without hitting the corner of a house. Is it better to do it drowsy or awake?" On the other hand, 9 percent opiate positives during a unit sweep is clearly a serious problem.

Many commanders will insist that drug abuse has no significant impact on readiness. As was reported to this Committee last year, a survey in Germany showed that of 39 factors, commanders considered drug abuse in the mid-20's in priority. A survey this year moved it up to 19 I believe, but still shows it low. From my conversations with commanders, I have concluded that most of them sincerely believe the drug abuse problem has been pushed way out of proportion. I'm not sure why this is so. My own sensing is that much of the decrement in performance is manifested by apathy, low motivation, and slow learning; thus, it is attributed to something other than drug use. This is precisely the kind of behavior that often accompanies heavy use of cannabis, however. Unfortunately, it is also the kind of behavior exhibited by many who never use drugs. It is difficult to find a cause-effect relationship. Also, commanders feel so constrained in dealing with drug users, they may unconsciously deny that there is a serious problem.

We know, however, that the prevalence of drug varies with units. On unit sweeps in Germany during one study our urinalysis rates ranged from 0.5 per-

cent to 9 percent positive; the latter were all opiates in one unit. Based on any yardstick, 9 percent use of opiates is a serious problem.

My own assessment is that drug abuse has a more serious impact on readiness than is generally accorded by commanders, but that it is not a crisis situation. The standards used to classify a unit at the highest level of readiness allow for approximately 10 percent of personnel shortage. Drug abuse would be just another factor in that equation. The statement is often heard that if the NATO Forces were attacked on a weekend we might be in trouble. No scenario we have calls for less than 10 days warning time, during which troops would be on alert. Consequently, I don't believe it is valid to measure the impact on readiness against the worst case of soldiers drinking and smoking hashish on weekends even though we certainly don't like such behavior at anytime.

IDENTIFICATION OF DRUG ABUSERS

I have mixed feelings on the use of urine tests as a means of drug abuse prevention. Logic tells me that large scale random urinalysis would inhibit the use of detectable drugs. We have no firm evidence that this is so. After all, Court of Military Appeals (COMA) decisions have required DOD to exempt from punitive action anyone detected in this manner. The vast majority of commanders tell me "what's the use of finding someone using drugs when all you can do is 'treat' them or give them an honorable discharge?" In fact, many commanders in Europe (including General Haig when he was there) contend that many people deliberately produce positive samples so they can curtail their tour with an honorable discharge.

While the value of large scale urinalysis as a deterrent is doubtful, its impact on morale is not. The overwhelming number of commanders with whom I've talked feel that large-scale urinalysis on a mandatory quota basis is a mistake. In my opinion, the mandatory quota policy we announced to this Committee last year—and which we tried for a year—did more to create hostility to our program than any other single thing. If we don't have command involvement and support, our efforts will be for naught. I strongly urge that DOD stay away from mandatory quotas in urinalysis. I believe the current policy, which ties urine tests to specific incidents where there is reason to believe drug abuse is involved, e.g., marked change in behavior, accidents, is a more sensible approach. The policy also suggests unit sweeps in areas where drug abuse is known to be a serious problem. I agree with that, but there must be a judicious use of that technique. There has been concern that the absence of mandatory quotas will result in some commanders' failure to use that tool for controlling drug use. My view on that is that OSD monitors the amount of urine testing, by command, and can take action against specific commanders. With the DOD-wide survey, "hot spots" can be identified and if commanders are lax in those areas, action should be taken.

TREATMENT OF DRUG ABUSERS

I want to discuss "treatment" briefly. We have very few drug addicts in DOD in the sense of physical addiction. Those who become physically addicted are readily spotted. What should DOD do with them? Research shows that when such persons are given professional treatment of the best we have, less than 10 percent "stay clean." The Navy Drug Rehabilitation Center at Miramar reports some 45 percent success rate, but the input there is carefully screened and only those who are considered to have good potential for further service are sent there. Most of these are not physically addicted. They are put through a two-week screening after arrival, which further "purifies" the sample.

Personally, I'm not sure the Navy program is cost effective. The Army and Air Force have chosen to take another approach. Addicts are detoxified, given treatment in a 30-day drug-free environment, and discharged. This 30-day period may be all in the military, or half in a VA hospital. Recent legislation, as you know, requires that the individual submit a request in writing if he wants to go to a VA facility. On balance, I believe the Army and Air Force have the best approach. The prognosis for addicts doesn't warrant keeping them in the military.

With respect to non-addicted drug abusers, most of these should be treated on an out-patient basis. Some should be given residential treatment, but I'm ambivalent about how much success we can have with individuals who need

such treatment. We are very successful with our alcohol rehabilitation, but not very successful with drug abusers who require residential treatment. So my focus would be on the out-patient treatment.

As I went around visiting the various treatment facilities in the four Services, I found that "treatment" was a misnomer. Most of the clients were entered into "treatment" because they had been caught using marijuana. At one base, for example, the program had 50 clients for drug abuse. Of these 39 were for marijuana. I asked the director how many were classified as "good airmen" when they were entered into the program. He estimated that 30 fit that category. What, then, is the "treatment? In essence, it "values clarification designed to assist the individual to accept the values of the military, that is, use of illegal drugs such as marijuana, is bad.

The vast majority of the out-patient load is "values clarification" for cannabis users. I'm not sure that most of these people should be entered into such "treatment." Most of them would tell me that they had no "values" problem; rather, it is the military and law that have the problem. I doubt that we make much of a dent in the values" of such people. At best, we get across the point that they must be more careful about when and where they use cannabis. Perhaps such people should be handled within their units.

My impression is that most of the activity in the out-patient program is designed to help clients grow up and accept the structured responsibilities of being a soldier/sailor/airman/marine. If this is the case, then we must take a close look at the type of skills required of counselors. My own bias is toward staffing with senior NCO's who have been good troop leaders, but who also have the interpersonal skills to be counselors. Perhaps senior NCOs on a twilight" assignment prior to retirement could be used. The better ones could then be offered civil service ratings in the same position. I believe we could get maturity, quality, and stability with such a policy. This kind of counselor would be able to relate well to the line commanders and provide a role model for the drug abusers.

AREAS FOR EMPHASIS

Where do I see a need for emphasis? Drug abuse is a function of three factors: the personality of the individual, the environment he is in, and opportunity. Opportunity includes availability of drugs. I believe the Committee has done a great service in focusing attention on drug trafficking. There will always be drugs available as long as there is a demand, but a high price caused by scarcity will discourage use. We should throw the book at dealers and traffickers.

Personalities, including values and habits, are deeply inbedded in our recruits. Unfortunately, many of our recruits have different values than we would like. We try to weed out the worst cases, but with the vast majority of youth positively oriented toward marijuana use, for example, how far can we go. Through basic and advanced training, we attempt to convert civilian youth into soldiers, sailors, marines and airmen with the kind of values we need. We need to do a better job here, but it is not totally within the control of the Services. Externally imposed constraints have cut basic training time to the bare bones—less than seven weeks for the Army. I received 13 weeks in 1947. One training center commander told me he had to eliminate the graduation ceremony where parents and relatives saw their kin go through the ritual of being given the status of "soldiers." This cutback of training time is, in my opinion, a tragic mistake.

Even with the short basic training we still find that esprit is probably at its peak at the end of this training. Research data shows it goes steadily down hill from there. The third factor in drug abuse, environment, is primarily the primary group in the military organization in which an individual is assigned. I believe the Committee members have read the "Boys in the Barracks," a research report which describe how barracks norms influence behavior. While some of that study tends to take poetic license, it is fundamentally accurate. We must do more to develop strong organizational norms that support healthy, wholesome behavior. I don't have time to detail how to go about that, but I don't believe it has been *systematically* addressed by any of the Services. We tend to be too task oriented in military units and neglect organizational maintenance. When we do, we tend to focus on material comforts and "just good leadership." The latter is a truism that leads to nothing more than

rhetoric. Leadership is the most important component of organizational esprit, but it is not the only factor. Furthermore, we spend little time in organizations developing leaders' ability to motivate their troops.

I would try to place more of the "counseling" functions down in the battalion. The Army is now testing a concept that adds another officer to the personnel management staff of each battalion. This officer receives several weeks of background in organizational behavior, counseling, drug and alcohol abuse, etc. Working with more highly skilled officers at division level, I believe this will be a valuable program. Also, I believe it will reduce manpower requirements in the Community Drug/Alcohol Abuse Centers (CDAAC) by reducing their workload. The CDAACs and residential facilities can then concentrate on quality counseling for those few who need it.

For those non-addicted individuals whose real problem is a lack of discipline that cannot be given in the units, I favor the use of "Retraining" units on the model of Ft. Riley, Kans. Marginal soldiers are put through a rigorous 6–7 week program. The results are remarkable and prove to be very cost-effective.

Lastly, we must recognize that drug abuse is a chronic problem of our society. It will be with us for the foreseeable future. DOD has to ask itself how much it can differ from the values of its members, especially on such drugs as marijuana. If we develop a capability to detect marijuana use through urine tests, how do we want to use that capability? Do we want to aggressively identify all users? If so, what do we do with them? We cannot punish them, so do we discharge them? The Strategic Air Command (SAC) adopted a "get-tough" policy a little over a year ago. Anyone identified as a drug user was offered the opportunity to attend a 14-day rehabilitation center at a centralized location or be discharged. Of 2,800 persons identified, 72 percent were discharged. Perhaps such a tough policy will deter others from using marijuana. I'm not convinced it will. With such a policy, what would DOD do in a draft situation? A person doesn't want to serve, he smokes marijuana and shows up positive on a urine test, and gets an honorable discharge. I believe such a policy is totally unrealistic even though I respect the effort of SAC to control drug use.

Consequently, I argue for realism in the DOD approach to drug prevention. Response must be commensurate with the seriousness of the consequences of drug use. This doesn't mean being "soft" on drug abuse; rather, it means being realistic.

I would like to close my testimony by saying that I believe this Committee has done a service by stimulating DOD to take a more aggressive program of Drug Abuse Prevention. At times I thought some of your criticisms were unfair, but I believe they were sincere and on balance, we needed the stimulation. Commanders and senior civilian executives have momentous problems in DOD and they have a tendency to neglect human resources, especially when there is little immediate, tangible evidence that increased resources and attention pay off. Drug and alcohol abuse fit this category of activity. I hope Congress and the White House keep an interest in this area and assist in a long-term effort to cope with it.

Are there any questions?

PREPARED STATEMENT OF HON. MATHEA FALCO, ASSISTANT SECRETARY OF STATE FOR INTERNATIONAL NARCOTICS MATTERS

I am pleased to appear before the House Select Committee on Narcotics today to discuss the progress that has been made during the past year with our European allies in improving narcotics control cooperation. The hearings chaired in West Germany last year by you, Congressman English, had a catalytic effect in developing high level European recognition both of the increasing heroin problem in Western Europe, and of the need for governments to take stronger measures to curtail the problem. The hearings today provide important follow-up for last year's efforts, and reflect the continuing concern of the Select Committee for the problems of drug abuse in United States armed forces overseas.

Before I begin a review of the Department of State's European initiatives over the past year, I would like to discuss illicit narcotics production and use as it affects Europe and our military forces there.

Europe's heroin addict population is growing rapidly. Estimates by the U.S. Drug Enforcement Administration (DEA) indicate that Western Europe had

approximately 234,000 addicts in 1978, up from 200,000 the previous year, plus thousands who abuse other drugs. Last year there were approximately 1,000 heroin-related deaths in Western Europe, and the number is expected to grow in 1979.

In West Germany and Berlin alone, there were at least 447 drug-related deaths by the end of last month. This total already exceeds the total number of drug-related deaths for 1978. West German authorities estimate that there are between 60,000 and 80,000 hard drug users in West Germany and Berlin. Sweden, the Netherlands, France and Italy are also suffering from increased drug addiction and its tragic consequences.

While the reasons for the increase are not well defined, increased availability is surely a factor. There has also been a continuation of the shift in trafficking patterns, transferring the bulk of European traffic from Southeast Asian to Middle Eastern sources.

Both the increase and the shift in sources are visible in West European seizure statistics provided by the Drug Enforcement Administration. In 1978, 611 kilograms of heroin were seized in Europe, 429 kilograms from Southeast Asia, and 182 kilograms from Middle Eastern sources. By June 1979, 262 kilograms of Middle Eastern heroin had already been seized, and by October 1979 only 245 kilograms of Southeast Asian heroin had been seized. Moreover, the farmer's price of Mid-east opium has plummeted, from $200 a kilogram in 1978, to $50 in 1979, at a time when Southeast Asian opium prices have increased up to 500 percent, according to information provided by DEA. Although the price is low, the purity is high, with some seized heroin identified as 80 percent pure. April 1979 street level purity in the United States was 3.5 percent, although DEA anticipates an increase to show up later this year.

The sudden increase in availability of Mid-east heroin over the past few years has brought a heroin epidemic to Europe of greater proportions than exists in the United States. We ourselves, however, have yet, I believe, to face the full brunt of the Mid-east opium crop, which has supplied U.S. heroin in steadily increasing amounts since 1977, when it jumped from a negligible share of the U.S. supply to 8 percent. Today, DEA estimates that 15 to 20 percent of U.S. consumed heroin originates in Afghanistan, Pakistan and Iran. The exposure of our military forces in Europe to this new supply is an indicator of the threat faced at home. It is also another clear demonstration that heroin is a global problem, and not only a U.S. problem as European countries tended to believe until very recently.

Because of the global nature of illicit narcotics problems, a major objective of our international narcotics program this past year has been to increase the responsiveness of other developed countries, particularly in Western Europe, to cooperative efforts to curtail worldwide illicit drug production and trafficking. Since I appeared before you in Stuttgart, Germany, last year, we have undertaken a number of initiatives in pursuit of this objective. At the same time, the problems of drug abuse in the military have been receiving continuing attention through the U.S.-German Central Working Group.

The prominence that the Department of State has given to narcotics control issues in bilateral and multilateral discussions has, we believe, contributed significantly to the effectiveness of the Central Working Group's efforts. Therefore, I would like first to place the Central Working Group in the context of the Department of State's broader European efforts, and then I will provide a report on the activities of the Central Working Group since this Committee held its hearings in Germany a year ago.

The basic goal of the State Department's antinarcotics efforts in Europe has been to try to focus the attention of top level European governmental officials on narcotics issues. We have sought to ensure that the Central Working Group receives the political support it requires to be effective by continually raising the larger, European-wide narcotics problem with top level West German officials. Our belief is that only prominent political commitment will enable day-to-day operational groups, such as the U.S.-FRG Central Working Group, to be productive.

We have, therefore, continued to raise narcotics issues in bilateral discussions and also sought new multilateral fora in which to draw attention to the problem. These include the OECD—Organization for Economic Cooperation and Development in Paris, NATO, the U.N. and the international development banks.

In May of this year the U.S. formally launched a narcotics initiative in the OECD by submitting two proposals addressing illicit narcotics use to the OECD

membership. We suggested that the OECD's Development Assistance Committee (DAC) study and report as to how bilateral development assistance programs of member countries can help toward the goals of international narcotics control. The proposal also suggested that the OECD sponsor a study to provide a basis for developing statistically comparable drug abuse data in OECD countries.

The OECD proposals are being discussed and debated in Europe. We are optimistic that they will be given favorable attention at OECD meetings in the near future. The U.S. OECD initiative has already served a highly useful purpose by focusing attention on the narcotics issue among the economic and foreign affairs ministries of the major industrial democracies. OECD representatives have begun to transfer this concern to their governments where the critical budgetary decision must be made.

A second forum where we have been active is NATO. Again, the thought here is that narcotics abuse is a critical European problem which must receive the highest government priority. NATO is an especially appropriate forum for this purpose from our point of view because of the U.S. concern about the potential for drug abuse to affect military readiness and because of the great importance our European allies attach to our participation in the organization.

Within the last month the subject of narcotics was raised at the NATO Committee on Challenges to Modern Society (CCMS). In addition, our Permanent Representative in NATO, Ambassador W. Tapley Bennet, has discussed the growing narcotics problem with the other permanent representatives during the series of periodic meetings held by the permanent representatives. The U.S. Representatives on the Military Committee have also introduced the subject for discussion by the military representatives in order to exchange views on the effects of narcotics on military readiness and effectiveness. I plan to attend the NATO Ministerial Meeting in Brussels in December with Secretary Vance.

Within the past year, we have also continued our efforts to stimulate increases in contributions to the U.N. Fund for Drug Abuse Control, which is an essential multilateral vehicle for international cooperation in narcotics control. As you know, the Congress has limited U.S. contributions to the Fund in 1980 to 25 percent of total contributions or $3 million, whichever is less.

Our European efforts with regard to UNFDAC have been quite successful, in that they have elicited substantially increased contributions to the Fund from at least two countries, the Federal Republic of Germany and Italy. During my recent visit to the FRG, German officials informed me that the Parliament has authorized increased contributions to the equivalent of $1.1 million to UNFDAC in 1980. This represents a 400 percent increase in their contribution, which has previously been about $250,000 annually. The West Germans are allotting an additional $1.6 million for bilateral projects sponsored by the U.N. Fund for Drug Abuse Control. FRG officials have estimated that as much as $5.5 million could be made available in 1981 if suitable narcotics related development projects are designed.

The Italians, who have not contributed to UNFDAC for several years, have responded to the current problem by allocating $120,000 for this year. While not large, this contribution demonstrates growing attention to narcotics abuse.

The funding by the Federal Republic of Germany and Italy for UNFDAC and related narcotics projects in 1980 represents a major breakthrough in European attitudes toward the drug problem, and an important victory for U.S. narcotics efforts in Europe and the FRG in particular. We are optimistic that our efforts in the OECD, NATO and with individual countries will yield comparable results over the coming year, as European governments become more aware of the grave narcotics problems facing them.

A fourth arena for increased international cooperation in narcotics control is in the international financial community. Since your hearing last year, we have entered into an Interagency Agreement with the Department of the Treasury, AID and other agencies aimed at focusing the attention of international financial institutions—and their voting members from foreign countries—on development assistance as it relates to narcotics control. Our goal is to have illicit narcotics production taken into consideration in bilateral and multilateral assistance. Consideration of narcotics problems could result the granting of loans to illicit narcotics producing areas to provide a basis for alternative development, or in the signing of anti-production clauses prohibiting illicit narcotics cultivation in geographic areas covered by the Agreement. We are hopeful of persuading

European governments to consider including this type of consideration to their own bilateral assistance programs.

Progress has also been made with the Federal Republic of Germany under the auspices of the Central Working Group. As you know, the U.S. and the FRG established the Central Working Group in June 1978 to deal with narcotics problems under a joint Narcotics Control Agreement. Twice yearly meetings are under a permanent coordinator from each government, and through four permanent subcommittees, which deal with: (1) Police and Customs Enforcement Measures, (2) controls among military personnel, (3) drug abuse prevention, and (4) legal questions.

Three meetings of the Central Working Group have been held with the next scheduled for November 16. The technical work of the CWG has been delegated to the four subcommittees named above, with the bulk of the substantive issues falling to the Subcommittee on Police and Customs Enforcement Measures. The PCEM has met formally and informally on a number of occasions—the most recent meeting is going on today and tomorrow in Bonn, Germany.

You have inquired specifically about the problem of ex-military drug traffickers returning to Europe as civilians in order to pick up old connections and customers and resume drug trafficking. This subject was delegated to the CWG's Police and Customs Enforcement Measures Subcommittee.

Efforts to deal with the problem have centered around two issues: (1) the exchange of information between U.S. military commands in Germany and German authorities, given the restrictions imposed by the Privacy and Freedom of Information Acts, and (2) the application of German immigration and transient laws and regulations.

The first of these two issues has been resolved by the German law enforcement officials putting restrictions which conform to U.S. legal requirements on the information they wish to receive. Information is requested only when: (a) a U.S. military person is detected, investigated, tried and convicted as a drug violator in Germany, (b) the sentence included discharge under other than honorable conditions from the military, since January 1, 1979, and (c) the sentence was confirmed after a final review.

As a result of the PCEM discussions, there is now a proposal before the CWG that German law enforcement agencies maintain this information on file and use the data as a basis for refusing entry to or to expel from Germany those individuals with histories of drug offenses.

Before the proposal to move against former U.S. military drug offenders can be implemented, the second issue under discussion—essentially legal and procedural—needs to be resolved. We have been told that German law enforcement authorities are currently discussing the application of German immigration laws and regulations to these cases. Assuming the laws can be applied in conformance with other applicable statutes, it will then be necessary to coordinate the policy among the German federal criminal and border police and customs agencies, and state ("land") police.

Meanwhile, the U.S. side is working out what U.S. authority will pass the information to the Germans, and at what point in a case it should be passed. There is a question whether the transfer should take place when a convicted member of the U.S. military departs for the U.S. to serve his sentence, or at some later point in the appeals process.

This problem of ex-military traffickers in Germany greatly concerns our Embassy and military commands in Germany. Evidence suggests that these individuals are frequently the link between German or foreign national traffickers and U.S. military abusers. In recent months, the U.S.-German cooperation fostered by the Central Working Group has resulted in a number of successful joint German-U.S. military enforcement operations. These have netted only small amounts of narcotics but significant numbers of small-time offenders around or near U.S. facilities. The publicity accompanying these operations has, our Embassy believes, served to deter at least the less determined military abusers.

In general, we are pleased with the progress being made in the enforcement subcommittee, which has helped to focus German-American cooperation in the law enforcement field, particularly as it regards our military. Our Embassy views the work of the other three subcommittees as primarily a means to sensitize German officials about the drug trafficking and abuse problems.

We believe that the Germans have come a long way toward grasping the significance of the narcotics problem. In due course, perhaps in the next year or so, our cooperation will focus more specifically on practical exchanges of current data and experience and bilateral programs. We anticipate that in the next Central Working Group meetings, German Government officials are likely to be more forthcoming than in the past in proposing narcotics initiatives.

The response to U.S.-European diplomatic initiatives on narcotics problems has been encouraging in a number of countries in addition to the Federal Republic of Germany and the regional organizations. The Italian Government, with whose representatives we have recently held discussions, in addition to its contribution to the UNFDAC, has sought technical assistance from us on developing drug prevention and treatment programs. An Interministerial Committee on Drug Abuse has recently been formed and the Minister of Health has personally undertaken a review of policy options which the Italian Government might pursue to deal with the serious drug abuse problem facing Italy and is seeking to interest other European Community Health Ministers in development of common programs in this field.

In Switzerland, a recent public opinion poll revealed that the Swiss consider drug addiction to be the leading national problem to be dealt with over the next four years. The Austrians are planning to hold an international conference on illicit narcotics this month which will offer an opportunity for the U.S. and invited representatives of Western Europe to share experiences in the drug prevention and enforcement areas.

In general, we are hopeful that 1979 will prove to be the year in which European governments begin to accord drug abuse the high priority it deserves. Although the recent German and Italian announcement of increased funding for UNFDAC is encouraging, Europe as a whole must participate far more actively in the international narcotics control effort if significant progress is to be made. To increase this participation has been one of our primary goals since last year and I believe we have come a long way. We welcome the continued interest of this Committee and believe that the public attention it has given to drug abuse problems in Europe will continue to be of critical importance in our continuing effort to tighten the international circle around illicit narcotics production and traffic.

PREPARED STATEMENT OF BRIG. GEN. JOSEPH C. LUTZ, DIRECTOR OF HUMAN RESOURCES DEVELOPMENT, OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL, U.S. ARMY

INTRODUCTION

Mr. Chairman and members of the Committee, I am Brigadier General Joseph C. Lutz, Director of the Human Resources Development Directorate, Office of the Deputy Chief of Staff for Personnel, Department of Army. Accompanying me today are: Colonel James M. Krebs, Chief, Human Resources Development Division, HQ, US Army Europe; Lieutenant Colonel John Valieant, Chief, Drug Suppression Operations Center, HQ, US Army Europe; Mrs. Helen D. Gouin, Chief of Alcohol and Drug Policy, Office of the Deputy Chief of Staff for Personnel; Major Jack Hackett, Law Enforcement Division, Office of the Deputy Chief of Staff for Personnel.

I appreciate the opportunity to appear before this Committee and discuss the Army's initiatives in regard to alcohol and drug abuse. I share your concern in this regard and believe that we have made considerable progress in control of these highly complicated problems during the past year.

Although I have only served in this position since June 25th of this year, the matter of alcohol and drug abuse in the Army has been a serious concern to me for a number of years, in my capacity as a commander of troop units. On arrival in my new assignment, I was personally briefed by my predecessor, Major General W. F. Ulmer, who assured me that the Army was complying with all the recommendations from previous hearings by this Committee and those transmitted directly by members of the Committee. Before General Ulmer left, he made a personal trip to Germany, to make on-site evaluations of the programs and to initiate corrective action as he deemed necessary. The following observations briefly summarize General Ulmer's findings.

He was pleased with the command emphasis and noted that community commanders were developing detailed narcotics control plans which included military police, CID, and local police, and that these operations were paying off. He also noted that the seriousness of the problem was recognized. Commanders and

staff Headquarters, US Army Europe and Seventh Army (HQUSAREUR) were concerned and interested in taking corrective action. Although there were problem areas with some of the Community Drug and Alcohol Assistance Centers (CDAAC), the Headquarters personnel generally were aware of them and were taking positive corrective actions. Since February of this year, HQUSAREUR has done an indepth manpower survey of the CDADC system and has done a major realignment of the system which should result in a more effective distribution of resources. In addition, MG Ulmer amended the regulation to provide the needed flexibility to local commanders. He believed this would alleviate the counselor client load to some extent.

He immediately implemented certain policy changes to our Army drug and alcohol control program. This included discontinuing the practice of referring cannabis abusers to the program if they were first-time users. Additionally, he directed that commanders, in conjunction with counseling staffs, determine the length of rehabilitation required for each client on a case-by-case basis. Regardless of the total length of rehabilitation, the requirement for a minimum 30-day period of treatment and rehabilitation for alcohol or drug dependent persons remains and is in consonance with public law. He also authorized, as an exception to the regulation dealing with discharges, approval authority for alcohol and drug discharges at the same level of command that now exists for approval authority for expeditious discharges. In other words, to colonel and lieutenant colonel command levels.

He directed an increase of programs personnel as well as ordered a concurrently upgrade of our enlisted counselors both from the standpoint of age as well as training. He noted that law enforcement efforts were extensive and effective. For example, the increased funding for CID was paying off. In the last year, over $5M worth of narcotics were confiscated in the Hanau vicinity alone.

General Ulmer observed that the urinalysis program, although expensive and susceptible to certain management deficiencies, was going well. The selected unit urine testing for company-size units (SUUTCO) was effective in locating hot spots, particularly when used in conjunction with individual commander-directed urinalysis.

General Ulmer summarized his observations by noting that in the final analysis, drug and alcohol abuse prevention and control are a chain of command responsibility and while support can help, the final battlefield is the barracks, the commander's management of the unit, and at the CDAAC's.

THE ARMY ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM INITIATIVES, FISCAL YEAR 1979

I now would like to address the status of Army initiatives for FY 79. The Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) continues to have as its primary objectives: (1) prevent and control alcohol and other drug abuse, (2) identify alcohol and other drug abusers as early as possible, (3) restore both military and civilian alcohol and other drug abusers to effective duty, or identify rehabilitation failures and separate them from Government service or employment, and (4) provide program evaluation, studies, and research, as appropriate.

As you know, we had a worldwide conference for drug and alcohol abuse program personnel at Fort Carson, Colorado, on January 8th of this year. At that conference, we determined there was one major goal—to improve program effectiveness in support of combat readiness and six subgoals of: (1) providing an ADAPCP which will support and be supported by the Army Personnel Management System, (2) increasing awareness and credibility for the ADAPCP, (3) ensuring that the ADAPCP is compatible with the concepts of the Human Resources Management System, (4) improving the civilian aspects of the ADAPCP, (5) enhancing law enforcement measures to support the ADAPCP and provide for appropriate interface between all alcohol and drug control efforts, and (6) developing operating guidelines and procedures for the Drug Abuse Technical Activity (DATA). As a result of the goal and subgoals, we developed some 82 actions which were to be ongoing for the next several years. I can report to you that progress is excellent in working toward these goals and subgoals.

During Fiscal Year 1979, the Army has continued its all-out effort to prevent or control the abuse of alcohol and other drugs by soldiers, civilian employees and their dependents, and retired military personnel. Our concept is to conserve

manpower, and our investment in training, through prevention, identification, rehabilitation or treatment, program evaluation, and appropriate studies and research. The ADAPCP directly supports and is an integral part of the Quality of Life Program. It assists in reducing personnel turbulence primarily through the rehabilitation of personnel in the military environment where substance abuse surfaces and by returning them to duty as soon as possible. In instances when rehabilitation is not possible or feasible, we are making it possible to eliminate the service member or employee from Government service in an expeditious manner.

During Fiscal Year 1979, ADAPCP enrollments totaled 22,075—63 percent for alcohol and 37 percent for other drugs. In that same period, 15,209 soldiers were treated and returned to duty, and 3,676 were separated from the Army for alcohol or drug-related problems.

It is not realistic to believe that total elimination of the abuse of alcohol and other drugs in the Army is possible. However, it is imperative that control of alcohol and drug abuse remains a top priority, and that we continue to commit substantial resources for a conscientious and sustained command effort to contain the problem. The impact of alcohol and drug abuse upon individual and unit combat readiness must be minimized. We cannot permit ourselves to be lulled into complacency as we were in 1976–1977 when there was a temporary downward trend in these problems. We also must continue to ensure that such downward trends are not the result of the lack of, or diverted resources in the field, which results in fewer individuals being identified as alcohol or other drug abusers. We believe we have learned this lesson well and that our commanders are increasingly aware of the important role that an effective alcohol and drug program can play in accomplishing their missions. Certainly, we must concentrate maintaining the combat strength of our units. It is self-defeating, however, if these personnel are not operating at full productivity or that the safety and well being of the unit is in jeopardy because some members are abusing alcohol and other drugs.

THE NINE MOST SIGNIFICANT ARMY INITIATIVES, FISCAL YEAR 1979

Of the follow-on actions mentioned previously, I believe nine will be of significant interest to this Committee. They include the following:

Establishment of the Drug and Alcohol Technical Activity (DATA)

On 7 July 1978, the Army Chief of Staff approved establishment of the Drug and Alcohol Technical Activity (DATA) as a field operating agency of the Office of the Deputy Chief of Staff for Personnel. The DATA Team, now fully manned, consists of 17 members and provides technical assistance to the field in the functional aspects of the ADAPCP. Two cases in point which illustrate the function of the DATA are requests from Korea and USAREUR. In Korea, they are faced with an immediate need for remedial counselor training for the ADAPCP country-wide, and the serious need to create a greater awareness of the problems of alcohol and drug abuse on the part of senior noncommissioned officers and commanders and part-time alcohol/drug control officers. Due to the shortage of trained personnel in Korea to accomplish these tasks and the highly dispersed nature of troop units, a segment of the DATA has deployed to Korea to conduct on-site training in five categories and in several locations within the Eighth US Army. There are: (1) ADAPCP military and civilian counselor personnel, (2) physician and other appropriate health care personnel, (3) alcohol and drug control officers, (4) commanders and senior NCOs, and (5) unit alcohol and drug abuse trainers. In USAREUR, another segment of the DATA will provide counselor and program management training for approximately 80 new ADAPCP staff members. Providing on-site training in areas of special need or in instances when it is cost-prohibitive to return large numbers of personnel to the United States for training is only one function of the DATA, but these needs could not be met with local resources.

Establishment of the Drug and Alcohol Review Board (DARB)

The Director of Human Resources Development institutionalized the ADAPCP by establishing the Drug and Alcohol Review Board (DARB). I serve as the Chairman of this Board and Mrs. Gouin serves as the Secretary-Coordinator. Members include representatives from The Surgeon General's Office; law enforcement, and all major Army Staff agencies. Additionally, there is

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representation from other Federal agencies such as the State Department, National Institute on Drug Abuse, National Institute for Alcohol Abuse and Alcoholism, Office of Personnel Management, and the Drug Enforcement Administration. This Board is making it possible to achieve greater awareness of the program and facilitates coordination on all alcohol and drug abuse matters. In addition, we are able to inform and be informed on the efforts of other Federal agencies.

Revision of Army Regulation 600–85, the Army alcohol and drug abuse prevention and control program (ADAPCP)

The revised regulation clarifies the Army position on alcohol and drug abuse. Illegal activities will not be tolerated and a greater emphasis will be placed on supervisory and leadership responsibility. The two consumers of the regulation are commanders who will use it as a resource for performance counseling and service members of all grades who are motivated to meet Army standards and obtain rehabilitation or treatment. The regulation has been revised on the basis of input from all levels of command and incorporates objectives identified after the Congressional visits to Europe in November 1978. It also includes specific results of research, studies, and recommendations to improve the quality of care and the cost effectiveness in the program. The revised regulation utilizes disciplinary or administrative measures for dealing with experimental or casual marijuana use and provides for an intensive educational approach to combat use of marijuana. The regulation also takes a firm stand on the illegality of use and possession of marijuana.

Special concern for alcoholism treatment

In the past three years, we have noted that our worldwide abuse pattern has shifted. Those clients entered into the ADAPCP for alcoholism have almost doubled where as those clients entered into the program for other drugs is almost halved. We are concerned with this development and are taking steps to deal with it. We have a residential alcohol treatment facility in Bad Cannstatt, Germany, for E–6's and above. Results from the pilot residential treatment facility are excellent. From this one facility alone, 660 career-oriented personnel have been restored to duty. In our 9 to 12-month follow-up of these clients, we have had an 87 percent success rate. For this reason, we have included provisions for short-term residential treatment in the revised regulation. Maximum utilization will be made of existing facilities; however, manpower to staff these facilities is crucial.

Army Advisory Committee for Education and Training

Through its education and training advisory committee, the Army's Alcohol and Drug Abuse Policy Office is developing comprehensive new initiatives in the prevention/education area based partially on the DOD requirements but going beyond the minimums set in those requirements. Alcohol and drug abuse education and training is being evaluated Armywide. A system for credentialing alcohol and drug abuse counselors is being explored. Instructional guidelines and learning objectives are being developed in 11 principal target areas to include military and civilian alcohol and drug counselors, alcohol and drug control officers, recovering alcoholics who wish to become counselors, commanders, supervisors, unit trainers, training centers, curricula for all service schools to include the War Colleges, adult dependents, DA civilian employees and dependent youth. Target date for completion of the Committee's work is September 30, 1980. Findings and general guidelines from this group will be forwarded to the U.S. Army Training and Doctrine Command for further development and implementation.

Reduction of tour length in West Germany

Representatives English and Gilman of this Committee recommended reduction of tour length for single or unaccompanied junior enlisted personnel in West Germany. An Army Research Institute Study and the Granger Study, concerning overseas tour lengths, determined that a correlation does exist between incidents of indiscipline in general and drug abuse in particular, and the period of time a soldier serves overseas. Accordingly, effective October 1, 1979, the Army instituted a three-year enlistment option with a guaranteed maximum of 18 months in Europe. This option is open to most military occupational specialities (MOS), and is the first phase of the Army's movement toward the goal

of an 18-month tour for all first-term, three year enlistees in long-tour overseas areas.

Additional military police and CID resources

In FY 79, the Army increased the number of law enforcement personnel devoted to drug suppression operations in Europe by 20 CID agents and 45 military police investigators. The FY 1980 budget continued these increased resources and added five civilian chemists to the CID crime laboratory in Germany. To support the increased drug suppression effort in Europe, $847,000 in operating funds was provided. A Drug Suppression Operation Center was established in Germany in November 1978. This center coordinates all drug suppression activities in USAREUR. There are 44 CID agents and 80 military police working together in Joint Drug Suppression Teams—33 such teams as compared to 13 teams in July 1978 in USAREUR. The number of Army law enforcement personnel involved in these efforts has increased over 200 percent from July 1978. This effort is reflected in the total drug seizure reported in Europe, increasing from $39.9M in calendar year 1978 to over $133M in the first nine months of calendar year 1979.

Additional treatment and rehabilitation personnel

This point also addresses the former Deputy Secretary of Defense's 15 points with respect to the Army's reassessing the adequacy of staffing for the drug program at Headquarters, major Army commands and all levels world-wide. The Army has been, and remains, concerned with the quality as well as the number of personnel assigned to the ADAPCP staffs. Particular emphasis has been placed on the ADAPCP in Europe. In FY 1979, the Army increased Europe's ADAPCP by 128 personnel. These increases were from within existing Army resources and included 40 clinical personnel (20 clinical directors and 20 counselors), 23 education and assessment personnel, and the 65 law enforcement personnel previously mentioned. The FY 1980 budget further increases Europe's program manning by 20 additional counselors. These manpower increases in Europe also were accompanied by an appropriate increase in USAREUR's ADAPCP funding for FY 1980. In regard to ensuring the quality for our ADAPCP personnel and the services they provide, several efforts have been accomplished or are underway to address this aspect of overall program improvement. I already have mentioned the DATA Team and Drug and Alcohol Review Board as well as the revised regulation which provides new directions and goals in dealing with the problem. Of particular note with regard to improving the ADAPCP staff adequacy, the revised regulation will include two major areas of interest. The first involves establishing more stringent minimum criteria for the award of the drug and alcohol counselor special qualification identifier (SQI) to the behavioral science specialist. These criteria will require more experience and maturity on the part of the counselors before they are eligible for assignment to the alcohol and drug program. It should be noted that the current behavioral science specialist training covers a wide range of duty assignments with the alcohol and drug program being only one. The second initiative involves establishing minimum staffing guidelines for ADAPCP counseling facilities worldwide. Population to be served will be used in conjunction with actual client caseload to determine staffing levels for a particular ADAPCP center. The use of a combined population served—client caseload staffing guideline—will reduce the current potential for keeping clients in the program only to maintain a client workload for the purpose of justifying staffing levels.

Department of the Army staff visits to all major Army commands (MACOM's) and briefing on the revised regulation

By the 15th of November, the staff of the Alcohol and Drug Abuse Policy Office, within my Directorate, will have visited every major command worldwide, to include Europe. Purpose of these visits was two-fold. The commands were provided briefings on the new policies in the proposed revision of the regulation, as well as provided staff assistance where necessary. All commands were positive in their acceptance of the new regulation.

INITIATIVES PROPOSED BY CONGRESSMAN GLENN ENGLISH

The Army has responded to all eight initiatives proposed by the Honorable Glenn English. The first initiative recommended that the West German govern-

ment should increase substantially the priority placed on reducing the availability of drugs in West Germany. Through the Drug and Alcohol Review Board and my Law Enforcement Division, we have established liaison with the Office of the Assistant Secretary of State for International Narcotics Control Matters for the purpose of expressing the Army's concern for maximum control of international drug traffic, particularly in Europe. The State Department efforts in establishing a Central Working Group on Narcotics to examine and develop recommendations to deal with the problem of drug abuse in Germany has been most fruitful in increasing German awareness on this problem. The Working Group first met on 15 December 1978 and has met periodically since that time. Senior representatives of the US Embassy, Federal Republic of Germany (FRG) Health Ministry, FRG law enforcement, and US military make up the Group. Four subcommittees of the Central Working Group were formed and have addressed and developed proposals on specific problem areas. These subcommittees are police and customs enforcement, legal, military, and preventive medicine. Additionally, the Berlin Drug Task Force, consisting of US military, embassy, and Berlin officials, was established to identify and suppress drug trafficking routes into Berlin. Efforts to date include increased police and customs seizures, community education, local rehabilitation program improvements, and increased cooperation and coordination between Berlin and US military officials. An additional Drug Enforcement Agency Narcotics Coordinator has been assigned permanently to Berlin and is a member of the Task Force. The Berlin Task Force has submitted four quarterly reports detailing their cooperative efforts. As a result of these actions, as well as a noticeable increase in drug abuse and drug overdose deaths among the German population during the past two years, the West German government has placed increased emphasis on reducing drug availability and abuse in Germany. The FRG Interior Minister was quoted in a national German magazine as stating that the battle against narcotics trafficking in Germany merits the same high priority as the fight against terrorism. West German law enforcement authorities cooperate in undercover CID operations targeted at identifying and arresting civilian wholesalers of large quantities of drugs (Level I operations). West German police have provided funds to assist in paying for information, paying informants, and setting up large drug buys. This support has increased noticeably over the past year. Once these cases have developed to fruition, German police make the arrest and seize the drug contraband. This represents a complete change in emphasis that we are sure is due in large part to the firm stand taken by Mr. English during his discussions with top level German officials. Serious alcohol and drug problems within the Germany population cannot be ignored and apparently now have been recognized by their own government.

Mr. English's second point stated that authority should be granted to the Department of Defense to appeal court decisions beyond the United States Court of Military Appeals (USCMA). During the 95th Congress, there was a proposal at Committee level in the Senate which would grant the fourth circuit of the US Court of Appeals appellate jurisdiction over final decisions by the USCMA. The Department of Defense has several proposals in this area which are being studied at that level.

The second point also is concerned with increasing our ability to detect and suppress drug trafficking. In this regard, during 1979, the US Army Criminal Investigation Command initiated a Drug Suppression Survey Program at each of the 118 military installations to which CID agents are assigned. This program, developed by CID and concurred in by the Army Staff, involves three phases: (1) an assessment of the drug abuse and drug trafficking situation at each location, (2) the development of drug suppression operations and covert investigations, and (3) the apprehension phase. The program is designed to provide the field commander with valid information relative to the drug situation in his command area so that he may employ those measures necessary to combat the drug problem. The assessment phase has been completed and provides information on trafficking and abuse patterns, drug seizures, and offender data. This program will better enable CID to adjust resources, place investigative emphasis where needed, and keep commanders informed.

Representative English's third point addresses the possibility of shortening the length of tours of duty in Europe for single or unaccompanied junior enlisted personnel to 18 months. That subject has been addressed above, and we believe the initiative is well on its way to full implementation.

The fourth initiative discusses creation of drug and alcohol abuse boards. The recommendation was that these panels should include the unit commanding officer, a medical doctor, a chaplain, and a representative of the local military drug and alcohol abuse center. The board would have the authority and responsibility to determine what action should be taken to rehabilitate abusers. The Army response to this recommendation is included in the revision of our regulation. Rather than call them boards (a term which has other connotations for us), we have stated that each client will have a rehabilitation committee which will include the immediate commander, the ADAPCP clinical director and assigned counselor, as well as additional medical personnel or other staff agency representatives (such as the chaplain) as required. We believe this is an excellent recommendation that will ensure greater command involvement with the program as well as provide more expeditious handling of cases which result in separation from the service.

The assignment of a service member with physical or psychological dependence to the Veterans Administration has been overcome by Public Law 96–22, dated June 13, 1979. The Public Law states that any person serving in the active military who has been diagnosed as having an alcohol or drug dependence or abuse disability may not be transferred to any VA facility, unless such transfer is during the last 30 days of the member's enlistment period and that such additional treatment is requested by the service member.

The fifth sub-initiative recommended is a Chapter 9 (Drug or Alcohol Abuse) discharge for those individuals who refuse or fail rehabilitation assistance. The revision of Army Regulation (AR 600–885), gives the commander the flexibility for separating a service member who fails to cooperate or participate in his own rehabilitation. Normally, Chapter 9, AR 635–200, will be used only to separate abusers of drugs, if that abuse is based solely on information obtained voluntarily or from urinalysis. However, the service member can receive less than an honorable discharge, provided exempt information is not used. As stated before, the revised regulation authorizes commanders, lieutenant colonel and above, to separate the recalcitrant soldier expeditiously.

The fifth initiative states that legislative action should be taken to broaden the options for Chapter 9 discharges to allow not only honorable discharges but also general discharges under honorable conditions for drug abusers. It was suggested that provision should also be made to allow Chapter 9 discharges with or without veterans benefits depending upon the circumstances. Department of Defense guidelines indicate that flexibility in the type of administrative discharge that could be given for drug abuse, to include determination of veterans benefits would be useful, but under the current provisions of Public Law, limitation of veteran's benefits may not be possible. Many of the administrative discharges now given, however, are based on evidence that might not be available if general discharges were given. As you are aware, the court of Military Appeals ruled in the United States vs. Ruiz (1974) that a soldier's statutory right against self-incrimination prohibits the use of test results taken from urine samples provided unvoluntarily, if the resulting information is to be used against the soldier in administrative procedures such as determining the character of discharge. While USCMA decisions govern decisions on individual cases only, there is now further litigation pending in U.S. District Court on this same matter. Flexibility would be useful for cases other than those identified through urinalysis, but it would be more useful if the Court of Military Appeals decision on urine tests, as set forth in the Ruiz case, could be overturned.

The sixth initiative states that personnel who have been charged with drug trafficking violations should be removed from their regular barracks; pending courts-martial. The objective of this proposal is self-evident; however, there are administrative and legal problems which make its execution infeasible for the Army. Each case must be judged on its own merits and the law still protects the individual in regard to pre-trial confinement or any implication that one is guilty before having an opportunity for a board, courts-martial, or trial. We believe the present policy which permits the local commander to decide this matter is the most judicious way to achieve the objective.

Representative English's seventh initiative states that the military should actively recruit senior NCOs for drug and alcohol counselors who have demonstrated compassion and proven their ability to command respect from both

junior personnel and the officer corps. This initiative is commensurate with the Army's long-range goals of the human resources management model where high caliber, professional NCOs with proper training in human services activities will be the standard. We have identified and assigned to USAREUR, 15 E6/E7 NCO drug and alcohol counselors in FY 79. An additional 30 NCO counselors are programed for USAREUR in FY 80. Senior NCOs such as these will be assigned to other commands as they are identified and trained. NCOs in senior positions are being encouraged to attend the US Army Drug and Alcohol and Team Training (USADATT) course to increase their awareness of alcohol and drug problems and their ability to counsel subordinates regarding these problems. The demand is great for senior NCO's with these skills, particularly in combat and combat support units. The drug program must compete for quality personnel in an arena of extremely short supply.

Representative English's last initiative states that the Department of Defense should institute an Army-wide policy prohibiting the sale of alcoholic beverages during normal duty hours. It is Army policy to discourage the consumption of alcohol just prior to or during working hours (prudent consumption with a meal is acceptable) and to stress moderation when alcohol is used at any time. The revision of the Army Regulation 600–85 stresses deglamorization of the use of alcohol. Action beyond the above has been considered but would adversely impact on those duty periods which occur at times other than the normal duty day, people who are on leave or not in a work status, and retired personnel. Exceptions to such a policy would be an administrative nightmare. Further, prohibition of sales during normal duty hours may encourage people to use off-post outlets, which is particularly troublesome overseas. Difficulty of enforcement would be compounded by the requirement for an additional set of waivers for special occasions, i.e., recognition luncheons and civilian/military or US/foreign functions and for cultural or social practices which include a cocktail period. Prohibiting the sale of alcoholic beverages during duty hours has been tried several times by local commanders. In each instance, the policy was found to be undesirable. Changing individual values, enforcing standards of conduct, and creating more awareness of the consequences of alcohol abuse have proved to be the only lasting deterrents thus far. These factors suggest that periodic reassessment and reemphasis of stated policy coupled with an aggressive alcohol and drug abuse education, identification and rehabilitation program is the most prudent course. In the Army, we consider the on-duty sale of alcoholic beverages to be the prerogative of the installation commander.

REPRESENTATIVE GILMAN'S RECOMMENDATIONS

Recommendations one through three by Representative Gilman have been addressed in the previous discussion. They include: reduction of tour length in West Germany, (2) assignment of additional qualified personnel to USAREUR's drug program, and (3) government of West Germany should provide greater support.

Recommendation number 4 to expand Army law enforcement personnel in West Germany was discussed in the section covering Army initiatives in FY 79.

Representative Gilman's fifth recommendation discusses improving troop morale by: (1) improved living facilities, (2) expanded recreational activities, (3) better planning/supervision of soldiers' time, and (4) foreign language training prior to assignment to West Germany. I will address each of these in order.

The Army is continuing to improve the living conditions in the barracks. Progress is being made in upgrading or constructing troop housing to current adequacy standards. In FY 1979, only 400 living spaces were authorized for construction. Over 2,300 living spaces at 11 locations are included in the FY 1980 budget. The Army's goal is to reduce the backlog of maintenance and repaid in Europe by $100M by the end of FY 1985. This added emphasis should result in improvements in troop housing facilities. In FY 1979, $6.8M was authorized for furnishings in Europe. The FY 1980 budget includes a request for $18.9M.

In regard to expanded recational activities, the FY 1980 budget includes a request for a Cost of Living Allowance (COLA) for single soldiers living in the barracks and eating meals in Government dining facilities. The allowance, if approved, would average about $30 per month and would assist in compensating for the decline in the value of the dollar. It would provide extra money to soldiers

for miscellaneous purchases, travel, entertainment, recreation, etc. Morale support activities (MSA) have many new and ongoing initiatives.

The matter of better planning and supervision of soldiers' time is continually stressed in leadership training. A comprehensive course to train battalion personnel staff officers in human resources management began in September of this year and military authorizations will increase. This is part of a long-term effort to employ and modify the organizational climate, values, and norms in order to reduce dysfunctional behavior, including drug and alcohol abuse. The Office of Drug and Alcohol Abuse Prevention in the Office of the Assistant Secretary of Defense (Health Affairs) also is working to develop Department of Defense initiatives in this area. Foreign language training is being provided now; however, it is provided after the soldier arrives at his new station. We have found that the training is more cost effective for the Army, and more meaningful for the soldier, when it is conducted in the host country. Cost savings are realized in that the training is consolidated into fewer locations in Germany than if it were presented at all installations from whence soldiers are assigned. Conducting the training in the host country is more meaningful in that the language and culture surround the student. For soldiers through the grade Staff Sergeant (E6), 40 hours of language is required druing their first 60 days in country.

Representative Gilman's sixth recommendation concerns improvement of treatment and rehabilitation through five subprograms. They include: (1) professional support and supervision; (2) more in-service training and continuing education for ADAPCP staff personnel; (3) expansion of in-patient drug care facilities in West Germany; (4) providing alcohol and drug abuse awareness training for first-line supervisors; and (5) referring personnel who are dependent upon hard drugs to in-patient rehabilitation units, when there has been no prior drug involvement in the service. I will address each of these subparagraphs individually.

The Army has taken strong measures concerning Mr. Gilman's recommendation for additional personnel for Europe's drug program. Several initiatives have been taken to enhance Europe's ADAPCP. Since January of this year, Europe has been provided 20 clinical directors and 20 enlisted counselors. The clinical directors and enlisted counselors will provide increased supervision and professional support to the rehabilitation program. In addition, 23 personnel (six officers, 17 enlisted) have been designated for drug and alcohol education and assessment teams. The teams will assist commanders in ensuring that their programs are being administered properly and their program personnel professionally trained. The Fiscal Year 1980 budget includes increases of $7.2M (Total Obligation Authority), 52 officers, 123 enlisted, and seven civilian spaces to support the Army-wide drug program. In addition to those personnel who are full time in the drug/alcohol program, the Army had developed a course to provide battalions with an officer knowledgeable in organizational behavior, to include drug and alcohol abuse problems. The concept also calls for adding an additional person to each battalion S1 staff.

The Army training of drug and alcohol program staff is being improved. Principal instructors used in alcohol and drug abuse education and training must be graduates of the US Army Alcohol and Drug Abuse Team Training Course at the Academy of Health Sciences in Texas or have completed an equivalent training course. The experience level and training of alcohol and drug counselors to be assigned to Europe has been increased. Drug and alcohol counselors first complete an 8-week behavioral science course which includes basic information on screening and counseling techniques in general. After completing this course, the majority of those who are to be assigned to Europe complete a 2-week US Army Drug and Alcohol Rehabilitation Training (USADART) Course which is specifically designed to train drug and alcohol counselors. Those counselors who do not complete the USADART course prior to assignment to Europe attend a US Army Europe school on individual and group counseling. The assignment of additional clinical directors and senior enlisted NCO counselors in Europe also has improved the quality of supervision and in-service training.

The Department of Defense (DOD) Education Policy Task Force set instructional goals for training of first line supervisors for all services on 18 September 1979. Through its Education and Training Advisory Committee, the Department of the Army (DA) Alcohol and Drug Policy Office is developing detailed instructional objectives and guidelines based on the DOD goals, that will be implemented by the major Army commands. This will be accomplished

through the Army Training and Doctrine Command. The US Army Drug and Alcohol Technical Activity (DATA) is assisting with training the trainers of first-line supervisors as part of its overall mission.

There are very few hard-core addicts in the Army. Service members diagnosed as drug dependent are provided detoxification, medical treatment and short-term rehabilitation within Army medical and drug rehabilitation facilities. Those drug dependent service members unable to be returned to effective duty following treatment in the Army's rehabilitation program are separated from the service.

Representative Gilman's seventh recommendation is to screen recruits to better identify narcotics abuse. The Army is participating in the DOD review of policies and procedures related to screening of recruits for drug abuse. A review of urinalysis results of recruits in basic training show that fewer than three tenths of one percent of recruits test positive for confirmed drug abuse upon arrival at reception stations.

ARMY POSITION ON FORMER DEPUTY SECRETARY OF DEFENSE 15 INITIATIVES

The Assistant Secretary of Defense (Health Affairs), Dr. John H. Moxley III, has testified on the status of the 15 initiatives. I would like to briefly highlight the status of each initiative as it pertains to the Army.

Intiative 1 concerns the administration of a Department of Defense Personnel Survey which will comprehensively assess the prevalence, nature, and effects of drug and alcohol abuse. The Army's share of the approximately 23,000 service members taking this survey worldwide will be 9,000 soldiers. The survey instrument is the result of several years of research into alcohol and drug abuse in the military. Pilot test to validate the survey will be administered during the week of 26 November by representatives from all the military services. The Army's share of the pilot will be approximately 800 soldiers.

Dr. Moxley already has testified on the status of the initiative concerning the use of epidemiological data to assess the extent and location of drug abuse.

The Army drug reporting system is totally compatible with the revised DOD system. As a separate initiative, the Army is studying its drug and alcohol management information system in an attempt to consolidate and simplify field reporting while providing accurate and meaningful data for program managers and supervisors.

Initiative 4 is the test of portable urinalysis equipment. A 6-month test period was concluded this past July. Final test reports from Military Enlistment Processing Command (MEPCOM) and USAREUR have been received and are being evaluated by Headquarters, Department of the Army prior to being forwarded to DOD.

Initiative 5 involves reemphasizing drug abuse control through increased staffs visits to all major Army commands and improved education, especially for commanders and supervisors. As of 15th of this month, all major Army commands will have been visited at least once and areas with more significant problems were visited more frequently. From the previous discussion, the Drug and Alcohol Technical Activity was created and this field operating activity of my office provides technical assistance in drug and alcohol abuse and related areas to Army elements and to commanders as directed by the Deputy Chief of Staff for Personnel. Details of DATA activities in this area were provided under Army FY 79 initiatives.

Initiative 6 is designed to provide better measures of dependent and civilian employee drug and alcohol abuse and an examination of the adequacy of services provided to dependents. Quantitative measures are being developed to augment existing Office of Personnel Management surveys of the civilian workforce within the Army. These surveys could be utilized to provide prevalence data. Surveys of dependents have been proposed to include dependents in overseas areas where outside resources are already scarce to meet actual needs. Strong qualitative measures for improving services provided to dependents are included in the revised Army Regulation 600–85. The Army recognizes the family system and its impact upon individual productivity and morale. While chronic manpower shortages hamper the delivery of counseling services to civilian employees and dependents, every effort will be made to utilize other resources and provide quality care within existing resources.

Initiative 7 focuses on a review of military law enforcement efforts. On 8 August 1978, a DOD Law Enforcement Task Force on Drug and Alcohol Abuse was

organized to review investigative procedures, criminal intelligence, interdiction techniques, and law enforcement staffing levels. The Army has two representatives on the Task Force from my Law Enforcement Division and from the US Army Criminal Investigation Command. The Task Force initially examined 24 short-term and long-range issues submitted by the services. These primarily were management or operational issues such as manpower requirements. In March 1979, the Task Force met with the Police Foundation Executives and examined techniques for measuring law enforcement productivity. The meeting emphasized the difficult nature of such a task and indicated that the civilian police community had no better means to do so than those employed by the services. The Army used the support of the Task Force to obtain approval from Department of Defense for the additional law enforcement resources obtained in FY 1979 and incorporated them into the FY 1980 budget.

Initiative 8 was a review of procedures concerning civilian arrests on military installations. In his testimony on drug abuse before the House Select Committee on Narcotics, Deputy Secretary Duncan indicated that DOD would examine the investigative and prosecution follow-through of civilians arrested for drug offenses on military installations. The DOD Law Enforcement Task Force examined this problem and determined that the problem was neither of sufficient size to warrant a request for assistance from Department of Justice nor did it merit extraordinary action within the military departments. The number of cases of civilians apprehended were relatively small and normally involved possession of marijuana. Regular law enforcement procedures appeared adequate. However, the Task Force resolved to review the situation again. That review has been accomplished and the extent of the problem remains relatively small. Current data again confirm that most civilian arrests involve use and possession of small amounts of marijuana. Sale and trafficking cases are few. Additionally, the Air Force Office of Special Investigations surveyed all 107 of its operating locations concerning referral of cases, and acceptance of cases by local US attorneys. That survey disclosed no serious problems regarding the acceptance of narcotics cases by local US attorneys. Generally, the acceptance and prosecution of cases involving civilians apprehended on military installations reflects the individual's state of residence and its attitude toward prosecution for similar offenses within the local community. Thus, prosecution is less frequent in such states as Alaska, California, and others with more liberal drug laws, and more frequent in states like Alabama and Texas. On the whole, Air Force Office of Special Investigations found that US attorney declination of narcotic cases does not appear to be a serious problem.

Initiative 9 is concerned with the Berlin Task Force on Drug Abuse, which was established in June 1978 to deal with the drastic increase in drug trafficking through Berlin and subsequent increase in heroin abuse in the area. Membership includes key command elements: US Public Safety Advisor, Berlin; West Berlin and US customs officials; Provost Marshal, US Army Berlin; Special Agent in Charge, Berlin Resident Agency, US Army Criminal Investigation Command; Drug Enforcement Administration; and others. The Task Force meets quarterly and submits written reports on its progress to Headquarters, Department of the Army. The Task Force facilitates coordination and cooperation between West Berlin and US military and Drug Enforcement Agency drug suppression operations. Intelligence data are exchanged and strategies to counter drug trafficking are developed. The Task Force monitors drug abuse identification, education, and rehabilitation program efforts. This concept has worked well in emphasizing the need for increased efforts to interdict drug trafficking through Berlin by West Berlin officials. Recent emphasis has been on determining legal actions, such as tax evasion, that can be taken by German authorities against known or suspected drug traffickers and increasing customs control.

Initiative 10 is concerned with job performance and combat effectiveness research. The statement by the Assistant Secretary of Defense, Dr. Moxley, sums up the Army's frustrations with funding in the research area. The goals of the Walter Reed Army Institute of Research were to: (1) establish impact of drugs/alcohol abuse on individual military performance, (2) relate drug and alcohol abuse to unit readiness, (3) relate patterns and distribution of military drug use to the uniqueness of the military environment, and (4) recommend actions by the Army to achieve maximum effectiveness in our alcohol and drug abuse control efforts. The cost was to be borne over a five year period with $2.7M programed for FY 80. As Defense has indicated, the

House Appropriations Committee deleted $1M. DA has attempted to obtain restoration of these funds and it is our understanding that this decision has been referred back to the Committee for reconsideration.

Initiative 11 is intended to develop and test program evaluation criteria primarily in the areas of education and treatment. Before adequate criteria can be established in the area of education evaluation, standardized educational goals and objectives must be set. We have developed these objectives and guidelines. They will be transmitted to the US Army Training and Doctrine Command for further development and implementation.

The DA evaluation criteria for treatment success also will follow the DOD guidelines. Our current reporting system does not have the capability of tracking career advancement of former program clients. We are committed to long-range statistical tracking to ensure that former clients are provided the same career opportunities as other soldiers. Implementation of such a system is at least a year away.

Initiatives 12 and 14 are concerned with an assessment of staffing levels within each of the military services. As I indicated previously we are concerned with quantity and quality of program staffing. I already have discussed the initiatives with respect to increased law enforcement personnel and rehabilitation and training personnel. Additionally, we have restored the Alcohol and Drug Policy Office in my directorate to separate division status. It is fully staffed with a secretary, four field grade officers, and Mrs. Gouin, serving as the Chief.

Initiative 13 centers on establishing formal programs or services for civilian employees overseas. In response to low participation by civilians and military and civilian dependents in the ADAPCP, a reevaluation of services available to our civilians has been conducted, and program modifications will be included in the current revision of the Army regulation for alcohol and drug abuse. While recent Office of Personnel Management statistics on the participation of civilians in the Army ADAPCP reflect the highest penetration rate for any of the services, utilization of the Army's alcohol and drug program by civilian personnel remains lower than we would like for the size of the civilian work force and for the extent to which we believe the problem actually exists. This assumption is based on a significant number of inquiries made to installation programs regarding the number of civilians who have elected to use the Army program as opposed to those preferring referral to approved community programs. In overseas locations referral of civilians to other resources or the inability to provide care was based on the lack of adequate resources, given the military client enrollment in the ADAPCP. A chronic problem area for overseas programs has involved insurance coverage for the treatment of civilians in military hospitals (this is particularly bad since adequate programs seldom exist overseas). The problem has been that the daily rate for hospitalization was prohibitive and discouraged many individuals from seeking treatment. In response to the identified need for clarification on hospitalization policies and treatment services, the Army Medical Command in Europe has issued a clarification of costs for rehabilitation services. In overseas areas, civilians are afforded opportunities to participate in these rehabilitation programs. which do not involve intensive hospitalization, at no cost on a "subsistence elsewhere" basis, or when insurance does not provide full coverage and provision of services is not in the best interest of the Army. Dependents provided care as part of family treatment will pay the normal maintenance cost for food and lodging but not per diem hospital and patient rates. These policies have been determined as cost effective and have resulted in increased participation of civilian personnel and dependents in Army programs. At this time, however, the Army is facing three chronic problem areas in regard to civilian participation: (1) limitation on manpower available to serve civilians as well as military and civilian dependents; (2) ambiguity regarding insurance coverage for alcoholism and the variety of civilian community programs that are open to employee participation, which makes application for reimbursement of cost extremely difficult; and (3) civilian personnel administrative procedures which in the past have made it impossible for supervisors to require civilian employees to seek assistance when alcohol or drug abuse is apparent or identified in relation to job performance or conduct. Based on the Civil Service Reform Act, supervisors are now asked to identify abusers. The Federal Personnel Manual Supplement 792–2, reemphasizes the importance of early

identification and treatment for civilian employees. It further requires supervisors and management employee relation specialists to work closely with the ADAPCP. Future directions for the interface between the ADAPCP and the installation civilian personnel office will be an increased emphasis on management employee relations office participation, as well as increased delivery of services to both civilian and dependent populations.

Initiative 15 involves the development of improved measures for drug abuse identification. The Army fully concurred in and supported the Department of the Defense decision to discontinue the 0.6 urinalysis level requirement for basically the same reasons enumerated in Dr. Moxley's statement. At the same time, we were concerned that a urinalysis program remain intact because it has value as a barometer to drug abuse prevalency as well as its unquantifiable, deterrent value. We know from field interviews with soldiers that those individuals who do not desire to use drugs, but who may feel or perceive peer pressure to do so, use the fact that they fear detection by urinalysis as a reason not to use drugs. Accordingly, in August of this year, we issued a directive to the field outlining the importance of continuing a viable urinalysis program, with particular emphasis on the use of command-directed urinalysis, both at individual and unit levels. Indicators which commanders could use in determining the need for urinalysis also were provided. These included incidents of unusual behavior, assaults or larcenies, accidents of all kinds, and increases in drug crimes, trafficking, or referrals for rehabilitation in their areas.

Statistical data you requested is appended to this testimony as follows:

Appendix 1—Heroin seizures in the Federal Republic of Germany (January 1978 through September 1979).

Appendix 2—U.S. Army personnel drug-related deaths (1978 through September 1979).

Appendix 3—Law enforcement (CID) arrest and seizure data (through September 1979).

Appendix 4—USAREUR Personnel Opinion Survey, drug-related update (November 1978 through September 1979).

Appendix 5—SUUTCO and commander-directed urinalysis frequency and results (1978 through September 1979).

Appendix 6—Other identification statistics (through September 1979).

ARMY GOALS, FISCAL YEAR 1980

Our four broad goals, in relation to alcohol and drug abuse, for Fiscal Year 1980 are: (1) institutionalize the Army Alcohol and Drug Abuse and Prevention and Control Program (ADAPCP), (2) improve Department of the Army civilian and dependent aspects of the program, (3) continue emphasis on upgrading quality and training of counselor personnel, and (4) strengthen and define the roles of the commander, the medical activity, and the counselor. I will discuss each of these goals briefly.

First our client caseload worldwide indicates alcohol has become the drug of choice. Its abuse and the consequences thereof in terms of broken homes, battered spouses, child abuse, financial disrepair, accidents, and lost productivity have been recognized throughout the Federal system, and the Army intends to focus equal attention on this problem. For example, in a worldwide survey of 3,000 officers, 79.7 percent of the officers in troop units stated that alcohol abuse was a problem in their unit and furthermore, that it ranked higher than marijuana abuse (73.8 percent) and other hard drug abuse (49.1 percent). Out of 13 social problems listed, alcohol abuse ranked number five. In the same survey, 81.7 percent of the commanders stated that alcohol abuse was a problem in their units, and the commanders rated alcohol abuse number two out of 13. Our total ADAPCP caseload for alcohol abuse has increased over the past three years (February 1976 to February 1979) from 7,000 to 9,200, while our caseload for "other drugs" during the same period has decreased from 10,000 to 6,300. From December 1978 to March 19, 1979, the caseload percent of personnel referred for alcohol abuse has jumped dramatically from 55 percent to 67 percent and has remained fairly constant at that level since March of this year. From July 1, 1978, to June 30, 1979, the number of personnel completing our program for alcohol (as a single drug of abuse) was 5,243 and a combination of alcohol and other drugs (poly-drug abuse) was 1,573 which is over twice the number completing our program for drugs (2,644). It is apparent then that we are in dire need of strengthening the

ADAPCP program through residential treatment facilities worldwide, which are capable of dealing not only with illegal drug abuse, but also with poly-drug abuse and alcohol abuse. The program at Bad Cannstatt, Germany, paved the way and we hope to open similar programs in CONUS and Korea in 1980.

The second goal is to improve the civilian employee aspects of the Army program, along the lines of the successful employee assistance programs we see developing elsewhere in the Federal Government and private industry. These, of course, will have to be structured to fit the military system and environment, but the principles remain the same. Concurrent with this is a focus on dependents of all categories of eligible personnel, i.e., military, retired, and civilian employees. Alcohol and other drug abuse is a family illness and we need to refocus our efforts into this area.

Our third objective is to continue to upgrade the quality and training of our military and civilian counselor personnel. As stated previously, we intend to establish stricter criteria for selection of military counselors who are to be assigned to the alcohol and drug program, especially with regard to maturity and judgment. Furthermore, we will provide additional specialized training for our military counselors to supplement the basic behavioral science specialist training they receive. We also will make specialized training available for our senior NCO's who also may be recovering alcoholics. Maximizing the use of interested recovering alcoholics who have the capability to become good counselors should greatly enhance the overall effectiveness of our program.

Our final broad goal is to capitalize on the evolution of the ADAPCP program from its early inception as a crisis program to an institutionalized program wherein policies and roles are well defined and accepted, especially for the commander, medical activity, and the program personnel as well as the client. In this way, we will maintain our offense against problems that we have now recognized as endemic within the Army today. The manner in which society chooses to deal with it remains the only difference. We choose to ensure combat readiness at all costs, but at the same time, live up to our inherent responsibility for the health and welfare of the total Army community. The Department of the Army is made up of thousands of dedicated military and civilian personnel. We can do no less in securing the national defense, than ensure that they perform their duties in an environment which does not tolerate abuse of alcohol and other drugs.

RECOMMENDATIONS TO STRENGHTEN THE ARMY PROGRAM

I have two recommendations whereby this Committee can further assist our efforts. First, I believe we need greater Congressional recognition of the degree to which alcohol abuse has become a significant problem. Secondly, we get mixed messages from the Congress concerning our efforts and the expenditure of funds in this area. In Fiscal Year 1976, Congress deleted $2.6M for alcohol and drug abuse research. The previous Congressional action was taken because it was felt that HEW, with its $31M budget should satisfy these DOD requirements. Subsequently, HEW has repeatedly stated they are unable to satisfy DOD's needs, that they recognize our needs as unique, and have strongly urged that DOD have its own funding for drug and alcohol abuse research. Last year, the Department of the Army was directed by the Department of Defense to be the lead service in researching the impact of alcohol and drug abuse on individual soldier performance and unit readiness. In the current Session, the House Appropriations Committee stated, "The Committee does not believe that substantial increases for such research (combat fatigue, jet lag, and alcohol and drug abuse) are warranted." The result of such cuts or failure to fund leaves the message that Congress really does not want a strong research capability in this program area. Any such budget cut will seriously curtail increasing Army efforts to address the effects of alcohol and drug abuse on our most serious concern—combat readiness.

In summary, I feel confident that the Department of the Army and USAREUR has made significant progress this past year in addressing our alcohol and drug abuse problem. We have affected the environment by: (1) strengthening and improving law enforcement efforts, (2) expanding both quality and quantity of personnel resources, and (3) developing quality of life programs directed at improving morale, living facilities, and acculturation of our soldiers in Germany. We have developed more systematic and professional approaches to alcohol and

drug abuse prevention, education, treatment and rehabilitation processes. Our management of these programs is better through improved surveys, reports, program evaluation and—most importantly—commander involvement. Most of our commanders now feel that this is their program, not one imposed by higher headquarters. We are aware that there remains much to be done in regard to services for civilian employees and dependents of both military and civilian employees. We are taking steps to alleviate remaining deficiencies.

I wish to assure this Committee, once again, that the Army remains fully committed to the problems of alcohol and drug abuse. The areas I have discussed are extremely important and directly impact on combat readiness at all levels. We appreciate the interest and support of this Committee and are now ready to address any questions you may have.

APPENDIX 1

ARMY LAW ENFORCEMENT HEROIN SEIZURES, EUROPE

	1978	[1] 1979
Unit of measure	[2]	[2]
Quantity	38, 761	50, 960
Street value	$31, 884, 763	$51, 069, 731

[1] Figures for calendar year 1979 are through September 30, 1979.
[2] Grams.

Note.—Chart includes drug seizures made by Army law enforcement authorities or by host nation police based upon Army investigative effort.

ARMY LAW ENFORCEMENT DRUG SEIZURES, EUROPE

Category	Unit of measure	Quantity of drugs 1977	1978	[1] 1979
Narcotics	Grams	12, 110	40, 768	51, 809
	Milliliters	0	5	7
(Tilidine)	Grams	0	5, 300	0
Cocaine	do	5, 258	261	6, 335
Hashish	do	367, 791	636, 849	378, 672
Hashish oil	Milliliters	0	1, 024	2, 129
Marihuana	Grams	24, 367	269, 861	27, 081
Dangerous drugs	do	261, 840	986	10, 963
	Units	146, 891	13, 391	8, 621
Hallucinogens	Grams	0	0	0
	Units	2, 945	15, 970	[2] 24, 825, 403
(Phencyclidine)	do	0	445	
Total estimated street value		$11, 253, 142	$39, 871, 044	[2] $133, 293, 878

[1] Figures for 1979 are through Sept. 30, 1979.
[2] Includes approximately $74,000,000 worth of drugs seized in raid on LSD laboratory in Berlin, July 1979.

Note.—Chart includes drug seizures made by Army law enforcement authorities or by civilian/host nation police based upon Army investigative effort.

APPENDIX 2

U.S. ARMY PERSONNEL DRUG-RELATED DEATHS

	1978					1979			
	1st quarter	2d quarter	3d quarter	4th quarter	Total	1st quarter	2d quarter	3d quarter	Total
Europe	10	25	6	4	45	3	4	5	12
CONUS	2	3	2	2	9	1	1	0	2
Pacific	0	0	2	0	2	0	0	0	0
Total	12	28	10	6	56	4	5	5	14

APPENDIX 3A

WORLDWIDE DRUG OFFENDERS IDENTIFIED

Year	Quarter	Army	Other [1]	Total
1978	1	8,356	399	8,755
	2	8,575	475	9,050
	3	7,414	511	7,925
	4	7,795	525	8,320
1979	1	8,160	602	8,762
	2	8,313	658	8,971

[1] Civilians and personnel from other services.

ARMY DRUG OFFENDERS IDENTIFIED BY AREA

Year	Quarter	CONUS	USAREUR	Korea	Other [1]	Total
1978	1	5,355	2,201	252	549	8,356
	2	5,022	2,724	264	565	8,575
	3	4,239	2,257	462	456	7,414
	4	4,601	2,394	466	334	7,795
1979	1	4,985	2,385	394	396	8,160
	2	4,918	2,550	473	372	8,313

[1] Other: Panama, Alaska, Hawaii, Japan.

APPENDIX 3B

ARMY LAW ENFORCEMENT DRUG SEIZURES, WORLDWIDE

Category	Unit of measure	Quantity of drugs		
		1977	1978	[1] 1979
Narcotics	Grams	12,165	41,087	51,871
	Milliliters	1	5	137
(Tilidine)	Units	0	1,075	1,455
Cocaine	Grams	0	5,300	0
Hashish	do	5,542	1,451	7,092
Hashish oil	do	378,240	661,753	384,023
Marihuana	Milliliters	1	1,084	2,132
Dangerous drugs	Grams	27,285,743	2,896,938	3,503,947
	do	264,317	1,215	14,360
	Milliliters	762	0	40
	Units	238,683	43,712	54,850
Hallucinogens	Grams	467	1,815	38
	Units	7,639	26,614	[2] 24,829,364
(Phencyclidine)	Grams	0	250	1,327
	Units	0	876	44
Total estimated street value		$39,317,138	$47,522,353	[2] $139,571,578

[1] Figures for 1979 are through September 30, 1979.
[2] Includes approximately $74,000,000 worth of drugs seized in raid on LSD Laboratory in Berlin, July 1979.

Note.—Chart includes drug seizures made by Army law enforcement authorities or by civilian /host nation police based upon Army investigative effort.

APPENDIX 4

DRUG ABUSE PREVALENCE IN USAREUR (UPOS UPDATE, NOVEMBER 1978 THROUGH SEPTEMBER 1979)

The USAREUR Personnel Opinion Survey (UPOS) conducted in July, 1979 indicated that 8.1 percent of the USAREUR military population admit to monthly or more frequent use of narcotic and/or dangerous drug. Most of these frequent drug users are casual or recreational users. Less than one-fourth of these frequent users (2 percent of the USAREUR population) engage in intensive abuse of five or more times a week.

The monthly or more frequent abuse level of 8.1 percent shows a slight increase from a level of 7.6 percent measured by the UPOS of November, 1978; however, the principal contributor to the increase was the abuse of cocaine. Admitted abuse of heroin showed a slight decline.

The latter trend is supported by the results of commander directed urinalysis throughout the command. During the period Aug. 78 through Aug. 79, the percentage of positives among all commander directed tests declined from approximately 5 percent to approximately 3 percent. Approximately one-half of these positives were for heroin. Cocaine testing began in Sep. 79. While the combined number of positives remained approximately 3 percent of all commander-directed tests, the positives for cocaine (0.5 percent) were second only to heroin (1.6 percent) in prevalence. Positives for amphetamines, barbiturates and methaqualone comprised the balance of the total.

Further, 60 percent of the cocaine positives came from the three communities of Giessen, Hanau, and Fulda. This provides the strong inference that cocaine availability is localized in a few areas and has not yet spread throughout the command.

The monthly or more frequent use of cannabis has remained stable for the past two years at 19 percent of the USAREUR military population.

The Jul. 79 survey findings are under analysis; however, no significant changes in drug abuse characteristics other than those noted above, have been discovered.

APPENDIX 5

SELECTED UNIT URINE TESTING FOR COMPANY SIZE UNITS (SUUTCO)

1. The authority for "unit testing" is DODI 1010.1, Department of Defense Drug Abuse Testing Program. Specifically, unit commanders are authorized to order their units to submit to urinalysis.

2. Unit testing in Europe began in April 1978. Of the 263 units that have been tested as of 30 September 1979, there have been 1,008 confirmed positives. Below shown is a breakout of those confirmed positives:

Opiates, 660; barbiturates, 75; amphetamines, 95; methaqualone, 130; poly-drug 21.

3. USAREUR-wide, unit testing has produced a 2.51 percent confirmed positive rate. Only eight requests for unit testing have been denied at USAREUR or Corps level. Those denied lack any justification whatsoever.

COMMANDER-DIRECTED TESTING FREQUENCY AND RESULTS 1978, 1979

Level of Urinalysis:

a. The 0.6 urinalysis quota imposed by DOD Directive in July 1978 was rescinded in July 1979.

b. Below shown are the Armywide levels since January 1978:

1978: 1st Q, 0.43; 2nd Q, 0.64; 3rd Q, 0.67; 4th Q, 0.55.

1979: 1st Q, 0.73; 2nd Q, 0.88; 3rd Q, 0.66; 4th Q, NA.

APPENDIX 6

IDENTIFICATION STATISTICS

1. ADAPCP ADMISSION BY METHOD OF REFERRAL

	Other drug abuse				
	Bio chem	Volunteer	Cdr/sup	Law enforcement	Medical
Fiscal year 1978	2,426	1,927	2,575	2,219	566
Fiscal year 1979	2,095	1,585	2,205	1,664	479

2. RECRUIT URINALYSIS (ACCOMPLISHED AT RECEPTION STATIONS)

	Tests	Conf abuse	Percent
Fiscal year 1978	172,275	286	0.17
Fiscal year 1979	179,127	360	.20

3. COMMANDER-DIRECTED URINALYSIS

	Tests	Conf abuse	Percent
Fiscal year 1978	236,448	3,514	1.5
Fiscal year 1979	337,156	3,665	1.1