DRUG ABUSE IN THE MILITARY

HEARINGS

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

SECOND SESSION

APRIL 27, MAY 24, JUNE 2, 16 AND JULY 27, 1978

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

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DRUG ABUSE IN THE MILITARY

THURSDAY, APRIL 27, 1978

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

The Select Committee met, pursuant to notice, at 10 a.m., in room 2337, Rayburn House Office Building, Washington, D.C., Hon. Lester L. Wolff (chairman of the committee) presiding.

Present: Representatives Glenn English, J. Herbert Burke, Robin L. Beard, Benjamin A. Gilman, and Tennyson Guyer.

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

Mr. WOLFF. The committee will come to order.

This morning's oversight hearings have been called by the Select Committee to pursue one of the most significant and far-reaching areas of our mandate; to conduct a continuing and comprehensive study and review of the problems of narcotics abuse and control as it relates to drug abuse in the Armed Forces of the United States.

Today marks the initial appearance of the Department of Defense before the committee. Consequently, we shall attempt to touch on a number of broadly defined areas that will give the committee a general overview of the complex problems that face the Defense Department and the service branches when dealing with this potentially serious threat to our national security.

During the Vietnam era, the American people read numerous stories about our troops and witnessed extensive television coverage depicting our troops overseas as engaged in widespread drug use. We all recall one major network showing pictures of open opium parlors. There were even reports suggesting that the My Lai incident may have been influenced by the abuse of marihuana.

The phenomenon of the use of drugs and armed conflict is not limited to Vietnam. It is ironic to note that while the medical use of opium in our Civil War caused addiction among soldiers of that era, soldiers in the modern army are turning to heroin and other narcotics not only to tolerate the miseries of war, but to cope with substantially less threatening environments.

While it has been suggested that a certain amount of heroin use is endemic to military life, particularly in Europe, this is not the only drug available to military personnel. Marihuana abuse among the men who are responsible for the safety and security of this Nation is believed to have grown to epidemic proportions.

Note in this I have said marihuana abuse and not marihuana casual use.

Amphetamines and barbiturates are also finding their way into military installations and are being used by soldiers who perform tasks that are crucial to the preparedness of our Armed Forces. The ready availability and low cost of alcohol on and around the bases has contributed to polydrug use among our military men.

The destructive effects of this is a very serious matter for us all, and particularly the Department of Defense, which they must firmly address.

The committee is certain that regular drug use does have an adverse effect on the combat readiness, job performance and morale of our Armed Forces. The Department of Defense and the services have an urgent responsibility to investigate thoroughly the full effects of this problem and to develop policy and program guidelines to turn the tide of this potentially dangerous threat to the safety of our Nation.

I remember when this committee first came into being, that one of the first calls that we made was upon the Secretary of Defense to acquaint him with the seriousness with which this committee viewed the problems of drug abuse.

One thing, however, that has disturbed this committee; reports it has received, in particular, correspondence dated March 1, 1978, from the President's Health Assistant, Dr. Peter Bourne, to the Secretary of Defense, Harold Brown. And I would like to read from that letter. He said:

> I'm particularly disturbed about the issue * * *—of drug abuse— * * * at this time because the indicators suggest that drug use, especially narcotic use among our servicemen overseas, is increasing and at a serious rate. Simultaneously, it appears that the efforts to detect drug use are waning.

I am happy to see that there was a report last evening, the President has reinstituted a program that was helpful, we believe, in attempting to stem the flow of narcotics into our military.

I am quoting from a letter from Dr. Bourne:

> In December, urine testing for opiates and other drugs was carried out onboard the aircraft carrier U.S.S. *Midway* en route from Singapore to Subic Bay. More than 20 percent of those tested were found to be users of opiates.
>
> U.S. Army, Europe, heroin overdose death rates increased by 50 percent last year, and are currently three times the average heroin overdose death rate for U.S. cities.
>
> Currently, over 8 percent of the Berlin Brigade admit to the use of heroin.
>
> The Berlin Brigade experienced four heroin overdose deaths last year, this death rate exceeding by 10 times the heroin overdose death rate of those American cities with the most severe heroin problem.
>
> Current U.S. Army personnel surveys indicate an increase in daily use of heroin among soldiers.
>
> On a recent visit by my Deputy, Lee Dogoloff, to several Army units in Germany * * *
>
> * * * he heard anecdotal estimates of heroin use which ranged up to 40 percent in some units.

This is quite distressing, and I hope Mr. Dogoloff will address himself to this today.

This is hardly believable. And I think that we have got to get some order out of the chaos of information that we, as a committee have been getting, and that the American people have been getting.

The reason for this investigation is not to criticize or castigate the military. To the contrary.

As chairman of this committee and as a Member of the Congress of the United States charged with the responsibility of protecting this Nation, I want to see to it that the military get all of the equipment and all of the support that is necessary to stamp out these problems. Because if drug abuse is not controlled, it represents a very serious threat to the security of our Nation.

We saw it in Vietnam, where there was an undermining of the morale of our military there. And one of the reasons was the ready availability of the narcotics that were there in the Vietnam area.

Our great problem today is the ready availability and the influx of heroin from the Golden Triangle, which is coming into Europe and elsewhere in very substantial quantities. I question very severely the type of cooperation that we may be getting from some of the European countries in controlling that flow into the areas that are adjacent to our bases.

And this presents a very serious security threat to the United States.

I want to comment on the fact that the chairman of the task force on drug abuse in the military, Glenn English of Oklahoma has done on outstanding job. He, together with the investigators that we have had in the field, spent almost an entire year in investigation.

I do find one element which I think is important. I find in some areas people are less than forthcoming with information.

I do find, however, as well—I want to compliment the Department of Defense for the cooperation with this committee in the survey activities in which we have been engaged. Without their cooperation the information that our task force chairman has collected, would never have been possible.

And it is on this basis that we now offer to our panel that we have before us today, some very serious questions. Actually, what is the status of the Department of Defense drug abuse assessment group report, which was prepared for the Office of Drug Abuse Policy.

What are the reporting procedures, the criteria by which DOD measures the extent and nature of its drug problem?

What is the status of interagency research efforts between the Department of Defense and the National Institute on Drug Abuse?

What are the security implications of the high number of military personnel having access to nuclear weapons who were removed from duty because of drug abuse?

How is the Department of Defense planning to come to grips with the possibility of a reduction in sentences for the casual users of marihuana in the civilian sectors?

I want you to know that we are having difficulty in getting the type of information that we need, not from the officials of the Defense Department, but from all sectors of our society, because they fear that if we develop the depth and the scope of the drug abuse problem as it really exists, there will be stigma upon the individual service that is involved.

Hardly, is that the case. What we are trying to do here is to make people aware of the seriousness of this problem so that we can take steps to address them. We want to cooperate with the military every way we possibly can.

Now, in order to address so many topics in the amount of time available to us, our discussions must be brief and to the point.

We have with us today, Mr. Vernon McKenzie, the Acting Assistant Secretary of Defense for Health Affairs; Mr. Lee Dogoloff, Associate Director, Domestic Policy Staff, the White House; and Dr. Robert Smith, former Assistant Secretary for Health Affairs, Department of Defense.

I would like to ask you gentlemen, if you wouldn't mind, being sworn.

[Witnesses sworn.]

Mr. WOLFF. Thank you very much.

I now turn the chair over to the chairman of the task force, Mr. Glenn English.

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

I have a statement that I would like to make as well.

We are, today, opening a series of hearings based on the findings of this committee's task force on drug abuse in the military, which I have had the honor to chair. Our study began in late 1976, and encompassed Army, Navy, Air Force, and Marine installations throughout the United States, Asia, and Europe.

Members of the task force interviewed hundreds of officers and enlisted personnel. In addition, the committee developed an original research tool, the drug abuse opinion survey, which was released to the public this morning.

The task force's findings were often astonishing, and frequently contradicted information provided by the Department of Defense.

In addition, we found that the attitudes of commanding officers, line officers, senior enlisted personnel, and lower ranking enlisted personnel varied widely.

During our 18-month investigation, I was able to make some general observations concerning the nature and extent of drug abuse in our Armed Forces today. In general, the level of drug abuse at any particular military base tends to reflect the abuse pattern in the surrounding community, and it is directly related to the availability of drugs outside of the post.

In fact, because of the military's control over its personnel, drug abuse on post appeared to be generally lower than in the surrounding community. Most drug violations occurred off base.

Clearly, the Department of Defense has a greater responsibility to identify drug abusers than does any civilian agency—but far too often that responsibility is not being carried out.

From installation to installation, we found that the attitude of the commanding officer toward this difficult problem determined the effectiveness of the antidrug efforts at that base. And many commanders perceived drug abuse as a problem which was important only during the Vietnam era, but is now only a minor irritant or an impossible problem to solve, and therefore is ignored.

There has been an inexcusable failure by the Department of Defense to carry out research to determine the extent of drug abuse among military personnel. The last independent study of any significant size was completed in 1975 on data accumulated in 1974—the year that most of our soliders returned from the Asian conflict. In those days, the primary drug of concern in our Armed

Forces was heroin. At that time, draftees made up a significant portion of our fighting forces.

Today, in addition to heroin, the major drugs of abuse are marihuana and various synthetic compounds, like PCP. We now have an All-Volunteer Army, and it is clear that the Department of Defense has not yet adjusted to the challenges of this new situation. In fact, even the urinalysis test which was most commonly used to detect drug abusers will not routinely be used to identify users of dangerous drugs such as LSD, PCP, or cocaine.

The lack of a strong commitment in the military toward ending drug abuse may well reflect a similar attitude in the White House itself. The President has called for the decriminalization of marihuana, which makes enforcement of drug regulations difficult within the military services, where the use of mind-altering drugs cannot be tolerated.

The Defense Department itself states that: "The rise in cannabis abuse is probably related to visible movements to legalize or decriminalize the drug."

Not long ago, the White House Office of Drug Abuse Policy was abolished and its mission deemphasized. In the Department of Defense, the Secretary recently proposed the elimination of the Office of the Assistant Secretary for Health Affairs.

This deemphasis on detecting and preventing drug abuse may partially account for some of the findings of our survey.

The drug abuse opinion survey was administered to over 2,100 enlisted men, and 200 officer personnel. The results show that 85 percent of the junior officers feel that drug abuse is a moderate to great problem; 81 percent consider that combat readiness is being adversely affected by drug abuse; 71 percent consider morale adversely affected; 89 percent consider discipline adversely affected; and an overwhelming 97 percent feel that job performance is being adversely affected.

We found that 65 percent of the enlisted personnel surveyed felt that half or more of our fighting personnel are using marihuana regularly—an opinion shared by 78 percent of their officers.

The amount of drug abuse throughout our Armed Forces is alarming. But it is even more chilling that the Defense Department still has not designed a drug abuse prevention program making use of data and recommendations obtained in 1974.

And, Mr. Chairman, I want to submit for the record at this time, the study performed by A. D. Little, Inc., which was published in 1975.

Mr. WOLFF. Without exception, the study will be included in the record at this point.

[The information referred to is in the committee files.]

Mr. ENGLISH. More recently, Defense Department statistics indicated that, for example, drug abuse in Germany increased by 25 percent between August 1976 and April 1977. Yet, drug abuse prevention and treatment programs are the first to suffer when the Department is called on to economize.

The Department states: "The estimated rise in hard drug abuse is probably related to the discontinuance of random urinalysis testing in October 1976."

The committee's findings suggest that the increase is the result of a much more general lack of commitment at the highest levels of our government.

When a difficult problem resists efforts to solve it, it is time to reexamine and increase the efforts to find a solution. The Defense Department has taken the opposite approach.

Drug abuse programs have been merged into alcohol abuse programs. Drug abuse counselors have been laid off. The Secretary recently proposed the abolishment of the Office of the Assistant Secretary for Health Affairs. And we are informed by officers working to end drug abuse, that their work is a "dead-end speciality" within the military.

Let me emphasize that the drug abuse problem is persistent and difficult to solve. It damages readiness and morale. And it will require a concerted and persistent effort before we will begin to see positive results.

While we do not single out the Defense Department for causing a problem which begins in the civilian community, we do believe that the Department must be required to exert an extraordinary effort to prevent drug abuse from interfering with the defense of our Nation.

Now is the time for the Department of Defense to begin this kind of effort.

Thank you, Mr. Chairman.

Mr. WOLFF. Thank you very much, Mr. English.

Mr. ENGLISH. Mr. Chairman, at this point I would like to call to the committee's attention, the survey that I mentioned in my statement, and also refer to the charts.

The first question that was asked on the survey—and the questionnaire that I will be using will be the officer's questionnaires. You will notice, Mr. Chairman, the number of officers that were included—and I might say that these were junior officers, not senior officers—were 213. In addition to that, we had similar questionnaires that were given to enlisted personnel, in which we had over 2,100 respond to those questionnaires.

Mr. WOLFF. As I understand it—if the gentleman will yield—this was done over a wide area. It was not at one selected post.

Mr. ENGLISH. That is exactly right. It was done throughout the United States as well as in Europe and Asia.

The first question, Mr. Chairman was, the committee is attempting to establish whether drug abuse within the military may be a problem. In your opinion, the military has—and there were four possible answers.

No problem with drug abuse, in which none of the officers who responded gave any indication, as can be seen from the chart:

A small problem with drug abuse;

A moderate problem with drug abuse; or

A great problem with drug abuse.

And I think the statistics, the charts particularly showing the enlisted personnel and the officers as well, gives—while there may be differences in opinion as far as percentages, they do tell a very telling trend as far as this particular indicator is concerned.

The second question, would the illegal use of drugs in the military affect any of the following personnel characteristics:

Combat readiness, morale, discipline, and job performance. And again, I think that the responses that we received with regard to this particular question are most telling, Mr. Chairman. And again reflect the percentages that I stated in my earlier statement.

The third question, which was not included on the charts, Mr. Chairman, but is one that I would like to go through—and again reading from the officers questionnaire, I think it gives some indication of the difficulty of the problem that we are facing. It states:

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

We started out with, No. 1, marihuana. We had difficulty to locate a seller; only 6 percent said it was difficult to locate a seller. Keep in mind this is throughout the Nation, as well as in foreign countries.

About 91 percent said it was very easy to purchase marihuana.

Second was hereoin—19 percent did not respond on this particular question; 54 percent said it was difficult to locate a seller; 27 percent, however, said it was very easy to locate a seller of heroin.

Cocaine—16 percent did not respond; 40 percent said it was difficult to locate a seller; 44 percent said it was very easy to locate a seller.

With regard to pills, downers—13 percent gave no response; 10 percent stated that it was difficult to locate a seller; 77 percent said it was very easy to locate a seller.

Uppers—15 percent did not respond; 8 percent said it was difficult to locate a seller; once again 77 percent stated it was very easy to locate a seller.

Other drugs. And I imagine this would get into the drugs such as LSD, PCP, and so on—33 percent no response; 14 percent stated it was difficult to locate a seller; 53 percent said it was very easy to locate a seller.

No. 4 is a question that once again is not on the charts. Do you feel that the permanent party, lower enlisted personnel on this installation have—and it gets into the issue of problem that they had with drug abuse.

The first answer is no problem with drug abuse. None of the officers responding came back with this response; 17 percent said that there was a small problem with drug abuse; 61 percent said a moderate problem with drug abuse; 21 percent said a great problem with drug abuse.

No. 5 is once again where we pick up the charts. Roughly speaking, how many of the permanent party, lower enlisted personnel use—No. 1 is marihuana. Notice on the left there is a chart regarding marihuana.

Mr. WOLFF. Now to explain that a little bit, where you say using marihuana, is that casual use or is that considered daily use or abuse?

Mr. ENGLISH. Again, the criteria that we used, that the individual would use marihuana at least once a week or more. And that was the statement that was used, or we put to both the officers and the enlisted personnel in answering this question; those who use marihuana once a week or more.

The second chart relates to heroin.

See, once again the interesting point about this particular chart is that the enlisted personnel feel that 53 percent, there is almost no heroin problem, or almost no heroin used within their particular units; and 31 percent said that less than half of those that they had knowledge of—which we would assume would be within their units—did use heroin; 2 percent said almost half; and again, 1 percent more than half; again 1 percent almost all.

It would be an interesting unit that had that 1 percent of almost all.

And again, I might point out that with regard to the officers, the perception there was much greater in the category of less than half. There were more officers that felt that they had almost no heroin problem within their unit; 75 percent felt that less than half their unit was using heroin, which would indicate a rather significant amount, I think, considering the fact that we are talking about heroin.

With regard to chart No. 4, amphetamines, it ended up that 2 percent of the officers said that none within their unit; 70 percent said a small number; 14 percent said about half; and 7 percent said more than half; and zero percent said almost all.

Chart No. 5, with regard to downers—1 percent said none; 77 percent said a small number; 11 percent, about half; 3 percent more than half; and 1 percent, almost all.

With regard to cocaine—8 percent said none; 80 percent said a small number; 4 percent about half; 1 percent more than half.

Mr. WOLFF. There is a contrast, as I see it, between the estimates by the enlisted personnel, as well as by the officer personnel. How do you account for that?

Mr. ENGLISH. Again this was a perception that we ran into throughout the survey and through the perception of the problem. It seems to break down even more from the officer-enlisted personnel problem that we are looking at here.

If you will notice that while you have quite a difference with regard to percentages and number, that the general trend is pretty much the same. But there is a significant number of both officer and enlisted personnel that feel that less than half—you have still got a rather sizable number on both sides of the second-ranking number, in fact, in the particular case, say almost none.

The differences really came about with regard to age groups, and this was with both enlisted personnel and the officers. The senior officers and senior enlisted men felt that there was little or no problem. The younger the officer and enlisted man was, the more, the greater the problem he saw, the more use that he said took place.

And this was something, I know when we started out, with regard to—and one of the reasons that we started this survey was the fact that when we first began our investigation we talked mainly to senior officers, and it is very seldom that we would have a senior officer that would admit on his installation, or to his knowledge, that even 10 percent of the enlisted personnel would ever smoke a marihuana cigarette. And it was just completely a lack of feeling.

And once we started talking to the enlisted personnel themselves, that is when we actually began to pick up large amounts of use, first of marihuana, and then of other drugs.

And the surprising thing—I know at one installation that we visited, in talking to the senior officers at that installation, again we were struck with the fact that certainly much less than 10 percent, and probably less than 5 percent of the men within his particular unit weren't using any kind or drugs whatsoever.

And we walked across the street, and where we were administering this survey to the junior officers under him, we got the kinds of numbers that you have been seeing on these charts. It was a completely different perception.

That particular officer, the way we brought it out was we were just carrying on some discussions with the junior officers after the questionnaires. Completely different perception of the problem, completely different perception of the amount of use.

And that was what, I think, was rather startling to the committee all the way through. And it is one that we came to expect, the further along that we went.

Mr. WOLFF. Mr. English, do you have any breakdown of the services individually?

Now this is an overall study. Has there been a breakdown made of the individual services to indicate whether there is a higher incidence of this in the Army and Air Force, Navy, or the Marine Corps?

Mr. ENGLISH. We deliberately stayed away from that. We are well aware of the interservice rivalry, but we are also well aware that each of the services has a different job to perform, and it would be very difficult to try to compare the Army against the Navy against the Air Force and against the Marines.

However, I might say that the overall results and trends were identical, regardless of the service. We were somewhat disturbed with the variance in attitude toward drugs among the various services and among the various installations that we visited. There seemed to be not only a breakdown as to attitude toward drugs varying from installation to installation, but we also found that there was a varying attitude toward drugs between the various services, the differences in programs that the services had.

And this is one of the problems that we saw. There was no consistent data and information available to compare the problems within the various services and the amount of drug abuse that was taking place. Each service had its own set of statistics, had its own approach to the problem and its own way of dealing with it.

I might say that some of the services were extremely rigid and felt that this was a problem that could not be tolerated with any person who was within the military, and certainly within their unit.

We had other services which came across with the attitude that whatever they do on their own time is their own business. As long as it doesn't affect the job they are doing here on post, we really don't care what they do.

Mr. BEARD. If the gentleman would yield?

Mr. ENGLISH. Certainly.

Mr. BEARD. Could you possibly mention which service came across as the most rigid, and which service you found to be the most lax?

Mr. ENGLISH. Again, I would hate to get into an interservice dispute.

Mr. BEARD. I don't think that would be interservice, though.

Mr. ENGLISH. It probably would be best to bring that out during the hearings. We will have the different services appearing later in the hearings, and that would be the point to bring it up.

I will certainly make note that the gentleman understands which ones had the most lax attitudes so that he can ask some rather difficult questions to that particular service.

But it was rather startling to find the differences in attitude between the services. And this is, I think, the point that we want to make at this time.

And then as we move through the hearings, I think we can bring out those attitudes. I can assure you that I will ask some questions along that line.

Mr. BEARD. All right. Thank you, sir.

Mr. ENGLISH. Question 6. Basically, do you see any of the following as a result of drug abuse on this installation?

And the first was, additional difficulty the senior or junior NCO has in providing leadership for his unit. In other words, this basically gets into the respect for authority issue.

And 64 percent answered yes; 34 percent no; 2 percent no response.

With regard to personnel not caring about their job. 72 percent said yes that there was; 22 percent said no; 6 percent gave no response.

Disciplinary problems—88 percent said yes; 14 percent no; 6 percent no response.

Lack of unit pride—50 percent said yes; 42 percent said no; and 8 percent had no response.

Additional use of alcohol—46 percent said yes; 46 percent said no; and 8 percent had no response.

In moving down to chart 7, given the amount of drug abuse as you perceive it in this installation, do you think that today the men and women could go into combat and perform to the best of their ability?

And I think this is a rather telling chart. 63 percent said yes; but 34 percent said no; and 2 percent gave no response. Again, I think that this is a very telling chart and one that should startle and alarm us all.

Chart No. 8 got into the issue of random urinalysis. And I might state that this issue of the urinalysis test was one that we found a great deal of disagreement and a great deal of controversy among services, both among the officers and among the enlisted personnel.

On that question we asked, do you think the random urinalysis program was an effective deterrent for drug abusers: 25 percent said yes; 70 percent said no; 5 percent had no response.

That pretty well covers the charts that we have made up with regard to the questions. It does not cover all of the questions, but it is my understanding that those questions have been—the responses

to those questions have been given to those that will testify before us as well as the press, and certainly to the committee members.

So with that, I think we will begin the hearings. And, I believe, Mr. Dogoloff, you have a statement.

TESTIMONY OF LEE DOGOLOFF, ASSOCIATE DIRECTOR, DOMESTIC POLICY STAFF, THE WHITE HOUSE

Mr. DOGOLOFF. Yes, thank you.

Mr. Chairman, and members of the committee, I appreciate the opportunity to appear before the committee, and to discuss with you the initiative that this administration has taken regarding drug abuse in the military.

This issue is very important and it is significant to note that one of the first areas of inquiry made by the White House—even before the activation of the Office of Drug Abuse Policy—concerned drug abuse in the military.

In February 1977, just 1 month after the inauguration, Dr. Peter Bourne, Special Assistant to the President for Health Issues, visited the U.S. European Command and received a briefing on the nature and extent of drug abuse among American service personnel in Europe, and the responses to this problem by the component commands.

Subsequently, I have visited various components of the U.S. Army in Europe, and have received a detailed briefing on the drug programs of the three component commands.

Mr. ENGLISH. Mr. Dogoloff, could I interrupt you?

Would it be possible—and I would like to make this request for all testifying before us—we are very limited in time—would it be possible for you to summarize your statement so we could get into the questioning?

Mr. DOGOLOFF. Certainly.

As a result of these visits, and two additional staff level visits, we instituted last year, a policy review of the ability of the Department of Defense to assess drug abuse among the troops.

The DOD assessment review, which I would request be included in its entirety in the record, if you will——

Mr. ENGLISH. Without objection, so ordered.

[The information referred to follows:]

Office of Drug Abuse Policy

Drug Abuse Assessment in the Department of Defense: A Policy Review

November 1977

DRUG ABUSE ASSESSMENT IN THE DEPARTMENT OF DEFENSE: A POLICY REVIEW

November, 1977

OFFICE OF DRUG ABUSE POLICY
THE EXECUTIVE OFFICE OF THE PRESIDENT

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EXECUTIVE SUMMARY

This report is the result of an initial review of the assessment and identification functions performed as a part of the drug abuse prevention efforts of the Department of Defense (DoD) which was conducted on July 14, 1977. The review was undertaken by Robert L. DuPont, M.D., Director, National Institute on Drug Abuse, Chairman; Professor John O'Donnell, University of Kentucky; Professor Mark Moore, Harvard University; and Mr. Charles V. Yarbrough, Veterans Administration.

The review was carried out at the request of the White House Office of Drug Abuse Policy. The Group's charter indicated that the review should cover the effectiveness of current policies and programs of DoD and the Military Departments regarding the methods by which the Armed Services identify and assess the nature and extent of their drug abuse problems.

The Review Group was asked to provide conclusions regarding the ability of the current identification process to reflect changes in the drug-using patterns of servicemen and to provide early detection of the hidden use of opiates, stimulants, or sedative-hypnotics, and to make

appropriate recommendations for improving the overall assessment capability of DoD.

DoD and each Military Department presented a briefing which followed the outline which had been requested. Each of them spoke to the organizational structure of their drug abuse prevention activities, described the identification process and subsequent review process, and discussed the issue of the use of such information by senior managers within DoD and the Military Departments.

CONCLUSIONS

Several general conclusions were reached after review of DoD's presentation:

1. Drug use in the military often has risk implications beyond those normally associated with drug use in society in general. Unlike the general social concern which focuses on the narrower patterns of chronic, intensive drug use, the Armed Services are concerned with not only those patterns of use, but also with what is often referred to as "recreational" drug use. Even occasional use in the Armed Services can have an important impact on the ability of the force to function. The Review Group accepts the fact that different standards of conduct may be necessary

for the proper functioning of a military force, and that the Armed Services have a special obligation to know the extent and understand the impact of its drug use.

2. Levels of illicit drug use have been relatively constant in the military since the Vietnam era. That the rates are not higher is due, in the judgment of the Review Group, to the 7 years of intensive effort on the part of DoD in developing drug abuse prevention programs. What is certain is that drug use within the military will continue to be a special problem and only by continued, persistent efforts will DoD be able to moderate the adverse consequences of such drug use.

3. DoD and the Military Departments have developed programs which give senior managers and commanders a variety of information related to drug use in the Armed Services. This information, however, is often disparate from the standpoint of definition or comparability of data, both within each of the Services and among the Services.

4. All information presently used by DoD and the Military Departments as the basis for management decisions regarding drug abuse prevention is subject to bias. There is no process to validate

current information. The former random urinalysis program of DoD--now prohibited by Congress--did provide a reliable independent indicator of drug use. This lack of a validating mechanism makes it impossible to measure or audit with assurance the current level of drug use within any of the Military Departments or to identify and compare levels of drug use by type of drug, Service, Command, geographical area, and so forth.

5. DoD and the separate Military Departments must have and use the option of drug monitoring/surveillance programs (i.e., random urinalysis, sample surveys) where circumstances warrant. The operational benefits of these programs are too great to deny their use to commanders who face a drug abuse problem.

6. Management emphasis regarding drug abuse appears o be waning. This lessening of emphasis may lead to a false sense of security by senior Defense managers and commanders regarding the nature of drug abuse in the Armed Services.

7. DoD programs for civilian employees appear to vary widely and should be enhanced. There are no separate service-wide programs for dependents, especially overseas. The absence of such programs represents

a serious shortfall in the existing drug abuse programs of DoD.

8. The current prohibition on DoD "drug abuse research" by Congress clearly hinders the development of a better understanding of those patterns of drug use which most adversely affect the readiness of the military force.

RECOMMENDATIONS

1. Congress should be asked to reconsider its current opposition to DoD using random urinalysis as a management tool. The present prohibition denies both DoD and the Military Departments a reliable method of independently assessing drug use. The current restriction on DoD severely limits its ability to confidently know the nature and extent of drug abuse within the Armed Services.
2. DoD and the Military Departments should review their existing drug abuse indicators and select a limited number (three or four) of standardized data elements and reporting requirements which are most needed in the making of drug abuse policy. DoD should establish clear guidelines for the Military Departments on the standardization and collection of such information.

3. An independent drug abuse assessment program should be established within DoD to validate other indicator systems. This program should include a modified random urinalysis effort and an integrated survey effort which would serve as the lynchpins of this independent system. The information developed in this program would be used for trend analysis only, and would not be used as an identification and referral process. Identification and referral can continue through existing programs.

4. DoD should identify those areas of "basic research" which are valuable for a better understanding of drug abuse, and encourage HEW to give priority support to such research. Further, DoD should identify those areas of applied research which will help it better understand the nature and extent of drug use in the military and the consequences of such drug use on the force readiness. A research program should be developed on a priority basis and should be integrated into existing DoD research plans. Further, an interagency drug abuse research committee, with membership to include DoD, VA, and HEW, should be

established to identify those research areas of common interest and make recommendations to the respective departments and agencies regarding the development of such efforts, including joint projects. The chairmanship of this committee should be rotated on an annual basis.

5. The DoD should assess the drug abuse problem of its civilian force and dependent contingent, particularly overseas, and develop and expand special programs for these populations

6. Greater emphasis to the drug abuse programs must be given by DoD. In addition to those reviews now completed by DoD managers, special trend reports should be made quarterly to the Secretary of Defense and the Service Secretaries. Further, DoD should initiate a program of concentrated field visits to not only learn about local program operations, but to evaluate their ability to reliably reflect drug abuse trends and levels. Each area overseas should be visited at least once a year, and major CONUS (continental United States) components should be visited at least biannually.

7. Current resource levels should be reviewed with a a view toward reversing the downward trend in

personnel and budget support. Areas such as drug and alcohol abuse, race relations, and other human resources programs are always vulnerable in times of budget restrictions. The current resource commitment to the drug abuse prevention effort must not be allowed to deteriorate any further. Adequate staffing and funding must be maintained to ensure that an aggressive, viable drug abuse program can exist.

INTRODUCTION

This report is the result of an initial review of the drug abuse assessment and identification of the Department of Defense (DoD) which was conducted on July 14, 1977. The review was undertaken by Robert L. DuPont, M.D., Director, National Institute on Drug Abuse, Chairman; Professor John O'Donnell, University of Kentucky; Professor Mark Moore, Harvard University; and Mr. Charles V. Yarbrough, Veterans Administration.

The Review Group selected to conduct these initial hearings represents a broad range of experience in the drug abuse field. Professor O'Donnell is a highly respected social science researcher who has done extensive work in the field of drug use. His national survey of drug use among young men is one of the premiere studies in the field. Professor Moore has been involved in the development of Federal drug abuse policy since 1972, first as a consultant to the National Advisory Council on Drug Abuse Prevention, then as Director of Policy Planning for the Drug Enforcement Administration, and most recently as co-author of the *White Paper on Drug Abuse* of 1975. Mr. Yarbrough has served in various capacities with the White House Special Action Office

on Drug Abuse Prevention, including Chief of Planning, and before that directed the DoD drug abuse program in Vietnam.

The review was carried out at the request of the White House Office of Drug Abuse Policy. The charter indicated that the review should cover the current policies and programs of DoD and the Military Departments regarding the methods with which the Armed Services identify and assess the nature and extent of their drug abuse problem.

The initial hearings were to include:

- An overview of the organizational structure of drug abuse prevention programs within DoD and the Military Departments, including a discussion of the relationship between the drug and alcohol offices, the Surgeons General, and the principal military law enforcement officials;
- A description of the process by which the drug abuse problem is assessed, to include an identification of the indicator systems used, the scope of such systems, and a discussion of how such systems are used (how the nature and extent of the problem is known, who makes this assessment, and on what basis?);
- An indication of the manner in which such information is used by senior managers within DoD and the Military Departments, including deliberations

at regular or special meetings chaired by the Secretary of Defense, the Department Secretaries, the Chiefs of each Military Service, or at the service-wide meetings of major field commanders or other extraordinary meetings.

At the end of these hearings the Review Group was asked to provide conclusions regarding the ability of the current identification process to reflect changes in the drug-using patterns of servicemen and to detect early the hidden use of opiates, amphetamines, or barbiturates, and to make any appropriate recommendations for improving the overall assessment capability of DoD.

Each Service presented a briefing which followed the outline reflected above. Each spoke to the organizational structure of drug abuse prevention within their organization, described the identification process and subsequent review process, and discussed the issue of the use of such information by senior managers within DoD and the Military Departments.

CONCLUSIONS

Several general conclusions are evident after review of DoD's presentation:

1. Drug use in the military often has risk implications beyond those normally associated with drug use in society in general. Unlike the general social concern which often focuses on the narrower patterns of chronic, intensive drug use, the Armed Services are concerned not only with those patterns of use, but also with what is often referred to as "recreational" drug use. In society, this "recreational" use is often considered benign although it can have grave, even tragic consequences, as when driving under the influence of drugs. In addition to such consequences, occasional use in the Armed Services can impact on the ability of the military force to function. Everyday there are literally hundreds of thousands of tasks performed which directly affect the ability of the military force to respond. Jet mechanics, riflemen, radar operators, munitions loaders, security police, and many others perform tasks organic to military preparedness. In these work environments the implications of even casual use can be grave. The Review Group accepts the fact that different standards of conduct regarding drug abuse may be necessary for the proper functioning of a military force and that the Armed

Services have a special obligation to know the extent and understand the impact of their drug use.

2. Levels of illicit drug use have remained relatively constant in the military during the post-Vietnam era. That the rates are not higher is due, in the judgment of the Review Group, to the 7 years of intensive effort on the part of DoD in developing drug abuse prevention programs. What is certain is that drug use within the military will continue to be a special problem and only by continued, persistent efforts will DoD be able to moderate the adverse consequence of such drug use.

3. DoD and the Military Departments have programs which give senior managers and commanders a variety of information related to drug use in the Armed Services. This information, however, is often disparate from the standpoint of definition or comparability of data, both within each of the Services and among the Services.

4. All information presently used by DoD and the Military Departments as the basis for management decisions regarding drug abuse prevention is subject

to bias. There is no process to validate current information. The former random urinalysis program of DoD--now prohibited by Congress--did provide a reliable independent indicator of drug use. The current lack of a validating mechanism makes it impossible to measure or audit with assurance the current level of drug use within any of the Military Departments or to identify and compare levels of drug use by type of drug, Service, Command, geographical area, and so forth.

5. DoD and the separate Military Departments must have and use the option of drug monitoring/surveillance programs (i.e., random urinalysis, sample surveys) where circumstances warrant. The operational benefits of these programs are too great to deny their use to commanders who face a drug abuse problem. This option should be made available to installation commanders under general policy guidance from DoD. Lodging discretion with the installation commanders ensures efficient targeting as a result of their extensive local knowledge. Bounding their discretion with policy directives from DoD makes it somewhat easier for them to take the necessary actions. To provide

incentives for installation commanders to pay attention to the drug use problem and to maintain some capability for DoD to monitor *levels* of drug use in installations over time, a small, centrally directed surveillance system should be developed. Without this small central capability, the incentives of the installation commanders to manage the drug use problem would be too small.

6. Management emphasis regarding drug abuse appears to be waning. This lessening of emphasis may lead to a false sense of security by senior Defense managers and commanders regarding the nature of drug abuse in the Armed Services. The development of a reliable assessment system and its more active use by senior DoD and Military Department managers and commanders on a clearly anticipated basis would provide a *minimum* forum for review of drug abuse trends and discussions of the operational consequences of those trends.

7. While each Service has established a formal drug abuse program for its civilian employees, the implementation of these programs appears to vary widely. There are no separate service-wide programs for dependents. The absence of such programs, especially overseas, represents a serious shortcoming in existing drug abuse programs of DoD.

8. The current prohibition on DoD "drug abuse research" by Congress clearly hinders the development of a better understanding of those patterns of drug use which most adversely affect the readiness of the military force.

RECOMMENDATIONS

In the first several years after the Presidential decision in 1971 to mandate drug abuse control in the Armed Services, DoD developed the most comprehensive drug abuse prevention-detection program in existence. An important element of this program was the use of mandatory urinalysis testing as the key means of early identification of drug users.

However, the single most important aspect of the military's laudable success in early detection and treatment of drug use was the emphasis placed on the program by commanders, from the top levels of the Office of the Secretary of Defense to the unit leaders. Without this considerable emphasis, the many elements of the broad program could not have been knit together and made to work.

There are indications that during the past several years there has been a definite downgrading by DoD and Congress of DoD's effort to deal with drug abuse. The recommendations made in this memorandum recognize the past successes by DoD in

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drug abuse prevention and are carefully designed to again upgrade DoD's effort by establishing--or reemphasizing--reasonable mechanisms within DoD and the Military Departments to take maximum advantage of the assets available for identification and treatment of drug abusers.

The mechanisms recommended here are limited and can be done. However, their effective implementation will require a renewed, active, and firmly institutionalized role on the part of senior members of the Defense establishment. In part, much of the downgrading which has occurred in the Armed Services' efforts to control drug abuse can be attributed to diminished management emphasis within DoD and the Armed Services as reflected in the reduced budgets, staff, and the lowered organizational placement of several of these offices, especially in DoD. To again attract--and sustain--the required level of attention, budget and personnel should be restored and the highest organizational position, consistent with good management, should be achieved.

The Secretary of Defense has identified control of drug abuse as a principal responsibility of the Assistant Secretary of Defense for Health Affairs (ASD/HA). The ASD/HA has been directed to fulfill this function by providing policy guidance, management control, and coordination for DoD drug abuse control programs.

The role of centralized DoD policy direction and control has been well established and the functions necessary to

increase emphasis have been identified. To effect any upgrading of management control of DoD drug abuse programs will require that these functions be fully exercised by DoD. With this vital preamble in mind the Review Group makes the following recommendations:

1. Congress should be asked to reconsider its current opposition to DoD using random urinalysis as a management tool. The present prohibition denies both DoD and the Military Deparments a reliable method of independently assessing drug use. The current restriction on DoD severely limits its ability to confidently know the nature and extent of drug abuse within the Armed Services.
2. DoD and the Military Department should review their existing drug abuse indicators and select a limited number (three or four) of standardized data elements* and reporting requirements which are most needed in the making of drug abuse policy. DoD should establish clear guidelines for the Military Departments on the standardization and collection of such information.
3. An independent drug abuse assessment program should be established within DoD to validate other indicator systems. This program should include a modified random urinalysis effort and an integrated survey

* See p. 18 for specific elaboration of this recommendation

effort which would serve as the lynchpins of this independent system. The information developed in this program will be used for trend analysis only and will not be used as an identification and referral process. Identification and referral can continue through existing programs.

4. DoD should identify those areas of "basic research" which are valuable for a better understanding of drug abuse, and encourage HEW to give priority support to such research. Further, DoD should identify those areas of applied research which will help it better understand the nature and extent of drug use in the military and the consequences of such drug use on force readiness. A research program should be developed on a priority basis and should be integrated into existing DoD research plans. Further, an interagency drug abuse research committee, with membership to include DoD, VA, and HEW, should be established to identify those research areas of common interest and make recommendations to the respective departments and agencies regarding the development of such efforts, including joint projects. The chairmanship of this committee should be rotated on an annual basis.

5. DoD should assess the drug abuse problem of its civilian force and dependent contingent and develop and expand special programs for these populations, especially in areas overseas where community drug abuse programs are not available.

6. The Secretary of Defense, Department Secretaries, the Chairman of the Joint Chiefs of Staff, and other senior DoD officials should receive comprehensive periodic briefings on current drug abuse trends. Further, DoD should initiate a scheduled program of concentrated field visits to not only learn about programs in the field, but to evaluate their ability to reliably reflect drug abuse trends and levels. Each area overseas should be visited at least once a year and major CONUS (continental United States) components should be visited at least biannually.

7. Current resource levels should be reviewed with a view toward reversing the downward trend in personnel and budget support. Areas such as drug and alcohol abuse, race relations, and other human resources programs are always vulnerable in times of budget restrictions. The current resource commitment to the drug abuse prevention effort must not be allowed to deteriorate any further. Adequate staffing

and funding must be maintained to ensure that an aggressive, viable drug abuse program can exist.

DISCUSSION

1. *The Concept of Assessment.* The word "assessment" is used in two senses. The Armed Services use it to mean essentially the identification of men who have a "drug problem," and "drug problem" means:

- A man's behavior or performance is below par and investigation shows that he is using drugs, which are presumed to be the cause of the deterioration in behavior or performance; or
- A man is detected (by one of the means below) as a user of illicit drugs, and this means he has a drug problem no matter how good his behavior and performance may be.

Commanding Officers clearly have a good deal of discretion in "confirming" that, for example, a man whose urine is positive is a "drug abuser," and it may well be that "confirmation" occurs only when there is some problem in addition to the drug use. Almost certainly, however, in this situation different commanders use different standards so that identical men would be treated differently in different units.

The second meaning of "assessment," and the one preferred by this Review Group, refers to a scientific estimate of the extent of drug use in the Armed Services and whether such use poses problems for the user or his commander.

The "assessment" data used by the military no longer include routine random urine testing. The random urine testing was an assessment tool in both senses. While there may have been some problems in making scientific inferences about prevalence due to variations in sampling fractions among units and practical problems about the conditions of obtaining specimens or getting them from all men in the designated sample, in principle, estimates about prevalence of drug use were justified using data from random urinalysis. Under present circumstances, however, *none* of the data available to the Armed Services justify inferences about the extent of drug use for the reasons discussed in section 2 below.

It is possible that presently available data sources identify the full or almost the full extent to which drug use in the Services constitutes a problem, but there is no way to know with any degree of certainty whether this is so. As far as one can judge from the data presented in briefings by the Armed Services, either *or both* of the following statements could be true:

- Men are being treated (and some discharged) because of drug use which--aside from the fact that it involves illegal behavior--does not adversely affect ability to discharge duties; and

- Undetected cases of drug use are causing damage (e.g., loss of efficiency, driving accidents, poor performance of duties). Some of this damage is known but its cause is not, and some is not known. In either case, nothing effective can be done to correct the situation.

Given the confusion resulting from such conclusions, the Review Group, for purposes of this paper, will use the term assessment to mean "scientific estimates of observed or reported data," and urge that this definition be adopted by DoD in any subsequent discussions.

2. *The Nature of the Current DoD Drug Abuse Assessment Effort.* Each of the Military Departments has a formal organization designed to develop policy and give broad program guidance to its units in the field regarding drug abuse prevention activities. The programs, both centralized and decentralized, are maintained essentially for active duty military personnel and include dedicated personnel down to and including the installation level.

Each Service has also developed a variety of indicators used in assessing the nature and extent of drug use among its military members. The indicators vary from Service to Service, and indeed within each Military Department. Data are available in the following areas which can indicate trends in drug use by Service and geographical area over time:

- Medical--Treatment, Hepatitis Rates, Emergency Room Reports, Overdose Deaths;
- Rehabilitation, VA Referral;
- Selected Urinalysis (Commander Directed, Unit Sweep, Event Oriented);
- Self-Referral (Exemption);
- Administrative Discharge, Punitive Discharge;
- Uniform Code of Military Justice (UCMJ) Drug Offenses;
- Drug Seizures, Drug Arrests (Use and Possession, Sale and Transfer);
- Supervisor/Commander Identified Drug Use; and
- Incident Reports.

a. *Lack of Standardization.* These indicators are potential data sources which may be helpful to managers in making drug abuse prevention policy. Taken together, they provide a family of indicators which could reflect the nature and extent of serious drug abuse within any Service or within a particular command. The difficulty with the indicators as presently developed is that there is often little standardization, either in regard to definition of the indicators themselves or in the collection of the data. This is true not only between Services, but within each of the Military Departments.

The end result is that the data presently available are often so disparate as to raise questions regarding their validity as indicators. Further, the prescribed guidelines for the standard collection of such indicator data, including guidelines for the collection and use of various urinalysis programs, are often broad and misleading. For example, within the U.S. Army, Europe, company commanders are authorized to use up to three urinalyses per day for their units. Some commanders may use all three, some may use less, but one can find a wide variation in the use of such urinalysis within and between units. Yet the data are aggregated as "commander-directed urinalysis" and have been used as an indicator within that particular command.

The question of guidelines is important because they provide important frameworks within which military commanders should develop their various assessment programs. The issues of standardizing existing indicator systems to a point where the aggregation of data can be used in a meaningful way for policy decisions and of identifying a select number of important indicator systems is central to this discussion. There are

some indicators which are more important than others for the commander or the policy manager and one does not have to rely on an array of 10 or more indicators. These select indicators may reflect basic law enforcement information, basic health data, data derived from commander-directed urinalysis, and perhaps an indicator which reflects incidence reports which may be associated with drug and alcohol use (i.e., driving under the influence). A standard definition of reporting requirements and a standard reporting criterion including frequency of reporting would be an important strengthening element to the existing indicator system of the Armed Services.

b. *Indicator Bias.* The present indicator system also presents one additional dilemma. All of the indicators mentioned in the above paragraphs are clearly susceptible to bias. This bias may be due to a local, command, or Service reallocation of resources, thereby preventing certain reporting functions from being developed as fully as needed; it may have to do with the structure of the process itself; it may have to do with direct command influence; it may have to do with a

willingness or lack thereof of medical officers to identify people as drug abusers; or, there may be any other number of reasons why particular data are influenced. But in every case, there is clear opportunity for the "system" to bias the data which is then presented to the commander. *The current major shortfall of the indicator system within DoD and the separate Services is that there presently exists no independent indicator which (a) can be used to validate the other indicator systems, and (b) can be used as a separate bench mark to alert commanders and managers to possible shifts in drug-abuse patterns.*

3. *Diminished Emphasis of DoD Effort.* While this is a more difficult area in which to mount concrete evidence, there was a clear sense among the Review Group that DoD and the Military Departments have over the past several years given less emphasis and resource support to the drug abuse prevention effort. At least one of the Services very explicitly noted that alcohol, not "drugs," was its major problem and that the Service was placing its emphasis and resources in this area "as directed by Congress." On several occasions the briefing officers noted that dollars, and more importantly resource staff, have been cut over the past several years,

most notably in the area of counselors for the local drug abuse rehabilitation effort. The organizational realignment of the drug and alcohol office with DoD and the drawdown of personnel in that office over time was also noted.

The Review Group is concerned that this apparent pattern of retrenchment, for whatever reason, may lead to a false sense of security by DoD and the Military Departments regarding the current or future nature of drug abuse within the military. Events of the past several years both within the military community and in the civilian communities in the United States clearly indicate that the dynamic of drug abuse is one of constantly shifting patterns of use with different drugs, and there is no reason to believe that these patterns will not continue both within the society at large and with the Armed Services. Without a continuing vigilance by DoD it is very conceivable that new drug-using patterns will develop or old ones will reappear which will have a very negative impact on the ability of the Armed Services to perform their basic mission.

4. *Surveillance of Drug Use as a Drug Abuse Control Policy Instrument.* In seeking to control drug use, the military relies on many of the same instruments used in the civilian sector. They have an enforcement program designed to restrict access to drugs, and a set of programs designed to treat and rehabilitate users. However, because the

military exercises much greater control over its members than any civilian government could or should, it can make use of a policy instrument that is for the most part denied to civilian sectors. This policy instrument is close, detailed surveillance of drug use by individual members of the military population.

To be sure, civilian sectors have some possibilities for surveilling drug use in the population. They conduct surveys of the population to identify patterns of drug use, and they screen some urines in jails and treatment programs or among parolees and probationers. Such techniques prove to be extremely valuable in gauging aggregate levels and trends in drug use, and (perhaps less frequently) in assisting the rehabilitation of individual users. However, the surveys and urine screenings can never be done comprehensively enough or frequently enough to take on operational value for society as a whole--*nor should they be*. Their value is largely restricted to providing information to guide policy judgments.

In the military, surveillance systems such as surveys and urine screening can take on much greater significance. They can be operated on a scale that is sufficiently comprehensive and frequent to directly assist in the operational control of drug use. The surveillance systems can aid *prevention* objectives by deterring drug use, and by identifying "infectious users." They can aid *rehabilitation* objectives

by identifying specific users for referral to treatment at an early stage of their involvement with drugs.

Thus, surveillance systems that identify individual drug users have several different benefits. If performed on an infrequent, *sampling* basis, they can provide valuable information about trends and levels of drug use in the military. If performed on a much more comprehensive and frequent basis, they can become a powerful instrument in controlling drug use. These systems can deter use, isolate infectious users, and permit the referral or large numbers of users at an early stage of use. However, the systems also have costs: the resources required to support the surveillance system; the potential loss in morale which may be associated with urine screening procedures; and the losses associated with identifying drug users whose performance is not being adversely affected. *The large potential benefits motivate strong support for the program. The potential costs indicate the need for tailoring the use of surveillance systems to particular situations and needs.*

The observations above suggest that one should not have a single policy position on the use of surveillance systems in the military. There are many possible versions of surveillance systems (varying in terms of testing procedures; comprehensiveness; frequency; criteria for indicating a "positive," etc.). Moreover, they can be set up to accomplish different

objectives (i.e., provide information about aggregate trends, which is valuable in setting policy objectives; or used operationally to deter drug use and identify and refer particular users). Thus, the best surveillance systems depend on the particular objectives, and they, in turn, depend on the particular situation.

The Vietnam War was surely a period when the most extensive surveillance was required. Much of our military force was located in an area where drugs were readily available. The personnel performed exacting tasks in which small errors could cost the lives of American military personnel or Vietnamese civilians on a daily basis. And there was hard evidence indicating high and still growing levels of drug use. In such a world it would probably have been irresponsible to do anything other than wring every possible operational advantage out of a surveillance program by running it at a *very* large scale. However, the testimony from the Military Departments before the Review Group indicated that a quite different situation prevails today. They asserted (but did not conclusively show) that drug use in the military has declined significantly from Vietnam days. They thought drug use continued to be a problem, but it was now much more local and sporadic than it had been in the late 60s. Hence, they argued that massive investments in the surveillance programs were no longer appropriate. It was much better to

allow individual commanders to take responsibility for the operational control of the drug use problem and let them use whatever screening procedures seemed appropriate. By tailoring their use of surveillance systems to local conditions, they could preserve much of the operational benefits of surveillance systems without paying very high costs.

To a great extent, these general observations seem correct. Though the military briefers appeared to have exaggerated the costs and minimized the benefits of the surveillance program, we agree that DoD probably does *not* now need the massive level of urine screening that was mandated in the Vietnam days and lingered on. Moreover, we are very sympathetic to the view that the military drug use policy should be designed primarily to avoid significant degradations in performance rather than focused exclusively on drug use per se, and we understand that military commanders have many different systems for observing performances beyond their drug use surveillance systems. Consequently, we expect military commanders to be very good at using drug surveillance, and can target the surveillance effectively on units or individuals where drug use seems to be a big problem. Thus, the military's desire to move from centrally directed, high levels of urine screening towards the selective, local use of screening by operational commanders seems to be reasonable.

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However, we continue to worry about one point; we worry that drug use in the military may sink once again into obscurity, flourish in that obscurity, and come to light sometime in the future when we may need a crack military capability. Our worry is based partly on speculation and partly on observation.

The *speculation* concerns the commander's incentives and capabilities to manage the drug use problem in a world where there is no central monitoring of drug use. Military commanders are busy people who have many different concerns competing for their attention. Which things they attend is determined partly by what they think is important, partly by what their superiors think is important and can directly observe, and partly by what they can easily do. In a world where no central policy directive mandates the use of drug surveillance methods, the military commander's incentives to manage the drug use problem through surveillance systems diminish significantly. In using the instruments, he risks exposing a substantial problem, and he has no central policy directive to justify his action to his superiors or subordinates. Thus, we would expect the use of drug surveillance systems to erode quickly.

The *observations* which trigger our worry that drug use in the military may sink into obscurity are two. The first is the simple observation that since the cessation of centrally mandated random urinalysis, no new policy has been

developed by the military to control the actions of military commanders. This indicates a relatively low level of concern about the problem of drug use and the potential role of drug surveillance systems in controlling drug use. The second observation is that actual levels of urinalysis have fallen dramatically since the cessation of random urinalysis. Moreover, we expect the decline to continue as officers who have experience with the system move to other positions, and the activity becomes rarer (and, therefore, more exotic) in the military.

Consequently, we are faced with trying to monitor drug use within the military when neither the size of the problem nor the trends can be confidently described. Ideally we would hope to be able to know absolute levels of drug use as well as the trends of such use. Presently, no DoD indicators, as presented to the Review Group, can provide either absolute levels or confident trend assessments. The reinstitution of a random urinalysis program can provide.us with a minimum aggregate assessment capability for trends; the addition of a random sample of drug use among military personnel can add to the trend capability and can begin to give us a true sense of level of use. Trend and level indicators coupled with a knowledge of what drug behavior indeed diminishes force readiness would finally give senior managers and commanders a confident assessment of the true nature, extent,

and *impact* of drug use within the Armed Services and would reduce to an acceptable minimum the intertemporal bias which exists in the present so-called "indicator system" of each of the Military Departments. It would provide one instrument for commanders which could be monitored with an assurance of validity not present in any of the existing "indicator" systems.

5. *The Surveillance System.*

a. *Urinalysis. DoD should design and manage a urinalysis surveillance system that allows observations of levels of and trends in drug use within installations.* To some extent the indicators generated by existing information systems, if revised according to our suggestions on pages 17 and 18 will meet the need for trend data. However, to gauge levels and *reliably* observe trends over time, these indicators should be complemented by a sample survey of drug use and the screening of drug users within installations. This sample would probably include about 200 to 300 individuals twice per year in 450 major installations--between 180,000 and 270,000 observations per year, or approximately 15-20 percent of the level of screening previously conducted. The purpose of this system would be to enable DoD to accurately

assess the drug use problem, *and* to provide incentives for installation commanders to stay on top of the problem. Since the purpose of this system would be *assessment* and not operational control through identification or deterrence, the names of the individuals identified as drug users would *not* be disclosed to the commanders. The installation commanders would know who was tested and what the aggregate level of drug users turned out to be, but not the positive cases.

Installation commanders should retain the option of using much more intensive screening systems in their efforts to control drug use. This should be explicitly stated by DoD.

DoD should review its current urinalysis guidelines for use in drug surveillance systems to ensure that adequate levels of random and other testing occur which are keyed to specific levels or trends in drug use within a specific installation. For example, DoD might state that a "high level" of drug use (10-15 percent) and a "rapid rate of increase" (20 percent above last period) required a "very intensive" use of surveillance systems (about 2 times per year for the general population and 5 times per year for those judged

to be particularly vulnerable). By creating presumptions and expectations among commanders and troops, these guidelines would make the decision to use surveillance systems much easier for individual commanders, and therefore much more likely to occur. However, the development of these guidelines would require more consultation and analysis than we can currently supply.

b. *Surveys.* Periodic (preferably annual) surveys should be done to assess the current prevalence of drug use and the varying levels of such use in the Armed Services.

   i. One or more of these surveys should, if at all possible, be designed so that data on a man's performance can be independently obtained from his military records and/or from interviews with his supervisor. The goal would be to determine the relationship between extent of drug use and quality of performance.

   ii. If random urine testing is being done, the sampling design for the surveys should be coordinated with the sampling design for the urine testing. This would make it possible to correlate findings from the two

types of studies, and develop an equation for the extent of drug use that is indicated by a given percentage of positive urine tests.

iii. Similarly, it would be desirable to frame the sampling design of surveys so that findings can be correlated with other indicators of drug problems such as:

(a) Referrals for treatment and rehabilitation;

(b) Drug use revealed under the exemption policy;

(c) Administrative discharges for drug use;

(d) Arrests or other military justice actions concerned with drug abuse.

iv. Surveys of the military should, unless there are specific reasons for exceptions, use operational definitions comparable to those used in HEW-sponsored surveys of the civilian population.

v. *Considerations on sample size of surveys.* The essential requirement is that each survey employ a probability sample to statistically justify generalizations extrapolated from findings about the populations of interest,

which may be the Army, Navy, Marines, or Air Force.

vi. Small samples often suffice--accurate predictions of Presidential elections are based on samples of 1,600 or so. There are, however, two factors which will require larger samples to survey drug use:

(a) One involves the various levels about which reliable estimates are sought. If one wants to know for example, the percentage of marihuana users in the Army as a whole, a sample of 2,000 or so would suffice. But if one wants to estimate separately for CONUS, Europe, and the rest of the world, the sample must consist of three subsamples, each a probability sample for its area--and each would have to be, say, 1,500 in size, for a total of 4,500. Similarly, if one wants to make an estimate for specific units, e.g., divisions in each area, each division must be sampled so the total sample grows.

(b) The second factor relates to the expected frequency of the behavior to be estimated. Larger samples are needed to give reliable estimates of relatively rare behavior. A sample size adequate to estimate marihuana use would be too small to estimate heroin use, but might be large enough if illicit use of heroin, opiates, barbiturates, etc. were combined.

Statistical formulae are available to determine minimum sample sizes needed, but as a general guide if there is no need to furnish estimates for small units, annual samplings of 10,000 to 15,000 people would probably be more than adequate.

The correlation of survey findings with performance data referred to above would not have to be done for the entire sample, but could be done for a small fraction of it.

It would be highly desirable to have at least one survey devoted exclusively, or primarily, to drug use for the purposes of studying the correlates and consequences, as well as the extent of drug use. Later surveys, however, and if necessary even the initial ones, could consist of a small number of

questions on drug use attached to surveys being done for other purposes.

The question of using interviews or questionnaires for surveys is open--both have advantages and disadvantages. Specific research questions included in a survey may make one preferable over another.

The consequences of such a revised indicator system are that commanders can use it as a basic planning aid, it will provide an incentive to unit commanders to actively promote drug prevention efforts since higher echelons will also be monitoring the data, and it can be implemented down to the operating levels of command (e.g., division, wing, etc.) with minimum cost.

6. *Problems of Definition.* The Review Group identified three areas of confusion which resulted from blurred definitions. In the absence of some clear, agreed upon definitions and due to hindered communications among DoD and military representatives, we believe that the clarification of several terms would help resolve confusion in these areas.

a. *Research.* In 1976 Congress prohibited DoD from conducting drug abuse research which duplicated that being performed or sponsored by HEW or other

civilian departments or agencies. The Review Group concluded that there were many areas of drug abuse research which were not part of DoD's mandate. For example, the investigation of the metabolism of cocaine, the likelihood of LSD producing flashbacks, or the potential harmful interactions of alcohol and marihuana on basic motor skill performance all seemed important but not central to DoD's primary objectives. These and a host of other research questions about drugs of abuse clearly belong within the area of responsibility of HEW. Where there are basic research areas of particular interest to DoD, the Review Group strongly encourages DoD to identify these areas for HEW, and the Group encourages HEW to give highest consideration to the priority inclusion of such areas in its various research plans.

There are other important questions about drug abuse which are not research in the same sense, even though some have been inappropriately included with this group. For example, determining the nature, extent, and trends of drug use within the Armed Services is not--in our opinion--defined as research in the sense of the congressional prohibition against DoD's drug abuse

research. Answers to these questions are vital to the military's capacity to manage its manpower and maintain troop readiness. Equally vital to DoD's basic mission is the development of specific knowledge on the impact of various types and levels of drug use on specific occupational performances. For example, determining whether marihuana or other drug use contributes to poor physical or mental performance of specific military tasks is clearly within the limits of approved DoD activity in our judgment, and the Review Group urges increased DoD attention to such personnel-related studies. The recommendation (p. 11) to establish an interagency drug abuse research committee is designed to further stimulate DoD and other department/agency activity. Because of the central nature of the military profession to national security, DoD and the Military Departments must share a special obligation to better understand the extent and impact of drug abuse within the Armed Services. The development of a major coordinated Federal research effort on the extent and specific impact of drug abuse on military preparedness is an integral part of this obligation.

b. *"Drug Use" versus "Drug Abuse."* The Review Group also noted that the illegal status of many drugs

poses unique problems for the Armed Services. Since any use of an illegal drug constitutes a violation of the Uniform Code of Military Justice, the military have found it difficult to officially recognize that some drug use by some people under some circumstances does *not* lead to early identifiable problems either in terms of dependence or decreased work performance. While recognizing the unique dilemmas faced by the military in this area about which our society is in conflict, we urge that the current constructive approach to alcohol use in the military be increasingly used as a model for the official approach to the problems associated with other drug use; namely, drug use should be operationally defined to include problem use as well as nonproblem use. Control, treatment, and administrative actions should be targeted on that drug use which causes identifiable problems. The approach clearly supports the President's recent message on drug abuse.

c. *Marihuana Decriminalization.* Related to the issues of drug use and abuse is the third area of definition problems--decriminalization of marihuana possession. While the Review Group does not recommend changes in military law to conform to the President's support for civilian law known as decriminalization, we observe that these changes in

> civilian law must be recognized by the Armed Services. The move to decriminalization is not a move toward legalization; it is rather a move to substitute civil fines instead of criminal penalties for possession of small quantities of marihuana for personal use. There is no move to remove criminal penalties from trafficking in marihuana.

One of the dilemmas which DoD faces is that according to the Uniform Code of Military Justice (UCMJ) (Article 134), all illicit drug use including marihuana use is punishable by the Code, regardless of consequences. This definition limits the options of DoD in dealing with any illicit drug use. As an illegal act, it cannot be condoned without laying the groundwork for encouraging noncompliance with other regulations. The result of a legal definition of *wrongdoing regardless of consequences* is that once drug use is brought to the attention of a commander something must be done. What is done varies widely and represents on the one hand a strength in the UCMJ since commanders have discretion, and a weakness on the other hand because this discretion can be imposed in relatively harsh terms. This is what happens in fact. As a general rule, for example, the Department of the Air Force gives commanders the option of excusing first-time marihuana offenders. Alternatively, severe penalties are often mandatory to first offenders of certain commands in the Navy, especially submarine commands. A clear question of equity does arise over such disparate penalties for identical violations of the UCMJ.

The overriding argument for the continued assessment of penalties for marihuana possession is that it is illegal behavior, not that the consequences of such behavior are damaging to the morale and readiness of the force. As society in general attempts to discourage marihuana use less through legal prohibitions than other social controls, the Armed Services will find themselves in a greater dilemma: they will be applying more severe sanctions on simple behavior--regardless of consequence--than society in general. If the military insists on promoting divergent standards, then it must expect continued differences from within on the issue of marihuana since the new officer and enlisted person will have been accustomed to a clearly different set of social values.

The Review Group is not arguing with the authority of the Armed Services to establish standards of conduct necessary for the training of an adequate military force, nor is it necessarily arguing for a change in the UCMJ, but it is saying that by departing from the changing social norms regarding marihuana use, Defense managers must face the fact that an inconsistent application of a policy already inconsistent with emerging civilian norms will cause a continuing controversy. Further, the policy as applied will penalize many for acts which, except for their illegality under the UCMJ, do not affect the morale or readiness of the force. These penalties can have clear force readiness consequences

since they may include the withdrawal of security clearance and reassignment of individuals in various commands because of marihuana use, regardless of frequency of use or consequence of such use, when similar *automatic* actions are not taken for isolated instances of alcohol intoxication, fighting, etc., where undesirable behavior does occur.

The Review Group believes that procedures in each Service should be reviewed to ensure that occasional use of marihuana not be treated in such a way as to deprive the Services of important manpower resources. For example, we questioned the current policy of excluding about one out of three applicants to the Air Force solely because they refuse to sign a paper indicating that they have not used any illegal drug (including marihuana) in the last 6 months. While this policy surely does screen out many undesirable individuals, it may be doing so at the expense of excluding large numbers of individuals who could make positive contributions to the Air Force. Similar issues may arise in in-service management of drug users, but if that is the case, the Review Group did not identify it. In fact, commander discretion in "confirming" drug abuse among drug positive urine cases was seen by the Review Group as a positive way for commanders to rationalize the current system making the distinction between drug use and drug abuse. Commanders now have flexibility in

handling drug users, expecially users who do not pose identifiable problems. On the one hand, this humanizes the system to protect against unnecessary loss of manpower, while, on the other hand, it is open to quite varying implementation as we discussed in an earlier section. New guidelines will help commanders in this decision-making process.

Mr. DOGOLOFF. The DOD assessment review points to the marked success that the military has had in using urinalysis as both an effective deterrent and identifier in our experience in Southeast Asia.

The review addressed three major things; the effectiveness of the current policies and programs, second, our ability to reflect changing patterns and to detect use, and the third provided very specific recommendations.

The conclusions of the review were that in terms of definition and comparability of data both within and among the services. The numerous indicators differed markedly.

Second, that the reliability of the indexes is in question, and that there was no real mechanism for validating the extent of use in the military.

The recommendations of the review were the following: one, to standardize the existing indicators within and among the services; and second, to develop assessment programs to validate that drug use, using random urinalysis and other survey techniques.

The results of the review have been transmitted to the Department of Defense, and they have developed a work plan, submitted that to us, and are now beginning to implement each of those recommendations.

In terms of an assessment of the current situation, to answer the question very specifically, we really don't know how much drug abuse is going on in the military today. You have given some figures on the basis of survey, and the chairman has talked about anecdotal information that comes from one place or another. However, in essence, we don't have a very accurate answer. The reliability of existing indicators is questionable. Those indicators such as medical, law enforcement, and other data show that drug use is clearly down from the epidemic proportions in Vietnam. But we have real concern, particularly in areas of high availability, such as Europe, the Pacific, and in areas close to the United States-Mexican border, as to the levels of drug use.

Our major concern, as is yours and the Department's, I'm certain, is the readiness of the force regardless of the substance of abuse. What we are interested in is behavior and military readiness, rather than whether a soldier is using this or that drug. If, in fact, the drug use interferes with the soldier's ability to perform, that is the real concern.

There are a number of realities facing the Department and our military today over which the Department has no control, that I believe impact on the drug situation. For example, we are dealing

with an All-Volunteer Army, many without a high school education, who are removed from family and friends, oftentimes in a foreign community where there is a declining U.S. dollar combined with, in some places, high availability of drugs like heroin, pills and cannabis. We also face the problem of changing social values and mores regarding the use of drugs in our society over the past 10 to 15 years. And, in effect, this new attitude, is brought to the military by the younger troops.

In summary then, although we cannot avoid the problem, I think we can do a good deal more than we are currently doing to minimize it.

Specific recommendations that I would offer include:

One, the Secretary of Defense should assume strong leadership to insure high priority and sufficient resources are applied to addressing this problem. We are concerned about the reduction in the DOD Drug and Alcohol Office, both in terms of financial resources, number of personnel, grade levels over the last several years, and its organizational placement. In this regard, we agree and support the DOD Health Council study which recommends increases in each of these areas.

Second, we must develop an accurate and reliable information and evaluation system which includes both random urinalysis and integrated survey data.

Third, we would ask that the Congress reconsider the current prohibition on the use of random urinalysis. It has been proven to be effective both as an assessment tool, and as a deterrent. The likelihood of detection has been proven both in our Vietnam experience, as well as in the only comparable civilian sector, which is the parole and probation sector, to be a clear deterrent for use.

The DOD should conduct its study, to objectively determine the deterrent value of random urinalysis. This study in fact, was ready to be launched at the time that the congressional prohibition for random urinalysis was transmitted.

One of the problems with random urinalysis is that when it is really working as a deterrent, in fact the cost per identified user goes up. So it becomes difficult at that point to prove its cost-effectiveness.

My experience, limited though it is, in discussing this issue with enlisted personnel, was that they would certainly not be insulted by the use of random urinalysis. And that line supervisors, at least most of those with whom I met in Germany, would also welcome it.

I want to also correct the chairman's opening statement about the President reinstituting a program of random urinalysis. This may have come from inaccurate statements by the news media. The President does not have the authority to do that, given the fact that the prohibition for random urinalysis is currently a congressional one.

In our assessment review, we have called for the reinstitution of random urinalysis and hopefully this committee and the Congress itself will take that under consideration.

In addition, the issue of my reported anecdotal information of 40-percent heroin use, coming from the few people I spoke with in Germany, it is important to recognize that that is anecdotal information, and not based on anything other than the perception of

some line recruits. Second, the 40 percent is use and not abuse, and not addiction. In summary, this is a serious issue, obviously, but we can't over generalize from that one statement.

We look forward to continuing our close working relationship both with the Department and with the committee, to deal with this difficult problem.

Thank you.

[Mr. Dogoloff's prepared statement appears on p. 144.]

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

I would like to say, since you brought the issue back up with regard to the amount of heroin use, and the 40 percent that was indicated, that was a part of a letter written by Peter Bourne, Special Assistant to the President on March 1, to Secretary of Defense, Secretary Brown.

And I would like to make that letter a part of the record at this particular point.

[The information referred to follows:]

THE WHITE HOUSE,
Washington, March 1, 1978.

Hon. HAROLD BROWN,
Secretary, Department of Defense,
Washington, D.C.

DEAR SECRETARY BROWN: I am very concerned about the possibility of increased drug use among the armed forces, especially among servicemen and women stationed in areas of high drug availability such as Europe and the Southwest Pacific. As you recall, the President indicated his clear concern about drug abuse at the November 1977 meeting of the Strategy Council on Drug Abuse. In addition, there has been growing Congressional interest in this area, currently manifested by the visit of Congressman Lester Wolff and other members of his Select Committee on Narcotics Abuse and Control to U.S. military installations in Europe.

I am particularly disturbed about this issue at this time because the indicators suggest that drug use, especially narcotic use among our servicemen overseas, is increasing at a serious rate. Simultaneously, it appears that efforts to detect drug use are waning:

In December, urine testing for opiates and other drugs was carried out on board the aircraft carrier U.S.S. Midway en route from Singapore to Subic Bay. More than 20 percent of those tested were found to be using opiates;

U.S. Army Europe (USAREUR) heroin overdose death rates increased by 50 percent last year and are currently three times the average heroin overdose death rate for U.S. cities;

Currently over eight percent of the Berlin Brigade admit to the use of heroin;

The Berlin Brigade experienced four heroin overdose deaths last year, this death rate exceeding by ten times the heroin overdose rate of those American cities with the most severe heroin problems;

Current USAREUR personnel surveys indicate an increase in daily use of heroin among soldiers;

On a recent visit by my Deputy, Lee Dogoloff, to several Army units in Germany, he heard anecdotal estimates of heroin use which ranged up to 40 percent in some units;

Law enforcement reports from U.S. agencies and German Federal and State narcotics police indicate a marked increase in the availability of high quality, inexpensive heroin;

While not optimal in all services to start with, the rate of urine testing for opiates and other drugs seems to be decreasing to the lowest common denominator rather than showing an overall increase to a more effective level; and

DOD is not taking advantage of the current technology available for both assessing drug use among the military and performing urinalysis testing.

There are two additional reasons for my concern. First, the U.S. Government has embarked on a major initiative to encourage Western European countries to respond more fully to their own growing drug abuse problems. We must provide the best support possible to our military drug abuse prevention efforts so that we will not be seen as contributing to the severe heroin problem in Western Europe. Second, we face the potential for serious embarrassment if we do not deal aggres-

sively with this problem, particularly in light of the strong Congressional interest. I would like to demonstrate that the Administration is clearly in the lead on this issue.

I previously raised the issue when I requested a review of the ability of the Department of Defense to reliably determine the nature and extent of its overall drug abuse effort. In my memorandum to you of December 19 (enclosed), I requested DOD comments, as well as a timetable for implementation of the recommendations of the DOD Drug Assessment Review Group. I have just received a response from Assistant Secretary of Defense John P. White. Candidly, I am disappointed in the reply because it indicates to me that the Department does not share an appropriate sense of urgency about this problem, nor does the Department commit to a specific implementation plan and timetable as requested.

In summary, I believe the current problem of drug abuse among American servicemen, especially overseas, is understated. I will be meeting with General Haig while he is in Washington this week to discuss the situation among the Armed Forces in Europe. If you think it appropriate, I would also like to meet with you in the near future to discuss this issue and the steps which we can take to deal effectively with these problems.

Sincerely,

PETER G. BOURNE, M.D.,
Special Assistant to the President.

Mr. ENGLISH. Now, with regard to the random urinalysis, I think we should do a bit of clarifying here for those who are not that familiar with it.

The random urinalysis in effect provided a great deal of flexibility to the commanders to use urinalysis testing at any point that they would like, or any time that they would like.

We found in our investigations, in our discussions, that the command-directed—the so-called command-directed urinalysis testing was in use, and was basically for commanders who suspected that someone might be using drugs, and that they could direct him to go over and take a urinalysis test.

The interesting point is, that once this committee got into this issue, and at the request of this task force, we did in effect, what I think most people would call random urinalysis tests. We asked the commanding officers of various military installations, to take whole companies and to go through a urinalysis test.

And the interesting point is that shortly after this committee made those requests—and we have done it at a couple of military installations—there was a new directive that came out of the Department of Defense that basically said that unit sweeps were not a part of the random urinalysis prohibition that Congress had placed in 1976.

And I would like to state that I think that is a pretty weak response to try to come back and say, well, Congress is responsible for the fact that we can't go in and do what, in effect, is random urinalysis.

Obviously, if you can take a whole company, great, commanding officers can take whole units and demand urinalysis testing at any point that they want to, which they now can—again I would like to say thanks to the ground that was broken by this task force—in effect we now have the authority within the Department of Defense to perform random urinalysis testing.

Mr. DOGOLOFF. I think we ought to differentiate in terms of clarity between command directed, and random.

Command directed is as you described, the ability of the commander to take one or all of the troops under his supervision and subject them to a urinalysis test.

Mr. ENGLISH. Mr. Dogoloff, the point is this; that up until this point the definition had been that he can only take one man at a time, and send him over and require that he take a urinalysis test.

Now, under the new interpretations, any commander can take his whole unit any time he wants to. He can take them over there every day if he wants to, and conduct that kind of test. And I think that there is a tremendous difference as far as the effectiveness of the urinalysis testing.

The other point is this, that the urinalysis testing is not a cure-all. It is not something that is going to detect every drug that is being used. And as we pointed out, particularly with PCP, LSD, cocaine, marihuana, that it is not going to be detected.

And in many points, particularly within the United States, the principal drug abuse is marihuana as has been pointed out by the survey that we have done.

The second point that I would like to get at, Mr. Dogoloff, and I want to move this as quickly as possible, because we still have got a lot of testimony here, is you stated that the recommendations that have been made from the White House have been followed by the Department of Defense.

Are you stating that every recommendation has been followed?

Mr. DOGOLOFF. I am saying that the Department of Defense has responded to those specific recommendations.

Mr. ENGLISH. That's right, they have responded, but have they not also objected to most or a good number of those recommendations?

Mr. DOGOLOFF. I don't believe it would be accurate to say that they have rejected a good number of them.

I might add that on the random urinalysis issue, the ability on an unannounced basis to have everyone within a service be called up to give a specimen on a truly random basis, is in addition to, not in place of a command directed one when the commander sees a specific problem. And that the random urinalysis is particularly helpful in terms of assessment, as well as in terms of letting everyone know that their number will come up at some point and they will be subjected to a test.

Mr. ENGLISH. It is my understanding Mr. McKenzie is going to submit, as part of his testimony, basically their response with regard to those recommendations. And as I understand it, the response is dated April 3, 1978.

Mr. MCKENZIE. That is correct, Mr. Chairman.

Mr. ENGLISH. And I would also like to point out throughout there, that there is an awful lot of "DOD does not concur" language that would not lead me to believe that they are following the recommendation of the White House.

I don't know how in the world you can interpret "it does not concur" to be a response, a positive response to the White House recommendations.

So, since that is going to be made a part of the record at a later point, I will not submit it at this point, but simply call attention to it.

Mr. DOGOLOFF. I think we were talking about degrees, rather than absolutes.

I was objecting to the idea that the Department disagreed with many or most. There was some disagreement, not all.

Mr. ENGLISH. You said in your testimony, that they agreed with the recommendations and those recommendations were now being followed out.

And what I said was, they disagreed with some, if not most of the recommendations that were made.

But the point is that your testimony led this committee to believe that the recommendations that were made by the White House were now being followed by DOD, and that DOD concurred with them and that they were carrying them out. And that is not true.

Mr. DOGOLOFF. We will be happy to submit as well, Mr. McKenzie, the responses we have received from the Department of Defense.

Mr. ENGLISH. Well, since we do seem to have a bit of dispute, I will just go through the Department of the Army comments:

Recommendation No. 1, nonconcur.
Recommendation No. 2, concur.
Recommendation No. 3, nonconcur.
Recommendation No. 4, concur.
Recommendation No. 5, concur.
Recommendation No. 6, nonconcur.
Recommendation No. 7, concur.

It seems to me like there are a few nonconcurs in there, Mr. Dogoloff.

Mr. DOGOLOFF. Yes.

And I think what I said is that they responded, rather than concurred.

Mr. ENGLISH. Well, you are slipping on us a little, slipping off.

Now there is one other point I would like to make very quickly, and I want to give the other members of the committee a chance to ask questions. One, I think, is a very important one.

And that is, when you made the statement that we do not know the amount of drug abuse within the military at the present time. And I think that is absolutely the bottom line, we do not know.

We cannot say that drug abuse is less than it was in Vietnam; we cannot say what it is in relation to any other time within military history; we cannot even say how it is affecting the combat readiness, because, unfortunately the most substantial information we had was this survey that was presented this morning. That is the most recent basis, and that was done by amateurs, quite frankly, with the help of some professionals in devising the questions.

But you know, it certainly is not the type of information we need, and certainly, considering the defense of this country is at stake, it is not the type of information that is going to be necessary to make judgments about the combat readiness of this Nation.

Mr. DOGOLOFF. That is the reason that we instituted our assessment review and we concentrated specifically on assessment because we were very concerned about the same issue that you are discussing here, that we don't know, and we wanted to know better.

We may never know absolutely and exactly, but I think we can know better than what we know now.

Mr. ENGLISH. I think my time has certainly expired.

Mr. WOLFF. Would you yield for just a moment, Mr. Chairman?

There is one aspect of this that troubles me greatly. It is not the amount of drug abuse that exists, but what were the causes of the drug abuse. And I don't think that anyone really has addressed that particular problem because I recall when this committee was in Germany, we talked to a number of the officer personnel there. They were indicating that one of the problems was boredom, which is similar to that which we experienced in Vietnam.

One of the other problems was the fact that there was separation from families and the lack of rotation of the men involved, the lack of time off for the men to go home and reunite with their families.

That because of specific policy directives, the lower enlisted personnel could not bring their families with them.

So that there are some very basic causes, in addition to the supply that is available, that are responsible for part of this problem.

And in this committee what we are hoping to address is not the idea of attempting to put blame upon anyone, but more to find where the root causes exist, and to see if steps are being taken to relieve those root causes.

Mr. DOGOLOFF. I touched on those briefly in my testimony. I could not agree with you more.

I had the privilege, when I was in Germany, to meet just privately with about 30 or 40 individual line or enlisted personnel in two different places. And many of those same kinds of issues came out that you discussed and they are serious issues, and they really are issues that need to be addressed if we are going to be able to deal with that plus the availability issue.

Mr. WOLFF. Thank you, Mr. Chairman.

Mr. ENGLISH. Mr. Beard?

Mr. BEARD. I will take a little bit harder line approach than that, possibly. I think we definitely have to find the root causes.

But I think also in the military, you know, we are finding ourselves spending 80 percent of the time trying to discover root causes of why young men can't read, why they are having all the social problems that they are having, to the point that we are losing the major thrust of what the military's mission is, and that is to provide a combat-ready unit.

So I look at—I think drug rehabilitation programs are important. But I don't know if the military can afford to be too much in the business of that, if there are problems.

So you know, I can understand the sensitivity of taking the young men away from their families, whatever, but I think the problems have got to be discussed, and I don't think they are going to be solved in the military, I guess is what I am trying to say.

One thing that concerns me a little bit, I see where the Secretary of Defense, or Dr. Smith, I believe or Mr. McKenzie, one of the two, wrote on behalf of the Secretary of Defense, one of the real concerns that we had in the Defense Department was the fact that the attitudes of the administration, or the movement of the administration, or the discussion of movement of the administration toward decriminalization of marihuana, and feeling that this has a definite

effect on the increase or the acceptance of use of marihuana in the military.

Are you familiar with that letter that was sent?

Is that you, Mr. McKenzie, that you wrote on behalf of the Secretary of Defense?

Mr. McKENZIE. I am familiar with the letter, Mr. Beard. I don't recall whether it was dispatched during Dr. Smith's tenure.

Mr. BEARD. I'm sorry. It is Dr. Smith. It is Dr. Smith who wrote the letter.

Dr. SMITH. I did.

Well at the time of the decriminalization of marihuana, I talked with Dr. Bourne about this, about the effect it might have on the military, and we made efforts to clarify the fact that decriminalization had no effect on the military services, and in no way was to be interpreted as being effective in the military.

Some of the people in the military, particularly enlisted people, misinterpreted the statement about decriminalization, but——

Mr. BEARD. They heard decriminalization, they thought it was going to be all right.

Dr. SMITH. Yes.

But we made every effort that we could within our ability to counteract that understanding.

Mr. BEARD. Did this have any reaction?

Was any reaction forthcoming as a result of this concern, which I think is somewhat——

Mr. DOGOLOFF. Sure. We share that concern, and we agree there is a very different issue of decriminalization as opposed to encouraging use or saying it is OK to use.

We are not saying that at all. In our decriminalization stance, all we are saying is that we don't want the reaction to the behavior to be more damaging to the individual than the behavior itself.

We are also talking about very small amounts of possession for personal use.

At the same time the administration has come down much harder on trafficking of marihuana as well as other drugs in our international efforts, as well as some of our domestic efforts in terms of trafficking.

The person who enters the military does so knowing full well that there is a different conduct code, there are different things that they are going to have to do when they enter the military.

Mr. BEARD. You apparently haven't talked to a recruiter lately, because that is not the case at all. As a matter of fact, the military is somewhat turning to an employer relationship, and these things really are not discussed.

So when a young man goes in, these things are not made clear.

Mr. DOGOLOFF. I think you will agree with me, that doesn't mean they should not be made clear.

Mr. BEARD. I think they should be made clear, but I think also, not to get hung up on this one issue, but to make it reflective in the record, that the young people, whether they be in the Army or whatever, as a result of the talk of decriminalization apparently react with the attitude of, well, maybe it is going to be all right now.

So I just don't think you can say that is an exclusive reaction from individuals in the military.

Mr. DOGOLOFF. It occurs in the civilian population as well.

Mr. BEARD. It just concerns me with the problems of the military and everywhere else that the administration would waste their time, or would for some strange reason, have the attitude that one of the big pushes of their drug program is to decriminalize marihuana. I think that is an absolutely naive and irresponsible approach.

But we have gone through that before, so let me ask you this: The Department of Defense has responded to the review group's recommendations that you had your little controversy on.

Now, what is the status of this review, and is there any—can you give us a timetable as to when you think that would be implemented?

Mr. DOGOLOFF. We have asked the Department of Defense to give us a timetable and they did in their response. And we will be working with them in monitoring that.

That was one of the things that we requested when we forwarded the review to the Secretary; asked back for reactions and a timetable.

Mr. BEARD. How long ago was that?

Mr. DOGOLOFF. Our first correspondence to the Department went out on December 19.

Mr. BEARD. December 19?

Mr. DOGOLOFF. Yes, sir.

Mr. BEARD. Well, has anyone come back and given any kind of ballpark figure?

I mean that has been several months.

Mr. DOGOLOFF. Sure.

We did get a response, and each of the individual recommendations were responded to individually, and there were different timetables for each of those.

Mr. BEARD. Does each military service give a different set of timetables?

Mr. DOGOLOFF. No, this is one response from the Department, and they coordinate, as I understand it, the responses of the individual services.

Mr. BEARD. All right.

Do you have a timetable to present to us for the record?

Mr. DOGOLOFF. I can present to the record the response of the Department to our letter.

Mr. BEARD. All right, I would appreciate that if you could.

[The information referred to follows:]

THE WHITE HOUSE,
Washington, December 19, 1977.

Hon. HAROLD BROWN,
Secretary of Defense,
The Pentagon, Washington, D.C.

DEAR SECRETARY BROWN: Enclosed is the Report of the Department of Defense Drug Abuse Assessment Review Group. The Review was carried out at the request of the Office of Drug Abuse Policy and covers the effectiveness of current policies and programs of the Department of Defense and the Military Departments to identify and assess the nature and extent of drug abuse problems in the Armed Services. The Review provides conclusions about the current identification process and makes recommendations.

We are currently reviewing the Report and would appreciate very much your comments within 30 days. Unless the facts are incorrect, or there are strong overriding management factors to the contrary, I would also like an implementation plan for the recommendations, to be submitted at the same time as your comments. In addition, I would be happy to accompany you up to the Hill to discuss lifting the random urinalysis ban with Chairman Mahon.

Thank you.

Sincerely,

PETER G. BOURNE,
Director, Office of Drug Abuse Policy.

Enclosure.

ASSISTANT SECRETARY OF DEFENSE,
Washington, D.C., February 23, 1978.

Hon. PETER G. BOURNE, M.D.,
Director, Office of Drug Abuse Policy,
Washington, D.C.

DEAR DR. BOURNE: We appreciate the opportunity to comment on the report of the Department of Defense Drug Abuse Assessment Review Group. Our comments on the recommendations are attached as Enclosure 1.

We appreciate your offer to visit Congressman George H. Mahon to discuss the random urinanalysis ban. However, I believe this action should not be taken until we have made a decision regarding our future program.

The time and energy spent by the Review Group in their study is appreciated. Hopefully, we and the Military Services will be able to translate its results into meaningful improvements in our programs.

Sincerely,

JOHN P. WHITE,
Assistant Secretary of Defense,
(Manpower Reserve Affairs & Logistics).

Enclosure.

THE DEPARTMENT OF DEFENSE DRUG ABUSE ASSESSMENT REVIEW GROUP RECOMMENDATIONS AND DEPARTMENT OF DEFENSE COMMENTS

Recommendation: 1. Congress should be asked to reconsider its current opposition to DOD using random urinalysis as a management tool. The present prohibition denies both DOD and the Military Departments a reliable method of independently assessing drug use. The current restriction on DOD severely limits its ability to confidently know the nature and extent of drug abuse within the Armed Services.

Comment: Congress objected to the cost and relatively low identification ratio of the DOD-wide, random urinalysis program. Some modified use of a random system to permit the option to periodically measure trends in abuse of urine-detectable drugs, or to determine drug abuse prevalence in a given area would be useful as a management tool. It should be noted that in mid-1976 the DOD initiated an effort to determine both the effectiveness of identification and the deterrent value of random urinalysis as part of a comprehensive reassessment of the entire urinalysis program. That reassessment included a review of the urinalysis laboratory functions, a review of the number and location of urinalysis laboratories, a survey of trends and prevalence, a cost analysis study and a contractor effort to determine random urinalysis identification effectiveness and deterrent value. A Request for Proposal for the random urinalysis study was prepared and promulgated, the contractors' proposals were received and were being reviewed when the Congress directed that random urinalysis cease on 1 October 1976. The random urinalysis study was then cancelled. In light of the Review Group's recommendations, the DOD now proposes to reinitiate the study regarding random urinalysis identification and deterrent effectiveness described above. At the same time it is proposed that a plan for the course of action which all urinalysis efforts should follow be devised. It is visualized that a revised plan for identification would be implemented: the plan would increase urinalysis following accidents and incidents to see if drugs were involved; and it would continue commander directed urinalysis, urine surveillance programs, use as a diagnostic tool in rehabilitation programs, and as a means of identifying drug abusers among recruits. In the meantime, the DOD is endeavoring to make the most effective use possible of those urinalysis programs which are left to it. Note that the DOD is not committed to random urinalysis as it existed prior to October 1976. It is believed that a better urinalysis identification program can be produced which may

or may not have a random component depending upon the study results and Congressional acceptance of subsequent proposals.

Recommendation: 2. DOD and the Military Departments should review their existing drug abuse indicators and select a limited number (three or four) of standardized data elements and reporting requirements which are most needed in the making of drug abuse policy. DOD should establish clear guidelines for the Military Departments on the standardization and collection of such information.

Comment: A contract has been let to collect the many indicators of both drug and alcohol abuse indices which will exhibit the prevalence of abuse. The indices will also provide a timely means of discerning trends of abuse in the military services. However, first, the set of presently available indicators, e.g., urinalysis data, separation data, treatment and rehabilitation data, and punishment data must be examined to determine if they are adequate to provide a basis for reliable indices, and if not, the additional information required will have to be identified and action initiated to collect it. Standardized data content, collection formats and frequency will have to be determined. Consideration of input data will focus on the reports submitted by the military services but may include information regularly obtained and published by other government agencies. Where necessary, the study and analysis effort will recommend additional reports or changes to existing reports that will provide standardization as well as a more effective system to describe trends and prevalence in drug and alcohol abuse in the military services.

Recommendation: 3. An independent drug abuse assessment program should be established within DOD to validate other indicator systems. This program should include a modified random urinalysis effort and an integrated survey effort which would serve as the lynchpins of this independent system. The information developed in this program will be used for trend analysis only and will not be used as an identification and referral process. Identification and referral can continue through existing programs.

Comment: The current prohibition on random urinalysis would appear to prevent implementation of this portion of the recommendation at this time. On the other hand, action has begun with respect to the survey. A contract has been let, the primary objectives of which are to prepare a survey instrument to use to determine the prevalence of both drug and alcohol abuse among enlisted and officer personnel of the Armed Forces, and to analyze previous DOD and military service drug and alcohol abuse surveys and studies in depth in order to develop a measurement methodology applicable to all and to provide a comparison, over time. To accomplish these objectives, a questionnaire is being developed for administration to a worldwide sample of service members to elicit information about respondents' current use of drugs and alcohol, demographic characteristics of users and non-users, and to assess the effectiveness of major programs designed to control the abuse of drugs and alcohol.

Recommendation: 4. DOD should identify those areas of "basic research" which are valuable for a better understanding of drug abuse, and encourage HEW to give priority support to such research. Further, DOD should identify those areas of applied research which will help it better understand the nature and extent of drug use in the military and the consequences of such drug use on force readiness. A research program should be developed on a priority basis and should be integrated into existing DOD research plans. Further, an interagency drug abuse research committee, with membership to include DOD, VA, and HEW, should be established to identify those research areas of common interest and make recommendations to the respective departments and agencies regarding the development of such efforts, including joint projects. The Chairmanship of this committee should be rotated on an annual basis.

Comment: Much of the action contained in this recommendation has already been accomplished. Following the Congressional ban on drug abuse research by the DOD, the DOD forwarded a request to the Alcohol, Drug Abuse and Mental Health Administration that certain research be undertaken by that administration's components; research that the military services felt was essential to the successful prosecution of the effort against drug abuse. More recently, the wording of the Congressional edict was re-examined, and it was determined that the interpretation of the wording on pages 277 and 278 of House Report 94-517 regarding military medical problems, when taken in the drug and alcohol abuse context, permits the Military Departments to engage in that scientific study and experimentation directed toward increasing knowledge and understanding in these biological-medical and behavioral-social areas of drug and alcohol abuse control which are peculiar to the military profession. For example, research into the effects of drugs and alcohol on the performance of service members performing typical military tasks is considered to

be the type of work which the Armed Forces can properly undertake. On the other hand, the DOD believes that research which provides fundamental knowledge for the solution of identified medical/behavioral technologies and of new or improved functional capabilities in the personnel support area—knowledge and capabilities which have relevance equally to civilian as well as to military abusers is available from the National Institute on Drug Abuse and need not be pursued by the DOD. Studies of addiction mechanisms fall into this latter category. The DOD also considers the House Report wording to permit general purpose data collection, i.e., activities that include routine product testing and monitoring activities, quality control, surveys and collection of general purposes statistics. Consequently, the military services have continued to engage in general purpose data collection and analysis of the data collected. This interpretation was disseminated to the Military Departments with the request that they seek funding for projects which fall within the acceptable limits of the interpretation. To date, the Army has initiated a request for research funding for two projects: (1) a project to identify the extent and patterns of substance abuse in the Army and, (2) a project to determine the impact of substance abuse on Army personnel readiness and task performance reliability. The DOD is willing to participate in an interagency drug abuse research committee, and to assume chairmanship of the committee on a rotating basis as proposed in the recommendation.

Recommendation: 5. DOD Should assess the drug abuse problem of its civilian force and dependent contigent and develop and expand special programs for these populations, especially in areas overseas where community drug abuse programs are not available.

Comment: The DOD agrees that civilian employees and dependents of both military and civilian personnel should have services available to assist them in dealing with problems of drug abuse overseas. Military programs in operation overseas are also available to civilian emloyees. Services to dependents, however, while available in some geographical areas, have not been addressed systematically by the DOD. In view of the Review Groups' recommendation regarding these populations, the Military Departments will be asked to evaluate the adequacy of their current programs in meeting the needs of these groups and to assess the need to expand or develop special programs for them.

Recommendation: 6. The Secretary of Defense, Department Secretaries, the Chairman of the Joint Chiefs of Staff, and other senior DOD officials should receive comprehensive periodic briefings on current drug abuse trends. Further, DOD should initiate a scheduled program of concentrated field visits to not only learn about programs in the fields, but to evaluate their ability to reliably reflect drug abuse trends and levels. Each area overseas should be visited at least once a year and major CONUS (continental United States) components should be visited at least biannually.

Comment: At present the Secretary and Assistant Secretaries of Defense receive information of the drug abuse situation in the Executive Management Information Summary. Plans call for Senior DOD officials to receive annotated index results (described under Recommendation 2 above) and the survey results (described under Recommendation 3 above) when these become available. Additional, or more in-depth briefings will depend, in large part, on the reaction to these two periodic presentations and the demands of the DOD officials for more information. Staff visits to units in the field are made as required by OSD and military service staffs.

Recommendation: 7. Current resource levels should be reviewed with a view toward reversing the downard trend in personnel and budget support. Areas such as drug and alcohol abuse, race relations, and other human resources programs are always vulnerable in times of budget restrictions. The current resource commitment to the drug abuse prevention effort must not be allowed to deteriorate any further. Adequate staffing and funding must be maintained to ensure that an aggressive, viable drug abuse program can exist.

Comment: Current resource levels are being reviewed.

THE DEPUTY SECRETARY OF DEFENSE,
Washington, D.C., April 18, 1978.

Hon. PETER G. BOURNE, M.D.,
Director, Office of Drug Abuse Policy,
Washington, D.C.

DEAR DR. BOURNE: We have received and carefully reviewed your recent letter which elaborates on the drug abuse problem among our service-members, particu-

larly those stationed in Europe. I wish to assure you that we share your concern about the situation.

I feel that there may have been some misunderstanding about the implementation plan submitted in our 23 February 1978 letter; and so to remove any doubt about the DOD commitment to a campaign against drug abuse in the military, we have reworked the plan and added dates. The revised plan is attached as Enclosure 1.

In addition to the actions detailed in the implementation plan, we will provide the military services with policy guidance leading to increased drug abuse indentification efforts on their part. We will also work to have a quick reaction urinalysis capability moved to West Berlin, so that the level of urinalysis testing there is increased; and we will request that West Berlin statistics be reported separately for the time being so that progress there may be monitored.

I am hopeful that with vigorous pursuit of the activities outlined above and in our attached implementation plan, we will see meaningful improvement in our programs.

Sincerely,

C. W. DUNCAN, Jr.

Enclosure.

THE DEPARTMENT OF DEFENSE DRUG ABUSE ASSESSMENT REVIEW GROUP RECOMMENDATIONS AND DEPARTMENT OF DEFENSE COMMENTS

Recommendation: 1. Congress should be asked to reconsider its current opposition to DOD using random urinalysis as a management tool. The present prohibition denies both DOD and the Military Departments a reliable method of independently assessing drug use. The current restriction on DOD severely limits its ability to confidently know the nature and extent of drug abuse within the armed services.

Comment: The DOD does not propose at this time to approach the Congress with the request that the ban on random urinalysis be lifted. Mr. W. P. Clements, Jr., when Deputy Secretary of Defense, did address a request to Mr. Mahan for a partial easing of the ban and was rather severely rebuffed. Instead, the DOD proposes to issue a revised policy for identification. The policy would increase urinalysis following accidents and incidents to see if drugs were involved; and it would continue commander directed urinalysis, urine surveillance programs, and as a means of identifying drug abusers among recruits.

It is planned to issue the policy on increased identification measures no later than the end of April 1978.

Recommendation: 2. DOD and the Military Departments should review their existing drug abuse indicators and select a limited number (three or four) of standardized data elements and reporting requirements which are most needed in the making of drug abuse policy. DOD should establish clear guidelines for the Military Departments on the standardization and collection of such information.

Comment: A contract has been let to collect the many indicators of both drug and alcohol abuse, study and analyze the relevant information contained therein and use that data to develop drug and alcohol abuse indices which will exhibit the prevalence of abuse. The indices will also provide a timely means of discerning trends of abuse in the military services. However, first, the set of presently available indicators, e.g., urinalysis data, separation data, treatment and rehabilitation data, and punishment data must be examined to determine if they are adequate to provide a basis for reliable indices, and if not, the additional information required will have to be identified and action initiated to collect it. Standardized data content, collection formats, and frequency will have to be determined. Consideration of input data will focus on the reports submitted by the military services but may include information regularly obtained and published by other Government agencies. Where necessary, the study and analysis effort will recommend additional reports or changes to existing reports that will provide standardization, as well as a more effective system to describe trends and prevalence in drug and alcohol abuse in the military services.

The contract to formulate the system was awarded in February 1978. It is scheduled for completion in June 1978 following which there will be about three months required in which to collect the standardized data and construct the desired indices.

Recommendation: 3. An independent drug abuse assessment program should be established within DOD to validate other indicator systems. This program should include a modified random urinalysis effort and an integrated survey effort which would serve as the lynchpins of this independent system. The information developed in this program will be used for trend analysis only and will not be used as an

identification and referral process. Identification and referral can continue through existing programs.

Comment: The current prohibition on random urinalysis would appear to prevent implementation of this portion of the recommendation at this time. On the other hand, action has begun with respect to the survey. A contract has been let, the primary objectives of which are to prepare a survey instrument to use to determine the prevalence of both drug and alcohol abuse among enlisted and officer personnel of the Armed Forces, and to analyze previous DOD and military service drug and alcohol abuse surveys and studies in depth in order to develop a measurement methodology applicable to all and to provide a comparison, over time. The questionnaire is being developed for administration to a worldwide sample of servicemembers to elicit information about respondents' current use of drugs and alcohol, demographic characteristics of users and non-users, and to assess the effectiveness of major programs designed to control the abuse of drugs and alcohol.

The contract was awarded in September 1977. It is scheduled for completion in June 1978 following which work will begin to administer the survey questionnaire. It is estimated that the analyzed data will be available six months after initiation of the survey administration phase. It is proposed further to repeat the survey administration annually or biannually, depending on cost and difficulty of administration, so as to gain a picture over time of the trends in drug and alcohol abuse prevalence.

Recommendation: 4. DOD should identify those areas of "basic research" which are valuable for a better understanding of drug abuse, and encourage HEW to give priority support to such research. Further, DOD should identify those areas of applied research which will help it better understand the nature and extent of drug use in the military and the consequences of such drug use on force readiness. A research program should be developed on a priority basis and should be integrated into existing DOD research plans. Further, an interagency drug abuse research committee, with membership to include DOD, VA, and HEW, should be established to identify those research areas of common interest and make recommendations to the respective departments and agencies regarding the development of such efforts, including joint projects. The chairmanship of this committee should be rotated on an annual basis.

Comment: Much of the action contained in this recommendation has already been accomplished. Following the Congressional ban on drug abuse research by the DOD, the DOD forwarded a request to the Alcohol, Drug Abuse and Mental Health Administration that certain research be undertaken by that administration's components; research that the military services felt was essential to the successful prosecution of the effort against drug abuse. More recently, the wording of the Congressional edict was re-examined, and it was determined that the interpretation of the wording on pages 277 and 278 of House Report 94-517 regarding the military medical problems, when taken in the drug and alcohol abuse context, permits the Military Departments to engage in that scientific study and experimentation directed toward increasing knowledge and understanding in these biological-medical and behavioral-social areas of drug and alcohol abuse control which are peculiar to the military profession. For example, research into the effects of drugs and alcohol on the performance of servicemembers performing typical military tasks is considered to be the type of work which the Armed Forces can properly undertake. On the other hand, the DOD believes that research which provides fundamental knowledge for the solution of identified medical/behavioral technologies and of new or improved functional capabilities in the personnel support area—knowledge and capabilities which have relevance equally to civilian, as well as to military, abusers is available from the National Institute on Drug Abuse and need not be pursued by the DOD. Studies of addiction mechanisms fall into this latter category. The DOD also considers the House Report wording to permit general purpose data collection, i.e., activities that include routine product testing and monitoring activities, quality control, surveys and collection of general purpose statistics. Consequently, the military services have continued to engage in general purpose data collection and analysis of the data collected. This interpretation was disseminated to the Military Departments with the request that they seek funding for projects which fall within the acceptable limits of the interpretation. To date, the Army has initiated a request for research funding for two projects: (1) a project to identify the extent and patterns of substance abuse in the Army, and (2) a project to determine the impact of substance abuse on Army personnel readiness and task performance reliability. The DOD is willing to participate in an interagency drug abuse research committee, and to assume chairmanship of the committee on a rotating basis as proposed in the recommendation.

It is too early to forecast firm dates for the initiation and completion of the desired research. There has been some preliminary contact with aspiring contractors; but before significant action can get underway, in-depth discussions are required among representatives of DOD, the military services, and NIDA. It is planned to schedule the first of these meetings in April 1978.

Recommendation: 5. DOD should assess the drug abuse problem of its civilian force and dependent contingent and develop and expand special programs for these populations, especially in areas overseas where community drug abuse programs are not available.

Comment: The DOD agrees that civilian employees and dependents of both military and civilian personnel should have services available to assist them in dealing with problems of drug abuse overseas. Military programs in operation overseas are also available to civilian employees. Services to dependents, however, while available in some geographical areas, have not been addressed systematically by the DOD. In view of the Review Groups' recommendation regarding these populations, the Military Departments will be asked to evaluate the adequacy of their current programs in meeting the needs of these groups and to assess the need to expand or develop special programs for them.

Queries to the Military Departments will be dispatched in April 1978. The timetable of events thereafter depends upon the adequacy of the programs reported by the Military Departments.

Recommendation: 6. The Secretary of Defense, Department Secretaries, the Chairman of the Joint Chiefs of Staff, and other senior DOD officials should receive comprehensive periodic briefings on current drug abuse trends. Further, DOD should initiate a scheduled program of concentrated field visits to not only learn about programs in the fields, but to evaluate their ability to reliably reflect drug abuse trends and levels. Each area overseas should be visited at least once a year, and major CONUS (continental United States) components should be visited at least biannually.

Comment: At present, the Secretary and Assistant Secretaries of Defense receive information of the drug abuse situation in the Executive Management Information Summary. However, entries in this document are aperiodic and abbreviated. Plans call for Senior DOD officials to receive annotated index results (described under Recommendation 2 above) and the survey results (described under Recommendation 3 above) when these become available. Additional, or more in-depth briefings will depend, in large part, on the reaction to these two periodic presentations and the demands of the DOD officials for more information. Staff visits to units in the field are made as required by OSD and military service staffs.

Recommendation: 7. Current resource levels should be reviewed with a view toward reversing the downward trend in personnel and budget support. Areas such as drug and alcohol abuse, race relations, and other human resources programs are always vulnerable in times of budget restrictions. The current resource commitment to the drug abuse prevention effort must not be allowed to deteriorate any further. Adequate staffing and funding must be maintained to ensure that an aggressive, viable drug abuse program can exist.

Comment: Current resource levels are being reviewed.

Mr. BEARD. I would like to get to the other statements.

Mr. ENGLISH. Thank you.

Dr. Smith, will you give us your testimony at this time? And if you could, summarize it and keep it as brief as possible.

Dr. SMITH. Yes, sir.

TESTIMONY OF DR. ROBERT SMITH, FORMER ASSISTANT SECRETARY FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Mr. Chairman and distinguished members of the Select Committee, I deeply appreciate your invitation to discuss with the committee the recent trends in top-level DOD management as they impact on health-related matters, and specifically on the DOD drug and alcohol abuse prevention programs. I share with you an anxiety about the recent trends in the military level of support given to all areas of health care and military medical preparedness in the DOD.

As you know, this hearing was originally scheduled in November and subsequently postponed. Since that time, I have resigned as Assistant Secretary of Defense for Health Affairs, as of January 8, 1978, for personal and policy reasons. But maybe it was political, too. And I am again practicing medicine in Toledo, Ohio.

However, my interest in and support of military medicine is as keen as ever.

Your letter asked me to respond to nine different subject areas. I intend to group these areas so that I can respond to them in a group.

The first question asked, in the broadest aspect is an assessment of the present quality of medical care within the military departments.

My assessment of the present quality of medical care within the military structure is that technologically and scientifically it is good, but quantitatively we cannot meet our peacetime responsibilities. And we are woefully short of our mobilization needs even for a limited contingency.

I would like to quote a small portion of a letter which I wrote to Secretary Brown on the eve of my departure, which touches on my assessment.

I said in the letter:

> I would be remiss, however, if I did not say to you at this time that in my judgment the resources, particularly personnel, allocated to health care by the Department of Defense, are not adequate even for our present peacetime situation. They are woefully inadequate to meet possible wartime situations.

At the end of the letter I said:

> I recognize the present budgetary crunch and the high cost of weapons and weapons systems and of the need to improve our military capability; but people, their well-being and their morale cannot be sacrificed in the process since they, too, are essential to the achievement of an increased capability.

My letter was supported by a memorandum from Gen. George Brown, Chairman of the Joint Chiefs, to the Secretary, in which he said in part:

> I have read with great interest, the comments of Dr. Robert N. Smith, the former Assistant Secretary for Health Affairs in his letter to you of January 6, 1978. The points concerning inadequate medical resources, particularly personnel, are supported by the Joint Chiefs of Staff.

The memorandum continues:

> Presently an assessment of the medical capabilities to support war plans is underway with that portion pertaining to a conventional NATO conflict near completion. We have progressed sufficiently with our review to support Dr. Smith's statement that shortages in medical resources exist.

He went on to recommend:

> Sufficient medical manpower must be authorized to provide adequate medical care for our people without imposing abnormal work demands on medical personnel.

Let me make a few more comments about the overall situation.

Our outdated facilities are being replaced and modernized, although not as rapidly as we would like. I think the caliber of the health personnel in general are excellent. However, the number of personnel is not satisfactory, and this shortage of personnel directly impacts on our beneficiary's view of quality of care.

Depending on the time, the location and the health care specialty involved, there are not enough people to provide our beneficiaries with the same range of services they formerly had available.

At times our medical people in their efforts to continue to help everyone extend themselves too far, and the quality of care suffers.

Our patients view this legitimately as a reduction in the quality and quantity of care available to them.

In addition, our beneficiaries are vocally critical of the increasingly expensive alternative of CHAMPUS.

In summary, the bottom line is that the Defense Department needs to provide more financial support, more personnel and improved facilities, if the military health care system is to meet its medical responsibilities.

The status of health care which I have just discussed is a reflection of the attitude toward health care matters in the Department of Defense today. The first four questions that you have asked me to comment on, question the character of that attitude.

And if you would look at the Chairman's letter—I won't read the four questions. The basic problem, it seems to me, is that there is no firm commitment to having an effective health care program within the Department of Defense.

May I illustrate by describing as I see it, the atmosphere relating to health within the DOD.

When I arrived in 1976, Health Affairs was authorized 47 persons. With these few people the Health Affairs Office was to carry out overall supervision of the military health care system, which represents 185 hospitals, about 200 clinics, with a budget of about $4 billion.

I was successful under the previous administration in establishing the Defense Health Council supported by six additional persons who were assigned to the Council's activities.

And I will answer questions about the Defense Health Council a little later.

I had direct access to the Secretary of Defense's office. Clearly, in the new administration there is a decreased emphasis on all health matters in the Defense Department to include drug and alcohol programs. Our personnel authorization was cut from 47 to 33, or a 30 percent cut.

Additionally, upon my departure, the staff supporting the Defense Health Council was eliminated. Adding these individuals to our other personnel cuts, we had nearly a 40-percent personnel loss within a 1-year period.

It was, and is, my judgment that to do an effective and credible job in health an authorization in excess of 53 people is absolutely required.

In addition to the personnel cuts, I was not permitted direct access to the Secretary or Deputy Secretary. I was required to report to the Secretary's office through the Secretary for Manpower and Reserve Affairs, and that is an extremely cumbersome method and causes long delays in many actions.

Finally, there was an effort to downgrade the Office of Health Affairs to a subordinate unit of Manpower and Reserve Affairs, which has already been alluded to.

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

It is extremely difficult to work in a state of chronic anxiety over what next may happen to the Health Affairs Office. It is difficult just to keep your head above water on a day-to-day basis.

The lack of support in the Health Affairs Office affected each of the component offices, one of which was the Office of Drug and Alcohol Abuse Prevention.

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

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

A recent congressionally mandated Defense Health Council study of ODAAP recommended creation of a short-term task force and the expansion of the ODAAP staffing from 4 to 10 in order that the problems of substance abuse could be effectively addressed.

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

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

I think the recent news that the former President's wife has a drug abuse problem and sought treatment at Long Beach, emphasizes the excellence of the Long Beach program, that program could be expanded into all the services, and it can be used as a touchstone for the Army and the Air Force. Those are the kind of activities that ODAAP should have the resources to execute.

Also, Mr. Dogoloff has referred to activities which we need to undertake in terms of the analysis of the data that we collected; from that analysis, conclusions should be reached; from those conclusions, new programs ought to be initiated.

Four people can't do that.

During the time the random urine testing program was going on, the DOD probably had the most accurate assessment of the extent of drug abuse in a large population that has ever been available in the United States or any place else in the world for that matter. We still get good information on the kind of drugs being used, and the frequency of use that leads to hospitalization or death.

However, without random testing the level of detection of drug abuse, which does not otherwise come to someone's attention, appears to have fallen.

In actual fact, I feel the apparent decrease is due to underreporting, but I have no idea by how much.

Drug abuse, while reduced from the epidemic proportions of the Vietnam era, continues to be present. The actual use runs higher than the number of detected users. But I am not sure that anyone knows just how much higher.

As far as I am concerned, any use is too much and has an adverse effect on personal and unit effectiveness. The extent of unit deterioration due to drugs and the criteria for its evaluation are elusive.

In years gone by the conventional wisdom was that an infantry unit that lost 30 percent of its personnel was no longer considered combat effective.

Obviously, this empiric point was preceded by a curve of diminishing effectiveness.

In today's combat of increasing technical intricacy, I think this figure is too high. In other words, with the complexities in our units today and the specialists that we have, maybe you have to lose 15 or 20 percent of these people before the unit becomes ineffective.

The effects of abuse hinge on the drugs used, its particular effects, the amount and frequency of use, and the timing of use. The effects could range from none on one extreme, to mistakes leading to personal death or injury, or to critical tactical decision mistakes that could hazard entire units.

Woven into this are the related, but yet distinct intangibles of morale, leadership, and effective exercise of command.

It is unreasonable in this day and age to expect that we can eliminate drug abuse. But we must do everything we can to reduce it. We may not find out the real answers to combat effectiveness until it is too late in a literal trial by fire.

Our efforts in drug abuse detection, the Defense Department's efforts in drug abuse detection, rehabilitation, education, must be increased and improved. Lip service to the DOD drug program is ineffective and deceptive. Here again, the bottom line is the commitment of resources that the Defense Department is willing to make to support an effective drug and alcohol program.

Thank you, Mr. Chairman.

[Dr. Smith's prepared statement appears on p. 146.]

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

Dr. Smith, one question I would like to start off with; given the fact that you were discussing 30 percent of the unit is not prepared for combat, then the whole unit's effectiveness is pretty much nil. And you said you thought that that was too high, that it would probably be fewer than that under today's circumstances.

Is that correct?

Dr. SMITH. Yes, sir.

Mr. ENGLISH. I would like then for your thoughts with regard to our questionnaire and the response that we got back from our junior officers, namely to the question:

Given the amount of drug use as you perceive it on this installation, do you think that today the men and women could go into combat and perform to the best of their ability?

And 63 percent said yes. But given the criteria you are using, 34 percent said no.

Does that disturb you quite a bit?

Dr. SMITH. It certainly disturbs me that that indicates the number of people who are not effective in doing whatever their assigned responsibilities are within that unit.

Certainly within an Air Force unit; I wouldn't want anybody on the line to prepare an aircraft, who were under the influence of any drugs. So anybody on the line using drugs would be a danger to the unit and to its effectiveness.

Mr. ENGLISH. Would you also agree that given the degree of sophistication, the more modern weapons, the more modern they become, the more complicated that they become, that probably this continues to increase, or take fewer and fewer people to really destroy weapons systems operations?

Dr. SMITH. Yes, sir, I agree with that.

Mr. ENGLISH. Would you care to make any observations with regard to nuclear power, this is nuclear-powered ships, nuclear weapons and so on and so forth, and the impact it would have in that area?

Dr. SMITH. Well, I am not an authority in that area, but I think intuitively you would say that people who were involved in that sophisticated work would certainly be people who, if they were under the influence of drugs, would be less than capable to perform the job assigned to them.

Mr. ENGLISH. Also, I would like to request that if you would not mind, to submit for the record, the letter that you mentioned that you had sent Secretary Brown.

Dr. SMITH. Yes, sir.

[The information referred to follows:]

TOLEDO, OHIO, *March 17, 1978.*

Mr. DON DUSKIE,
Military Task Force Coordinator,
Drug Select Committee, Washington, D.C.

DEAR DON: Pursuant to our conversation this afternoon, I am enclosing a copy of my letter to Secretary Brown, dated 6 January 1978, and a copy of General George Brown's memorandum for the Secretary of Defense, dated 20 February 1978, commenting on my 6 January letter.

Nice seeing you again.

Sincerely,

ROBERT N. SMITH, M.D.

Enclosures.

ASSISTANT SECRETARY OF DEFENSE,
Washington, D.C., January 6, 1978.

Hon. HAROLD BROWN,
Secretary of Defense,
Washington, D.C.

DEAR MR. SECRETARY: I wish to express my appreciation for the opportunity to have served the Department of Defense as Assistant Secretary of Defense for Health Affairs from August 30, 1976 to January 7, 1978. My association with all those who have been striving to promote an adequate system of health care for mobilization and national defense contingencies and for the men and women of the Armed Forces, their dependents and the retirees has been a challenging experience.

I would be remiss, however, if I did not say to you at this time that, in my judgment, the resources—particularly personnel resources—allocated to health care by the Department of Defense are not adequate even for our present peacetime situation; they are woefully inadequate to meet possible wartime situations. For a considerable period, the devoted medical personnel of the Armed Forces have been

required to assume a posture of "can do" with less and less resources to the point where this does not make sense. The results can only be further deterioration. Present arrangements are not adequate to attract and retain the needed medical professionals or to maintain the high quality medical care that the men and women of the Armed Forces and their dependents deserve.

I recognize the present budgetary crunch and the high cost of weapons and weapons systems and of the need to improve our military capabilty; but people, their well-being and their morale cannot be sacrificed in the process since they, too, are essential to the achievement of an increased capability.

Specifically, I must comment on the transfer of the TRIMIS Program Office from Health Affairs to the Defense Logistics Agency on the basis that it was judged "to be operational" and, therefore, not a proper function within OSD.

In my judgment, this view is contrary to the fact. The goal of the TRIMIS Program is the development of a "medical information system" and a "medical management information system" using advance computer technologies. Progress to date has been uneven, erratic and a matter of considerable Congressional interest and criticism. It should be noted, however, that in the past 1½ years under the overall supervision of the Assistant Secretary of Defense for Health Affairs a realistic development schedule with specific goals has been developed and implemented. This activity emphasizes that the TRIMIS Program is a development program and is clearly not "operational."

Furthermore, I emphasize that the agency to which the program is to be transferred (DLA) has no medical expertise by which to guide further development. The lack of adequate guidance will result in a return to erratic programming and again raise Congressional suspicion and criticism which will reflect adversely on the Defense Department and the Secretary. I strongly believe that the decision to transfer this "developmental program" to an agency with no appropriate expertise is untimely and unwise. It should be reconsidered and, in my judgment, reversed.

With warm regards.

Sincerely,

ROBERT N. SMITH, M.D.

THE JOINT CHIEFS OF STAFF,
Washington, D.C., February 20, 1978.

Memorandum for: The Secretary of Defense.
Subject: Health affairs.

1. I have read, with great interest, the comments of Dr. Robert N. Smith, the former Assistant Secretary of Defense (Health Affairs), in his letter to you, 6 January 1978. The points concerning inadequate medical resources, particularly personnel, and the planned transfer of the Tri-Medical Information System (TRIMIS) to DLA are supported by the Joint Chiefs of Staff.

2. Presently, an assessment of the medical capability to support approved war plans is underway with that portion pertaining to a conventional NATO conflict near completion. We have progressed sufficiently with our review to support Dr. Smith's statement that shortages in medical resources exist. It is anticipated that specific recommendations concerning the shortage of medical personnel and other medical resources will be forwarded to you in the near future.

3. I have discussed this matter with the Chiefs of the Services. We recognize the need for frugality in authorization of medical manpower. However, sufficient medical manpower must be authorized to provide adequate medical care for our people while imposing normal work demands on medical personnel.

Gen. GEORGE S. BROWN, USAF,
Chairman, Joint Chiefs of Staff.

Mr. ENGLISH. Mr. Burke?

Mr. BURKE. Thank you, Mr. Chairman.

I probably am a little reluctant to ask this question, but I think I will ask it in any event.

How do you characterize Secretary Brown's attitude with regard to the drug problem in the military?

Would you say he was affirmative with respect to his attitude, or would you say he was negative or in the middle?

Dr. SMITH. Well, I don't believe I can characterize the Secretary. I am sure that the Secretary is concerned about drug abuse.

Where it impacted in the office was the fact that ODAAP with only four people in it, in my judgment, was not capable of carrying out the responsibility that we knew we had. And when I was there, I directed my people to work on a plan to draw up an effective program. And part of that came out in the study that was just completed by the Defense Health Council which does recommend an increase in people.

But unless we can get an allotment of people and resources, we don't do anything. And that is the same difficulty as I see it, that was reflected in the time that I was there, in the overall attitude toward health. That when you cut the budget, you start cutting in health because then you don't lose any weapons systems that way. But you lose people support, and that is the argument that I tried to make, obviously not as effectively as it should be, or we wouldn't have suffered a 30-percent personnel cut.

Mr. BURKE. I think Mr. English touched upon the question with regard to the combat effectiveness of the military, particularly with the sophisticated weaponry which we now have, and the fact that it takes a good deal of training of many of the personnel.

Your answer, of course, indicated that that would lose some of its effect. But, how serious do you think the drug problem is, particularly as far as our troops in Europe, with respect to defense of the NATO groups, bearing in mind——

Dr. SMITH. When I was in Europe, I talked to the commanders, to officers, to enlisted people. Their judgment, I believe, was that they had a drug problem. However, the training exercises carried out were still carried out effectively.

I don't believe they know any more than we know, and accurately, the level of drug abuse. It is difficult to measure a decrease in capacity to perform tasks unless it is pretty clear. So that I don't know how you make this judgment as to whether a unit is in top—working up to the top efficiency, or is minus 10 percent. That is an elusive evaluation to try to make. I don't know——

Mr. BEARD. Will the gentleman yield on that point?

Dr. SMITH [continuing]. That we can ever arrive at a criteria which was that accurate. But they are concerned about it and I feel that we have not been aggressive enough in the Defense Department to provide the kind of leadership, the kind of programs and the kind of analysis that should have been done.

But I have appreciated the efforts that office made, given the limited resources that they have.

Mr. BURKE. Dr. Smith, one of the things that concerns both the commanders and some of the civilian enforcement officers in Europe when we were there a few months ago, is the fact of the question of decriminalization of marihuana, particularly with the use of hashish over there, and the question specifically of what decriminalization meant. And I think there is some confusion with regard to the use of the word "decriminalization" as distinguished from legalization.

In view of these circumstances, should this continue? And in view of the fact that many States have statutes of certainly reducing the penalties of the use of marihuana, would you think it more effective that the military maintain its enforcement through the military code, rather than based upon civilian standards?

Dr. SMITH. I think it is absolutely necessary to maintain the nonuse of any kind of drugs in the military, including marihuana, obviously.

As I said before when we spoke about this, we did see an increase in the use of marihuana in the period immediately after the decriminalization announcement was made, and it was at that time that we made strong efforts to make it very clear to the military and all the people in it, that this had no effect on the conduct of the people in the armed services.

And that anyone who had misinterpreted that was wrong.

Mr. BURKE. Thank you.

I will be glad to yield to my colleague.

Mr. BEARD. May I take my line of questioning?

Mr. ENGLISH. We will let Mr. Wolff go first.

Mr. WOLFF. I will let Mr. Beard proceed.

Mr. BEARD. Regarding the use of drugs in Europe, I have run into situations in talking to young platoon commanders and some of the enlisted men, that in many cases they were not supported when they would try to crack down on what they would find to be severe usage of drugs. They would not receive support from their commander, because the commander would feel this could be a reflection on his capabilities and could affect his career to say, hey, my unit really is not ready because I have got a serious drug problem. To the point that some of the officers, literally were either moved out or just so much pressure applied that they just ceased activity on this.

Did you ever get any type of feeling along these lines?

Dr. SMITH. No, sir.

But I know that the attitudes in the services differ. I think the Navy has taken a very forward approach in saying that people who turn themselves in for treatment of drug abuse—I am talking specifically about individuals—will no longer be threatened with the loss of their command. When they are rehabilitated, they can go back to their command position and serve again.

Some of the other services have taken the attitude——

Mr. BEARD. I think you misunderstood me. I am saying the particular man who tried to clean his platoon up and really come down hard, and try to give some article 15's, or whatever, have really come down hard and report I've got a serious drug problem which could affect the readiness of the unit, was discouraged just to not react that way.

Dr. SMITH. I have no knowledge of that.

Mr. BEARD. Well, let me—the bells have rung. I would like to ask real quickly, how many times did you personally meet with Secretary of Defense Brown and tell him how critical the medical situation was in our overall Defense Establishment.

Dr. SMITH. I never met with him.

Mr. BEARD. You never met with the Secretary of Defense?

Dr. SMITH. No?

Mr. BEARD. Well, I find that somewhat reflected then, as to possibly his lack of emphasis being placed on the medical problems.

Dr. SMITH. I took occasion on two different meetings of the Armed Forces Policy Council, which meets on Mondays, to speak

once about the CHAMPUS program, and to speak about medical care and its need for support.

I did speak to the Chief of Staff of the three services and asked them to give us support in trying to get more resources in personnel to do the job, which I thought we should do.

Mr. BEARD. What was your position now?

Dr. SMITH. I was Assistant Secretary of Defense, Health Affairs.

Mr. BEARD. So you were the top health man for the military?

Dr. SMITH. Yes, sir.

Mr. BEARD. And we have got a situation throughout this country, forgetting drugs and whatever, where men and women have not seen a doctor in 3 years in the military, because they don't have enough doctors, and we have got problems with them not able to take care of the active duty people, the dependents over in Europe. If there were a war, we would not have doctors. We have not fulfilled the contract.

And yet, you did not meet once with the Secretary of Defense, even though you were the top man for health?

Dr. SMITH. I reported to the Secretary, through the Secretary for Manpower and Reserve Affairs. I discussed this matter—I'll take it back. I'll take this back.

When Mr. Clements was the Deputy Secretary, I did meet with him, but that was in the last administration.

But I did not meet with either Dr. Brown or Mr. Duncan on these matters, because I had to go through another office.

Mr. BEARD. Well I find that just very, very tragic and very offensive, because I think the Secretary of Defense Brown then maybe had better go out in the field and talk to some of these young people and find out just the horror stories and then talk to some of the doctors saying the medical care we are providing today is dangerous.

I think maybe he had better quit fooling around and go out in the field and start paying some attention to whoever——

Dr. SMITH. Well, we sent memorandums to him with regard to the difficulties.

Mr. BEARD. I know how the memorandums go.

Mr. GUYER. Will you yield?

Mr. BEARD. Certainly.

Mr. GUYER. Doctor, it is good to se you again. He is from our part of the State, and I think he has done a very good job.

One thing I would like to say which I think has not been mentioned here, is that when the President declared war on drugs, we have not had the first smell of smoke of battle yet. And I can say this as a Congressman, that our mail and phone calls and incidents of people in trouble over drugs, has been tenfold over what it was the first year I came here.

We have had people on submarines, on ships, who said they have discovered drug rings and they are afraid of their lives. I can show you my mail and files on this.

I would say that it is epidemic right now, and I do not know whether your experience has been the same as that or not. But we can say here, just from our standpoint, that this thing is far more serious than anybody has ever acknowledged, and we do not have the tools or the manpower to cope with it.

Mr. BEARD. One last question.

Mr. McKenzie, how many times have you visited, as Acting Secretary in this particular time? How many times have you met with the Secretary of Defense on this critical problem?

Mr. MCKENZIE. I have not met with the Secretary of Defense on an individual basis in regard to these matters.

I, too, have participated in the weekly staff metings that the Secretary has had. Medical subjects have come up for discussion during those meetings when I have been in attendance.

Just as in Dr. Smith's case, I report to the Secretary, as the Acting Assistant Secretary through the Assistant Secretary for Manpower, Reserve Affairs, and Logistics. I met with that Assistant Secretary quite frequently.

Mr. BEARD. I think that is a sad commentary, and I hope maybe this committee can hopefully encourage the changing of that.

Mr. ENGLISH. Mr. Chairman?

Mr. WOLFF. We have to go over to answer a vote. However, there is a matter in my mind which is really of very critical nature.

We received a report from the Department of Defense on the nuclear weapon personnel reliability program.

The report indicated that during the years 1975 and 1976, 3,444 individuals were transferred from nuclear weapons duty because of drug and alcohol abuse [indicating chart].

Now we have heard a lot about the question of alcohol abuse, we haven't heard as much about drug abuse. But, if there are this many people who have been transferred, it might indicate a very serious problem with perhaps one of the most critical areas of our whole Defense Establishment.

Now the one point, however, is that in the calendar year 1976, the largest number of personnel were disqualified from the program because of drug abuse and alcohol abuse was the lowest.

Would you concur in that, Dr. Smith?

Dr. SMITH. I am not familiar with this report, Mr. Chairman. Did that come after I left?

Mr. MCKENZIE. No.

Mr. O'CONNOR. I might be able to respond to that.

My name is Tom O'Connor. I am Chief of Physical and Installation Security Division under the Office of the Assistant Secretary of Defense, Comptroller.

Initially I might state that our office is not concerned with drug abuse per se. We are, however, concerned with the security, physical security of nuclear weapons. And we have a whole range of things that we do in that connection.

The personnel reliability program is something over and above the physical security that we give to it now. In putting people into the nuclear weapon security program, a number of factors are considered.

There is the initial screening which involves a clearance procedure; there is a medical evaluation; there is a personal interview with a certifying official; and then an actual formal certification.

Now, among those things which would be disqualifying after the person is in there—as well as before he gets in—would be drug abuse, alcohol abuse, and a number of other things. I think we

gave you a copy of the directive that covers it. I will be glad to supply you with another one if you need it.

Now, it is true—and I have the current figures for 1977, which I will be glad to supply to the committee, too, and those are the ones that I will address—about 4 percent of the personnel that were in the personnel reliability program and initial screening is thorough—but that doesn't assure the continuing behavior—about 4 percent of those people in the program, about 118,000 all together, somewhat less than 5,000 were disqualified last year; somewhat less than 30 percent were disqualified for drug abuse. Of that, by far, the highest was use of marihuana, cannabis.

I don't mean to discount the use of marihuana, because there has been a lot of discussion here.

But for the sake of what we are talking about, heroin and other things, if you were to discount the use of that in the drug abuse program, you would find that the percentage of those disqualified for drug abuse, less cannabis, would be about three-tenths of 1 percent of the people in the program, which would be in effect, about the same as that for alcohol abuse.

Mr. WOLFF. What I had reference to was the fact that these people are the most highly screened of any of the military, and it is even after that screening that we come up with a percentage figure as you have indicated here, which would, if extrapolated from other figures or placed in relationship to other figures, would indicate that the problem is probably much greater in other areas, since these people are the most highly screened.

Mr. O'CONNOR. I wouldn't quarrel with that.

Mr. ENGLISH. Mr. Chairman, I would like to make one comment with regard to that.

You seem to place less emphasis on the fact that because the majority of it was marihuana—I would simply like to point out, if you are stoned, you are stoned.

And if you are handling nuclear weapons when you are stoned, it doesn't make any difference what you are on.

Mr. O'CONNOR. I did not mean to.

We consider, and we have very rigid—we treat them very rigidly. We disqualify people on a rather rigid basis for any of the things, including marihuana.

Mr. ENGLISH. We will break for about 5 or 10 minutes, so that we can make this vote.

[Recess.]

Mr. ENGLISH. The hearing will resume.

Mr. O'CONNOR. Mr. Chairman, may I clarify something we were discussing just before you recessed?

Mr. ENGLISH. Certainly.

Mr. O'CONNOR. You took somewhat of an exception that I was discounting the use of marihuana.

I want to assure you I was not.

I would like to clarify, I used the word discount perhaps inappropriately, but I was talking as far as discounting it in light of the total figures for drug abuse, in light of previous conversations that had gone on.

The Department of Defense agrees with you that someone who is stoned on marihuana is stoned just as well as he is stoned on something else.

And we treat the use of marihuana in the program very seriously as a disqualifying factor, as I think the figures we submitted to you will show. And I just wanted to clarify that if it needed clarification.

And the total, if I did not say before, disqualification on drug abuse is approximately 1 percent of the total people that are in the personnel reliability program for last year.

Thank you, sir.

Mr. ENGLISH. Thank you.

Mr. WOLFF. Mr. Chairman, one aspect of this should be clarified. There are a lot of statements that are being made here and a lot of assertions that are being made, and they are really in the nature of being very preliminary and in rough form. And I don't think that we should, as a result of a survey that has been made in a short period of time, come down hard on any one particular source as a basic reason of why this problem exists.

I do think, however, that it is significant to understand that we are an oversight committee, and in our oversight capacity we took it upon ourselves to do this job because we did not find the job being done in monitoring the problems of abuse within the military.

The other point I think that should be important is the fact that—and I am sure that the chairman does not mean to imply that we have people handling our nuclear weapons who are stoned on the job. Much of this occurs off base and does not occur during the time of duty of the individual involved.

Am I correct in that?

Mr. ENGLISH. Somewhat, Mr. Chairman.

There are some instances that we have found, where we have heard a great deal about stories of drug abuse taking place on duty, and this has happened far too often, I am sorry to say.

Mr. BEARD. If the gentleman will yield, I think we can assume that reading the articles we read every day about the activity going on in our high schools and grammar schools right there on the scene, I would probably—it would be legitimate to expect that that is going on——

Mr. WOLFF. The only point on that, if the gentleman will yield, is that there is not that type of availability—now maybe I am wrong in this--on the base itself. I remember we did a study when I was on the Banking and Currency Committee, of loansharking. There was some loansharking that did occur within the military, but most of it was done adjacent to the base. And we have so many people living off base now there is a problem in certain areas.

Mr. ENGLISH. Let me say, Mr. Chairman, for the record, without question, most of it has taken place off base, off duty. However, there are strong indications that it has taken place on base, on duty. And I think that those cannot be discounted.

And I will simply state as an indication of that—and again I don't want to single out any one service because it occurs with regard to all services—but again with regard to one ship that we visited, in talking to the military personnel on that ship, indicated

that at least 60 percent of the crew were using marihuana while they were at sea.

And certainly I think that would have to be classified as on base and on duty.

Mr. BEARD. If the gentleman will yield, just on your chart right here, based upon your knowledge in community drug trafficking situations, would you say the following drugs are easy or difficult for men and women here on the base to obtain? As far as marihuana, easy to purchase, 91 percent.

So I think that says something.

Mr. ENGLISH. I might also add to that the investigators within the Navy in discussion with them afterward indicated that they thought that a general figure to be used would not only be that 60 percent were using, but 10 percent of the crew was probably selling while at sea.

So that gives some indication of the difficulties that we are running into.

So I think we do have to categorize and say that certainly most of it takes place off duty, off base. But there are definitely instances where it takes place on duty and on base.

Dr. SMITH. Mr. Chairman?

Mr. ENGLISH. Dr. Smith?

Dr. SMITH. In order to complete my testimony, may I request that the chairman's letter to me be included as part of the official record, because I referred to subjects by 1, 2, 3, 4.

Mr. ENGLISH. I would be delighted.

Certainly, Dr. Smith.

[The information referred to follows:]

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, D.C., April 13, 1978.

Dr. ROBERT SMITH,
Toledo, Ohio.

DEAR DR. SMITH: The Select Committee on Narcotics Abuse and Control would like you to testify at our hearings on April 27, 1978, at 10:00 a.m. (room number to be assigned), to discuss the recent trends in top-level Department of Defense management as they impact on health-related matters. Having served as the Assistant Secertary for Health Affairs for fifteen months, the Committee would be especially interested in your views and evaluations regarding the following issues in your prepared remarks:

(1) An assessment of the efficacy of the Office of the Assistant Secretary of Defense for Health Affairs in promoting any major new policy initiatives at the time of your departure.

(2) The shifts in manpower in your office that occurred during your assignment as Assistant Secretary (HA).

(3) The overall shifts in emphasis away from Health Affairs (and its impact) while you were Assistant Secretary.

(4) An assessment of the emphasis placed on health-related matters by Secretary of Defense Brown (with appropriate examples).

(5) An assessment of the present quality of medical care within the military structure.

(6) The number of personnel assigned to the Office of Drug and Alcohol Abuse Prevention and your assessment of its ability to exercise any major management initiatives.

(7) An assessment of the efficacy of ODAAP's coordinating and supervisory devices in supplying a reasonable accurate estimate of drug abuse levels within the military.

(8) The extent and nature of the Armed Forces drug problem as it negatively affected combat readiness.

(9) The criteria by which DOD determines when there is a sufficient amount of drug abuse so as to a negative impact on combat readiness.

It would be helpful if you could include in your testimony any recommendations which you feel would strengthen DOD's efforts in this area. If so desired, at the end of your testimony, please state your predictions, based on prior trends and present circumstances, for the future of Health Affairs.

Your testimony should be no longer than fifteen minutes. Any material which you feel would further explain your position on health (and drug) related issues in your prepared remarks will be gratefully accepted and made part of the permanent record.

It is required by the rules of the House of Representatives that 50 copies of your testimony be presented to the Committee at least 48 hours before your appearance. Please contact Mr. Don Duskie of the Select Committee staff on (202) 225-1753 if you have any questions and to make arrangements for your appearance.

Sincerely,

LESTER L. WOLFF, *Chairman.*

Mr. ENGLISH. I would simply like to say now Mr. McKenzie is going to—the Acting Assistant Secretary of Defense for Health Affairs will give his testimony.

I would like to state for the record that the Secretary of Defense was invited to participate in these hearings and testify before these hearings today.

The Secretary of Defense is testifying in the Senate today we understand. However, communications from the committee to the Department of Defense, we also indicate to the Secretary we would be delighted to hold these hearings on whatever date he could appear and whatever date would be convenient to him. The Secretary of Defense sent word back to us—or at least DOD did—that there would be no date that would be convenient.

And with that, Mr. McKenzie, we will let you proceed.

Mr. MCKENZIE. Thank you, Mr. Chairman.

I appreciate the opportunity to appear before your committee this morning to discuss drug abuse in Armed Forces. I am accompanied by Mr. E. D. Schmitz, Chief of our Office for Drug and Alcohol Abuse Prevention and Mr. James F. Holcomb, Director for Identification, Program Evaluation and Research in that office, and Mr. Thomas M. O'Connor, Chief, Physical and Installation Security Division of the Office of the Assistant Secretary of Defense, Comptroller.

Mr. ENGLISH. Excuse me, Mr. McKenzie. Again I want to say to you, as I stated to the other witnesses, if you could capsulize it and summarize it for us, we will submit all written testimony for the record.

We will try to keep it as brief as possible, so we will leave the maximum amount of time for questioning.

Thank you.

Mr. MCKENZIE. Certainly, Mr. Chairman.

TESTIMONY OF VERNON McKENZIE, ACTING ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE; ACCOMPANIED BY E. D. SCHMITZ, CHIEF, OFFICE FOR DRUG AND ALCOHOL ABUSE PREVENTION; JAMES F. HOLCOMB, DIRECTOR FOR IDENTIFICATION, PROGRAM EVALUATION AND RESEARCH; AND T. O'CONNOR, CHIEF, PHYSICAL AND INSTALLATION SECURITY DIVISION, OFFICE OF ASSISTANT SECRETARY OF DEFENSE (COMPTROLLER)

As you know we received a letter from the committee outlining your areas of interest and concern and particularly specifying those that you would like to have me address in my prepared statement.

I will go through and summarize most of the items that appeared in your lettter, that were so designated.

The first particular item that you mentioned, had to do with the recent proposed reorganization of the Office of the Secretary of Defense, which had it been placed into effect, would have resulted in redesignating our office from that of an Assistant Secretary of Defense, to that of a Deputy Assistant Secretary of Defense within the Office of the Assistant Secretary of Defense for Manpower, Reserve Affairs and Logistics.

The Secretary did testify before the Investigations Subcommittee of the House Armed Services Committee a couple of months ago on his proposed reorganization order.

Following his testimony, and additional testimony, the subcommittee voted on the issue and a few days thereafter, the Secretary withdrew the proposed reorganization order.

Mr. ENGLISH. Can I interrupt you, for the record, at that point? Was that the House Armed Services Committee?

Mr. McKENZIE. Yes, Mr. Chairman, it was the Investigations Subcommittee of the House Armed Services Committee.

Mr. ENGLISH. I'm given to understand that that was a unanimous vote in disapproval of that particular proposal; is that correct?

Mr. McKENZIE. That's correct, Mr. Chairman. The vote was 9-0.

As a consequence of the withdrawal of the reorganization order, our office remains that of an Assistant Secretary.

Mr. ENGLISH. Mr. McKenzie, one other question. I don't want to continue to interrupt you here, but again the question has been brought up by Dr. Smith. Do you report directly to the Secretary of Defense?

Mr. McKENZIE. No, Mr. Chairman, I report normally to the Secretary through the Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics.

Mr. ENGLISH. Is that true of any other Assistant Secretary?

Mr. McKENZIE. No, Mr. Chairman, it is not.

Mr. ENGLISH. Please proceed.

Mr. McKENZIE. One of the most important questions raised in the committee's letter had to do with the extent and nature of the drug abuse problem in the Armed Forces. There has been a considerable amount of testimony already this morning on that point, and I certainly would not disagree with the more significant points of the testimony given thus far.

There is no question, we do have a serious problem, and generally the problem is proportional, as one might expect, to the avail-

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ability of drugs to the people in the Armed Forces and it is sort of inversely proportional to the attention given to the problem by the commanders of the various units concerned.

We do find that drug abuse is more of a problem outside of the United States in the Armed Forces than it is inside the United States, although that's not to say that it isn't a problem in both places.

There has been testimony pointing out that when men are separated from the restraints of their families, where living conditions are difficult and sometimes dangerous, the conditions for drug abuse are certainly present. In many locations throughout the United States, these conditions do prevail.

Our ability to assess trends quantitatively is limited. We are not as knowledgeable as we would like to be. However, we expect a survey effort which we recently initiated, will give data on trends, by service, by geographic area, and by drug abusers.

We consider the problem of drug abuse among our service members to be serious enough to warrant our continuing concern.

Another question raised by the committee in its letter was: What are the tools currently employed by DOD to identify drug abuse within the Armed Forces, and are there any new alternative methods currently under study?

The primary mean by which drug abusers in the military service are identified today are by law enforcement and investigative agency activity, by commander and supervisory referral, by medical referral, by urinalysis, and by self-referral.

At the present time, a portable kit for testing urine samples for possible drugs of abuse has successfully completed its field tests. The potential for use of these kits in the field has been found to be so promising that we are now working on a protocol to guide service elements in the proper employment of the kit.

Mr. ENGLISH. For the record, Mr. McKenzie, can you state what drugs can be identified with this kit? Routinely. I should say routinely identified.

Mr. MCKENZIE. Routinely, it would be the same drugs that we have been identifying through our urinalysis program.

Mr. ENGLISH. Basically, it would not identify PCP, cocaine, LSD, marihuana?

Mr. MCKENZIE. Cocaine, yes, Mr. Chairman.

Mr. ENGLISH. Routinely?

Mr. MCKENZIE. I might add, since you mention marihuana, that we are working with a firm that manufactures the reagents that we use in our urinalysis program, and they are attempting to develop a method for us of detecting cannabis. Preliminary results indicate that they are going to be successful, and we are hopeful that, within the next 2 or 3 months, we will make a real breakthrough in this particular area.

Mr. ENGLISH. I hope you will advise this committee when such a breakthrough is forthcoming.

Mr. MCKENZIE. Certainly, Mr. Chairman.

The committee also raised the question of our research program. This is a question that has been raised frequently of late. There was some language in a congressional report which, initially, we

construed as prohibiting research on drug abuse within the Armed Forces.

However, after further study and further consultation with the general counsel, Department of Defense, we arrived finally at a different conclusion last year in that regard. It is now our position that the language in the report, when taken in the drug and alcohol abuse context, does permit the military departments to engage in scientific study and experimentation directed toward increasing knowledge and understanding in those biological-medical and behavioral-social areas of drug abuse control which are peculiar to the military profession.

For example, research into the effects of drugs on the performance of service members performing typical military tasks is considered to be the type of work which the Armed Forces can properly undertake.

On the other hand, we believe that research which provides fundamental knowledge for the solution of identified medical-behavioral technologies and of new or improved functional capabilities in the personnel support area, knowledge and capabilities which have relevance equally to civilian as well as to military users is available from the National Institute on Drug abuse, and need not be pursued by the Department of Defense.

Mr. WOLFF. Can I interrupt for a moment?

I would like to know, from Mr. Dogoloff, whether or not there is a continuing relationship between NIDA and other of the civilian agencies with the Defense Department to share the knowledge obtained in the civilian field?

Mr. DOGOLOFF. There is that communication. We want to formalize that. One of the recommendations in our policy review on health issues was that there be such a formalized mechanism in place, led by the Department of HEW, to be certain that that knowledge is shared not only with the Department of Defense, but with the Veterans Administration, with the Department of Transportation, and other Government agencies that would have an interest.

Mr. WOLFF. What is the status of that now?

Mr. DOGOLOFF. Those recommendations were just transmitted to the Secretaries about 2 or 3 weeks ago, and we are expecting time table and implementation plans back from the Secretary of HEW on his specific recommendations, by the 15th of May.

Mr. MCKENZIE. To conclude the formal statement portion of my testimony, Mr. Chairman, while we do not expect to eliminate drug abuse in the foreseeable future, the military services are operating, we believe, sound programs which they continue to refine in order to cope with this complex problem. My hope is that we will see a significant decline in drug abuse to levels well below those in the similar civilian population.

That concludes my prepared statement.

Mr. ENGLISH. Thank you, Mr. McKenzie.

There were a couple questions. I want you to place some emphasis on question No. 2. Discuss the status of current resources available to ODAAP for exercising new major policy initiatives and for developing and supervising uniform and successful drug programs within the individual services.

You state that present resources in ODAAP are adequate for devising new policy initiatives and for updating old policy.

I found that very startling. Mr. McKenzie, given the fact that we have heard, I think, and had it demonstrated over and over again that the DOD or anybody beneath the DOD or anybody in the military knows what kind of a drug abuse problem we have at the present time. And, from what we can tell, there's absolutely nothing within DOD to really determine the full extent of drug abuse at this time.

And I would also like to point out, from what we can understand, with the changes that have taken place within the military, mainly from changing from a draft-oriented type military to one that is an all-volunteer service, raises some serious questions in this particular area.

And to simply come back with a two-line response and saying that everything is adequate is really surprising. And I think, considering the concern of members of this committee, that that is something that would have to be described as shocking.

Plus, you only have four people to do the job. How many people do you have in the military?

Mr. MCKENZIE. Slightly over 2 million.

Mr. ENGLISH. 2 million. You have 4 people to handle 2 million people, and that's an adequate program?

Mr. MCKENZIE. Mr. Chairman, you may recall, from earlier testimony this morning, that the DOD Health Council developed, a plan to significantly increase the size of our drug abuse prevention office. But that plan ran into considerable opposition, and it was eventually determined that the kind of management that that plan contemplated, with more than doubling of the staff, was not the type of management that the Secretary wanted us to be exercising.

Mr. ENGLISH. Are you stating that the plan ran into significant opposition from the Secretary, from Mr. Brown?

Mr. MCKENZIE. No, Mr. Chairman, I'm not saying that, precisely.

Mr. ENGLISH. Well, that's exactly what I understood you to say. You led off the last sentence with the Secretary.

Mr. MCKENZIE. The opposition centered on the fact that the type of management control——

Mr. ENGLISH. Who did the opposition come from? That's what I'm getting at.

Mr. MCKENZIE. The opposition came from the military departments and some other elements of the staff of the office of the Secretary.

Mr. ENGLISH. Did the Secretary support the plan?

Mr. MCKENZIE. The Secretary eventually made a decision approving——

Mr. ENGLISH. I didn't ask you who made the decision. I just asked if he supported the plan. Either he did, or he didn't.

Mr. MCKENZIE. Not totally.

Mr. ENGLISH. Not totally. Any part of it?

Mr. MCKENZIE. Yes, Mr. Chairman.

Mr. ENGLISH. What did he support?

Mr. MCKENZIE. He supported that part having to do with the formation and establishment of an advisory and coordination committee to assist the drug abuse office in carrying out its duties.

Mr. ENGLISH. That's all we need in Washington, is another advisory committee. That's all he supported, was an advisory committee?

Mr. MCKENZIE. Yes, sir.

Mr. ENGLISH. Was it ever formed?

Mr. MCKENZIE. It's in the process of being formed. Yes, sir.

Mr. GILMAN. Would the gentleman yield?

Mr. WOLFF. May I——

Mr. ENGLISH. The chairman, then Mr. Gilman.

Mr. WOLFF. As I understand it, in the programs I have seen on education and the question of treatment programs, the major emphasis today seems to be on alcohol abuse and treatment. Am I correct on that?

Mr. MCKENZIE. I believe it varies, from program to program.

Mr. WOLFF. I'm talking about Europe, particularly. We visited the program in Europe, and the major emphasis there was on rehabilitation of alcoholics, as a major threat to efficiency in the area. There were rehabilitation programs, rap sessions, and everything else you want to call it, in the area, and there was very minor activity when it came to the question of drug abuse. And the reason that was given for it at the time—this was about a year ago—the reason that was given for it at the time were the constraints that were placed upon the office budgetarily.

Do you have sufficient money? That's the crux of the entire situation. Do you have sufficient money to be able to do the job that it requested of you? And I know that money is not the only answer to the problem.

Mr. MCKENZIE. In my opinion, we do have.

I would like to amplify that by saying that annually, during the budget review process, our budget receives a fair amount of scrutiny, our portion of the budget. This year, our portion amounts to $4.1 billion.

Mr. WOLFF. $4.1 million or billion?

Mr. MCKENZIE. Billion. That's the military health care program, the military medical budget.

Mr. WOLFF. Well, you're talking now about hospitals, you're talking about quite a few other things. We are specifically interested in one particular aspect of this, which is drug and alcohol abuse and treatment.

Mr. MCKENZIE. The point I'm leading up to is that although cuts are regularly made in the total health budget of the Department of Defense each year, there has not been a single penny cut out of the drug abuse portion of that budget.

Mr. WOLFF. Then, actually, what you're saying is that you have enough money to do the job, but you're not doing the job. Because the figures, with all due respect, sir, the figures just show that, unfortunately, the problem continues. The fact is, that with the money that is requested, that is available to provide you with adequate manpower and with the facilities that are afforded to you, the job is not being done.

Now, what could possibly be the reason why drug abuse is on the increase and that the problem does not seem any closer to a solution today than it was some time ago? If you have the available facilities, what else do you need?

Mr. McKENZIE. We feel that this is an extremely difficult—I think it's obvious that it's a difficult problem to cope with. It's complex. We have been addressing it, certainly not with the degree of success that we, or anyone else, I'm sure, would hope for. We are continuing to do the best that we can to try to improve this program. I think we are making progress. Not only have we not had any reduction in funds that have been requested by the departments to do this, but in addition to our own immediate office, each of the military departments also has similar offices which are concerned with managing and planning and developing programs of this sort.

Mr. BEARD. Mr. Chairman.

Mr. ENGLISH. I want to make one point. Mr. Gilman has been very kind. He hasn't had opportunity to ask his questions today.

One question—I just want a one-word response to it—and that is: The four people that work on this adequate program over at ODAAP, how many of them are strictly drug abuse?

Mr. McKENZIE. Three of the four.

Mr. ENGLISH. Three of the four are strictly drug abuse?

Mr. McKENZIE. I'll have to beg off, Mr. Chairman. The word "strictly" throws me.

Mr. ENGLISH. Well, it's my understanding that three of them are alcohol and one of them is drug abuse.

Mr. McKENZIE. No, sir, that's not correct.

Mr. ENGLISH. And one research. Excuse me.

Well, Mr. Gilman, you've been very patient.

Mr. GILMAN. Thank you, Mr. Chairman.

I would like to address questions to the entire panel.

Has the incidence of drug abuse in the military been steadily climbing over the last decade, or has it been decreasing in the last few years?

Mr. McKENZIE. Mr. Gilman, it has fluctuated, and I have to qualify that by saying, to the extent that we can determine how much is going on, certainly we can't positively state at any particular time——

Mr. GILMAN. Is it more this year than it was last year or the year before?

Mr. McKENZIE. That's an extremely difficult question to answer.

Mr. GILMAN. Are you saying that you don't know?

Mr. McKENZIE. I'm saying that we can detect trends, that we can zero in on a particular area at a particular time, but we don't——

Mr. GILMAN. Based on the number of personnel that were under treatment and have reported drug abuse what does your information show? Is there a greater amount of abuse now than there was last year and the year before?

Mr. McKENZIE. Proportionately, there is an increase.

Mr. GILMAN. Is there more spending by the military to do something about it now than there was before, or is it less?

Mr. McKENZIE. Well, there again, you have to go into particulars. For this year, it's more.

Mr. GILMAN. How much more?

Mr. McKENZIE. Roughly $8 million more.

Mr. GILMAN. And how much more is the incidence now than it was in the preceding few years?

Mr. McKENZIE. It's extremely difficult to quantify the incidence.

Mr. GILMAN. Why is there such difficulty in making that determination?

Mr. McKENZIE. There are difficulties involved, both in reporting and in identifying a drug abuser, in the first instance.

Mr. GILMAN. Well, you do get some reports from your units out in the field of treatment, abuse, of urinalysis, and that sort of thing; do you not?

Mr. McKENZIE. Yes, we do.

Mr. GILMAN. Well, what do your reports show from those sources? How many people are using drugs out in the entire military complex today? Do you know that from your reports?

Mr. McKENZIE. We can't state positively, from those reports. No, sir.

Mr. GILMAN. What do your reports show in approximate amount of people involved in drug abuse? You must have some idea of what you're dealing with. You mean to tell us that the military administration does not have any idea of what they're dealing with?

Mr. McKENZIE. No, Mr. Gilman, I don't mean to say that at all. And I would like to call on Mr. Schmitz, who is the head of our drug abuse office, to respond to that question.

Mr. GILMAN. Could someone tell our committee what the problem is, roughly?

Mr. SCHMITZ. Well, again, to repeat what Mr. McKenzie said, we don't have a precise, accurate figure of the amount of——

Mr. GILMAN. Can you give us an estimate, then?

Mr. SCHMITZ. The number that have entered into treatment and rehabilitation, which would be the number that are identified as having a serious enough drug problem to need that kind of attention, is about 40,000 last year.

Mr. WOLFF. Would the gentleman yield?

Mr. GILMAN. I'd be pleased to yield to the chairman.

Mr. WOLFF. Does not the military have an efficiency report on each member of the military?

Mr. SCHMITZ. Yes, sir.

Mr. WOLFF. You do?

Mr. SCHMITZ. Yes.

Mr. WOLFF. You do. Is not the question as to whether or not somebody is using drugs part of an efficiency report?

Mr. SCHMITZ. No.

Mr. WOLFF. Well, why isn't it? I think that is basically something that is part of the real test of efficiency or readiness of the service individual. I mean, we know a lot of other things about the individual.

Do we know, for example, how many homosexuals we have in the military today?

Mr. SCHMITZ. I couldn't answer that, but I would say no.

Mr. GILMAN. If I might reclaim my time, Mr. Chairman.

Mr. WOLFF. Reclaim your time, but it becomes very frustrating for us to have to vote upon hundreds of billions of dollars for appropriations, and come up with a simple situation such as this that we cannot get any information, where we get information that is, "Well, we have a program. We're spending a lot of money on

that program, but we don't know what we're really dealing with. All we know is that those people are in treatment."

Well, those people in treatment, we're not worried about. It's the people that are not in treatment that we're really worried about.

Mr. DOGOLOFF. I think that there is no way, under current practices, to get an answer to your question. And one of the reasons there isn't is because we don't have random urinalysis. When we had random——

Mr. WOLFF. That's not the point.

Mr. DOGOLOFF. Hear me out, please.

When we had random urinalysis—that is a sampling technique that can give us indication in all theaters as to what was happening. Now, if we are trying to identify, for example, through command directed urinalysis as the primary tool, we are victim to the line supervisor's interest in what and whom he identifies.

So, for example, we obviously had the number of urinalyses conducted and what happened as a result of that in terms of drug use. But that doesn't get at the nature and extent of the problem. That only tells you how many people were selected for urinalysis testing and what the results of the testing were, and I'm sure that that information could merely be supplied for the record by the departments. That's a different question from what is the nature and extent of drug use and abuse in the military throughout. That, under current procedures and policies, is not available.

Mr. GILMAN. Mr. Chairman, I'm going to ask if Mr. McKenzie's office could supply this committee with some definition of the problem in the military, something to do with the scope, extensiveness of the abuse. I'm certain there must be some statistical information out there so that the Defense Department knows what they're dealing with.

When we were in the Frankfurt area, back in November of 1976, there were 23,000 military men and dependents under the V Corps Command at that time, and from that group there were more than 300 reported heroin cases in a 1-year period, and about 5 percent of the cases that were rehabilitated and returned to active status, and the remainder were administratively separated and shipped home due to drug dependency.

Now, that's over a 1.3 percent, and if we were to extrapolate that figure to the 2 million, I would assume that we would have many more than the 40,000 that you're talking about.

While we were there, also—it's approximately 10 percent, my colleague tells me. I haven't done the mathematics.

In examining the unit in Frankfurt, when we were out there, we found that, while your community drug and alcohol assistance centers were properly motivated and certainly had the right objectives, they lacked qualified staff and sufficient counseling programs and, on the average, each patient received only 1 hour of counseling a week from an enlisted nonprofessional. These are people who were using hard narcotics.

Due to the large number of cases under the jurisdiction of the individual psychologist, patients were receiving only one short initial interview during his entire treatment period, from a professional.

In addition to that, we found that many of the men in the drug clinics in the rehabilitation centers that we interviewed were complaining that they took to drugs because they found that the tours of duty were much too long, prevented—led to unrest and an increase use of drugs to escape the boredom out there.

We found that, with regard to screening and training process, there was increased—a need for increased and more indepth screening of the military men having some history of drug use.

Compound that factor for all the troops was an inadequate training and preparation system for the culture shock that they sustain in going to an entirely new area, new nation, new languages, new traditions and customs, and, as a result, were reacting to it. And those who were seeking treatment felt they were being treated somewhat as criminals. They felt that self-enlistment in rehabilitation programs should separate the users from the incarcerated drug dealers and abusers.

And in the barracks, we found that drugs of all types were available in the enlisted barracks, and the availability, combined with peer pressure and fear of harm for disclosure, led to a climate of increased drug usage.

As a result of that, we submitted a report, and I welcome your comments about some of these recommendations:

That tours should be shortened out in the area of Germany, where there is a great deal of drug usage available. And some of you testified to that this morning. In Frankfurt, they have a park known as hash park, where practically anything can be purchased for very small amounts.

That we increase and improve training to prevent the culture shock.

That we establish some sort of a mandatory program before separation to prevent the wholesale dumping of addicts on the American populace.

And that we improve occupational opportunities, to eliminate the motor-pool syndrome that is caused by the tedious job requirements out in the field.

And that there should be an increased use of urine testing for drug detection. And I was pleased to hear that recommendation made today.

These were some of the recommendations that we made as a result of our field survey, and I welcome your comments with regard to that situation and those recommendations.

Mr. McKENZIE. Mr. Gilman, to get back to the first point I believe you made when you started out, certainly we will be happy to provide incidence data on a detailed basis for the record, similar to the kind that you were referring to, that you are aware of in the Frankfurt area.

[The information referred to follows:]

Following is a series of tables which provides a measure of the extent of drug abuse in the Armed Forces as well as some indication of the trends of abuse and the services' efforts to combat it.

Table 1
Drug Abusers Identified by Urinalysis

Calendar Year	Number Tested	Number Identified	Percent Identified
1971	855,306	18,166	2.1
1972	2,221,085	31,652	1.4
1973	1,905,157	20,499	1.1
1974	982,495	10,270	1.0
1975	1,233,015	13,455	1.1
1976	1,303,504	10,045	0.8
1977	332,100	4,174	1.3

Table 2
Drug Abusers Volunteering for Assistance

Calendar Year	Number Volunteering
1971	10,539
1972	4,438
1973	2,585
1974	1,982
1975	1,352
1976	1,311
1977	937

The next two tables illustrate the average percentage of drug abusers confirmed by random and commander-directed urinalysis respectively from among those tested.

Table 3
Drug Abusers Confirmed through Random Urinalysis

Calendar Year	Number Tested by Random System	Number Confirmed	Percentage of Confirmed Drug Abusers
1972	621,819	5,417	0.88
1973	1,392,530	7,767	0.54
1974	664,145	4,189	0.64
1975	974,547	6,136	0.64
1976	919,864	4,057	0.44 *

* Figures averaged only through January - September 1976.

Table 4
Drug Abusers Confirmed through Commander-Directed Urinalysis

Calendar Year	Number of Commander Directed Tested	Number Confirmed	Percentage of Confirmed Drug Abusers
1976	128,762	1,268	1.03 *
1977	318,213	3,240	1.13

* Figures averaged only through October-December 1976.

After identification, confirmed drug abusers are entered into rehabilitation. Table 5 shows this number. This number is probably the best indicator of the lower limit of drug abuse in the Armed Forces. In 1977, when the total strength of the military was about 2,060,000, the number entered into rehabilitation amounts to 1.7% of the total strength.

Table 5
Drug Abusers Admitted to Rehabilitation

Calendar Year	Armed Forces Strength	Number Admitted	Percent of Total Strength
1972	2,323,000	19,746 *	0.9
1973	2,253,000	51,227	2.3
1974	2,162,000	40,743	1.9
1975	2,128,000	46,197	2.2
1976	2,082,000	41,056	2.0
1977	2,075,000	35,472	1.7

* Data begins with June 1972 and is not totally complete for all services for the first few months after June 1972.

Some drug abusers are ultimately discharged for drug abuse. Table 6 lists the number.

Table 6
Administrative Discharges for Drug Abuse

Calendar Year	Number of Discharges
1971	8,818
1972	8,357
1973	4,462
1974	4,607
1975	4,937
1976	5,321
1977	6,380

A large number of service members are punished under the Uniform Code of Military Justice for one form of drug offense or another. Table 7 lists the total number of Non-Judicial Punishments and Courts Martial of all types. These punishable offenses include the use, possession, sale and trafficking of all types of drugs.

Table 7
Drug Offenders Punished
under the
Uniform Code of Military Justice

Calendar Year	Number of UCMJ Actions
1969	9,700
1970	11,368
1971	11,304
1972	12,028
1973	27,980
1974	36,310
1975	39,899
1976	42,533
1977	42,444

Mr. McKENZIE. As to the other matters that you rise, I must confess that you have overwhelmed me. There must have been—what—10, 12, or 15 of them. While most of the issues impact on the question of drug abuse prevention, they are more personnel policy issues than they are drug abuse issues, and would fall within the area of responsibility of the Assistant Secretary of Defense, Manpower, Reserve Affairs, and Logistics.

I would be happy, though, Mr. Gilman, to arrange to provide comments for the record on the points you've raised.

Mr. GILMAN. I hope you're not absolving yourself of some responsibility in those areas, because they go to the very heart of the problem.

Mr. McKENZIE. I acknowledge the fact that they certainly do have that bearing, and we would be collaborating with the other office that I mentioned, in formulating responses.

Mr. GILMAN. In listening to your testimony, Mr. McKenzie, you seem to think that you have sufficient personnel and everything is moving in the right direction.

I note, from Dr. Smith's testimony—and I regret I wasn't here when he did testify—that he feels that things are not going along the way they should be going, that we don't have—are not moving in the right direction.

Am I correct, Dr. Smith, in my analysis of your presentation?

Dr. SMITH. Yes; that's correct. I think that a word of explanation is necessary, and that is that the responsibility of the office, as defined, says that it has overall supervision of the military health-care system.

Now, supervision, to me, means a much broader responsibility than just the development of policy, and it makes little sense for me—to me, that you develop policy but you don't have anything to do with finding out whether it's being implemented or how it's being implemented.

And I think Mr. McKenzie and I are discussing two different aspects. I believe that what he is talking about is the development of just policy, and then the execution is to be done by the military department. And that, I believe, is a simple explanation of the management philosophy of the Secretary today.

I think that it differs—I think that can't be applied as rigidly to health affairs, because in fact, we do run and supervise a direct-care medical-care system, involving a great many people, a great many hospitals, which is different than the responsibilities of any other Assistant Secretary. Nobody else is in the actual business of operating whatever the responsibilities are of that office. Nobody else is building airplanes or guns or shoes. That's all put out, but we have that responsibility, and my judgment is that we cannot perform and are not performing in the drug and alcohol abuse prevention area, including what I think is necessary for evaluation of whether or not the policies are being carried out with the budget and the people we have.

Mr. ENGLISH. Mr. Beard.

Mr. GILMAN. Thank you, Mr. Chairman.

Mr. BEARD. Thank you, Mr. Chairman.

Mr. McKenzie, I'm disappointed the Secretary of Defense has not accepted the opportunity to come and testify before our committee before what I consider a very important issue.

I'm sorry I was not here at first. The witnesses are under oath; is that correct?

Mr. ENGLISH. Yes.

Mr. BEARD. I was just curious as to—on your statement, did you personally write your statement?

Mr. MCKENZIE. I wrote portions of it, Mr Beard. I did not write it in its entirety.

Mr. BEARD. Did someone else in your particular specific division write part of your statement?

Mr. MCKENZIE. Yes, Mr. Beard.

Mr. BEARD. Did your statement go to the Secretary of Defense for approval before you were to present it?

Mr. MCKENZIE. To the best of my knowledge, it did not. However, it went to the Assistant Secretary of Defense for Public Affairs for review.

Mr. BEARD. Public affairs?

Mr. MCKENZIE. Public affairs.

Mr. BEARD. What the hell does he knows about health? Did he change anything that was in your statement? Did your statement come back changed in any way, shape or form?

Mr. MCKENZIE. To the best of my knowledge, it was not changed. But if I can confer with one of my staff for a moment, I can either confirm or deny that.

I'm advised that no words were changed.

Mr. BEARD. There were no changes at all? Did your statement go to OMB?

Mr. MCKENZIE. To the best of my knowledge, it did not.

Mr. BEARD. All right.

I will say, in defense—I think it would be impossible, to a certain degree, to have statistics when you've only got four people in your

whole department. We still go back to you've got four people in your department, at ODAAP; right,

Mr. McKENZIE. Well, technically, I have four people who are assigned to that office. There was testimony earlier this morning about the fact that the secretary was removed from the office when the 30-percent cut occurred a few months ago, and that's true. But she is still available, and still performs secretarial services, but not on a full-time basis.

Mr. BEARD. But she's not a professional?

Mr. McKENZIE. No, sir.

Mr. BEARD. And the comment was made or the question was asked: How many of the four deal strictly with drugs? And what was your response, again?

Mr. McKENZIE. Well, I admit a concern about the word "strictly." There is some interchangeability among the staff, but basically, one of them is concerned with alcohol abuse and three of them are concerned with drug abuse.

Mr. BEARD. OK. So, you've got one man that deals strictly with—or specifically with alcohol.

Mr. McKENZIE. Primarily with alcohol.

Mr. BEARD. And three really don't fool with alcohol too much; they——

Mr. McKENZIE. Deal with drug abuse.

Mr. BEARD. And who are those three, by name? Who are those three that deal with——

Mr. McKENZIE. Mr. Schmitz, Mr. Holcomb, and Dr. Mazzuchi.

Mr. BEARD. And, like Dr. Mazzuchi, what is his function?

Mr. McKENZIE. Dr. Mazzuchi is primarily concerned with the educational training programs in relation to drug abuse.

Mr. BEARD. And that's it? Or anything else?

Mr. McKENZIE. Again, that's primarily his duties. With a staff that size, there has to be some interchange from time to time. But basically, primarily, education is his functional area.

Mr. BEARD. Does he deal with any other type of educational programs, such as venereal disease or anything along these lines at all?

Mr. McKENZIE. No, sir. Drug abuse.

Mr. BEARD. Mainly drug. All right. Mr. Schmitz?

Mr. McKENZIE. Mr. Schmitz and Mr. Holcomb. Mr. Holcomb is mainly indentification and program development.

Mr. BEARD. Identification of what?

Mr. McKENZIE. Identification of drug abusers.

Mr. BEARD. And the other gentleman, Mr. Schmitz?

Mr. McKENZIE. The fourth man is Colonel Darnauer, who is primarily concerned with alcohol abuse.

Mr. BEARD. But what about Mr. Schmitz?

Mr. McKENZIE. Mr. Schmitz is the chief of the entire office.

Mr. BEARD. He is the chief——

Mr. McKENZIE. He is the chief of the drug and alcohol abuse prevention program in the office of the Assistant Secretary of Defense for Health Affairs, of which I am the acting head.

Mr. BEARD. So, who do you supervise, him?

Mr. McKENZIE. Yes, sir.

Mr. BEARD. And then he supervises the other members?

Mr. MCKENZIE. The other members of the staff.

Mr. BEARD. That is one of the smallest organization charts I've seen in a long time. You all have a problem with communication in your own little office, I can see that.

Staff has a question, here.

Mr. LAWRENCE. Just in light of the testimony, I am wondering who is in charge of implementing new policy, reviewing and updating old policy, receiving the reports from the various services as they come in, and compiling them and preparing projections based on that? Who is in charge of overseeing the standardization of the reporting procedures?

I share the members' loss at how three individuals—2½—actually, can perform these functions adequately.

[Mr. McKenzies' prepared statement appears on p. 148.]

Mr. MCKENZIE. Again, it's our position that given the management, style, and philosophy of the Secretary, the number of people that we have allotted to our drug and alcohol abuse prevention program is an adequate one.

Mr. BEARD. Given the Secretary's style, his style, I think—I really think that we should—I don't know what our abilities are, but I just feel that some way, somehow, we should encourage the Secretary to come and speak to this committee. I don't know—if he refuses to, I don't know what alternatives we would have. But I think this is critical enough—I don't know if a Select Committee has subpena power, if he continues to refuse to, but—it is tragic that you would even mention that—but I think it's either he comes and testifies before this committee or faces the possibility of subpena from this committee, so that we can get down to the crux of it.

Mr. McKenzie is not in a position to talk about the Secretary of Defense's job, because he will no longer be acting temporary Assistant Secretary for Health Affairs.

So I would urge the chairman of the committee that we make one more sincere effort to let the Secretary of Defense know our feelings.

Mr. WOLFF. If the gentleman would yield—let me just say that the Secretary has a time problem, as we all do, and I think that he has been cooperative in the past and I think he will be cooperative in the future. I don't think it's necessary for this committee to get involved in a jurisdictional adversary position.

We will make a further attempt to get the Secretary to appear before us.

I think that one of the reasons—and I'm in no way defending his position, but I think that the reason he has provided Mr. McKenzie for us here is that he is more familiar with the problems personally, than he is.

Mr. ENGLISH. Let me speak for the record, Mr. Chairman.

As I stated earlier, the Secretary was invited to attend today. The Secretary is testifying in the Senate today. It is also my understanding that an alternative time was given the Secretary. In fact, the Secretary was told that this task force would be willing to meet at any time it was convenient for the Secretary, and the response from the Department of Defense was that the Secretary would find no time convenient.

Mr. WOLFF. Well, I think we ought to, in deference to the chairman of the task force involved, I think we ought to give the Secretary another opportunity to come down, since there are some very serious questions relative to the overall policy.

And while we're on overall policy, I should just like to pose to either Mr. McKenzie or perhaps another representative of DOD is present.

Do you or does the Department consider that a drug abuser is a security risk?

Mr. MCKENZIE. I would defer to our personnel reliability program representative, Mr. O'Connor.

Mr. O'CONNOR. Certainly, that would be an item that would be considered before granting anybody a clearance in the Department of Defense, and I would say, if a person was——

Mr. WOLFF. I am not talking about a sensitive position now; I'm talking about on an overall basis, is a drug abuser in the military a security risk?

Mr. O'CONNOR. I can only answer in reference to the responsibilities of my office.

We do deal with personnel security matters up there, and I'm saying; yes, drug abuse would be considered a probable bar to a grant of a security clearance, for example.

Mr. WOLFF. Again, I'm talking of an overall security risk to a particular unit.

Mr. O'CONNOR. Again—I'm going to answer again—I'm going to have to confine myself to the context with which I am familiar.

Mr. WOLFF. Is there somebody else here who can talk about it on an overall basis?

Mr. O'CONNOR. I don't know, insofar as the military services, how they would consider them. I have no idea. In the personnel security program we consider the drug abusers to not be reliable.

I don't know if that's an answer for you.

Mr. WOLFF. Well, it's a partial answer to the question.

You have a particular responsibility for the area of sensitive—I take it—of sensitive security problems.

Mr. O'CONNOR. That's precisely right. We are answering on what we know.

Mr. WOLFF. What I'm wondering is, is there anyone else here from DOD who can give us an indication of how the Defense Department treats a drug abuser, and is that a consideration of a security risk.

I imagine there are other aspects of security risks within the military. However, I wonder whether or not this is a consideration of a security risk.

Mr. MCKENZIE. We have no other person present, but I would be happy to respond to that for the record.

Mr. WOLFF. What I'm getting at basically, and I would ask that you provide this for the record, is on an overall basis, how the military considers the question of drug abuse on an overall basis. That's what we're all here for, to determine whether or not the security of the United States is being threatened today as a result of the amount of drug abuse that exists. That's the bottom line of all of this.

We are concerned for the welfare of the men and the women who are in our military services, but we are, as well, concerned for the security position of the United States, which seems impaired or threatened by the vast amount of drug abuse that exists today.

And with the amount of attention that it is being given by having a four man, or four women or three and a half—I don't know what it is, but whatever it is, the amount of people who are addressed to that particular area seems to be a downgrading of the risks that are being shared by this Government taken against the number of people who are abusing drugs within the services.

This seems to be a very serious threat to the security of this Nation.

Mr. GILMAN. Would the gentleman yield?

Mr. WOLFF. Yes.

Mr. GILMAN. Thank you.

I thank the gentleman for his comments. He's certainly right on target on many of our concerns.

I would like to ask Mr. McKenzie, has your office prepared a recommendation of a program for combating drug abuse and drug trafficking in the military service and submitted that to the Secretary?

Mr. MCKENZIE. We have not submitted such a plan to the Secretary.

We have over the years developed a number of policies which guided the Army, Navy, and Air Force in the development of their existing drug abuse programs.

Mr. GILMAN. Have you submitted any policy recommendations within the last year to the Secretary?

Mr. MCKENZIE. To the best of my recollection, we have not.

Mr. GILMAN. When was the last policy recommendation that you made that was submitted to the Secretary?

Since the administration took office, have any recommendations come out of your office to the Secretary of Defense with regard to drug abuse and drug policy?

Mr. MCKENZIE. We have promulgated a number of policies during that period.

Why I was hesitant was because of the way the question was phrased about going to the Secretary of Defense. It isn't necessary for us in each instance to go to the Secretary.

Mr. GILMAN. All right.

Have you made some policy recommendations to some office besides the Secretary?

Mr. MCKENZIE. Yes; Mr. Gilman, we have.

Mr. GILMAN. To what office?

Mr. MCKENZIE. What we have done is submitted papers to the Assistant Secretary of Defense, Manpower and Reserve Affairs. We have also submitted papers to the Assistant Secretaries of the Army, Navy, and Air Force for Manpower and Reserve Affairs regarding these programs.

Mr. GILMAN. Could you provide us with copies of those recommendations?

Mr. MCKENZIE. Yes; Mr. Gilman.

Mr. GILMAN. Mr. Chairman, with your permission, I'd like to make those policy recommendations part of our record.

Mr. ENGLISH. Without objection, so ordered.

[The information referred to follows:]

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

FEB 2 1977

MEMORANDUM FOR ASSISTANT SECRETARIES OF THE MILITARY DEPARTMENTS
(MANPOWER AND RESERVE AFFAIRS)

SUBJECT: Drug and Alcohol Education Materials

REFERENCES: (a) Change 1 to DoD Directive 1300.11, subject - "Illegal or Improper Use of Drugs by Members of the Department of Defense," dated 23 Oct 1970

(b) Change 1 to DoD Directive 1010.2, subject - "Alcohol Abuse by Personnel of the Department of Defense," dated 1 Mar 1972

Forwarded herewith in accordance with the policy established in References (a) and (b) are data which include

- new cumulative list of audio-visual materials that have been approved or disallowed for use in the DoD Alcohol and Drug Education Program

- list of pamphlets, posters and subscription materials that are recommended for use as the core of printed materials in the DoD alcohol and Drug Education Program.

Robert N. Smith, M.D.

Robert N. Smith, M.D.

Enclosure

The following films have been approved by the committee and purchased by the services; they are available through service channels:

AFIF NUMBER	TITLE
199	DRUG ABUSE: EVERYBODY'S HANGUP
211	ABOUT ADDICTION
215	DRUG ABUSE: FACTS EVERYONE NEEDS TO KNOW
217	PERFECT DRUG FILM
244	DRUGS, DRINKING AND DRIVING
245	CHALK TALK ON ALCOHOLISM
248	HOOKS
254	BOOZERS AND USERS
255	ALCOHOL: DRUG OF CHOICE
259	WE DON'T WANT TO LOSE YOU
269	DRYDEN FILE
270	WE HAVE AN ADDICT IN THE HOUSE
271	BOURBON IN SUBURBIA
272	THE FIRST STEP
277	SO LONG PAL
284	I'LL QUIT TOMORROW
288	AMERICA ON THE ROCKS
291	GUIDELINES
292	ALCOHOLISM: THE BOTTOM LINE
293	LIVING SOBER: THE CLASS OF '76
294	UNDER THE INFLUENCE
295	WEBER'S CHOICE
296	A TIME FOR DECISION

The following films have been approved by the committee and are recommended for use if acquired locally:

ALCOHOLISM IN INDUSTRY
THE CARING COMMUNITY
HEY, HOW ABOUT ANOTHER ONE
TURNING POINT
THE SECRET LOVE OF SANDRA BLAIN
LET'S CALL IT QUITS
UNDER THE INFLUENCE - OUT OF CONTROL

The following films have been approved for use if acquired locally:

BY A JURY OF HIS PEERS
NARCOTICS FILE - THE VICTIMS
ADDICTIVE: SOPORS
GETTING BUSTED

TITLE

GRADUATION DAY
ALCOHOLISM, INDUSTRY'S COSTLY HANGOVER
IT'S MY HOBBY
LICENSE TO KILL
COUNTDOWN
SMOKING, A NEW FOCUS
ALCOHOL, A NEW FOCUS
ALMOST EVERYONE DOES
ASHES TO ASHES
DRINK, DRIVE, RATIONALIZE
DRINK, DRANK, DRUNK
THE DWI'S
ALCOHOL, DRUGS OR ALTERNATIVES
THE ALCOHOLISM FILM
YOU CAN'T JUST HOPE THEY'LL MAKE IT
A FIGHT FOR BREATH
WHY BE DOWN WHEN YOU CAN BE UP
99 BOTTLES OF BEER
NO DRINKER UNAWARE
ALCOHOL, CHOICES FOR HANDLING IT
PSYCHOACTIVE
FIVE DRINKING DRIVERS

The following films which had been purchased by the services are obsolete and have been disallowed by the committee:

AFIF NUMBER	TITLE
196	MARIJUANA
205	11:59 - LAST MINUTE TO CHOOSE
209	ACID
210	WEED
212	SPEEDSCENE
213	NINE-IN-ONE CONCEPTS
220	ALCOHOLISM: OUT OF THE SHADOWS
230	US
253	GO ASK ALICE

The following films have also been disallowed by the committee:

SKEZAG
MEDICAL ASPECTS OF ALCOHOL
BEYOND THE FINISH LINE
DEAD IS DEAD
PORTRAIT
ALCOHOLISM: A MODEL OF DRUG DEPENDENCY

TITLE

JUST ONE MORE TIME
CASE #7201
ASHES OF DOOM
FIFTH OF DESPAIR
FIFTH STREET
ALCOHOLISM: ALMOST EVERYTHING YOU NEED TO KNOW TO RECOGNIZE IT
AND ANYBODY ELSE WHO'S LISTENING
ME, AN ALCOHOLIC?
THE GAME
AND I'M AN ALCOHOLIC
THE DRUG MEMO
A DISCUSSION OF DRUG ABUSE
UP THE LADDER DOWN
BREAKTHROUGH
THE CURIOUS HABITS OF MAN
THE METHADONE CONNECTION
THE DWI DECISION
UP FRONT
GROOVING
ALCOHOL AND DRUGS: A WAY OUT

The following pamphlets and posters have been approved by the committee to be used as the core of printed materials and have been purchased by the services and are available through service channels:

PAMPHLETS*

WHAT EVERYONE SHOULD KNOW ABOUT DRUG ABUSE
WHAT EVERY PARENT SHOULD KNOW ABOUT DRUGS AND DRUG ABUSE
WHAT EVERYONE SHOULD KNOW ABOUT ALCOHOL
WHAT EVERYONE SHOULD KNOW ABOUT ALCOHOLISM
ABC'S OF DRINKING AND DRIVING
TO SMOKE OR NOT TO SMOKE
DO YOU KNOW THE FACTS ABOUT DRUGS
QUESTIONS AND ANSWERS ABOUT DRUG ABUSE
AN EMERGING ISSUE, THE FEMALE ALCOHOLIC
HOW TO BE A GOOD HOST: A GUIDE TO RESPONSIBLE DRINKING
AA AND THE ARMED SERVICES
FACTS ABOUT ALCOHOL AND ALCOHOLISM
ALCOHOLISM, THE FAMILY DISEASE
THE EXQUISITE PAIN
HOW TO TALK TO YOUR TEENAGER ABOUT DRINKING AND DRIVING
THE DRINKING QUESTION

*Every publication may not have been purchased by each service.

POSTERS

IF YOU DRINK A LOT OF BEER, YOU DRINK A LOT
IF YOU NEED A DRINK TO BE SOCIAL, THAT'S NOT SOCIAL DRINKING
THE TYPICAL ALCOHOLIC AMERICAN
GETTING DRUNK DOESN'T MAKE YOU ---
WHAT KIND OF DRINKER ARE YOU
THE NATURAL THINGS, #1
THE NATURAL THINGS, #2
POLLUTION
THE TYPICAL DRUG ABUSER

The following subscription materials have been reviewed and approved by the committee:

ADDICTION AND DRUG ABUSE REPORT
YOUTH REPORT
ADDICTIONS
WASHINGTON DRUG REVIEW
THE JOURNAL OF DRUG EDUCATION
GRASSROOTS
ALCOHOLISM AND ALCOHOL EDUCATION
ALCOHOLISM DIGEST
ALCOHOLISM REPORT
US JOURNAL OF DRUG AND ALCOHOL DEPENDENCE
LABOR-MANAGEMENT ALCOHOLISM JOURNAL

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

2 MAY 1977

HEALTH AFFAIRS

MEMORANDUM FOR THE ASSISTANT SECRETARIES OF THE MILITARY DEPARTMENTS (MANPOWER AND RESERVE AFFAIRS)

SUBJECT: Radioimmmunoassay Cutoff Levels for Urinalyses Conducted in Drug Testing Laboratories

REFERENCES:

a. ODASD(DAA) Memorandum, subject, Drug Testing Laboratories Cutoff Levels, dated 30 May 1974

b. OASD(HA)/ODAAP Memorandum, subject, Methaqualone Urinalysis with Radioimmunoassay Technology, dated 27 February 1975

c. ODASD(HA) Memorandum, subject, Cocaine Urinalyses for Drug Abuse, dated 13 July 1976

Laboratory experience has shown that the radioimmmunoassay cutoff levels prescribed by reference a are, in general, higher than they need be. The RIA procedure is sensitive enough to detect drugs of abuse in the urine at lower concentrations than presently prescribed and those lower concentrations are confirmable using the gas chromatograph process. Therefore, effective 1 July 1977, reference a is rescinded and the following new RIA cutoff levels are prescribed:

Opiates	200 ng/ml
Amphetamines	1000 ng/ml
Barbiturates	200 ng/ml

Cutoff levels for methaqualone and cocaine metabolite each remain at 1000 ng/ml per references b and c respectively.

Vernon McKenzie
Principal Deputy Assistant Secretary

cc: Chairman, Laboratory Methodology Subcommittee
HQ, DA - OTSG
Col. A. Dominguez, Armed Forces Institute of Pathology

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

9 JUN 1977

MEMORANDUM FOR Assistant Secretary of the Army (M&RA)
Assistant Secretary of the Navy (MRA&L)
Assistant Secretary of the Air Force (MRA&I)

SUBJECT: Increased Urinalysis for Drug Abuse Detection

A review of the military service monthly reports of urinalysis for drug abuse detection (RCS DD-H&E(M)1094) received since cessation of random urinalysis on 1 October 1976 reveals widely differing levels of effort in the use and application of commander-directed urinalysis within each service. In some localities it is apparent that commander-directed urinalysis is being aggressively and effectively used as a tool to detect abuse. In other areas it is equally apparent that commander-directed urinalysis is not being used to best advantage -- for example, in one high-risk area only three urinalyses have been directed since 1 October 1976. In another high-risk area only 47 have been directed, and in one medium-risk area only 21 have been directed.

Commander-directed urinalysis has considerable potential not only to detect the deeply involved but also the incipient drug abuser whose early detection leads to a high probability of successful rehabilitation. It is imperative that the tool be used to its full potential. Therefore, request that measures be taken to increase the use of commander-directed urinalysis in those geographic areas of low usage, and that this office be advised of the actions taken.

Robert N. Smith, M.D.

Robert N. Smith, M.D.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

20 SEP 1977

MEMORANDUM FOR Assistant Secretary of the Army (Manpower and Reserve Affairs)

SUBJECT: Drug Related Crime on Guam

This office is in receipt of correspondence from the White House which forwards a request from the Governor of Guam for assistance in combating a growing problem with drug-related crime. In order to assist the Governor, the White House requests certain data with respect to military actions directed against drug abuse on Guam. It is known that the Army contingent on the island is quite small; nonetheless, your office is requested to review the drug abuse control programs for Army personnel on Guam and report:

a. Efforts to identify, treat and rehabilitate Army drug abusing personnel on Guam. Information is particularly desired about current identification, and treatment and rehabilitation programs, new initiatives to upgrade the extent and quality of your programs, and an assessment of the relative success of your efforts.

b. Military customs procedures andactivity designed to intercept potential drugs of abuse. Again, information of current programs is desired as well as information of new initiatives taken to combat the problem and an assessment of your efforts.

Further request that the required information be submitted so as to arrive in this office no later than 18 October 1977.

SIGNED

Robert N. Smith, M.D.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

20 SEP 1977

MEMORANDUM FOR Assistant Secretary of the Navy (Manpower, Reserve Affairs and Logistics)

SUBJECT: Drug Related Crime on Guam

This office is in receipt of correspondence from the White House which forwards a request from the Governor of Guam for assistance in combating a growing problem with drug-related crime. In order to assist the Governor, the White House requests certain data with respect to military actions directed against drug abuse on Guam. Accordingly, your office is requested to review the drug abuse control programs for Navy and Marine Corps personnel on Guam and report:

a. Efforts to identify, treat and rehabilitate Navy and Marine Corps drug abusing personnel on Guam. Information is particularly desired about current identification, and treatment and rehabilitation programs, new initiatives to upgrade the extent and quality of your programs, and an assessment of the relative success of your efforts.

b. Military customs procedures and activity designed to intercept potential drugs of abuse. Again, information of current programs is desired as well as information of new initiatives taken to combat the problem and an assessment of your efforts.

Further request that the required information be submitted separately for the Navy and Marine Corps so as to arrive in this office no later than 18 October 1977.

SIGNED

Robert N. Smith, M.D.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

20 SEP 1977

MEMORANDUM FOR Assistant Secretary of the Air Force (Manpower, Reserve Affairs and Installations)

SUBJECT: Drug Related Crime on Guam

This office is in receipt of correspondence from the White House which forwards a request from the Governor of Guam for assistance in combating a growing problem with drug-related crime. In order to assist the Governor, the White House requests certain data with respect to military actions directed against drug abuse on Guam. Accordingly, your office is requested to review the drug abuse control programs for Air Force personnel on Guam and report:

a. Efforts to identify, treat and rehabilitate Air Force drug abusing personnel on Guam. Information is particularly desired about current identification, and treatment and rehabilitation programs, new initiatives to upgrade the extent and quality of your programs, and an assessment of the relative success of your efforts.

b. Military customs procedures and activity designed to intercept potential drugs of abuse. Again, information of current programs is desired as well as information of new initiatives taken to combat the problem and an assessment of your efforts.

Further request that the required information be submitted so as to arrive in this office no later than 18 October 1977.

SIGNED

Robert N. Smith, M.D.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

6 OCT 1977

MEMORANDUM FOR ASSISTANT SECRETARY OF THE NAVY (MRA&L)

SUBJECT: Increased Urinalysis for Drug Abuse Detection

REFERENCES:

a. ASD(HA) memorandum, subject as above, dated 9 June 1977

b. ASN(MRA&L) memorandum, subject, Urinalysis for Drug Abuse Testing, dated 12 September 1977

Reference a described the situation whereby commander-directed urinalysis for drug abuse detection was not being used to its potential, and requested that measures be taken to increase the use of commander-directed urinalysis in those geographic areas of potential drug abuse.

Reference b described the Navy's efforts in testing portable urinalysis kits and in soliciting subordinate commands' views on minimum levels of urinalysis testing. This office finds both programs interesting and valuable, and requests that it be kept advised of the progress of both. The latter effort is of particular interest -- this office would like to consider the Navy's findings in its forthcoming comprehensive review of the entire urinalysis program and subsequent issuance of a new urinalysis program directive. In the meantime, however, it is noted that the situation which prompted the issuance of reference a continues to exist. Commander-directed urinalysis is not being used to best advantage nor has there been any significant increase in urinalyses or effectiveness of urinalysis in certain geographic areas. In the case of the Navy, the levels of commander-directed urinalyses in CONUS, Europe and Japan/Okinawa are not commensurate with the availability of drugs and the potential for abuse. In the case of the Marine Corps, levels of commander-directed urinalyses in CONUS, Europe, Guam and Japan/Okinawa are particularly low.

Therefore, request that a more direct approach than that represented in reference b be taken to increase the number of commander-directed urinalyses. A positive directive to commanders through the chain of command is recommended. Further request that this office be advised of the actions taken by both the Navy and the Marine Corps.

SIGNED

Vernon McKenzie
Acting Assistant Secretary

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

6 OCT 1977

MEMORANDUM FOR ASSISTANT SECRETARY OF THE AIR FORCE (M&RA(I)

SUBJECT: Increased Urinalysis for Drug Abuse Detection

REFERENCES:

a. ASD(HA) memorandum, subject as above, dated 9 June 1977

b. ASAF(M&RA) memorandum, subject as above, dated 13 July 1977

Reference a described the situation whereby commander-directed urinalysis for drug abuse detection was not being used to its potential, and requested that measures be taken to increase the use of commander-directed urinalysis in those geographic areas of potential drug abuse.

Reference b forwarded a Urinalysis Program Staff Training package which was published on 10 May 1977 and which was designed to train drug abuse control personnel to more effectively manage the urinalysis program. The initiative which prompted development of this training package is to be commended.

On the other hand, it is noted that the situation which prompted the issuance of reference a continues to exist. Commander-directed urinalysis is not being used to best advantage nor has there been any significant increase in urinalyses or effectiveness of urinalysis in certain geographic areas. In the case of the Air Force, the levels of commander-directed urinalyses in CONUS, Guam, Japan/Okinawa, Korea and Taiwan are not commensurate with the availability of drugs and the potential for abuse.

Therefore, request that a more direct approach than that represented by reference b be taken to increase the number of commander-directed urinalyses. A positive directive to commanders through the chain of command is recommended. Further request that this office be advised of the actions taken.

Although commendable in its context and intent, the training program forwarded by reference b was found to have some inconsistencies in it. A member of the DoD Office of Drug and Alcohol Abuse Prevention is available to assist in correcting these few inaccuracies.

SIGNED

Vernon McKenzie
Acting Assistant Secretary

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

26 OCT 1977

MEMORANDUM FOR Assistant Secretary of the Army (M&RA)
Assistant Secretary of the Air Force (MRA&L)

SUBJECT: Navy Alcohol Safety Action Program Seminar

The seminar held at the Navy Alcoholism Rehabilitation Center, San Diego, California, during 21-23 October 1977 provided an excellent opportunity to examine the Navy's alcohol abuse programs, particularly the prevention/intervention aspects of the Navy Alcohol Safety Action Program (NASAP). This approach to alcohol abuse prevention has proven effective, especially with young enlisted servicemembers who violate existing laws and regulations through the intemperate use of alcohol.

Three key aspects of the NASAP which make this approach effective are: (1) the required 36 hours of remedial education are sufficient to impact on the student's attitude; (2) referrals to the program are made for alcohol-related offenses from off-base sources as well as from on-base sources; and (3) the program is not limited to only a few select installations. It is essential that a vigorous, effective plan to make the individual servicemember aware of the detrimental consequences of his improper use of alcohol be formulated and implemented. The NASAP represents such a program.

Request that this office be advised of your current alcohol abuse prevention/intervention programs as well as any plans contemplated for the future in this area.

Robert N. Smith, M.D.
Robert N. Smith, M.D.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

1 NOV 1977

MEMORANDUM FOR Secretaries of the Military Departments
Directors of the Defense Agencies

SUBJECT: Implementation of Alcohol and Drug Abuse Programs in Defense Agencies

In reviewing the recently released GAO report ("Most Federal Programs for Employees With Alcohol-Related Problems Still Ineffective") and the Civil Service Commission's report on Federal Employees Occupational Health and Alcoholism and Drug Abuse Programs, it is apparent that some DoD agencies have not fully implemented the Civilian Employees Drug and Alcohol Abuse Programs. Additionally directors of local treatment programs in the Washington, D.C. area have indicated that there is a need for greater coordination of their efforts with DoD agencies' program coordinators in treating civilian employees.

In order to insure that DoD agency program coordinators are made aware of the requirements of PL 91-616 and 92-255 and the Civil Service Commission's annual reports requirement, this office has scheduled a conference for 22 November 1977, with presentations planned by representatives of this office, the Office of the Assistant Secretary of Defense for Manpower, Reserve Affairs and Logistics, the Civil Service Commission, and the National Institute on Alcohol Abuse and Alcoholism. The drug and alcohol abuse program coordinator of each defense agency addressee is requested to attend. Additionally, a representative from each treatment and/or counseling center operated by a Military Department within 30 miles of Washington, D.C. and which provides services to Federal civilian employees is invited to attend.

It is proposed that these representatives will discuss the services available for civilian employees at their installations. A tentative agenda is attached.

Names and telephone number of individuals expected to attend should be provided to Colonel Raymond M. Marsh (telephone 695-6800) by 18 November 1977.

Vernon McKenzie
Acting Assistant Secretary

1 Enclosure
a/s

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

14 NOV 1977

MEMORANDUM FOR Assistant Secretary of the Army (M&RA)
Assistant Secretary of the Navy (MRA&L)
Assistant Secretary of the Air Force (MRA&I)

SUBJECT: Drug and Alcohol Abuse Research and Development

Reference is made to the U.S. House of Representatives Report 94-517, Committee on Appropriations on HR 9861, 94th Congress, 1st Session. The text on pages 277 and 278 of the report addresses military medical investigations and, specifically, research on drug and alcohol abuse matters (enclosure 1).

In preparation for hearings before the U.S. House of Representatives Select Committee on Narcotics Abuse and Control, the views of the Office of the General Counsel of the Department of Defense with respect to the subject text were obtained. Our interpretation of the textual matter, concurred in by the Office of the General Counsel, is set forth in and attached as enclosure 2. Note that this interpretation considers certain types of research to be permissible within the intent of the Committee on Appropriations.

Recommend that each addressee review its requirements for drug and alcohol abuse research within the constraints of enclosure 2, and request funding during the FY 80 Program Objectives Memorandum cycle for projects in those areas which fall within the acceptable limits set forth in that enclosure.

Robert N. Smith, M.D.

2 Enclosures
a/s

94TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 94-517

DEPARTMENT OF DEFENSE APPROPRIATION BILL, 1976

SEPTEMBER 25, 1975.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MAHON, from the Committee on Appropriations, submitted the following

REPORT

together with

SEPARATE VIEWS

[To accompany H.R. 9861]

The Committee on Appropriations submits the following report in explanation of the accompanying bill making appropriations for the Department of Defense for the fiscal year ending June 30, 1976, and the period ending September 30, 1976.

APPROPRIATIONS AND ESTIMATES

Appropriations for the military functions of the Department of Defense are provided for in the accompanying bill for the fiscal year 1976 and for the three month transition period ending September 30, 1976. This bill does not provide for military assistance, military construction, military family housing, or civil defense, which requirements are considered in connection with other appropriation bills.

Manpower and Human Resources Development

A total of $16,760,000 and $4,270,000 is requested for the two Manpower Resources programs in fiscal year 1976 and the transition period, respectively. The Manpower and Human Resources Technology program provides for exploratory development in areas like personnel selection, classification, training and career management; leadership; psycho-social adjustment of soldiers to the Army; quality of life in the Army; motivation; morale, and job satisfaction. The Manpower Resources Development program provides for advanced development in such areas as drug abuse; improved psychological operations and civil affairs; troop/community programs; race harmony promotion programs; and other related research. The Committee recommends an appropriation of $8,380,000 in fiscal year 1976 and $2,136,000 in the transition period. This is one-half of the funding requested.

Army Support of DARPA Hostile Weapons Location System

The Defense Advanced Research Projects Agency (DARPA) and the Army have been conducting a joint research program on solutions to the problem of locating hostile indirect fire weapons since 1974. A total of $1,400,000 and $280,000 is requested for the Army's share of this program in fiscal year 1976 and the transition period, respectively.

The Committee found that the Army is also developing an artillery locating radar and a Mortar Locating Radar. Considering these two programs, the Committee believes that the Army support of the DARPA Hostile Weapons Location System program can be reduced and research continued at a lower level of effort. Accordingly, the Committee recommends an appropriation of $400,000 in fiscal year 1976 and $100,000 in the transition period. This funding level is equal to that provided in the authorizing legislation.

Military Medical Investigations

The Military Medical Investigations program includes $2,600,000 in fiscal year 1976 and $500,000 in the transition period for the biomedical factors in drug abuse project. This project continues research on: (1) the effect of alcohol and drugs on military performances; (2) epidemiology of drug abuse which defines risk of drug abuse in terms of demographic, environmental, historical and psychological factors; and (3) the rehabilitation of military drug users. The Committee found that the Department of Health, Education and Welfare budget includes about $309 million for efforts related to drug abuse and alcoholism, including $31 million for research. Accordingly, the Committee recommends that the funds requested for the biomedical factors in drug abuse project be denied.

The Committee also plans to make a detailed review of the various medical research programs of the Department of Defense to determine if this effort duplicates other Department of Health, Education and Welfare medical programs. Defense medical research should be di-

rected at only military unique medical problems. Medical research in fields not unique to military operations should be conducted by the Department of Health, Education and Welfare.

Unattended Ground Sensors

In fiscal year 1975 a total of $2,300,000 was provided for the Unattended Ground Sensors program. The fiscal year 1976 request for $9,630,000 represents in excess of a 300 percent increase in program funding. The Committee does not believe this increase is justified, and questions whether the sensors being developed duplicate the capability of other target locating systems. Accordingly, the Committee recommends an appropriation of $5,000,000 in fiscal year 1976 and $1,400,000 in the transition period. This is a reduction of $4,630,000 and $1,060,000 in fiscal year 1976 and the transition period, respectively; and is in agreement with the authorizing legislation.

Surveillance, Target Acquisition, and Night Observation

The purpose of the Surveillance, Target Acquisition and Night Observation program is to conduct advanced development on night vision devices and unattended ground sensors, with some effort in radars, physical security and special purpose detectors. In fiscal year 1975 $11,770,000 was provided for this program. A total of $16,430,000 and $4,191,000 is requested in fiscal year 1976 and the transition period, respectively. Considering the related research and development on unattended ground sensors, TOW missile night sights, M60A1 tank thermal sights, forward looking infrared sensors, and other night vision devices and sensors, the Committee does not believe the increase in funding is justified. The Committee recommends an appropriation of $12,000,000 in fiscal year 1976 and $3,000,000 in the transition period, the amounts authorized.

Chemical Defense Material Concepts

As explained previously in the report, the Committee believes that a high priority should be assigned to the development of chemical warfare defensive capabilities. The Chemical Defense Material Concepts program provides for advanced development of individual chemical protection devices and alarm systems to alert personnel that chemicals have actually been released into the atmosphere. This program, however, includes funds to continue development of the Long Path Infrared (LOPAIR) area scanning alarm. This alarm has not demonstrated sufficient effectiveness and may have been overtaken by other technological advancements. Consequently, the Committee recommends a reduction of $1,850,000 from the request of $6,890,000 in fiscal year 1976 and a reduction of $550,000 from the $1,620,000 request for the transition period. These are the amounts provided in the authorizing legislation.

Combat Support Equipment

A total of $4,930,000 and $1,607,000 is requested for the Combat Support Equipment program in fiscal year 1976 and the transition

DEPARTMENT OF THE ARMY—RESEARCH, DEVELOPMENT, TEST, AND EVALUATION—Continued

[In thousands of dollars]

	Budget estimate, fiscal year 1976	Reduction	Recommended appropriation, fiscal year 1976	Budget estimate, transition	Reduction	Recommended appropriation, transition
Other equipement—Con.						
Clothing equipment technology	3,040		3,040	860		860
Food technology	7,540		7,540	2,130		2,130
Computer software	2,920		2,920	900		900
Army support Darpa Howls	1,400	1,000	400	280	180	100
Military medical investigations	8,390	2,600	5,790	2,025	500	1,525
Tropical medicine	10,030		10,030	2,508		2,508
Infectious disease investigations	14,025		14,025	3,680		3,680
Electric power sources	6,250		6,250	1,525		1,525
ADPE developments	2,200		2,200	465		465
Unattended ground sensors	9,630	4,630	5,000	2,460	1,060	1,400
IFF developments	2,000		2,000	63		63
Communications development	5,400		5,400	1,960		1,960
Mapping and geodesy	420		420	198		198
Surveillance/target acquisition/night OBS (STAND)	16,430	4,430	12,000	4,191	1,191	3,000
Chemical defense materiel concepts	6,890	1,850	5,040	1,620	550	1,070
Tactical operations system (TOS)	4,800		4,800	1,006		1,006
Command and control	7,190		7,190	1,770		1,770
Remotely piloted vehicles drones	10,830		10,830	2,260		2,260
Combat support equipment	4,930	775	4,155	1,607	60	1,547
Counter battery radar	13,340	3,000	10,340	1,960	760	1,200
Tactical surveillance system	5,750		5,750	1,850		1,850
Manpower/human resources development	9,480	4,740	4,740	2,443	1,221	1,222
Medical field equipment	50		50	12		12
MILCOM and engineering	915		915	355		355
WWCCS architecture	200		200	200		200
Standoff target acquisition system	2,750		2,750	800		800
Antiradiation MSL counter measures	1,500		1,500	105		105
Communication engineering dev	7,009		7,009	2,798		2,798
Unattended ground sensors	3,250		3,250	686		686
Nuclear surveillance survey	2,228		2,228	405		405
Joint advanced tactical command/central communications prog	6,050		6,050	2,026		2,026
Combat equipment development	3,739		3,739	1,452		1,452
Manpower resources training applications	3,350		3,350	790		790
Mapping and geodesy	3,900		3,900	715		715
General combat support	8,655	655	8,000	2,254	154	2,100
Surveillance/target acquisition/night OBS system	8,984		8,984	1,722		1,722
Biological defense materiel	4,334		4,334	810		810
Chemical defense materiel	1,877		1,877			
Meteorological equipment systems	1,450		1,450	198		198
Command and control	696		696	1,505		1,505
Family of military engineering construction equipment (FAMECE)	3,900		3,900	891		891
Counter mortar radar	10,820	2,000	8,820	1,925	500	1,425
Communication electronics testing	3,480		3,480	758		758
Testing	33,340		33,340	9,961		9,961
Materiel concepts evaluation	11,160		11,160	2,818		2,818
Support OTE of combat equipment	4,450		4,450	1,425		1,425
Nuclear vulnerability and assessment	4,000		4,000	400		400
Evaluation of foreign components	1,510		1,510	300		300
Joint CB contact point and testing	765		765	223		223
OTEA-operational testing	3,900		3,900			
Classified programs	90,026		90,026	17,947		17,947
Subtotal	533,134	30,320	502,814	122,416	7,339	115,077
Programwide management and support:						
Programwide activities	58,206		58,206	14,048		14,048
International cooperative research and development	425		425	100		100
Technical information activities	3,815		3,815	1,013		1,013
Major R.D. & T.E. facilities—AMC	141,263		141,263	36,678		36,678
General reduction		18,000	−18,000		2,839	−2,839
Subtotal	203,709	18,000	185,709	51,839	2,839	49,000
Reimbursement from foreign sales	−7,700		−7,700			
Communication systems reduction		6,800	−6,800			
Intelligence reduction		17,200	−17,200		2,500	−2,500
Subtotal	−7,700	24,000	−31,700		2,500	−2,500
Total	2,181,700	258,867	1,922,833	585,600	120,876	464,774

It is the opinion of the Department of Defense that the subject wording, when taken in the drug and alcohol abuse context, permits the Military Departments to engage in that scientific study and experimentation directed toward increasing knowledge and understanding in those biological-medical and behavioral-social areas of drug and alcohol abuse control which are peculiar to the military profession. For example, research into the effects of drugs and alcohol on the performance of service members performing typical military tasks is considered to be the type of work which the Armed Forces can properly undertake. On the other hand, it is the opinion of the Department of Defense that research which provides fundamental knowledge for the solution of identified medical/behavioral technologies and of new or improved functional capabilities in the personnel support area -- knowledge and capabilities which have relevance equally to civilian as well as to military abusers is available from the National Institute on Drug Abuse and need not be pursued by the Department of Defense. Studies of addiction mechanisms fall into this latter category. The Department of Defense also considers the report wording to permit general purpose data collection, i.e., activities that include routine product testing and monitoring activities, quality control, surveys and collection of general purpose statistics.

Enclosure 2

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

12 DEC 1977

MEMORANDUM FOR Assistant Secretary of the Army (M&RA)
Assistant Secretary of the Navy (MRA&L)
Assistant Secretary of the Air Force (MRA&I)

SUBJECT: Urinalysis Selective Testing

Reference OASD(HA) memorandum, subject, Urinalysis Selective Testing Study (U), dated 24 August 1976.

Recently the Laboratory Methodology Subcommittee of the Tri-Service Committee for Drug Abuse Testing reviewed the selective testing prescribed by the reference and found it to be working in a less than satisfactory manner. A primary fault found with selective testing is that any commander-directed urinalysis -- which comprises the bulk of all urinalysis today -- would not necessarily include testing for the common drugs of abuse. Depending upon the laboratory to which it is sent, the sample would be tested for opiates and then it may or may not be selected for testing for other drugs. Yet the individual whose urinalysis is directed by a commander is just that individual who the commander has reason to suspect of drug abuse, and his sample should be thoroughly checked for all of the prevalent drugs of abuse. Again, in the case of samples submitted from a commander-directed urinalysis sweep, all are not tested for all drugs, thus presenting the commander of the swept installation with a false picture of the drug abuse prevalence at his installation.

Further, with the cessation of random urinalysis, all laboratories are capable of conducting many more tests than they are presently handling.

The committee recommended that the sample technique of testing 8 percent of incoming samples for certain drugs cease, and that the laboratories return to a 100 percent testing of urine samples for common drugs of abuse. Initially, it is recommended that all laboratories test all incoming samples for opiates, amphetamines and barbiturates, and that the laboratory in Wiesbaden, Germany, also test all samples for methaqualone. In the future, the Subcommittee recommended, the drugs for which the laboratories should test should be based upon the results of a review of other indicators, e.g.,

Drug Enforcement Administration intelligence data, military service law enforcement and investigative agency findings, and the results of short, intensive urinalysis sweeps of suspect areas or installations.

The Laboratory Methodology Subcommittee recommendation is approved, and the referenced memorandum is rescinded. The effective date for the increased testing is 1 January 1978.

Robert N. Smith, M.D.

Robert N. Smith, M.D.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

3 FEB 1978

MEMORANDUM FOR The Assistant Secretary of the Army (M&RA)
The Assistant Secretary of the Navy (M,RA&L)
The Assistant Secretary of the Air Force (MI)

SUBJECT: Drug and Alcohol Abuse Education Materials

References: (a) Change 1 to DoD Directive 1300.11, subject: "Illegal or Improper Use of Drugs by Members of the Department of Defense", dated 23 October 1970

(b) Change 1 to DoD Directive 1010.2, subject: "Alcohol Abuse by Personnel of the Department of Defense", dated 1 March 1972

Forwarded herewith in accordance with the policy established in References (a) and (b) is a new cumulative list of audiovisual materials which have been approved or disallowed for use in the DoD alcohol and drug abuse education program by the DoD Media Support Committee.

Vernon McKenzie
Principal Deputy Assistant Secretary

Enclosure (1)

The following films have been recommended by the committee; the rights to these films have been purchased through AFIS funds and they are available through service channels:

AFIF NUMBER	TITLE
199	DRUG ABUSE: EVERYBODY'S HANGUP
211	ABOUT ADDICTION
215	DRUG ABUSE: FACTS EVERYONE NEEDS TO KNOW
217	PERFECT DRUG FILM
244	DRUGS, DRINKING AND DRIVING
245	CHALK TALK ON ALCOHOLISM
248	HOOKS
254	BOOZERS AND USERS
255	ALCOHOL: DRUG OF CHOICE
259	WE DON'T WANT TO LOSE YOU
269	DRYDEN FILE
270	WE HAVE AN ADDICT IN THE HOUSE
271	BOURBON IN SUBURBIA
272	THE FIRST STEP
277	SO LONG PAL
284	I'LL QUIT TOMORROW
288	AMERICA ON THE ROCKS
291	GUIDELINES
292	ALCOHOLISM: THE BOTTOM LINE
293	LIVING SOBER: THE CLASS OF '76
294	UNDER THE INFLUENCE
295	WEBER'S CHOICE
296	A TIME FOR DECISION
322	CHALK TALK ON PREVENTION
323	LIFE, DEATH AND RECOVERY OF AN ALCOHOLIC
324	ALCOHOLISM AND THE FAMILY
325	HOLLYWOOD AND VINE

The following films have been recommended by the committee but must be acquired locally:

ALCOHOLISM IN INDUSTRY
THE CARING COMMUNITY
HEY, HOW ABOUT ANOTHER ONE
TURNING POINT
THE SECRET LOVE OF SANDRA BLAIN
LET'S CALL IT QUITS
UNDER THE INVLUENCE - OUT OF CONTROL
TO MEET A NEED
FRANCESCA BABY
A SLIGHT DRINKING PROBLEM

The following films have been approved by the committee for use if acquired locally:

BY A JURY OF HIS PEERS
NARCOTICS FILE - THE VICTIMS
ADDICTIVE: SOPORS
GRADUATION DAY
ALCOHOLISM, INDUSTRY'S COSTLY HANGOVER
IT'S MY HOBBY
LICENSE TO KILL
COUNTDOWN
SMOKING, A NEW FOCUS
ALCOHOL, A NEW FOCUS
ALMOST EVERYONE DOES
ASHES TO ASHES
DRINK, DRIVE, RATIONALIZE
DRINK, DRANK, DRUNK
THE DWI'S
ALCOHOL, DRUGS OR ALTERNATIVES
THE ALCOHOLISM FILM
YOU CAN'T JUST HOPE THEY'LL MAKE IT
A FIGHT FOR BREATH
WHY BE DOWN WHEN YOU CAN BE UP
99 BOTTLES OF BEER
NO DRINKER UNAWARE
ALCOHOL, CHOICES FOR HANDLING IT
PSYCHOACTIVE
FIVE DRINKING DRIVERS
NEW PERSPECTIVES ON ALCOHOLISM
THE NEW LIFE OF SANDRA BLAIN
ALCOHOL, AN UNDERSTANDING OF THE DRUG
A CONSPIRACY OF SILENCE
THEY DO RECOVER

The following films which had been purchased by the services are obsolete and have been disallowed by the committee:

AFIF NUMBER	TITLE
196	MARIJUANA
205	11:59 - LAST MINUTE TO CHOOSE
209	ACID
210	WEED
212	SPEEDSCENE
213	NINE-IN-ONE CONCEPTS
220	ALCOHOLISM: OUT OF THE SHADOWS
230	US
253	GO ASK ALICE

The following films have been disallowed by the committee and may not be used in the DoD for alcohol and drug abuse education:

SKEZAG
MEDICAL ASPECTS OF ALCOHOL
BEYOND THE FINISH LINE
DEAD IS DEAD
PORTRAIT
ALCOHOLISM: A MODEL OF DRUG DEPENDENCY
JUST ONE MORE TIME
CASE #7201
ASHES OF DOOM
FIFTH OF DESPAIR
FIFTH STREET
ALCOHOLISM: ALMOST EVERYTHING YOU NEED TO KNOW TO RECOGNIZE IT
AND ANYBODY ELSE WHO'S LISTENING
ME, AN ALCOHOLIC?
THE GAME
AND I'M AN ALCOHOLIC
THE DRUG MEMO
A DISCUSSION OF DRUG ABUSE
UP THE LADDER DOWN
BREAKTHROUGH
THE CURIOUS HABITS OF MAN
THE METHADONE CONNECTION
THE DWI DECISION
UP FRONT
GROOVY'NG
ALCOHOL AND DRUGS: A WAY OUT
RASPBERRY HIGH
ALCOHOL, THE NUMBER ONE DRUG
ONE DAY
DON'T LET IT BOTHER YOU
THE PCP STORY
MEDICAL ASPECTS OF ALCOHOL (REVISED)
RETURNABLE BOTTLE

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

3 MAR 1978

MEMORANDUM FOR The Assistant Secretary of the Army (M&RA)

SUBJECT: Drug Abuse Situation in West Berlin

Reference DOD Instruction 1010.3, subject, Drug and Alcohol Abuse Reports, dated 22 May 1974.

Information obtained during recent visits to West Berlin by representatives of this office, the White House Office of Drug Abuse Policy and the National Institute on Drug Abuse leads these individuals to the conclusion that heroin abuse among U.S. Army personnel in West Berlin is approaching alarming proportions. Further, the purity of the heroin which is available in West Berlin is relatively high, thus causing overdose situations in abusers who are accustomed to less pure heroin. For these reasons, it is imperative that increased measures be taken to identify heroin abusers early in their involvement, and to deter those who may be inclined to experiment with heroin. Therefore, it is recommended that the following drug abuse identification measures be emphasized:

. Increased publicity of the exemption policy.

. Review of procedures to insure that abusers detected by medical, law enforcement and investigative agency personnel are referred to commanders for disposition.

. Review of liaison procedures to insure that abusers detected by civil authorities are referred to commanders for disposition.

. Increased use of urinalysis. Consideration should be given to periodic urinalysis sweeps of entire units as well as to commander directed urinalysis of suspect individuals. Typical situations in which commanders may suspect drug abuse and order a urinalysis are upon return from, or apprehension after an unauthorized absence, failure to obey lawful orders, irregular performance or abnormal behavior, safety violations, accidents of

all types, assault, larceny and indebtedness. This office further recommends that a minimum of 3.0 urinalyses per man per year be set as the goal for the total number of urinalyses that should be conducted for drug abuse identification, both from individuals and from unit sweeps.

. The Enzyme Multiplied Immunoassay Technique (EMIT) portable urinalysis test kit be taken to West Berlin for a period of intensified testing. This kit has been tested by the Navy and shows promise of providing a quick, on-site capability to test for seven potential drugs of abuse in a urine sample. The Commander in Chief, U. S. European Command has requested the Navy to demonstrate the equipment in Europe. Arrangements can be made to use it in West Berlin for operational testing.

It is requested that West Berlin statistics be reported separately in the Report of Urinalysis Testing for Drug Abuse (RCS DD-H&E(M) 1094) and Report of Personnel in Treatment/Rehabilitation for Drug Abuse (RCS DD-H&E(M)1194). These reports are described at enclosures 2 and 5 respectively of the reference. It is also requested that a one-time report be prepared and submitted which exhibits the separate West Berlin statistics in the two reports cited above for the period January 1976 through the present. Note that in further reports the West Berlin figures are desired separately from the Germany/Europe figures; they should not also be included in the totals of the Germany/Europe statistics.

The heroin situation in Berlin is serious; however, with commander awareness and the vigorous use of the tools available, it is felt that the problem can be attacked and the seriousness moderated before the problem assumes the proportions of the heroin situation in Vietnam.

Vernon McKenzie
Principal Deputy Assistant Secretary

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

3 APR 1970

MEMORANDUM FOR The Assistant Secretary of Defense (MRA&L)
Assistant Secretary of the Army (M&RA)
Assistant Secretary of the Navy (MRA&L)
Assistant Secretary of the Air Force (MRA&I)

SUBJECT: Drug and Alcohol Abuse Advisory Committee

Reference: DoD Directive 1300.11, "Illegal or Improper Use of Drugs by Members of the Department of Defense," October 23, 1970

It is the policy of the Department of Defense to prevent drug and alcohol abuse in the Armed Forces and to attempt to restore members so involved to useful service. In order to better implement this policy, the Drug and Alcohol Abuse Advisory Committee, formerly known as the Drug Abuse Control Committee (reference), is reactivated.

The purpose of the Drug and Alcohol Abuse Advisory Committee is to advise the Office of Drug and Alcohol Abuse Prevention within the Office of the Assistant Secretary of Defense (Health Affairs) in planning and coordinating policy and program initiatives that will enhance the DoD Drug and Alcohol Abuse Program. The Advisory Committee will meet quarterly or more frequently if required. Membership on the committee will consist of the following: a representative from each of the military services responsible for the drug and alcohol abuse program for military personnel; a representative from each of the military services responsible for the drug and alcohol abuse program for civilian employees; a representative from the Office of the Deputy Assistant Secretary of Defense for Civilian Personnel Policy and a representative from the Office of the Deputy Assistant Secretary of Defense for Military Personnel Policy. The committee will be chaired by the Chief, Office for Drug and Alcohol Abuse Prevention. The Veterans Administration will also be invited to participate on the Advisory Committee.

Request that each of the services, the ODASD (Civilian Personnel Policy)and the ODASD (Military Personnel Policy) advise the Office of the Assistant Secretary of Defense (Health Affairs) of the names and telephone numbers of the representatives who will serve on this committee. Names should be submitted to the Office for Drug and Alcohol Abuse Prevention by close of business 18 April 1970.

Action officer is Dr. John F. Mazzuchi, 695-6806.

SIGNED

Vernon McKenzie
Principal Deputy Assistant Secretary

Mr. BEARD. Let me ask one question.

Has there been any tie-in to the recent results shown, for example, in the All-Volunteer Army that your percentage of 3-B mental categories, which is very low—3-B is almost as low as you can get—has gone from 32 percent in the All-Volunteer Army to—now it's up to 49 percent?

And if you throw in the category 4's, which are—you have to aim them in the right direction as to putting their shoes on, which is harsh to say, but it's true—you have almost 59 to 60 percent of the entire Army today is either a low 3-B mental category or below that, in a 4, which is way below the standards.

Has there been any tie-in or any comment as to this being related to the increase in drugs?

Mr. MCKENZIE. To the best of my knowledge; no, Mr. Beard.

Mr. BEARD. Would that be one area, do you think—is there any kind of relationship at all with your taking category 4's and 3-B's?

Mr. MCKENZIE. I'm not aware of a relationship, but certainly we would be willing to pursue that line and respond.

Mr. BEARD. Here we keep talking about—and I somewhat tend to disagree, as far as the impact, cultural impact on these young kids—and you're taking them away from their homes and their families—a lot of the times these kids are coming from something—they've had all the cultural impact they can stand. The reason why they're joining the Army is because they're looking for something better, and usually what they go into is better than what they just came from.

So you know, I question the significance of cultural impact and being taken away from their loved ones, because that's a lot of times the reason why they joined the service.

So I would just say that it might be interesting to see if there are any relationships or ties to the fact that the mentality of our Army has decreased to the point of just almost disaster.

Mr. MCKENZIE. We will pursue that point, Mr. Beard.

Mr. ENGLISH. We're going to have to recess for another few minutes to make another vote.

I would like to make one statement, Mr. Chairman, with regard to the issue of the Secretary.

I agree with Mr. Beard. I think we should give the Secretary another invitation to appear before the committee and, if necessary, take the drastic step of the subpena, if that is necessary.

And I would also urge, Mr. Chairman, that we ask for a meeting with the President at the earliest possible moment to discuss this very serious matter of drug abuse in the military.

Mr. GILMAN. Mr. Chairman, I would like to also have the opportunity of submitting written questions to the panel following the hearing.

Mr. ENGLISH. Without objection, so ordered.

Mr. GILMAN. Thank you.

Mr. ENGLISH. We will take a break now for about 10 minutes.

[Recess.]

Mr. ENGLISH. The hearing will resume.

Mr. McKenzie, the second part of your testimony, question No. 4, the committee asked what steps has DOD taken to standardize the reporting procedure of drug-related data from the various services.

And your answer was, drug data reporting procedures were standardized through the issuance of several DOD instructions.

These regulatory documents provide instructions and formats to the military services for the reporting of the following:

(A) Disciplinary actions taken for drug abuse offenses;

(B) Administrative discharges for drug abuse; and

(C) Drug abusers detected by urinalysis.

And you went on then with rejection of drug abusers at Armed Forces examining and entrance stations:

(E) Drug-abusing recruits detected by urinalysis;

(F) Service members entering treatment and rehabilitation for drug abuse; and

(G) Drug abusers volunteering for assistance under the exemption policy.

I would simply like to point out again the findings of the task force in this particular area in that we found that this was one of the principal problems as far as dealing with the small amount of information that was available, and that while you have these certain standardized types of flags that are very easy to obtain and very easy to get, that they, in fact, do very little as far as reflecting the actual problem, and it also does very little as far as indicating the exact extent of the problem.

And I might say that they're probably not too good an indicator because of the fact that you have quite a wide variety of enforcement, and from the standpoint of individual commanders, each commanding officer is a little bit different. Each commander perceives the problem a little bit differently, emphasizing different aspects differently.

And from this standpoint, these commanding officers who are probably emphasizing drug abuse detection and prevention the most are the ones that are going to show up with the largest figures, and the whole thing is misleading.

Now, the whole other problem we go into, as I stated before, is that there is absolutely nothing that we found, at least, as far as DOD is concerned, that has any indication as to the exact extent of this problem, how much of a problem we have, how much abuse is taking place. And those indicators that you listed here, particularly the urinalysis, does not detect some of the drugs that are in most general use now. And as I've said before, urinalysis varies from post to post and almost from commanding officer to commanding officer on how much it's used.

It seems to me that this is a very weak type of standardization policy. It's a very weak thing from the standpoint of trying to say that there is uniformity, that each of the services looks at it completely differently. And this is a problem that we've had in trying to get this information together.

Mr. MCKENZIE. We were not attempting, Mr. Chairman, to mislead you on that.

Mr. ENGLISH. Before you answer that, I might also—before you get to far—it was just pointed out to me that the White House found the same type of problems as far as standards.

It states—this is lifting it out of context, I must admit, but it does—from what Mr. Dogoloff said this morning: "However, the

information is often prepared from the standpoint of definition or comparability of data within and among the services."

So I think this points out they found about the same thing that we did.

Mr. McKENZIE. I wouldn't argue, Mr. Chairman. We were using the word "standardized" in a broad, general sense. There are all kinds of variations, certainly, within the formats that are prescribed.

Mr. ENGLISH. Well, then, how in the world can you, heading up ODAAP and having the responsibility as far as the Department of Defense is concerned to try to understand this problem and perceive the depth of the problems—how in the world can you do it when you don't have a standardization?

Is it not your responsibility to make certain that a standardized format is carried out among the various services?

Mr. McKENZIE. It certainly is desirable to have such a standardized procedure reporting system in effect. We have been attempting to perfect our system for several years.

Admittedly, we have not achieved that perfection yet.

Mr. ENGLISH. Well, what's the problem?

Mr. McKENZIE. Mr. Chairman, standardizing reporting systems within a 2-million-man organization is an extremely difficult task.

Mr. ENGLISH. You're not talking about a 2-million man; you're talking about four different services. Basically, you've got four different procedures. I'm not certain—I believe the Marines probably follow what the Navy does, so your probably talking about three.

Mr. McKENZIE. Well, what I was alluding to is the fact that these reports are generated at a local area, of which there would be hundreds throughout the system. And to devise a technique of making sure that each person is thinking along the same precise lines as he completes a form is difficult.

Mr. ENGLISH. I just can't believe that it would be that difficult to sit down and come up with procedures and have them in set form. And I notice DOD is great on forms. You've got all kinds of standardized forms you use over there. I can't understand why you can't have a standardized form on this and why in the world it would be so difficult to go back down through there and say, OK, Air Force, you throw away form No. AF whatever it is that you're using, the Army throws away whatever form it's using, and you come up with a form, with a standardized procedure for determining the extent of this problem.

Of course, the other problem that we perceive is that there's been no effort to even try to determine the extent of the problem, regardless of what form you use.

Any comment?

Mr. McKENZIE. Yes; Mr. Chairman.

We have exerted, we think, tremendous efforts over the past few years in trying to come to grips with our drug abuse problem in the Armed Forces.

Mr. ENGLISH. All four of you?

Mr. McKENZIE. Well, in that case it would be all five of us, Mr. Chairman.

Mr. ENGLISH. All five of you.

I will yield to counsel.

Mr. NELLIS. I would like to address two questions to the panel, and I will make them brief.

The first relates to a personal experience that I had at Subic Bay and Clark Air Force Base, and it is related to recommendation No. 5 in the review, which is: DOD should assess the drug abuse problem of the civilian force and dependent contingent and develop and expand special programs for these populations, especially in areas overseas where community drug abuse programs are not available.

I have not heard the word "dependents" mentioned in this hearing yet, and I think it goes without saying that the morale of the services is largely dependent, overseas, at least—perhaps even here—on the extent to which the family unit functions together.

Now, when I was at Subic and at Clark I found that there were no facilities whatever for dependents, that the facilities that did exist were reserved exclusively for the military.

My question, therefore, is: What is being done to provide facilities not only in the education and prevention field but in the treatment area for dependents of servicemen?

Mr. MCKENZIE. Mr. Nellis, we don't have a formally established program for dependents. It is comparable to the so-called "space-available" concept that we operate the health care system generally on, from the standpoint of dependents.

Where there is a capability, particularly in an overseas area, left over after the active force's requirements are met, in some instances dependents do participate in the programs.

We have had a few special programs overseas—one in the Frankfurt area, another joint program that we had in the Bangkok area when that was a large area of concern.

Mr. NELLIS. What would you sday to a young lieutenant that I met at Clark Air Force Base who told me about his wife's addiction to amphetamines who could not get treatment, not even from a civilian doctor for some reason, because there was no facility available for her. What do you suppose that did to his morale?

He was a pilot, by the way.

Mr. MCKENZIE. I'm sure that had an adverse impact on his morale, Mr. Nellis.

Mr. NELLIS. Don't you think the Department of Defense should do something concrete and affirmative about making sure that the dependents problems of drug abuse and alcohol abuse are resolved in some way?

Mr. MCKENZIE. I certainly agree with you, Mr. Nellis.

Mr. NELLIS. Has there been any planning in this regard?

Mr. Dogoloff?

Mr. DOGOLOFF. We raised the issue, as you know, in our assessment review. DOD's response was that they agreed with that issue. They thought it was an important one. And they agreed to have military departments evaluate the adequacy of their current programs in meeting the needs of these groups and to assess the need to expand or develop special programs for them.

So I think we are on track in terms of raising the issue as you so aptly have here today; getting a response back from the military saying that they are going to report back to us on it.

We will be glad to share that response with you.

Mr. NELLIS. That response is due this month, according to this document. It's due in April 1978.

Then it goes on to say: "The timetable of events thereafter depends upon the adequacy of the programs reported by the military departments."

We learned a little while ago that they are largely inadequate; is that not correct?

Mr. DOGOLOFF. What it says is that the queries to the military departments by the Department of Defense will be dispatched in April 1978. In other words, that's the question being asked. The timetable of events thereafter would depend, obviously, on the adequacy of the programs reported; that if the programs are seen to be adequate or very inadequate, it might take longer to respond to them, to changes that are needed; if they are only moderately inadequate, it would take a shorter period of time.

I think that's what the military is saying in their response.

Mr. NELLIS. My experience is anecdotal, Mr. Dogoloff. But I think you've had the same experience. There is a paucity of facilities available for dependents of servicemen overseas, and I think the Department of Defense is derelict in its duty to its own personnel if an affirmative program is not developed to take care of this problem.

Dr. Smith, do you have a comment?

Dr. SMITH. I agree with you totally. I believe that treatment of dependents is a responsibility of government, particularly in the overseas area. Within CONUS, where other facilities may or may not be available, we can use those, but I am very impressed with the Navy's program at Long Beach in San Diego. I would like to see that program—made the standard program, and similar programs be developed in all the three services; that the attitudes that support those programs be developed, too.

Mr. NELLIS. Mrs. Ford is at the facility at long Beach, as you know.

Dr. SMITH. Yes.

Mr. NELLIS. Unfortunately, this cannot be duplicated in the Philippines, according to my personal observations. Is there some reason why we don't have facilities abroad for the same purpose?

Mr. DOGOLOFF. It seems to me that part of that would depend upon population concentrations and the degree of specialty needed and so forth, and that the response should differ in different places; that in a place where there's a concentration of military dependent personnel and high availability of illicit drugs, or licit drugs, for that matter, we might want to have specialized facilities.

Now, I would not subscribe to having specialized facilities everywhere in the world. There may be other instances where it would be much more cost-effective to bring people in remote areas or areas where there's a small concentration of personnel to a more centralized facility for that kind of care and treatment.

Mr. NELLIS. Mr. Dogoloff, would you undertake to advise this committee on this subject matter with respect to the plans being made for taking care of this problem?

Mr. DOGOLOFF. Certainly.

Dr. SMITH. To amplify that—I agree with what Mr. Dogoloff said, and in fact the treatment center at San Diego and at Long Beach,

many of the people who are there are brought in. It's also perfectly possible to treat drug addiction, whether it's drugs or alcohol, on an ambulatory basis and continue to have the person function in some capacity.

Mr. NELLIS. Assuming you have physicians available.

Dr. SMITH. Yes; you have to have the facilities and the manpower. But that can vary, depending on what class of patient you are treating.

Mr. NELLIS. I would like to turn briefly to my second question, and that relates to prevention and evaluation of prevention.

Mr. McKenzie, you alluded to some educational programs. Can you briefly describe to the committee whether the Department of Defense has a policy and a program with respect to the prevention or the intervention with potential users of drugs or alcohol?

Mr. MCKENZIE. Yes, Mr. Nellis, we do have an education program which covers the aspects that you mentioned.

Mr. NELLIS. Would you make that material available for the record.

Mr. MCKENZIE. Certainly, Mr. Nellis.

[The information referred to follows:]

The DoD preventive education policy and program was established in 1970, and revised in December 1974. The military departments have provided regulations and instructions which implement this policy, and the major operating commands and installations design programs within the established guidelines to meet local needs.

The DoD education policy calls for classes for specific target groups which present accurate and relevant information about alcohol and drug abuse. Education is required for all active duty officer and enlisted personnel as well as for Reserve and National Guard personnel. DoD and service policy regarding abuse is emphasized as well as the reasons for and alternatives to abuse. In addition, supervisors and professionals and paraprofessionals receive continuing education through workshops, conferences and seminars. DoD policy also calls for drug and alcohol abuse education to be included in the curricula of DoD dependent schools and requires that commanders cooperate with local school officials in establishing drug abuse education in public schools, attended by DoD dependents.

To assure suitable education materials, the DoD Media Support Committee establishes guidelines for the selection of audio-visual and printed materials and reviews and evaluates materials issued at the DoD or service level.

Through the American Forces Information Service (AFIS), education materials, such as films, pamphlets, posters, radio and television spots and appropriate publications are provided for service programs.

In October 1975, the DoD issued specific policy for personnel entering the military. This policy requires that such personnel be provided information concerning:

- The exemption policy
- The identification program, including urinalysis and medical, command and law enforcement identification
- Treatment and rehabilitation opportunities and procedures
- The legal and career consequences of abuse
- Alternatives to abuse

Education for personnel entering the service is to be completed before the first permanent duty assignment and given during scheduled presentations by qualified instructors using approved lesson plans.

Mr. NELLIS. Do you have an evaluation program designed to determine whether your prevention programs are fruitful?

Mr. MCKENZIE. We do have such a program, Mr. Nellis.

Mr. NELLIS. I'd like to have that made available for the committee, if you would, please.

Mr. MCKENZIE. Certainly.

[The information referred to follows:]

The evaluation program we have designed includes:

- Staff visits
- Review of service programs
- Screening of education materials
- Cooperation with other Federal Agencies

During staff visits, service programs at the installation level are examined in detail. Presentations are observed and recommendations for improving course content, technique and lesson plans are made. In recent years, the emphasis was changed from pharmacology to the career and legal consequences of abuse and alternatives to abuse.

Service-wide education programs are also reviewed. Centrally developed plans of instruction and guidebooks for education specialists are evaluated both for their compliance with the overall objectives of the DoD education program and for specificity of information provided to service members.

The DoD Media Support Committee established guidelines for the evaluation of proposed education materials. Materials are compared with these guidelines for accuracy of information, compliance with DoD policy, effectiveness of the message, usefulness as an instructional aid and appropriateness for a military audience. Lists of recommended, approved or disallowed materials are promulgated annually.

The DoD uses educational materials produced and evaluated by the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism and the Drug Enforcement Agency whenever possible. Our key educational program directions, i.e., providing factual information about drugs and an emphasis on alternatives to drug abuse are supported by the National Institute on Drug Abuse.

The evaluation program, as presently designed, has not enabled us to measure the fruitfulness of our prevention programs with the degree of confidence we would like; accordingly, we plan to also evaluate the programs through the survey questionnaire later this year. Appropriate changes in policy will be made based on the survey's findings and conclusions.

Mr. ENGLISH. I believe this will complete the hearings for today.

I want to thank each of you gentlemen for appearing before us. I hope that you haven't felt that this committee was too hostile, but I think you probably got the general impression that this committee feels very strongly about this issue and is extremely concerned about the problem.

I believe Chairman Wolff also has a statement he would like to make.

Mr. WOLFF. First of all, I want to congratulate the chairman of the task force for the monumental work that has been done in this area.

In addition to that, we thank our witnesses for appearing before us here today and their spirit of cooperation. However, what has been pointed up as a result of this hearing is the very serious nature of the drug problem that exists within the military, one of a

critical nature, and one which I believe very strongly impacts very heavily upon the security of the United States.

And I do think that because of the widespread drug abuse that we have found now that exists, that I am going to ask the committee for an immediate meeting with the President to discuss this. The President has been very cooperative with this committee in the past. An announcement that he has made relative to the reinstitution of the urinalysis program for screening is a step forward.

However, I think that it is greater importance that this committee communicate directly with him as to what we feel is a very serious threat to the security of this country.

Thank you very much.

Mr. ENGLISH. Thank you, Mr. Chairman.

This hearing will stand in recess until May 18 for the next hearing.

[Whereupon, at 1:20 p.m., the Select Committee recessed, to reconvene Thursday, May 18, 1978.]

[Additional material submitted to the committee follows:]

PREPARED STATEMENT OF LEE I. DOGOLOFF, ASSOCIATE DIRECTOR, DOMESTIC POLICY STAFF, EXECUTIVE OFFICE OF THE PRESIDENT

Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before the Committee and discuss with you the initiatives this Administration has taken regarding drug abuse in the military. This issue is very important and it is significant to note that one of the first areas of inquiry made by the White House—even before the activation of the Office of Drug Abuse Policy—concerned drug abuse in the military. In February 1977, just one month after the Inauguration, Dr. Peter Bourne, Special Assistant to the President for Health Issues, visited the United States European Command and received a briefing on the nature and extent of drug abuse among American service personnel in Europe, and the responses to this problem by the component commands. Subsequently, I have visited various components of the U.S. Army Europe and have received a detailed briefing on the drug programs of the three component commands (Army, Navy and Air Force). In addition, two staff-level visits have been made on behalf of my office. This early interest in the drug abuse programs of the Department of Defense grew out of a knowledge that the random urinalysis effort had been ended and a concern over the reliability of remaining indicators of drug abuse.

One of the major activities of the Office of Drug Abuse Policy was to do a series of policy reviews in several important areas of drug abuse. Because of our concern regarding the indicator systems of the DOD effort, Dr. Bourne directed a review of the processes by which the Department knew the extent of its drug problem and the reliability and validity of such processes. This review occurred in the summer of 1977, and a copy of the review has been furnished to the Committee. However, for the record, Mr. Chairman, I would like to ask that this review be formally entered as part of this hearing.

The review should be placed in the context of an ongoing and active DOD drug abuse prevention effort of long standing and no small consequence. One of the real success stories of the Federal Government's drug abuse prevention activities of the past several years has been with our service personnel. The active intervention of the Department of Defense through an aggressive random urinalysis program and subsequent treatment and rehabilitation efforts were responsible for a major and dramatic reduction in drug use among our servicemen in Southeast Asia. The basic programs which were developed at that time remain essentially intact—with one important exception, the random urinalysis effort—and the energy that is currently expended by all of the Services is to be commended. My current concern is that we forestall any significant degrading of this active program, and it was in this light that the review was undertaken.

The Review Group was asked to inquire into the effectiveness of current policies and programs of the Department of Defense and the Military Departments regarding the methods by which the Armed Services identify and assess the nature and extent of drug abuse problems. Further, it was asked to evaluate the ability of the current DOD drug abuse identification process to reflect changes in the drug using

patterns of servicemen and women and to provide early detection of hidden use of drugs. Finally, the Review Group was asked to make appropriate recommendations for improving the overall drug abuse assessment capability of the Department.

The conclusions of the Review Group can be summarized as follows:

(1) The Department of Defense and the Military Departments have a variety of indices of drug abuse which are used by senior commanders and managers. These indicators include such things as hospital reports, reports of drug seizures, incident reports, etc. However, the information is often disparate from the standpoint of definition or comparability of data, both within and among the Services; and

(2) All of the indices that are used on a service-wide basis are subject to bias and there is no ongoing process to systematically validate these indices. This lack of a validating mechanism makes it very difficult, if not impossible, to estimate with high reliability the current level of drug use within any Military Department.

The review recommends that the Department of Defense standardize existing indicators of drug abuse within and among the Armed Services and that it develop an independent drug abuse assessment program to validate these indices. This program should include a modified random urinalysis effort for trend data and an integrated survey effort which would form the lynchpins of this independent assessment.

The results of the review have been transmitted to the Department of Defense and the Department has developed a work plan to respond to the concerns of the policy review. We have been and remain in continual discussions with DOD regarding the implementation of these recommendations.

You asked for an assessment of overall drug use as it relates to the military environment. The honest answer is we do not know, since the reliability of existing indicators is at question. In terms of existing indicators—that is medical reports, law enforcement reports and so forth—it appears that overall drug use within all three Services is down from the epidemic proportions experienced during the Vietnam era. But we are not confident we know the trends of drug use or can quickly identify shifting patterns of drug use. Further, we are very concerned about drug use in areas of known high availability such as Europe, parts of the Pacific theatre and along the U.S./Mexican border. For this reason we have taken a special interest in the potential drug abuse problems in these areas and, beginning with Europe, intend to give special scrutiny to each of these areas. We have selected Europe first because of its vital strategic position in the U.S. deterrent posture. I have personally talked to commanders at all levels, and to troops in the field. I am concerned about the potential impact of high levels of drug use, though I am heartened by the current activities within the European Command to enhance the existing drug abuse prevention and rehabilitation efforts of the component commands. Since my major concern regarding drug abuse in the military is for the readiness of the force, I am equally as concerned about a soldier, sailor or airman who is intoxicated from marihuana—or drunk from alcohol for that matter—and cannot perform his duty, as I am the individual who is high on heroin and similarly cannot perform his duty. There is no question that drug use in the military often has risk implications beyond those normally associated with drug use in society in general. Hence, we have to be concerned with the consequences of any drug use which can severely impact on performance of duty. Unfortunately, the answer to this question of "impact" is not known. As the Department of Defense will indicate in its testimony, this is a research area which must receive priority attention.

We must be especially aware of the situation facing the young soldier now, particularly in Western Europe. Many of the enlisted men and women joining the Services today are doing so because they cannot find jobs in the civilian sector. Often without a high school education, these young people are given complex training. The problems are compounded when they are sent to a foreign country, away from their families and friends, often not accepted in the local community, and faced with the economic problems of a declining U.S. dollar. Add to this the high availability of drugs in parts of Western Europe, the age of most servicemen and women and the changing mores regarding drug use in our society, and it becomes clear that we are not going to avoid the problems of drug use. The question is how we can minimize it. In order to more effectively deal with the problem of drug use among the military, the Secretary of Defense should assume a strong leadership role. There must be a strong and aggressive policy setting and policy oversight responsibility in the Office of the Secretary to assure that the problem of drug abuse is given a high priority, as well as all necessary resources. Over the past five years, there has been a reduction in resources allocated to the DOD Drug and Alcohol Office. Both the number and grade levels of personnel assigned to that Office have been reduced, as has the organizational placement of the office. A

recent DOD Health Council study addressed these issues and we are in agreement with their general recommendations regarding the necessary increase in resources and staff for the Drug and Alcohol Office.

The most important step we can take at this time is to develop a valid, accurate and reliable information system to evaluate the nature and exent of the drug abuse problem among the Armed Forces. There are two key elements to such a system: random urinalysis and an integrated survey effort. However, the current Congressional prohibition on random urinalysis denies both the DOD and the Military Departments a fundamental and reliable tool for independently assessing drug abuse within the Armed Services. To deny Defense the option of using the random process deprives the Department of a major management alternative which it must have.

We are convinced of the efficacy of random urinalysis as a deterrent, based on the overwhelming experience both within DOD and among parole and probation programs. In this light, one of the important research initiatives that the DOD has indicated it is going to undertake is a study regarding the effectiveness of the random urinalysis program. This study should help to clearly measure the degree of deterrence with exists in the random process.

Concerning the impact of random urinalysis on the morale of the troops, the majority of the enlisted men and women with whom I spoke on my recent trip to Europe did not object to the random system, as long as everyone participated. A good number of them readily welcomed the tests because they were concerned about drug use among their peers. The majority of the line supervisors with whom I spoke also welcomed random urinalysis. In fact, they would prefer to be directed to conduct random tests, rather than having to select, and appear to prejudge, those individuals to be tested.

Mr. Chairman, you asked for specific legislative recommendations to strengthen DOD's efforts in the drug abuse area. This Committee could be most helpful if it would request the House of Representatives to withdraw the current prohibition on the use of random urinalysis. This would allow the DOD simultaneously to utilize random urinalysis in areas of high drug availability and risk and to go forward with its study of the effectiveness of random urinalysis.

We will be working closely with the DOD to resolve the problems of drug abuse among the military. I will be returning to Europe within the next several months to follow-up on the situation. I look forward to the results of the Committee hearings and would be more than happy to meet with members of the Committee to discuss the issue further.

Mr. Chairman, that concludes my testimony.

PREPARED STATEMENT OF DR. ROBERT SMITH, FORMER ASSISTANT SECRETARY FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Mr. Chairman and distinguished members of the select committee, I deeply appreciate your invitation to discuss with the committee the recent trends in top-level DOD management as they impact on health related matters and specifically on the DOD drug and alcohol abuse prevention programs. I share with you an anxiety about the recent trends in the level of support given to all areas of health care and preparedness in the DOD.

As you know, this hearing was first scheduled for 14 October 1977, and subsequently postponed. Since that time, I have resigned as Assistant Secretary of Defense for Health Affairs as of 8 January 1978 for personal and political reasons, and am again practicing medicine in Toledo. However, my interest in and support of military medicine is as keen as ever.

In your letter, you asked me to respond to 9 different subject areas. I intend to group those subject areas so that I may respond first to the overall assessment of our current capabilities to meet our peacetime and mobilization medical responsibilities (subject 5); second, to respond to the present attitude toward health matters in DOD (subjects 1, 2, 3, and 4), and third and lastly, to respond to subjects 6, 7, 8, and 9 in regard to drug and alcohol abuse in the military.

My assessment of the present quality of medical care within the military structure is that technically and scientifically it is good, but quantitatively we cannot meet our peacetime responsibilities and we are woefully short of our mobilization needs—even for a limited contingency. Let me quote portions of a letter which I sent to Secretary Brown on the eve of my departure from the Defense Department:

"I wish to express my appreciation for the opportunity to have served the Department of Defense as Assistant Secretary of Defense for Health Affairs from August 30, 1976 to January 7, 1978. My association with all those who have been striving to

promote an adequate system of health care for mobilization and national defense contingencies and for the men and women of the Armed Forces, their dependents and the retirees has been a challenging experience."

"I would be remiss, however, if I did not say to you at this time that, in my judgment, the resources—particularly personnel resources—allocated to health care by the Department of Defense are not adequate even for our present peacetime situation; they are woefully inadequate to meet possible wartime situations. For a considerable period, the devoted medical personnel of the Armed Forces have been required to assume a posture of 'can do' with less and less resources to the point where this does not make sense. The results can only be further deterioration. Present arrangements are not adequate to attract and retain the needed medical professionals or to maintain the high quality medical care that the men and women of the Armed Forces and their dependents deserve.

"I recognize the present budgetary crunch and the high cost of weapons and weapons systems and of the need to improve our military capability; but people, their well-being and their morale cannot be sacrificed in the process since they, too, are essential to the achievement of an increased capability."

My letter is supported by a memorandum, dated 20 February 1978, from General George Brown, Chairman of the Joint Chiefs of Staff, to Secretary Brown which reads in part "I have read, with great interest, the comments of Dr. Robert N. Smith, the former ASD (HA), in his letter to you, 6 January 1978. The points concerning inadequate medical resources, particularly personnel . . . are supported by the Joint Chiefs of Staff."

The memorandum continues "presently, an assessment of the medical capabilities to support war plans is underway with that portion pertaining to a conventional NATO conflict near completion. We have progressed sufficiently with our review to support Dr. Smith's statement that shortages in medical resources exist." Finally, the memorandum recommends "sufficient medical manpower must be authorized to provide adequate medical care for our people while imposing normal work demands on medical personnel."

In summary, the bottom line is that DOD must provide more financial support, more personnel (professional, technical and support) and improved facilities if the military health services system is to meet its medical responsibilities.

The status of health care first discussed is a reflection of the attitude toward health care matters in the Defense Department today (subjects 1, 2, 3 and 4). The basic problem, it seems to me, is that there is no firm commitment to having an effective health care program. May I illustrate by describing, as I see it, the atmosphere relating to health within the DOD.

When I arrived in 1976, Health Affairs was authorized 47 persons. I was successful, under the previous administration, in establishing the DOD health council supported by six additional persons assigned the council's activities. I had direct access to the Secretary of Defense's office. Clearly, in the new administration, there was a decreased emphasis on all health matters to include drug and alcohol programs. Our authorization was cut from 47 to 33 or a 30 percent cut. Additionally, upon my departure, the staff supporting the council was eleminated. Adding these individuals to our other personnel cuts, we had nearly a 40 percent personnel loss within a one-year period. It was and is my judgment that to do an effective and credible job in health an authorization in excess of 53 is required.

In addition to personnel cuts, I was not permitted direct access to the Secretary or Deputy Secretary. I was required to report through the Assistant Secretary for Manpower, Reserve Affairs, and Logistics. This was and is extremely cumbersome and caused prolonged delays in many actions. Finally, there was the effort to downgrade the office to a subordinate of MRA&L. To summarize, it is clearly difficult, if not impossible, with the lack of interest and inadequate resources for the Health Affairs Office to have any new effective health initiatives. It is extremely difficult to work in a state of chronic anxiety over what next may happen to Health Affairs and to keep your "head above water" on the day-to-day matters.

The lack of support for the Health Affairs Office affected the performance of each of its component offices of which ODAAP was one.

There are four professionals presently assigned to ODAAP. They no longer have a Secretary, as I had to eliminate that position in the recent 25 percent DOD staff reduction in order to protect the professional capacity that exists. I have no complaints with the quality of the present staff, they are excellent men, but there simply are not enough of them to do a proper job. They operate in a totally reactive mode to the outside pressures of DOD, the military departments, Congress, and the White House. They have not the time to do the long range and innovative planning and execution of initiatives that could improve the significant problems of drug and

alcohol abuse in the military. A recent congressionally mandated defense health council study of ODAAP recommended that creation of a short term task force and expansion of ODAAP staffing from 4 to 10 in order that the problems of substance abuse be effectively addressed. No one in the DOD or the military departments agreed with or supported this recommended increased effort to combat drug and alcohol abuse in the military. For the moment, ODAAP is doing the best it can with what it has available. It could be so much more!

During the time the random urine testing program was going on, the DOD probably had the most accurate assessment of the extent of drug abuse in a given large population that was ever available in the United States, or anywhere in the world, for that matter. We still get good information on the kind of drugs being used, which drugs and their frequency that lead to hospitalization or death. Without random testing, the level of detection of drug abuse, which does not otherwise come to anyone's attention, has fallen. Thus, I feel there is underreporting; but I do not know how much. It could easily be 100 percent. The existing cooperation with and reporting of that testing which is still done by the military departments is entirely satisfactory.

Drug abuse, while reduced from the epidemic proportions of the Vietnam era, continues to be present. The highest levels are less than 5 percent detected users; the actual use runs higher, but I am not sure anyone knows just how much higher. As far as I am concerned, any use, whether drug or alcohol, is too much and has an adverse impact on personnel and unit effectiveness. The extent of deterioration and criteria for its evaluation are exclusive. In years gone by, the conventional wisdom was that an infantry unit that had lost 30 percent of its men was no longer considered combat effective. Obviously, this empiric point was preceded by a curve of diminishing effectiveness. In today's combat of increasing technical intricacy, I think this figure is too high. The effects of abuse hinge on the drug used and its particular effects, the amount and frequency of use, and the timing of use. The effects could range from none to inability to muster to mistakes leading to personal death or injury or to critical tactical decision mistakes that could hazard entire units. Woven into this are the related but yet distinct intangibles of morale, leadership and effective exercise of command. It is unreasonable, in this day and age, to expect that we can eliminate drug abuse, but we must do everything we can to eliminate it. We may not find out the real answers to combat effectiveness until it is too late in a literal trial by fire.

From a technological and scientific point of view, I think military medical care is excellent. Our outdated facilities are being replaced and modernized, though perhaps not as rapidly as we might like. I think the caliber of our health personnel is generally excellent. However, the quantity of personnel is not satisfactory, and this has a direct impact on how our beneficiaries view the quality of care. Depending on time, the location and the health care specialty involved, there are not enough people to take care of everyone with the same range of services we formerly offered. At times, people, in their efforts to continue to help everyone, extend themselves and staff too far; and the quality of care suffers.

Our patients view this legitimately as a reduction in the quantity and quality of care available to them. In addition, our beneficiaries are very vocally critical of the increasingly expensive (to them) alternative of CHAMPUS. Nowhere is this a greater problem than in our clinics, dispensaries, outpatient departments, and emergency rooms. We simply cannot continue to provide the same amount of high quality care everyone expects without adequate personnel. In addition, several of our hospital based physician specialties are in critically short supply, such as radiology and obstetrics and gynecology, which has led to the curtailment of services and expensive alternatives, such as contracted radiology services.

PREPARED STATEMENT OF VERNON MCKENZIE, ACTING ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

I appreciate the opportunity to appear before your committee this morning to discuss drug abuse in the Armed Forces. I am accompanied by Mr. E. D. Schmitz, Chief of our Office for Drug and Alcohol Abuse Prevention and Mr. James F. Holcomb, Director for Identification, Program Evaluation and Research in that office

I am in receipt of you recent letter in which you specify a number of issues and questions upon which the committee wishes to focus. With your permission I will list each issue of question in turn, and then provide and answer or comments.

Certain aspects of the drug abuse problem deal with functions which do not fall under the responsibilities of my office. In order to be completely responsive in all

areas, therefore, I have asked representatives of the other responsible offices to be present to provide information in their areas of expertise and responsibility.

Following are the issues/questions and our comments or answers: 1. Discuss the recent top-level managerial approaches to the handling of the Office of the Assistant Secretary of Defense (Health Affairs) in general, and the Office of Drug and Alcohol Abuse Prevention in particular.

Answer: Although the Secretary of Defense has not testified personally before this committee regarding his management approach to handling the Office of the Assistant Secretary of Defense (Health Affairs), he has gone to great lengths to keep Congress informed of all of his organizational initiatives including those affecting the health affairs function.

On April 7, 1977, Secretary Brown submitted to Congress a legislative proposal to disestablish on of the two authorized Deputy Secretaries Defense and the Director of Defense Research and Engineering, and establish in their place two new Under Secretaries of Defense, one for policy and the other for research and engineering. This legislation did not directly affect the Assistant Secretary of Defense (Health Affairs). However, in a letter to the chairman of the Senate Armed Services Committee on May 17, 1977, testimony before the Subcommittee on Investigations of the House Armed Services Committee on May 23, 1977, Deputy Secretary Duncan explained the intent of the legislation and outlined a number of complementary actions either being implemented or under consideration to further streamline the Office of the Secretary of Defense. On both occasions he indicated that one of the actions under consideration was a proposal to transfer the functions of the Assistant Secretary of Defense (Health Affairs) to a new Deputy Assistant Secretary (Health Affairs) reporting to the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics). The head of the health affairs function has been reporting to the Secretary of Defense through this Assistant Secretary since 1976. This proposal would have integrated health programs even more closely into the overall manpower program. This possibility was again relayed to Congress by the Secretary of Defense as part of the DOD Annual Report for Fiscal Year 1979, Dated February 2, 1978.

Subsequently, on February 2, 1978, pursuant to section 125 of title 10, United States Code, the Secretary forwarded to Congress a Department of Defense reorganization order which, among other things, reflected his decision to restructure the health affairs function along the lines described above. His reasons for pursuing this course of action were outlined in the transmittal correspondence and later discussed in detail, on March 3, 1978, with Chairman Stratton and the members of his Investigations Subcommittee.

Subsequently, after considering the objections of the subcommittee, the Secretary withdrew the reorganization order and on March 7, 1978, submitted to Congress a new version of the order which deleted all reference to health affairs. He now intends to continue the relationship which has existed since 1976. That is, the Assistant Secretary of Defense (Health Affairs) will report to him through the Assistant Secretary of Defense (Manpower, Reserve Affairs. and Logistics).

In regard to the Office for Drug and Alcohol Abuse in particular, this recent top level management approach has had no direct effect.

2. Discuss the status of current resources available to the ODAAP for exercising new major policy initiatives and for developing and supervising consistent, uniform and successful drug programs within the individual services.

Answer: Present resources in the ODAAP are adequate for devising new policy initiatives and for up-dating old policy.

If the ODAAP were charged with developing and supervising drug programs within the military services, then the current resources would not be adequate.

In general, there are adequate resources to support the ODAAP and any new initiatives which it may undertake.

3. What is the extent and nature of the Armed Forces drug problem as DOD has determined it since the Arthur D. Little Study of 1975?

Answer: We 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.

With few exceptions the military drug abusing population consists of the enlisted men or women in the 18–25 year old age group. They seem to use drugs primarily for recreational purposes while off duty. The most prevalent drugs of abuse 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 among Army personnel and amphetamines on Air Force

bases. In the United States we see nearly everything; use of LSD is down, but use of PCP and cannabis is on the rise.

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 lonely and 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 U.S., these are the conditions that prevail.

Our ability to assess trends quantitatively is limited; we are not as knowledgeable as we would like to be. However, we expect that a survey effort which we recently initiated will give data on trends, by service, by geographic area, and by drug of abuse.

To briefly summarize, we consider that the problem of drug abuse among our servicemembers is serious enough to warrant our continuing concern and effort.

4. What steps has DOD taken to standardize the reporting procedures of drug-related data from the various services?

Answer: Drug data reporting procedures were standardized through the issuance of several DOD instructions. These regualtory documents provide the instructions and formats to the military services for the reporting of the following: (*a*) Disciplinary actions taken for drug abuse offenses; (*b*) Administrative discharges for drug abuse; (*c*) Drug abusers detected by urinalysis; (*d*) Rejection of drug abusers at Armed Forces examining and entrance stations; (*e*) Drug abusing recruits detected by urinalysis; (*f*) Servicemembers entering treatment and rehabilitation for drug abuse; and (*g*) Drug abusers volunteering for assistance under the exemption policy.

Copies of these DOD instructions are provided for the record as exhibits 1, 2 and 3 respectively.

5. What are the tools currently employed by DOD to identify drug abuse within the Armed Forces, and are there any new alternative methods currently under study?

Answer: The primary means by which drug abusers in the military services are identified today are by: (*a*) Law enforcement and investigative agency activity; (*b*) Commander and supervisor referral; (*c*) Medical referral; (*d*) Urinalysis; and (*e*) Self referral.

At present a portable kit for testing urine samples for posible drugs of abuse has successfully completed its field tests. The potential for use of these kits in the field has been found to be so promising that we are now working on a protocol to guide service elements in the proper employment of the kits.

The kits lend themselves to use in situations where quick results are required or where it is inconvenient for a service element to use our established laboratories, e.g., at Armed Forces examining and entrance stations, aboard ship, and in units on duty in isolated locations.

6. Provide an assessment of the effectiveness and reliability of those identification tools utilized by DOD to monitor and evaluate its drug problem, with particular emphasis on the benefits of commander directed urinalysis when compared to the defunct random program.

Answer: The typical drug abuser is a devious individual—he doesn't want his drug activity known and so, normally he goes to great pains to keep his habit secret. For this reason the assessment of abuse in the Armed Forces can never be a precisely known figure. However, there are many indicators which, when considered singly, offer little substantive information, but when considered as a group, can provide a reasonable picture of the drug abuse situation. By observing all available indicators together, rough trends can be detected, drugs of choice identified.

One means of obtaining drug abuse data is through use of the personnel survey. We periodically sponsor worldwide, all-service surveys to obtain comparable trend, prevalence and program data. In September 1977, we let a contract to have the preliminary work accomplished for our next survey. That work has progressed to the point where the survey instrument is almost completed. The next phase is to administer the instrument and then analyze the results.

There are a number of other indicators available which we collect, display and consider in our deliberations on the extent of the problem. These types of data are listed below: (*a*) Results of urinalysis screening; (*b*) Number of rejections for drug abuse at Armed Forces entrance and examining stations; (*c*) Number applying under exemption policy; (*d*) Number in treatment/rehabilitation for drug abuse; (*e*) Administrative discharges for drug abuse; (*f*) Disposition of drug abusers under the Uniform Code of Military Justice (UCMJ); (*g*) Army Criminal Investigation Command report of drug statistics; (*h*) Army Provost Marshal report of drug offenses; (*i*) Naval Investigative Service report of individuals in completed narcotics cases; (*j*) Air Force

Office Special Investigations Report of Narcotics Investigations; and (*k*) Active duty military personnel admitted to Veterans Administration drug dependence programs.

Where specific areas of the world are of particular concern, e.g., Europe, data are collected where possible by service for that specific area.

Publications from other agencies are also received and examined for information of trends and prevalence. We obtain the following documents from the National Institute on Drug Abuse: (*a*) Drug abuse warning network statistical summary; and (*b*) NIDA statistical series quarterly report, data from the client oriente : data acquisition process.

From the Drug Enforcement Administration we receive and study: (*a*) DEA weekly Digest of Narcotics Intelligence; (*b*) DEA quarterly intelligence trends; (*c*) Drug Enforcement statistical report; (*d*) DEA performance management system report; and (*e*) DEA special purpose reports, e.g., *alternative sources to Mexico for heroin supply to North America and Europe.*

The U.S. Joint Publications Research Service also provides a weekly volume of translations on narcotics and dangerous drugs which is reviewed.

The judgment on the extent of the problems, trends, etc., is obtained quantitatively from analyzed survey data. We doubt that we will ever be able to provide precise numbers with a high statistical confidence level on the extent of the various elements of the drug abuse problem, but we feel confident that we do know where we have our most serious problems and what drugs are involved.

Commander directed urinalysis is proving to be more effective than random urinalysis, test for test, in identifying drug abusers. Commander directed has the advantage of being selective of those tested whereas random was not, and it is less expensive. Both types detect drug abuse, identify drug abusers early in their involvement, and serve as a visible component of the drug abuse control program. Random was more difficult to administer; on the other hand, local commanders do not like the onus placed on them of having to select those to be tested.

7. Are there additional reporting procedures utilized by DOD to measure the ongoing nature and extent of its drug abuse problem? What are the criteria by which DOD determines when there is a sufficient amount of drug abuse so as to have a negative effect on combat readiness?

Answer: All of the reports used by the DOD to measure the extent of drug abuse were described in the answer to the previous questions. They are the urinalysis, exemption, rehabilitation, discharge, UCMJ, law enforcement, VA, NIDA and intelligence reports which were mentioned earlier. In addition, we have initiated work to have all available data integrated into an index of drug abuse, much like the consumer price index which will, over time, give us a measure of drug abuse trends by service, geographic area and type drug.

We have not developed specific criteria to measure the impact of drug abuse on combat readiness. There are established systems for determining and reporting the overall levels of combat readiness of units, including personnel and equipment. Units also participate in tests, alerts, exercises and maneuvers to assess their state of readiness. Although these do not address the effect of drug abuse per se, they do evaluate ability to perform missions. While we know that drug abuse can effect individual behavior and performance and therefore impact on ability to accomplish military assignments, we have not had reports of combat readiness degradation due to drug abuse.

8. What is the position of DOD regarding the future of the in-house drug-related military specific research projects? What is the current status of interagency efforts between DOD and NIDA to begin implementation of selected projects?

Answer: Our position is that the interpretation of the wording on pages 277 and 278 of House Report No. 94-517 regarding military medical problems, when taken in the drug and alcohol abuse context, permits the military departments to engage in scientific study and experimentation directed toward increasing knowledge and understanding in those biological-medical and behavioral-social areas of drug and alcohol abuse control which are peculiar to the military profession. For example, research into the effects of drugs and alcohol on the performance of service members performing typical military tasks is considered to be the type of work which the Armed Forces can properly undertake. On the other hand, we believe that research which provides fundamental knowledge for the solution of identified medical/behavioral technologies and of new or improved functional capabilities in the personnel support area—knowledge and capabilities which have relevance equally to civilian as well as to military abusers is available from the National Institute on Drug Abuse and need not be pursued by the Department of Defense. Studies of addiction mechanisms fall into this latter category. The Department of Defense also considers the report wording to permit general purpose data collection, i.e., activi-

ties that include routine product testing and monitoring activities, quality control, surveys and collection of general purpose statistics. Consequently, the military services have continued to engage in general purpose data collection and analysis of the data collected. This interpretation was disseminated to the military departments with the request that they seek funding for projects which fall within the acceptable limits of the interpretation. To date, interagency efforts between DOD and NIDA to implement selected R&D projects have not actively begun. DOD is awaiting a response to its letter which forwarded a request to Alcohol, Drug Abuse and Mental Health Administration that ADAMHA assume responsibility for certain drug and alcohol abuse R&D projects.

9. A review of those drug-related studies performed by the Department of Defense prior to fiscal year 1976 indicates that a significant research effort was completed on both the rehabilitation of drug users and, in selected cases, on the effects of drugs on military performance. Based on the large number of these projects completed, the Appropriations Committee questioned the need for additional efforts in 1976. The GAO report: *"Alcohol abuse is more prevalent in the military than drug abuse,"* (April 8, 1976 MWD-76-99), states, "The use made of the drug (and alcohol) studies has not been apparent." What was the mechanism of informational transfer utilized by DOD when findings from these studies were significant and how were they operationalized in drug treatment on the service level?

Answer: Work completed was reported in the R&D literature and disseminated; it was also presented in lecture form to the appropriate audiences. When R&D work reaches the point where it can be translated into guidance to the field it is published in one of the standard forms of guidance literature which the services routinely issue. An example is the guidance developed and issued to physicians to aid in recognizing drug abuse in a clinical setting. That guidance reached the field as a Department of the Army technical bulletin, a Department of the Navy publication, and a Department of the Air Force pamphlet, all standard publications within the respective services for providing guidance to medical officers. The DOD also avails itself of R&D completed and translated into operational usable form by other agencies; for example, NIDA sponsored the research and preparation of the research results in a volume entitled, *diagnosis and evaluation of the drug abusing patient for treatment staff physicians.* The volume was then printed and distributed to military physicians worldwide through the services distribution system.

10. What is the status of the drug and alcohol abuse prevention action plan prepared by the Office of Planning and Policy Analysis in December 1977?

Answer: Upon completion of the plan, it was staffed with the military services and pertinent DOD staff agencies. The plan recommended an expansion of the mission of our drug abuse office and consequent increases in personnel. To carry out these recommendations would have been in conflict with the management philosophy of the Secretary of Defense that we not manage the service programs, but limit ourselves to policy guidance and coordination. It was therefore decided to implement the recommendation to establish a DOD Drug and Alcohol Abuse Advisory Committee composed of members of the ODAAP, the Military Departments, the ASD(MRA&L) and the Veterans Administration. This will improve communication and coordination within the management philosophy and resources.

11. How does DOD intend to formally respond to the recommendations in the November 1977 Department of Defense drug abuse assessment review group report for the Office of Drug Abuse policy?

Answer: The formal response to the assessment review group report appears at exhibit 4. In general the DOD agrees with the recommendations presented by the review group to devise assessment systems using existing indicators and surveys, to identify needed research and proceed with its implementation, to address drug abuse among Military Departments and the defense civilian work force, to better inform DOD management of the drug abuse situation and to review resource levels. The DOD does not concur in the recommendations to ask Congress to remove its ban on random urinalysis and to use urinalysis in conjunction with the survey to obtain trend data.

12. What special measures are DOD and the services using to cope with the placement of personnel in areas where the potential for a heroin epidemic is greatest, such as in Germany or in the Pacific theatre?

Answer: Prior to dispatch overseas, all services screen their service members to insure that those selected for deployment are not known drug abusers—personnel in rehabilitation are not sent to an overseas station until they complete the full course of rehabilitation, including follow-up, successful. Briefings on the drug situation are provided before and after deployment overseas and at regular intervals thereafter.

13. Have there been any efforts by DOD to promote law enforcement intelligence work between the service intelligence divisions and DEA or Customs?

Answer: The relationships of DOD law enforcement personnel with those of the drug enforcement administration and the U.S. Customs Service can be described as close, continuous, cooperate and on a first name basis. The free exchange of criminal information and the cooperative assistance rendered in collection operations to gain criminal information is "business as usual" and typical of the relationships our investigators enjoy with other Federal agencies including DEA and Customs. This cooperation takes the form not only of sharing information, but in conducting reciprocal and joint investigative work in matters of common interest. This close cooperation is extremely important because the bulk of exchange of narcotics intelligence occurs at the local or operational level. In this regard, the Army is planning to assign a full-time agent to the DEA El Paso Intelligence Center (EPIC) as part of a continuing effort to enhance the exchange of information and the overall drug abuse law enforcement effort.

In pursuit of DOD efforts to promote law enforcement narcotics intelligence work, the Defense Intelligence Agency has issued narcotics intelligence collection requirements to DOD collection elements throughout the world. These collection efforts are on an opportunity basis and are not limited as long as they are lawfully conducted, directed at foreign intelligence targets and not performed in a manner detrimental to the military intelligence mission. Service intelligence and counterintelligence collection agencies supporting this effort have been urged to coordinate their narcotics intelligence acquisition activities with the military service criminal investigative offices. This cooperation includes lateral transfer of information and investigative leads for further exploitation.

Finally, as you requested, these are my goals for the coming year—

To reduce the amount of hard drug use and the number of frequent cannabis users by at least 15 percent.

To continue reduction of prescriptions for barbiturates and other sedative-hypnotic drugs.

To reduce the demand for drugs by convincing our young service members that drug abuse is not a solution, but a problem, and there are numerous excellent, less costly alternatives to whatever they seek in drugs.

To have the portable urinalysis test kit fully operational.

To improve and expand the use of commander-directed urinalysis, including its use in connection with accidents and incidents to determine whether drugs were involved.

To apply the results of the personnel survey to improve the education and identification programs.

To train all supervisors in the means of identifying and referring probable drug abusers.

To expand use of early intervention techniques for first-time cannabis users, using an intensified educational approach.

To work with the strategy council in developing a government-wide research plan and a uniform data collection system.

To install an improved reporting system for periodically informing management of trends and problems in drug abuse.

To capitalize on the knowledge and expertise of the DOD Drug Abuse Advisory Committee to improve communication and coordination.

We expect the accomplishment of these goals to give us a better knowledge of the extent, trends and patterns of drug abuse, reduce the amount of drug abuse, increase the effectiveness and efficiency with which we identify drug abusers and help us coordinate and communicate efforts with internal and external organizations. While we do not expect to eliminate drug abuse in the foreseeable future, the military services are operating sound programs which they continue to refire in order to cope with this complex problem. My hope is that we will see a significant decline in drug abuse to levels well below those in the similar civilian population.

This concludes my prepared statement. My colleagues and I will be happy to answer any questions you may have.

DRUG ABUSE IN THE MILITARY

WEDNESDAY, MAY 24, 1978

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

The Select Committee met, pursuant to notice, at 10:20 a.m., in room 2118, Rayburn House Office Building, Washington, D.C., Hon. Lester L. Wolff (chairman of the Select Committee) presiding.

Present: Representatives Paul G. Rogers, James R. Mann, Glenn English, Leo C. Zeferetti, J. Herbert Burke, Tom Railsback, Robin L. Beard, Benjamin A. Gilman, Tennyson Guyer, and Joe Skubitz.

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

Mr. WOLFF. The committee will come to order.

Our study of drug abuse in the military continues this morning with testimony to be taken from representatives of the U.S. Army. Testimony taken April 27 from the Acting Assistant Secretary of Defense for Health Affairs, Vernon McKenzie, centered principally around the issue of DOD policy and resource allocations in the drug abuse field.

The present program in DOD relies on the Department to establish policies and priorities, while each individual service is responsible for implementing a drug abuse program.

In all candor, I must say that the testimony which we received at our initial hearing into this subject was less than satisfying. I certainly am not reassured that the Department of Defense has a vigorous, forward-looking drug abuse program.

We were told that there are only three persons in the entire Department who work on this subject. How that degree of commitment can be expected to foster an effective and vigorous drug abuse program is really beyond me. I am profoundly concerned that the individual services are being given inadequate direction and very little assistance in identifying existing problems or devising appropriate responses.

I share the view of the Task Force Coordinator, Mr. Glenn English, that we must recieve testimony from the Secretary of Defense, who is ultimately responsible for the entire program, both in policy matters, the very basic elements that are involved in the coordination of our efforts in all services, and as well resource questions and in overseeing the individual services implementation of those programs.

To this morning's witnesses, I would say that the committee has two major concerns:

First, of course, we are concerned with the human issue of drug abuse. We want to know the extent of drug abuse in the Army and the nature of the specific Army programs which are designed to address that threat.

Our second question is much more difficult to address because it deals with a concept; the concept of readiness of our fighting forces and the impairment thereof if there is significant drug abuse.

Drug abuse in the Army unit affects morale, it affects discipline, health, and the ability of the drug-abusing soldier to perform vital duties.

I have asked the witnesses to tell us how much drug abuse there is in the Army, but I don't think they will be able to do that. I don't think anyone would be able to do that. We simply know that it exists in all areas with certain high-risk areas being more severely impacted than others.

None of the forms which the Army fills out every day concerning readiness contain a subject heading of "Degradation of Readiness Due to Drug Abuse." But that there is some impact cannot be denied.

The important element, I think, that is involved here is how the amount of drug abuse within the military exists, how this affects the security interests of the United States. To my mind, it is a very serious threat to our security.

And there is great concern by this committee as to whether or not the very basic security interests are being addressed in the amount of activity and the amount of effort that is being employed by our Defense Department in handling this problem.

It seems to me that there have been a number of instances where the military itself, the people, the field commanders, and the heads of our individual services, have required and requested the opportunity to put into action various programs that they feel are necessary to control this problem.

These have met with rejections upon the part of the policymaking officials within Government and also by the people who are out of Government who might declare that certain measures that have been recommended might impair the civil liberties of the individuals involved.

I am a civil libertarian, but I am always one that understands the threats to the defense of our Nation. And I think this is a very serious threat that we face.

And, therefore, with that in mind, I welcome you gentlemen to the witness table. But before proceeding with your testimony, I want to recognize the chairman of the task force, Glenn English, for any statement which he may wish to make.

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

As we start our second day of hearings into drug abuse in the military, I would like to take a moment to assess the information which we obtained on April 27 during the appearance of Acting Assistant Secretary of Defense for Health Affairs, Vernon McKenzie, and Deputy Special Assistant to the President for Health Affairs, Mr. Lee Dogoloff.

I think that rather than answering questions, that hearing posed several issues which remain unresolved before this committee. Most central, of course, is the question of the attitude of the

Secretary of Defense toward commiting resources in the drug abuse field.

Present resources are obviously inadequate at DOD, but Mr. McKenzie testified that they are all the Secretary wants.

He said that the Secretary's philosophy toward dealing with drug abuse did not warrant having more than three employees in DOD working on the subject.

As you know, we have made repeated attempts to convince Secretary Brown to appear before us so that we could have the opportunity to explore his reasoning. Our first request went out to him in February of this year, and there has been yet another one pending on his desk for weeks.

I will take this opportunity to extend yet another invitation to Secretary Brown.

Proposals from the Secretary that we accept alternative witnesses are clearly unacceptable. We tried that. The witness simply told us that all he could do was to try to reflect the Secretary's philosophy. It is this lack of interest on the part of the Secretary that appears to be hampering the ability of each service to mount a worthwhile and consistent attack on their drug and alcohol abuse problems. It is time to speak to the Secretary.

Let me proceed to the purpose for today's hearing. We are receiving testimony from the U.S. Army concerning its management and operation of drug abuse programs. The Army is rather unique today in that both in Korea and West Germany, they stand face to face against a hostile and armed enemy.

They are our first line of defense against a conventional attack anywhere in the world. Weapons that the Army has today are more complicated and technically demanding than ever in the history of mankind.

And there is a drug abuse problem in the Army.

No one disputes this point, but we have gotten wildly varying estimates of the degree and impact of drug abuse in the Army. What bothers me is that no one knows with any degree of certainty how many drug abusers there are, what kind of drugs they are abusing, or what their impact would have on combat readiness if the Army was called into the field today.

This task force has visited Army installations around the world. We have seen the situation in Berlin where 40 percent pure heroin is available on the streets to any GI who wants it.

In fact, the only commodity that appears to be cheaper in Berlin than in the United States is heroin. Not only is it cheaper, it is 800 percent more pure. Tragically, many of them are buying and using it.

In the United States, we have seen indications that drug abuse is again on the rise, although more slowly than in Germany. In Korea, where armed incidents along the DMZ are not uncommon, where tension is at a very high point every day of the year, we heard of substantial abuse of pills and alcohol.

Let me emphasize that, in my opinion, the Army does not create drug abusers. Drug abuse is rampant in our society. Life in the Army is not easy, however, and factors such as loneliness, boredom, inadequate training, social isolation, peer pressure, and inadequate

pay abroad go far toward creating a climate where narcotics abuse will flourish.

The Army has changed visibly in the past 4 years. The all-volunteer concept has had a dramatic impact, reducing the number of soldiers which we have, and causing the average mental level of the soldier to decline.

The Army is often an employer of last resort where, according to the Beard report, many of society's "losers" try to find a job. Almost 50 percent of the young soldiers entering on duty do not complete their first tour.

What this all represents is a general decline in morale. It is not necessarily the fault of the U.S. Army. But it is the plain truth.

We ask our witnesses today to describe for us the response of the Army to the problem of drug abuse. What are your priorities? Indeed, exactly what is the situation which you are attempting to address? Can you define it? Are you confident that your information is correct?

If Gen. George Brown, Chairman of the Joint Chiefs of Staff, is correct about the degradation of medical services in Europe affecting our readiness, and if former Assistant Secretary of Defense for Health Affairs, Dr. Robert Smith, is correct about the continuing degradation of DOD's commitment to provide medical services, then where does that put us with regard to readiness in Western Europe or anywhere else in the world?

Drug abuse is on the rise according to Army surveys in Europe. If we do not understand how much drug abuse there is now, but it continues to rise, how long can we call drug abuse the "invisible" factor in evaluating readiness?

I would like to also state an observation on my own. That is, namely, that the Army is the best of the services in terms of attitude and effort in dealing with their drug abuse problems. But I would like to also state that for the most part, the Army has been very cooperative with this committee and that cooperation is very much appreciated.

I am looking forward with great anticipation to the statements of today's witnesses.

Thank you, Mr. Chairman.

Mr. WOLFF. At this point, I should like to have the consent to include in the record the statement of the ranking Republican member of this committee, Mr. Burke, with reference to his own investigation in Berlin. If you will make it part of the record at this point; and also include a greeting from Mr. de la Garza, who is unable to attend these hearings.

[Mr. Burke's remarks and Mr. de la Garza's prepared statement follow:]

REMARKS OF HON. J. HERBERT BURKE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, in the course of working with the Task Force on Drug Abuse in the Military, I had the opportunity to personally inspect the situation in Germany, and in Berlin in particular. I wish to express my appreciation for the Army's help and cooperation during these inquiries.

As a result of my investigation in Berlin, I have become deeply concerned over the long-term implications of the relatively recent influx of near eastern heroin into that city. There is not only a potential for severe heroin addiction among our

soldiers stationed in Berlin, but also the possibility of the establishment of heroin trafficking routes from that area.

Because of the political and economic situation in Berlin, heroin is permitted to flow in almost unchecked. Young Turks, many who are in Berlin illegally, transport large quantities of heroin from East Berlin, where customs checks are minimal, into West Berlin with the aid of the extensive subway system. This underground network is a veritable gateway to the free world. The heroin is stored in any one of the almost 200 subway stations in West Berlin, and is brought out in small quantities for street sale. Small amounts of heroin can be bought on most street corners and subway stations with virtually no active soliciting on the part of the buyer. Large quantities, however, can be purchased when prior arrangements are made. Once the heroin has reached West Berlin, the remainder of Western Europe and, conceivably, the United States are vulnerable.

I would like to reemphasize that, as Congressman English has pointed out, this is not the same heroin one buys on the streets of New York. It is pure, inexpensive and dangerous. Civilian overdose rates in Berlin have climbed from 6 in 1973 to 84 in 1977. Last year the Berlin Brigade had 4.

How can the Army insure that young soldiers, who often are away from home for the first time in their lives, will not be drawn into addiction by this kind of drug availability? I believe that in addition to prevention programs, stronger deterrents need to be established. In discussions with unit commanders there, I now firmly believe that commander-directed urinalysis can, when used intelligently, weed out those soldiers who are unable to disguise their drug usage. There is, however, no method of reaching both the early experimenter, and those who are highly skilled at hiding their drug usage.

In view of the sensitive nature of our presence in Berlin, I am deeply concerned about the ever increasing heroin abuse rates there. The Army must take firm action to suppress this intolerable activity. I hope that today's witnesses can reassure me of the possibility that the situation will improve.

PREPARED STATEMENT OF HON. E (KIKA) DE LA GARZA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman, it is a pleasure to send greetings to you, other Members, and representatives of the American military, who today consider a problem whose gravity cannot be questioned—drug abuse in our military.

Testimony already heard by the Select Committee indicates that forty percent of our Army in Europe regularly abuses drugs. There are many who believe this figure represents only the tip of the iceberg. No one really knows for certain how widespread drug abuse is.

If we are to plan programs which will effectively curb drug and alcohol abuse in our armed forces, Mr Chairman, we must know the extent of the problem. If we have a fair picture of the nature and scope of the abuse, then what would we do about it? What are the Army's programs in this area? Today we will receive testimony from two members of the military which will address these concerns, I hope.

There should be no doubt about the importance of finding answers to these questions. The Army is America's first line of defense against a hostile enemy, both in West Germany and Korea. The security of our country depends in no small part upon the battle-readiness of our soldiers stationed overseas. And a stoned soldier is a weak soldier.

If drug and alcohol abuse is widespread, if drug abuse in not curtailed—then we are in grave danger.

Having met frequently with representatives of our military, I know that drug and alcohol abuse is a problem which the Army is striving to solve. No one maintains that there is nothing wrong.

Perhaps these hearings will indicate what we, the Congress, and you, the military, can do to help. If inadequate funding is hampering correctional efforts, we should consider greater financial support. If a retooling of military procedure is necessary, the service involved should be open to constructive change.

Indeed, Mr Chairman, this might be an appropriate forum to determine whether the volunteer army, rather that a conscription army, tends to attract a greater proportion of those likely to abuse drugs. Perhaps we should carefully scrutinize the volunteer army concept to see if it remains a viable military entity.

Mr. Chairman, let me conclude my remarks by reiterating my deep concern about drug and alcohol abuse in the military. This disease saps the lifeblood from our national security system, and must be cured.

It is with anticipation, therefore, that I look forward to the statements of today's witnesses.

Mr. WOLFF. I might also say to both of you gentlemen, our thanks to Col. Ted Dolloff who has been very cooperative in working with this committee and providing the committee with liaison with the Army and other forces.

Our witnesses today are Brig. Gen. William Henry Fitts, Deputy Chief of Staff for Personnel, U.S. Army, Europe and 7th Army since October 1977;

Brig. Gen. John Johns, Director of Human Resources Development, Office of the Deputy Chief of Staff for Personnel, U.S. Army.

You have prepared statements. The representation has been made we ask each of you gentlemen to give us your separate statements, and we will proceed with questioning.

I am hopeful that part of this meeting, as soon as a quorum is present, will be able to proceed in executive session because of security concerns that we do have in particular areas.

However, at this point, if you would like to either read your statements or summarize it, either way.

General Johns, if you would proceed first.

I note you have been sworn before and sworn at and sworn to, but we would like to swear you in.

[The witnesses were sworn by the chairman.]

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

General JOHNS. Mr. Chairman, members, of the committee, I am Brigadier General Johns, the Director of Human Resources Development of the Office of the Deputy Chief of Staff for Personnel, Department of the Army.

With me today is, as you stated, General Fitts, the Deputy of Staff for Personnel for the U.S. Army, Europe.

I also have with me Mrs. Gouin, who is the most knowledgeable member of my Drug Policy Branch of my Directorate; Lieutenant Colonel Karney who is the Consultant to the Surgeon General of the Army; and Lieutenant Colonel Reed who is from the Law Enforcement Division of my Directorate.

I will summarize my statement since you have the written version.

I would like to make the point, though, that the witness statement that I have submitted in fact represents my personal views. There was no censorship in any of the staffing of that statement. I will put that on the record.

And I would also say I am personally committed to complete cooperation with this committee.

My comments here are going to cover four aspects of my statement:

Our assessment of the nature of the problem;

A brief description of our alcohol, drug abuse prevention and control program;

An assessment of that program; and

Some plans we have for improvement of our program.

As you have suggested in the committee, the deviant behavior of drug abuse is due to two basic factors:

One, the personality of the soldier; and

Two, the kinds of environment we provide him.

Since the personality is largely dependent on the accessions we have, obviously, that is a very important factor in what kind of drug abuse behavior we have in the Army. We consider that we can influence that in two ways:

One, by the selection of our accessions; and

Two, by some amount of education and value clarification.

However, we believe that the major impact we can have on drug abuse behavior is through influencing environment in which we put people when they come in the Army.

Now, I think you have identified accurately the factors in that environment. They are the loneliness, isolation, the job satisfaction, in many cases the social isolation in overseas areas, peer pressure is certainly an important factor, general alienation of youth toward institutions in the society, and inadequate quality of life. And as might be expected, we try to counteract those adverse conditions by creating a satisfactory climate, good leadership, good challenging jobs, wholesome recreation, and adequate quality of life.

Now, let me address the magnitude of the problem as we see it today. From the time that it was brought to our attention in Vietnam, we have seen during the last 4 years, the time we have accumulated trend data, a steady decline in the use of hard drugs. We have seen a leveling or a continuation of the alcohol abuse and marihuana. There has been no downward trend in the latter two. There has been a steady decline on hard drugs.

On what do we base that? We have several means of detection and measurement, including the participation in our program; including command-directed urinalysis.

But the two that we think are more representative of the abuse in the Army are law enforcement data and personal opinion survey data that we conduct quarterly. Each 6 months, we include items on drug abuse. We have currently six items, six questions, in our opinion survey on drug abuse.

We intend to put four more in this summer, in August. Those four items will allow us to compare our measures with the HEW measures of civilian society abuse, We have not done that to this point.

Now, we have not from that indication there, as I have stated, detected a significant upturn of hard drug abuse Armywide that you have indicated in your study. In local areas, we indicate some change. We do detect some change. And we can identify those trouble spots.

Our data sample of 10,000 per quarter allows us to isolate certain units. In spite of the fact that our data shows that hard drug use is not on the upswing, even with our conservative estimate, we have a serious problem of concern. If you take our figures of frequent use of hard drugs, we are talking about over 10,000 soldiers, and that is obviously a significant problem.

Now, when you talk about impact on morale and readiness, as you correctly stated, that is a tough one. We have wrestled with the concept of readiness in all areas, including equipment status,

training, and so forth. We simply have not been able to make any definitive positive correlation between drug abuse and readiness or morale.

The unit readiness report which is our standard measure of readiness does not include anything on this. There is a section where the commander uses his subjective judgment on personnel readiness and morale. Theoretically, that allows the commander to put in the readiness report an item and assessment of the impact of drug abuse.

In practice, I think it is fair to say that is not done. It is rarely if ever done.

So we are left with a general assessment of the problem today as being a steady decline in hard drug use. It impacts, obviously, on morale and combat readiness to some extent. We cannot say exactly how much.

We do attempt to make an Armywide assessment of the human readiness of the Army. And we publish annually a human readiness report which if you desire, you can have. And it represents our best effort to try to say what is the state of readiness of the human system.

Let me discuss briefly our program, the Army program. It involves both the prevention and treatment. And philosophically, it is a command program, not a medical program.

And we emphasize this because we think that the solution eventually lies in the commander's view and involvement from the grassroots level all the way up.

The medical people do support us; they do advise us. It is a centralized policy and a decentralized implementation. That is the general philosophy of management of the Army today.

We have 1,700 full-time specialists in our program plus the law enforcement personnel and the part-time medical people who work with us as consultants.

Now, the prevention consists of three aspects—education, control, and the healthy environment I talked about.

The education is basically that of dependents, soldiers, and commanders.

The control is exercised by the commanders, law enforcement personnel, and a selection of accessions, people coming in, and the administrative discharge of those who we cannot rehabilitate.

Treatment uses the facilities, the same facilities, for both alcohol and drugs. The caseload has run about 50–50 between drug abuse and alcohol abuse.

We treat active duty personnel and their dependents, the Department of the Army civilians and retired personnel. It is primarily now an outpatient treatment facility.

We do have some inhouse or what we call halfway houses where they can live in, but many of those have been closed because commanders have considered them not cost-effective. We have less than 1 percent of our participants who have to go through detoxification.

We identify abusers through five means:

One is self-referral.

The second one is law enforcement referral.

Another one is supervisor or commander referral.

Another one is medical referral.

And the last one is through command-directed urinalysis.

We monitor this program in my office, the Director of Human Resources Development, with six people that I have in the drug and alcohol branch associated with it. We do it primarily, because of the limited resources—five people in the branch and the division chief—we do it primarily by visiting service schools and looking at the instructions that are given and by visits to the major command headquarters. And other than that, it is only by specific request when someone wants a visit or if we spot a trouble spot, a hot spot, and we manage by exception, by going and taking a look.

The Inspector General also goes out and gives us feedback. That is part of his regular business, to go out and check on the programs.

Now, when we want a more thorough analysis, we have to turn to either a study or a contract. I did this last fall when I took over my present job. I wanted a more thorough analysis of the program to see if my basic instincts were correct.

We now have a thorough contract study by Presearch Corp., and we would expect that result in the early fall. We will make them available to you.

What is our assessment of the Army program? And this, I must say, is tentative pending the results of the study that I just mentioned.

We believe that the spirit of the congressional legislation and Department of Defense directives is reflected in our policy. We believe that for the most part we have dedicated, competent, qualified people in this program—those 1,700 specialists I mentioned.

I consider our treatment and rehabilitation moderately successful. We believe we have a good teen involvement program.

Here are the weaknesses. There is a persistent stigma on drug abuse that hampers our involvement for commanders who are getting people involved in the program.

I said we were decentralized. Our preliminary data from the study we have just conducted, confirms what we suspect, that commander involvement and interest varies from commander to commander. And as a general statement, we do not believe commander commitment is nearly what it should be.

Education programs. We have required amounts for the basic trainee coming in and in the service schools. Often, we find that that is perfunctory and not very effective.

Treatment and rehabilitation. We are looking now at the Navy program. We have been in the last few months looking at the regional centers as being more effective since we have closed many of our halfway houses.

Lack of staff expertise at the grassroots level. The lowest level we have specialists is the installation level. We believe we need more expertise at the battalion command level. The personnel staff officers need some special training in human resources development, including the drug/alcohol problem.

Lack of voluntary community involvement. Unfortunately, the Army is a victim, as is general society, of a weakening of community spirit. We do not have the voluntary community involvement that we think we ought to have in the program.

Lastly, the last weakness I would mention, is we have little research and study capability in the Army. You are aware that we were cut off from certain kinds of research.

In addition to that, we have not put resources within our capability in the study of this problem.

Those are the weaknesses and the assessment. Here are our general plans for improvement.

We had a destigmatization conference about 2 months ago. My staff is now writing up a plan to try to attack this business of the stigma associated with program participation.

I mentioned the Presearch Corp. analysis. It is a very extensive, complete analysis of our program and will be ready this fall.

Education of commanders. We did an analysis of personnel management in leadership subjects, including alcohol/drug abuse in the services schools. We were dissatisfied with it. We have asked the Training and Doctrine Commander to improve this area, and he agrees with this. He is to improve this.

We asked him also to look at what we need to put in terms of resources to provide staff expertise at the battalion level in human resources development.

Treatment and rehabilitation. We are going to test a couple of regional halfway houses, centralized treatment.

Lastly, we are now conducting, and this will be of interest, I think, to some of you who are interested in the overall quality of the Army, a very extensive assessment of the Army, the command climate, the quality of life. We are asking three questions:

What kind of Army do we want?

What kind do we now have?

And what do we have to do to close the gap between what we have and what we want?

That will be available also in the early fall.

This completes my prepared statement, a summary of my statement, and I stand ready for questions.

Mr. WOLFF. Thank you very much, General Johns.

There is one question I have, then we are going to pass on to the other members here. Or I should say two areas that I am very much interested in.

One is you indicated that the program is in the hands of the commanders, field commanders. Am I correct in that?

General JOHNS. Yes, sir.

Mr. WOLFF. That does downgrade the ability of the medical and health facilities to be able to impart some degree of either control or input.

General JOHNS. I don't believe so. Of course, the medical officer is on the staff of that commander.

The reason we put it in command channels is if you put something in the medical channel, it tends not to get the involvement of the commander. So we call it a command program, and the surgeon general works for the chief of staff. And when you get down to an installation level, he is on that staff. I believe he does exert considerable influence.

Mr. WOLFF. The other part of it is you have indicated that marihuana use or abuse is on the rise or that it has leveled off. That doesn't coincide with the findings of this committee.

with other things, is used in combination with alcohol and others. And we include that.

We simply do not know how much of that is social on weekends or during the duty day.

Now, unfortunately, we rely on commanders' judgment to assess whether or not the use of drugs impacts on a man's performance of duty. That varies. It is an unreliable measure, and we simply don't know, as you suggested.

What we have proposed, we have asked and programed in our plan for fiscal year 1980 research tha' will look in more depth at the use of substances.

Mr. WOLFF. Is it the fact that you don't have the resources or the funds within the military, that you have to go outside for contract services, or is it because you feel that the services can be provided with greater efficiency outside?

General JOHNS. We would have to go outside and contract. We do not have a reservoir of talent to do these inhouse studies as we do in things like battle systems, weapons systems. It is correct, yes, sir.

Mr. WOLFF. Thank you.

Mr. English?

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

Mr. Chairman, I would like to ask for the record that General Johns' statement and the addendum be included in the record without objection.

The Chairman. That will be done.

[General Johns' prepared statement and the addendum appear on p. 204 and p. 228.]

Mr. ENGLISH. And also, I would like to request that the document General Johns referred to in his testimony, his verbal testimony, be included in the record as well.

The CHAIRMAN. Without objection, so ordered.

[The document referred to is in the committee files.]

Mr. ENGLISH. General Johns, on page 4 of your testimony, obviously in the written testimony, you make the following statement:

> Perhaps the most accurate measure we have is a personnel opinion survey which is administered anonymously to a random sample of our soldiers on a quarterly basis. The sample, while it is random, is large enough to enable us to do analysis by grade, age, sex, and other relevant variables. The survey is scientifically designed and we have over 4 years of reliability and solidity analysis. We have a great deal of confidence that this gives us a valid assessment of the approximate magnitude of the problem.

And I would like to assume that you are referring in that statement to the quarterly survey that goes out and that the survey sample is in the neighborhood of 10,000.

You referred also in your statement, I believe, to the effect that there were six questions on this survey that pertained to drug abuse. Could you tell us the total number of questions on this survey?

General JOHNS. No, I cannot. I believe it varies from time to time.

It covers so many subjects that it runs over 100. There are over 100 questions on the survey.

Mr. ENGLISH. Over 100 questions on the survey?

You know, we have had a variety of people here in this country attempt to decriminalize marihuana because of the personal likes or dislikes of individuals who believe in marihuana as a substance, that it is not a harmful substance.

One element, however, that you don't address in your statement on this is the question of hashish which is prevalent throughout Europe. Hash is a lot stronger that marihuana—adulterated marihuana, the so-called Thai sticks in the question of marihuana abuse.

It is not use that we are talking about; we are talking about drug abuse and how that affects readiness. Someone who is, according to some of the studies that we made, and some corroborated information that we were able to obtain, there are a number of the military in Europe, particularly, who are abusing marihuana to the extent that are smoking about five joints a day.

Now, if you classify that under the question of marihuana use, that is hardly use; that is abuse of a substance. On that basis, somebody who is constantly stoned certainly is not in a very good state of readiness. And therefore, I think that that particular element should be addressed as well as the question of hard drug abuse and the extent you may confuse hash with marihuana.

The other point is that we live in a multidrug society today. Those people who are using marihuana are also reinforcing that with booze. Some of the people who are so-called alcoholics are reinforcing their alcoholism with the occasional use of other drugs, pills, Thai sticks, and the like, which are readily available.

This is not only a problem for the military, but is a problem as well for our State Department to see to it that we get the cooperation from host nations where our military is stationed, to deny the availability of these drugs, which perhaps when used individually are not that onerous, but when used in combination with others like cocaine, which is a reinforcing drug.

I don't imagine there is much cocaine abuse in the military today because of the high cost that is involved. However, how about the particular abuse patterns, especially in areas where we do have highly secure installations, what are the numbers of people who have been suffering from either discharge or removed from a strategic service as a result of abuse of a particular substance. All this leads to very serious questions as to whether or not we are fully addressing the problem.

This may not be your fault; it may be lack of resources that are available to you and as well to particular thinking upon the part of the policymakers in the DOD.

Therefore, I just wish you would address the question of marihuana abuse. Is that included within the purview of your remarks?

General JOHNS. The problem, yes, sir. When I said marihuana and alcohol have stayed the same, alcohol is considered by most commanders to be the most serious problem—we show soldiers, 5.6 percent that have alcohol problems. And that obviously has a big impact, as does the marihuana use.

We do lump marihuana and hashish together. We show that 40 percent of the junior first-term personnel do admit to some use of marihuana and hashish. And as you have stated, it is often laced

General JOHNS. Yes, sir.

Mr. ENGLISH. You stated there were six. Is that six on the officers and six on the enlisted men or is that three on the officers and three on the enlisted men?

General JOHNS. It is a combination of both.

I am sorry, correction. There are 80 in the total survey, 80 items.

Mr. ENGLISH. 80 questions?

General JOHNS. That's right.

No, we have in addition to the statements of personal use, the judgment of officers and enlisted.

When it goes out, the sample includes officers, and it includes enlisted men.

Mr. ENGLISH. Isn't it true that on the two surveys, on the enlisted men's survey, for instance, to use that as an example, there are only two questions on the survey that relate to drug abuse.

General JOHNS. No, sir.

I believe the version, I am told, that had been given to you only had two questions on that. The last ones we have had have six questions. And they address both officers and enlisted.

Mr. ENGLISH. The survey that I have is as of the date February 28, 1977. And you are stating that since that time, four additional questions relating to drug abuse have been added for a total of six on that survey? Was that correct?

General JOHNS. That's correct.

Mr. ENGLISH. Could you read for the record what those six questions are and the responses that are provided?

General JOHNS. Yes, sir. They are rather lengthy response choices, but it says:

Which best describes your use of marihuana or hash during the last 6 months?

The three choices are "never," "sometimes," "frequently."

Which term best describes your use of hard drugs such as heroin, LSD, and so forth, over the last 6 months?

The response items are "never," "sometimes," "frequently."

Which of the following do you consider to be the greatest personnel problem in your unit?

And here we list a long range of "poor officer leadership," "poor senior NCO leadership," "none of the soldiers seem to care about their jobs," "use of marihuana and hash," "use of hard drugs," "racial problems," "use of alcohol." We have those choices on that.

Then, we have three more questions. It says:

In your opinion, whether there is a problem in your unit organization or staff element, and if the problem is increasing or decreasing.

And understand that officers, NCO's, and lower ranking enlisted men answer this. And we have a large enough sample where we can break it down accordingly.

1. The use of marihuana or hashish:

(a) Is not a problem;

(b) Is a problem and has increased greatly, increased some, remained about the same, decreased some, decreased greatly or don't know.

Then, we use a similar one on use of hard drugs, the same stems, the stem of hard drug with the same response choices.

Then, we say:

Which of the following do you consider to be the greatest personnel problem in your unit organization?

And this causes them to prioritize. And in that are the same choices that they had on the previous questions.

So those are the six that are currently in. It does not address the four which we are going to add in August.

Mr. ENGLISH. Can you describe for me exactly what the terms "never," "sometimes," and "frequently," mean.

General JOHNS. It is what the individual concept is.

Mr. ENGLISH. As the chairman described, you have an individual there smoking five joints of marihuana. And he says "sometime user."

General JOHNS. That's correct. Yes, sir. And simply we wouldn't know. It is what he defines as "frequently."

Mr. ENGLISH. Whatever he wants to speak out.

General JOHNS. That's right. That is the weakness of the question.

Mr. ENGLISH. I would agree with you, it is a very serious weakness as far as his response at issue.

The second thing that I would like to ask you is with regard to question No. 8 of the survey—do you have the survey before you?

General JOHNS. No, sir, I don't.

Mr. ENGLISH. Would you like me to read it for you?

General JOHNS. Yes, sir.

Mr. ENGLISH. Question No. 8, the last question in the survey:

Do you feel that your answers on this survey can be traced back to you?

Do you know what the responses were on that?

General JOHNS. No, but I know that a significant number of people say "yes."

Mr. ENGLISH. Fifty percent respond "yes." So, basically, we have up here: Which best describes your use of marihuana? What term best describes your use of hard drugs?

An individual who believed that this survey can be traced back to him, would he not be admitting a crime if he says even sometimes I use hard drugs or sometimes I use marihuana?

General JOHNS. I don't know whether you consider that or not. I don't believe that——

Mr. ENGLISH. It is a crime in the Army to use hard drugs, is that not correct?

General JOHNS. That's correct.

Mr. ENGLISH. And is it not a crime to use marihuana in the Army?

General JOHNS. It is a crime to use marihuana, yes.

Mr. ENGLISH. So, therefore, if an individual says "yes," as half of those responding to this question do. "I believe you can trace this back to me and you can identify that was my answer;" isn't, in effect, what that individual is going to think, "I am going to be admitting to a crime"?

General JOHNS. Well, we have an easy way to see if there is a significant difference in the response of those——

Mr. ENGLISH. That is my next question. But isn't it true with regard to the individual who says, "Yes, I think you can trace this back to me," and I put down "sometimes I use hard drugs," does

that not mean that he is admitting to a crime and he is thinking, "Golly, they can trace that right back to me, they can identify that is the questionnaire I responded to"?

General JOHNS. I think that is a reasonable inference.

Mr. ENGLISH. Even if he were not fearful of prosecution, would it not also be true he would also be fearful that his commanding officer and all those in his unit might determine the fact that he has admitted he uses hard drugs?

General JOHNS. He might.

Mr. ENGLISH. Wouldn't that make life difficult, a bit difficult, in the Army for him?

General JOHNS. It could. We, of course, can test that to see.

Mr. ENGLISH. We will get into that area, too. That is another one.

The second point that I wanted to get back to was this issue of the second half. There are only two responses on this question. One is either yes or no. It doesn't say "maybe."

Now, obviously, those who believe that this response can be traced back to him will answer "yes." Those that don't, "no." They can fall in either category. And they will probably say, "I don't know, so I will put down "no."

And I know that the response as far as the Army is concerned to these questions, due to the fact that the responses have both yesses and noes, cannot possibly be the same. Therefore, it is valid they don't because whether you trace it back to them or not, they are going to answer "yes" to the use of drugs. And that is pointed out by the fact you have 50 percent that answer "no," and they come out approximately the same.

Isn't it far more likely from a commonsense standpoint that those who don't know are going to respond up here, "I never use marihuana; I never use hard drugs"?

General JOHNS. I really can't answer that question.

Mr. ENGLISH. As I pointed out, up until February of last year——

By the way, when was the change made? When were the additional questions included?

General JOHNS. I don't know. I will have to provide that. I just looked at this, the last one. This is the February one which——

Mr. ENGLISH. Does Mrs. Gouin know?

Mrs. GOUIN. February, I believe.

Mr. ENGLISH. This year?

Mrs. GOUIN. Yes.

Mr. ENGLISH. So, February 1978.

Do you have the response from the February survey?

General JOHNS. Yes, sir, they are here.

Mr. ENGLISH. They are included in that report for the record? OK.

So up until February of this year, the U.S. Army relied on two questions sent out in a survey containing 80 questions that dealt with all kinds of subject matter, all forms of Army life and all kinds of attitudes, all kinds of problems that the Army might face, two questions. An you come back in this statement and say that this is the most accurate measure we have of determining the amount of drug abuse in the Army.

General JOHNS. That is correct, yes.

Mr. ENGLISH. Two questions in which you are asking the individual to admit he has broken the law. You are putting him in a position he feels this survey can be traced back to him and, therefore, can be prosecuted.

And what were the responses you received off the survey? How many people who were then in the Army answered that survey positively on those two questions?

General JOHNS. The question about whether yes or no.

Mr. ENGLISH. One is the question of which describes the use of marihuana or hashish during the past 6 months. How many answered sometimes, infrequently?

General JOHNS. Our last survey showed that we have 31 percent.

Mr. ENGLISH. That answered positively on that?

General JOHNS. That's right.

Mr. ENGLISH. So, even under the threat of prosecution, even under the threat of the fact 50 percent said yes, I think you can trace it back to me, you had 31 percent respond and say, "yes, I use this stuff."

General JOHNS. That's right.

Mr. ENGLISH. Isn't that rather alarming to you?

General JOHNS. The 31 percent is.

Mr. ENGLISH. Isn't it a concern to you that this is what the entire question of the amount and the types of drug abuse that we have in the Army today rests on, those two questions, up until February of this year? Isn't that just a little bit scary?

General JOHNS. We have, as I mentioned, law enforcement data also. The trend data parallels almost exactly this survey data.

Mr. ENGLISH. There has just been handed to me a statement the wording "sometimes" was since February of 1977 changed to "occasional." Is that correct?

General JOHNS. I believe it is. The one we have now is occasional.

Mr. ENGLISH. We are not even talking about sometimes we do; we occasionally do.

General JOHNS. That's right.

Mr. ENGLISH. Mr. Chairman, at this point, I would like to offer for the record a copy of the Select Committee questionnaire so that a comparison can be made with the two questions that were used up until February of this year.

The committee's questionnaire is comprised of 16 questions. And General Johns, I think you are probably familiar with it and have seen a copy of it.

I would like to also point out that this survey was created with the assistance of Dr. Backenheimer of NIDA and that it contains 16 questions, is addressed only to drug abuse and nothing else.

And I think in comparison, it becomes very obvious that it is much more in depth. And if we want to use the term "scientific," certainly it is much more scientific a survey.

And I would simply like to also point out this committee has refrained from describing it either as an indepth survey or a scientific survey. In fact, this committee has felt extremely uncomfortable with trying to pinpoint figures that we arrived at through the use of this survey.

And in fact, we have stated that it only provides a ballpark figure in our opinion as to the problem as it exists.

But in comparison with what has been used in the Army, two questions up until February of this year determine the attitude toward the drug abuse problem within the Army, and that is it. And if we feel uncomfortable with that kind of a survey, the type of indepth survey that we have had, you ought to be scared to death of relying on those two questions.

Wouldn't you agree?

General JOHNS. No, sir, not completely.

Mr. ENGLISH. You think those are a couple of pretty good questions?

General JOHNS. I believe so.

Mr. WOLFF. Would the gentleman yield.

Mr. ENGLISH. I would be happy to yield.

Mr. WOLFF. One aspect of this that troubles me as a result of this exchange is how do we know trend lines? How can we determine trends? Has it remained even or has it dropped off if we have nothing to compare it with?

I mean, based upon this exchange where the committee does not feel that previously steps have been taken to correct this, now with the addition of certain information, but you have no standard to jump off from as a result of a lack of depth that has exited prior to this time.

General JOHNS. We have. We started this about the time the Arthur D. Little study came out with their statistics.

We also had an overlap the last year we had the random urinalysis where these two questions, they went almost exactly parallel. For three different surveys, they were almost exactly——

Mr. ENGLISH. But the Arthur D. Little study was conducted in 1974.

General JOHNS. That's right. We started our survey data back then.

Mr. ENGLISH. 1974 is when you inserted those two questions, and you have been riding on those two questions all the way through until February of this year? And now you decided to add four more. And now we rely on six instead of two. Is that correct?

General JOHNS. That's correct.

Mr. ENGLISH. I would like to also ask you to read the quote from your addendum statement—basically that statement is on page 9; and to identify that quote, it is at the bottom of page 9—General Johns, if you would.

General JOHNS. In 1975 Dr. David Marlow, the Project Director of the Walter Reed Army Institute for Research (WRAIR) study stated:

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

Mr. ENGLISH. Thank you, General Johns.

Would you identify WRAIR?

Oh, you did that. Excuse me, Walter Reed.

So this is the research from the Army. Dr. Marlow was doing this research in behalf of the Army.

Dr. Marlow warned in 1975, "the possibility that a potential enemy could exploit this weakness constitute a chronic threat that must constantly be kept in mind."

And your response to this warning within the Department of the Army was to insert two questions on a questionnaire asking servicemen to admit that they broke the law. And with that type of survey we end up with 40 percent in spite of the fact they believed that they could be identified responded positively. That is a pretty sad record. And it is a pretty frightening record, I would think, to the Army. And certainly, I would think it would be frightening to the American people.

Now, General Johns, I want to state at this point that I personally, as I stated before, have found that many of the people within the Army from the lowest ranking enlisted person up to the highest ranking officer, are very concerned about this particular problem in this particular matter. And quite frankly, I don't believe that those two questions found on that questionnaire reflect the concern that the Army has for the drug abuse problem.

I feel that much more would like to be done within the Army. Can you tell me if my assumption is correct?

General JOHNS. Yes, we would like to have a more definitive analysis of it. That's right.

Mr. ENGLISH. Can you tell me why that analysis has not been done?

General JOHNS. Well, you mentioned the Walter Reed study. That was terminated prematurely because, I believe, of congressional directive that we would not conduct certain research.

Mr. ENGLISH. Could you identify that congressional directive?

General JOHNS. No, sir, I can't.

Mr. ENGLISH. OK. It came from the Appropriations Committee. It was contained with the appropriations report. And the language was aimed at duplication of effort by the Department of Defense as well as Department of Health, Education, and Welfare into this area.

To your knowledge, has there been any effort by the Army to receive a—I shouldn't say "by the Army"—by the Department of Defense to receive a clarification as far as this report is concerned?

General JOHNS. I believe there has been. I understand that the Surgeon General informally talked with DOD, and DOD did send a letter to HEW and——

Mr. ENGLISH. I am not talking about HEW; I am talking about the Appropriations Committee.

General JOHNS. I am not sure on that, but I——

Mr. ENGLISH. Let me assure you when it was, and I will clarify it very quickly. It was November 17, 1977, after this committee wrote the Appropriations Committee requesting a clarification.

Let me further state for the record that this committee and the Department of Defense received the clarification, indicating that the Appropriations Committee fully intended that the Department of Defense carry out any research that is necessary and relates solely to military matters.

You tell me now when the request from the Department of Defense for additional funding to begin this study once again will start.

General JOHNS. We put it in our program objective memorandum as a result of what you have just spoken, we requested that DOD authorize a series of projects beginning in fiscal year 1980, going from $590,000 up to $1 million for the next 4 years to:

One, to identify the extent and patterns of substance abuse in the Army.

Two, to determine the impact of such abuse on Army personnel readiness and task performance reliability.

Mr. ENGLISH. So month after month after month went by with no request for clarification, no contact from the Department of Defense with the Appropriations Committee attempting to clarify this issue up until this committee showed interest, requesting clarification in October of 1977. And then the Department of Defense comes in with their clarification. They received a clarification.

And the first request that we have for reinstatement of these funds is not for this next fiscal year or this fiscal year, but fiscal year 1980. General Johns, that is a pretty sad commentary, not for you and not for the Army, but for the Department of Defense, and certainly for Secretary Brown.

Thank you, Mr. Chairman.

Mr. WOLFF. I am going to ask the Congressman to take the Chair, since he has been chairing this all along.

And the Chair recognizes Mr. Beard.

[Mr. English assumed the chair.]

Mr. BEARD. Thank you, Mr. Chairman.

General, how many times have you been in the Secretary of the Army's office to discuss this particular problem for the past year.

General JOHNS. Remember, I have been in this job 10 months. I have not——

Mr. BEARD. The Secretary of the Army has never called upon you to give him a thorough briefing? You would be the one that he would request or who would be extremely concerned or show an interest. You would be the one he would call upon, would you not, to come and brief him as to the status.

General JOHNS. It would either be me or the action officer, Mrs. Gouin, what we call the action officer.

Very often we do that in the Army. They bring the lieutenant colonel level up to dicuss it. And without the——

Mr. BEARD. Are you knowledgeable if any of those individuals have been brought to the Secretary of the Army's office for a briefing?

General JOHNS. The answer is no.

Mr. BEARD. You nod, madam.

Mrs. GOUIN. We have just recently provided a briefing to the Secretary. And in the past when issues have come about that we need to provide him some information, we did.

Mr. BEARD. Provided information?

Mr. ENGLISH. For the record, Mrs. Gouin, would you identify yourself.

Mrs. GOUIN. I am Mrs. Helen Gouin. I am Action Officer in the Drug Policy Branch. I am with General Johns.

Pardon me, sir, for the record, Mr. Alexander was in Europe at the time of the briefing. We briefed the Under Secretary.

Mr. BEARD. You briefed the Under Secretary. So the statement still holds that the Secretary has not been briefed?

Mrs. GOUIN. Not personally, sir.

Mr. BEARD. And at any time, have you been requested to go and appear before the Secretary of Defense to present this?

General JOHNS. No.

Mrs. GOUIN. We have presented a briefing to Dr. White recently on the status of the drug program. And that is as far as we have gotten.

Of course, we work with the alcohol and drug people at that level.

Mr. BEARD. General, do you feel any potential problem as far as increase in the use of drugs if the administration's proposal to decriminalize marihuana was to come into effect? Do you have any personal feelings or professional feelings as to what effect this may have in your endeavors to limit the use of drugs?

General JOHNS. Yes, sir. I think that any time we decriminalize something of this sort, it creates the impression that it is less serious. And I think, yes, it would increase it.

Mr. BEARD. I will jump ahead, but I would like to ask you both while we are here, it has been stated there is a strong relationship that exists between drug abuse and age, education, and ethnic groups.

Do you feel comfortable with that as far as being one of the rationalizations for drug use, the fact of——

General JOHNS. Yes, sir.

Mr. BEARD [continuing]. The age, education, and ethnic groupings?

Could you relate to me, have you found that there is a problem among certain ethnic group moreso than in others?

General JOHNS. In our analysis, we took that from some of the data. We do not have this currently within our data, a breakdown by ethnic groups.

We do know that particular kinds of locations, in locales, we found that certain ethnic groups tend toward certain type drugs.

Mr. BEARD. This is not broken down to where it shows a heavier drug problem with whites or blacks or other minority groups?

General JOHNS. No, sir, I do not have that data.

General FITTS. If I may, in the Army of Europe—I think it gets somewhat to this issue—our military police and criminal investigators tell us that among the offenses for drug abuse that in terms of the ethnic distribution, that they would find probably 50 percent Caucasian, somewhere in the range of 45 percent black, and another 5 percent of all others.

We have not pursued that to analyze it any other context. But I suspect, Mr. Beard, that it gets somewhat to the issue that you are raising.

Mr. BEARD. Would you say that 50 percent white, 45 percent black, is that somewhat representative of what the breakdown is as far as the percentage of troops that are stationed over there? Is there any relation there?

General FITTS. No; it wouldn't be directly proportional to that. It probably would be more on the order of 30, 35 percent black in the general units that we have, and then running the entire range of the rest of them.

Mr. BEARD. Yes, General Johns.

General JOHNS. There is a problem with that. You can have a bias and do have the law enforcement people on it. So it may be true, and it may not be true. But there may be a systematic bias in that. That is the reason I said we don't have any impartial data.

Mr. BEARD. I understand.

General Johns, I have just released a study, as you are probably aware of, on the all-volunteer service. It has been stated that strong relationships also exist between drug abuse and age and education.

I would like you to tell me your personal opinion of the status. We talked about readiness, and I know maybe it is because we are sitting in the Armed Services Hearing Room, whatever, but I would like to ask you a personal opinion as to the status as to its success of the all-volunteer service.

And you might want to point out as far as education, as far as quality, goes, but I would like to have your gut personal feeling.

General JOHNS. When you say "success of the all-volunteer force," I will start out by saying would you prefer me to say which I prefer—the conscript Army or volunteer Army?

Mr. BEARD. Just, you know, rather than worrying about who you are going to offend or what remarks of the politicians, you have to have a gut reaction. If you were sitting in a room with me, but saying, "we have got three of the problems, and I don't know whether it is working or not working, straight high school graduates," and all that.

General JOHNS. Yes, sir. We tried to do that in this, and I signed this report. So when we give it to you, you will see it is a mixed bag. We have some indicators that are better and some that are poorer.

Including the educational level you talked about, the mental category, the upper mental category, is less. We have gone down in college type youths significantly under the all-volunteer force.

The bulk, as you have seen, are in the mental category three. Most of those are in three bravo, 3-B category.

The Army is not representative of the other services. Our mean score is significantly lower than the Air Force and the Navy. We have lower disciplinary rates on AWOL's and desertion than we did under the conscript Army.

But we have, as you know, a high discharge rate. Our administrative discharges which contaminates whether or not you can compare those. We threw up in this study a couple of red warning flags. And this was from the commanders' views.

And we said that we have got a lot of junior enlisted men who are married now. The rate has gone up. The increase is self-reported family problems has occurred in almost all commands and all types of units.

A number of financial assistant transactions have increased over the last 4 years. Particularly in Europe, family problems are prevalent. The financial plight of junior enlisted is of serious concern.

Mr. BEARD. You really can't tell me. In other words, you can't say. I have heard all these things, and I understand. But you don't have any just gut emotional reaction about how things are in serious trouble or how things are going to work? You don't have any emotions when you say that the Army would be 500,000 men short within 60 days of outbreak of hostilities? Or as Director of Human Resources, do you have any real hardcore emotions about the fact we are not providing safe medical care to our young people, our young military dependents, and the fact that the doctor was saying the military health is dangerous?

Don't you have any kind of emotional outburst about, you know, it is not going to work on this line? We have got to look at some other alternatives such as drafting doctors or something?

General JOHNS. Yes. Yes, sir.

Mr. BEARD. You would?

General JOHNS. Yes, sir. I have had concern all along as an individual. It is one of the reasons why we undertook this very massive study on what kind of Army we want. We call it command climate, but we will get a fix on it, and we think we will.

Some of the questions you have asked, there is a high degree of concern among commanders about quality of personnel. More than 80 percent of commanders state that low ability personnel are a problem in their unit.

So this data is here that you will see.

Mr. BEARD. As a matter of fact, the trend has been 32 percent 4 years ago, 32 percent of the men in the Army 3-B mental categories. Presently, I think it has gone to 49 percent.

And if I am not mistaken, the statistics show they are in the lower bottom or lower portion of the 3-B, almost into the class 4 categories.

General JOHNS. That's correct.

Mr. BEARD. So you add those to almost 10 percent of categories, 49, almost 60 percent of the Army today is below average.

General JOHNS. That's correct, for nonprior service males accessions in fiscal year 1977.

Mr. BEARD. And this definitely could have something to do with the abuse of drugs.

General JOHNS. It could We have not correlated mental categories. We have educational level. And of course, the high school graduate is much less prone to use drugs than the nonhighschool graduate. But we have not on the mental category, no, sir.

Mr. BEARD. Do you feel you are getting the backing? Are you in charge of the medical situation, the doctors?

General JOHNS. No, sir. I monitor it because of human readiness, I am very concerned about medical support and morale. I monitor it. We work with the Surgeon General only.

Mr. BEARD. Of course, I have been to about five or six bases on this one particular issue and have been extremely concerned and just shocked and horrified at what I have found when I hear officers and enlisted men tell me they have not seen a doctor in 3 years. And all they have seen is a physician's assistant because that is all there are and that they can't get an appointment with a doctor.

Or I hear there are problems, and they take their child to the emergency room because that is the only way they can be assured that they will see a doctor. Maybe a psychiatrist, but they know if they sit there all night, they will finally see a doctor.

I just don't understand how Secretary of Defense Brown or whoever—I don't understand why someone is really not reacting. Has anyone presented to them a strong case of, listen, we can go no further downhill. We have reached the point of just absolute a critical nature. And we have got to consider alternatives, including the draft.

Has anyone said that to the Secretary of Defense or the Secretary of the Army? And if so, what kind of response?

General JOHNS. With respect to medical?

Mr. BEARD. Yes.

General JOHNS. If I could, I would like to have Colonel Karney from the Surgeon General's office address that.

Colonel KARNEY. I am not in a position to answer it specifically.

Mr. ENGLISH. Would you identify yourself?

Colonel KARNEY. I am Lt. Col. David Karney. I am the Alcohol and Drug Abuse Consultant in the Office of the Surgeon General.

By virtue of that fact, this question is a little bit out of my area of expertise.

Mr. BEARD. Are you a doctor?

Colonel KARNEY. Yes; I am a physician.

I can say without any hesitation, though, that the medical department shares your concern about the quality of the military medical care.

As to the exact presentations at the Department of the Army level and Department of Defense level, I would have to refer you to someone from our Health Care Operations Directorate whom I can provide for you.

Mr. BEARD. But you don't know whether it has been presented to anybody, the fact we should consider going back to the draft?

Colonel KARNEY. Personally, I do not. But that is not within my purview. And I would not necessarily know it.

General JOHNS. I am not aware of that either.

Mr. BEARD. Do you feel we have reached that point in time that you would feel comfortable with putting your name on a request such as that, saying we have reached that point in time we can no longer talk about sharing concerns; that if we are going to provide medical care and provide medication in the case of an outbreak or whatever, would you be prepared to stand up and be heard on that and say we need to look at that? Or is that a wife-beating unfair question?

General JOHNS. No; it is not unfair. In my personal opinion, I would be prepared to do that.

I don't know if you are just restricting it to medical or the all-volunteer force.

Mr. BEARD. Let's go one step further since I see Mr. White says the all-volunteer service is working because we are going to get more high school graduates. And I see the next day the Army is going to be allotted $13.1 million to conduct reading schools and math schools to bring recruits up to the fifth grade reading level.

Are you prepared or would you feel personally, your personal opinion, that we need to look at as a result of the shortage in reserve, et cetera, we need to consider going back to the draft, some form of the draft, whether it be universal service draft in reserves, but start today to consider this as an alternative.

General JOHNS. I believe on balance, we should go back to a conscript army.

Mr. BEARD. Thank you, general. Thank you for your candor.

Mr. ENGLISH. Mr. Skubitz.

Mr. SKUBITZ. No questions.

Mr. ENGLISH. Mr. Guyer.

Mr. GUYER. I will wait.

Mr. ENGLISH. Counsel has some questions.

Mr. NELLIS. General Johns, you mentioned in response to one of the questions from one of the members the fact that in Europe, family problems are a problem. Would you agree that the treatment facilities available to the Army are pretty well overtaxed, that when drug abusers are identified, the facilities for outpatient care are pretty well overtaxed at this point?

General JOHNS. In Europe, in particular, you are speaking of?

Mr. NELLIS. Yes.

General JOHNS. I would defer to General Fitts.

Mr. NELLIS. General Fitts, what would be your impression of the availability of treatment facilities for service personnel overseas?

General FITTS. I think I would have to say that they are generally available. On the other hand, I think we also have to recognize that if we get down to requirements for doctors per se that we are filled right now at about an 80-percent level. So that gives us a limitation almost immediately in that area.

And then, in terms of the facilities themselves, they are largely inadequate all the way from the very basic treatment facilities to the hospitals that we have there.

It strikes me that having said all that, if you look at the serious nature of drug abuse, if someone were identified and put into that category, as they are, they probably would be handled as we would expect them to be. But I wouldn't want to suggest to you that it is not a difficult process for us.

Mr. NELLIS. Yes. Our understanding is that psychiatric care is generally at a very low point.

And I think you would take it as a matter of course if I said that generally speaking, drug abusers who are in the counseling program need psychiatric care. Would you agree with that?

General FITTS. Well, I think that we would have to say that at some point for a drug abuser to enter into one of those programs, they need that type of evaluation. And beyond that, then, the support of good quality counsel would be my judgment.

Mr. NELLIS. General Fitts and General Johns, this is one of the areas I have been particularly concerned about, having visited a number of bases overseas. If so, dependents on whose welfare much of Army morale depends are really not being served by any bases that I visited, the treatment facilities were so badly overtaxed that dependents who had alcohol or drug problems naturally affecting the morale of the servicemen involved had to seek civilian assistance in order to cope with their problems.

Would you agree with that?

General JOHNS. I can't answer Army-wide. We have no evidence that that is true. But I cannot say that it is not true.

Mr. NELLIS. General, don't you think it would be a very good idea if the Army instituted some serious inquiries to determine the extent and nature of dependents' drug and alcohol problems as these affect service morale and the availability of facilities in terms of these people who are overseas and civilians obviously depend upon the service for assistance.

So I think it would be a very useful thing, and the committee has considered this problem from various angles. And I think it would be very useful if we could find out what facilities could be made available where dependents are involved.

Where you have wives, you have no set programs, they wait for their husbands. I don't have to paint that picture for you.

Thank you, Mr. Chairman.

Mr. ENGLISH. I think this would be an appropriate time for General Fitts to give his testimony, and we could get on with his section of the program today.

Mr. SKUBITZ. Mr. Chairman, may I ask one question?

Mr. ENGLISH. Excuse me. Certainly.

Mr. SKUBITZ. General Johns, you addressed yourself to the question of the increasing family problems abroad in the service. Were you referring to problems relating to drugs or problems other than drugs?

General JOHNS. All types of family problems.

Mr. SKUBITZ. What would you say would be the major cause of family problems abroad?

General JOHNS. Financial problems of the junior enlisted man.

Mr. SKUBITZ. The reason I raise that question is, I just have returned from Vienna, where I attended a conference there, and while there I talked to two gentlemen who are not a part of our Government service, who are part of the Austrian service, but were familiar with the economic plight of some of our junior officers and our people in Germany and in Austria and this area of the world.

One of them said, "Mr. Skubitz, you have no connection at all with your service, but please, something ought to be done about your military people over here."

That is because of the rate of inflation over there, which is much greater than ours and, in turn, the lower value of our dollar over there. He said: "Some of these people are having a difficult time making ends meet."

Do you agree with that statement or not?

General JOHNS. Oh, very definitely. That is a subject of great interest to the Secretary of the Army, and the Chief of Staff has been personally involved in that. That is a very serious problem.

Mr. SKUBITZ. Now, there is one other question, if I may, Mr. Chairman.

Mr. ENGLISH. Sure.

Mr. SKUBITZ. You addressed yourself to the drug problems being a personal problem in the service. I think your statement said that—that drugs are a personal problem—and that the command itself was responsible for carrying out a program from the grassroots.

Am I correct or not?

General JOHNS. Personnel problem, sir, not personal. Personnel.

Mr. SKUBITZ. Are you telling me you don't have any overall program dealing with the drugs in the service, and you leave the development of a program to each command?

General JOHNS. No, sir. We establish policy in the Department of the Army which is very explicit and puts minimum requirements, educational, rehabilitation, requires every command to have a rehabilitation and treatment facility.

We spell all that out and require them to do that. The implementation is the responsibility of the local commander. By that, I meant that the commander himself has to be personally involved and not just our specialists who are in the program.

Mr. SKUBITZ. The third point I was interested in with regard to the problem itself is: Do you have any control whatsoever over the pusher who is outside of the Army installation? Do the military police have a right to make an arrest if they find someone? How do you handle that problem?

General JOHNS. Well, we work with the local police. As you are well aware, posse comitatus prohibits us from doing certain things.

Mr. SKUBITZ. I understand that. That's why I wondered how you did get to the problems.

Do you have the same problem on the base itself with servicemen being pushers and selling to other servicemen?

General JOHNS. No, sir, we don't have any.

Mr. SKUBITZ. You don't have it at the bases?

General JOHNS. We don't have our hands tied in dealing with them, no.

Mr. SKUBITZ. Is that on the increase in the service or not? That is, servicemen themselves pushing drugs on the base.

General JOHNS. Our law enforcement data do not indicate that that is on the increase. There is a lot of it. We have had a steady level of it, particularly in marihuana. That is where most of the problem is on base.

Mr. SKUBITZ. In those instances, what do you do with those caught pushing drugs on the base? What sort of a penalty?

General JOHNS. We take punitive action under the Uniform Code of Military Justice under article 134.

Mr. SKUBITZ. I think you also mentioned that a number of the cases that you had—that is, the use of drugs—if I understood you correctly, you send the veterans home, is that correct?

General JOHNS. For those who cannot be rehabilitated, the commander has a choice.

Mr. SKUBITZ. Did you discharge them from the service and then send them? What sort of discharge are they given—honorable, dishonorable, or what kind?

General JOHNS. Well, we currently have an exemption program that if a person is discovered through urinalysis or turns himself in on medical, he gets an honorable discharge. That is policy.

Mr. SKUBITZ. That makes him eligible, then, for all veteran benefits; is that correct?

General JOHNS. That's right, yes, sir.

Mr. SKUBITZ. Thank you, Mr. Chairman.

Mr. ENGLISH. General Fitts, would you give your testimony at this time?

General FITTS. Mr. Chairman, with your permission, I would like to enter my statement into the record.

Mr. ENGLISH. Without objection, so ordered.

[General Fitts' prepared statement appears on p. 236.]

TESTIMONY OF BRIG. GEN. WILLIAM HENRY FITTS, CHIEF OF STAFF FOR PERSONNEL, U.S. ARMY, EUROPE AND THE 7TH ARMY

General FITTS. So not to waste your time, I will give a rather brief presentation and skip over some of the things that would be a duplicate of what has been said by General Johns and bring out others.

Mr. ENGLISH. Thank you very much.

General FITTS. I think one of the things I would like to get to, looking at our program as we see it in Europe, is the area of problem assessment and how we know what kind of a problem we have, and then ultimately how we deal with it.

We think that the indicators for that get to the issue of availability of drugs and potency; the question of sale and trafficking which Mr. Skubitz just brought up; and finally, the rate and frequency of abuse.

Sources of data to back us up in this area include our command-directed urinalysis, and our own personnel opinion survey, which we think has been validated pretty well since 1974 by Army Research Institute (ARI) and other personnel who have looked at it. We think there is a scientific basis behind it as far as you can go with this type of thing.

That survey has consistently since 1974 had more than 70 items. in it. And seven of those have been uniquely associated with the drug issue in Europe.

Beyond that, when we were doing the random urinalysis there was a pretty clear correlation between what was being said on those surveys and what we could find out on the random survey, at least concerning those drugs that you could pick up on urinalysis.

So we have some confidence that we know what our situation is in Europe. We are inclined to believe that since it has been consistent since 1974, and since we have done this every 6 months, it gives us a pretty good feel for what the trend lines have. been.

If they have been understated or overstated, we think there has been enough consistency in it that has been pretty much of a straight line for us.

As to the matter of soldiers being intimidated, there is enough consistency between the urinalysis and surveys to assure us that they were not intimidated when filling out the questionnaire.

In terms of availability of drugs in Europe, I think it is pretty widely known that hashish is widely available. Heroin is getting to be widely available. And its purity, as indicated by this committee, is extremely high.

When this committee visited us some 18 months ago, I think we were still talking about the Netherlands and talking about heroin coming out of the Far East. And there has been somewhat of a switch in that area, so that now we are really seeing it coming

from places like Afghanistan, Turkey, and more of the Mideast countries.

It is our sensing that, in that regard, much of that is transshipped through Turkey, that it is converted from opium into heroin in those countries, and then comes into Germany through a variety of sources. And one of those, by the way, is Berlin, from our indication.

There is rather easy access to the large Turkish population in Berlin and to East Berlin and then on into West Berlin. And beyond that, going from West Berlin into any part of West Germany is considered in country and is not subject to any type of a customs inspection.

We see the land routes from Italy and Austria as being another route of drugs coming in there. And certainly, the seacoast is still another route to a pretty widespread avenue of availability of these drugs. They are available, as indicated by the committee, in large quantity and relatively inexpensively today.

We see other drugs there as being fairly stable. There was an effort within the last year or two to establish a kind of cocaine net. And we don't believe that that has been unusually successful.

There are several hotspots that we see in Germany today. Berlin would have to be one of those. Frankfort would be one, Kaiserslautern, Munich, Stuttgart, Nuremberg, and Heidelberg. Heidelberg is probably the only one of those that would probably not be a hotspot were it not for the U.S. Forces there. All the rest of them probably would be.

As we look to the area of sale and trafficking, we see about a five-tier level of trafficking running from a very broad wholesale level down to the individual pusher/user in the community. The first three of those levels are very much the wholesale area.

We don't see U.S. servicemen involved at all in either of the two top. Generally, it is a German or third country national. And most of the apprehensions in that area are with Turks.

When we get down to the third area, we think that is largely the same. There have been observed, on some rare occasions, U.S. civilians involved in that level. But we think that members of the U.S. military wouldn't be able to provide the money to get into that level without an awful lot of additional outside support.

Where we begin to see the servicemen showing up in the trafficking area is when we get down to the street level pusher in his own local community. At that point, he is probably peddling to his friends or other individuals to keep up his own use.

Now, our look at soldier peddlers show that more than 60 percent of those we apprehend are really peddling hash.

On the other hand, on the civilian side, probably 63, 64 percent of those apprehended are handling the harder drugs.

So we tend to see that the U.S. soldier himself is not the major contributor to the hard drug area, although I would hasten to add that it is bothersome to us. We are apprehending probably 250 U.S. soldiers a quarter for some form of offense, and by and large in the area of hash itself.

In the abuse area, we have tracked this by our personnel opinion surveys since 1974. In that survey in 1974— and we gave this data to the committee 18 months ago when it was over there—we saw,

based on the admissions of the soldiers themselves, there were about 9.8 percent that would agree that they took some form of dangerous drug at least once monthly.

If you track that on through 1975 and 1976, those figures went down. As we moved into 1977, we saw them start to rise again. And as we did our last survey in January of 1978, it stood at 7.1 percent that would agree they took some form of hard drug at least monthly.

Now, I should add that this was an area where we had not dealt with the question of PCP before January 1978. On this last study, we added PCP to it, and 0.6 percent of this total population of several thousand indicated they were into that.

Now, if you could evaluate or compare and combine those two, you are talking about 7.8 percent of that population that would agree that they were into some type of a hard drug at least monthly. We believe that there is some validity to that data.

To sum up, it appears that while opiates were probably the most popular in 1974, they seem to be among the least popular in 1978. And we sense also that the whole area of cannabis abuse has risen in the last year or so.

In terms of who is doing this, the abuse by rank, in the hard drug area shows that about 91 percent of that was being done by E-1's through E-4. And we would tend to agree that there is a relationship between age, education, and ethnic groups as related the abusers themselves.

On impact, I don't think we need to tell this committee that, from the individual basis, it is a tragic thing, the involvement in drugs. We all understand that.

From the command point of view, more than 60 percent of our commanders would say that this is a very bothersome thing to them in terms of the resources that they have to employ to deal with these issues, its ultimate impact on morale and how they see it in terms of viewing effectiveness.

For us, this has been a very elusive thing. How do you really get a handle on what is the ultimate impact on combat readiness of drug abuse in the Army in Europe? We have grappled with this for a long time. I have looked, I suspect every month for the last 3 years at our combat readiness reports from the more than 350 units that report those to us. And we have never had a commander indicate to us in that period of time that drug abuse was preventing him from getting his mission done, from meeting the ultimate test that he is there for, or from carrying out his mission.

Until recently, we were never really certain whether failure to indicate a problem was just an oversight, they didn't see it that way, or what. Most recently, we have gone out to over 300 of our commanders, company commanders, and battalion commanders, and we have asked them to put this issue in some type of context.

We did not do it by saying, "Hey, there is a big drug problem there and how do you weigh it?" We merely asked them: "Among the many issues that have to impact on combat readiness in your organization, how would you rate these issues,"

It listed issues all the way from the matter of shortage of spare parts to small tools to drugs, to administrative processes and all of those things.

In the responses that we have gotten back, we found that our commanders are telling us, those that have to deal with it every day, out of those 39 issues, the first time they get to the matter of discussing any type of a drug or depressant or anything like that was number 20. They saw that to be alcohol.

I might tell you that number 18, before that, was small tools. And from their point of view, the number one issue was that they would like to move them on out of the Army more rapidly and probably not go through the process of rehabilitation, because it is a burden for them.

We got to number 26 before any drug-related item was listed. The abuse of heroin and other opiates was listed as item 27. Other drugs such as marihuana and hashish were felt to have a lesser impact on combat readiness.

I think this is probably as valid a look as we have had as to what the commanders personally are seeing this issue. It certainly has told us something we did not have before.

Concerning the area of general prevention, we think that there are some good things going on in Europe. A year and a half ago when this committee was over there, I seem to recall that one of our problems was at that time that Germans still largely saw drugs as an American problem. There were a few places where we could say, yes, we are getting cooperation.

Well, I can tell you that they no longer see it as a uniquely American problem. They are seeing it as a very distinct German problem today as well. And the working groups that have been sponsored by the Germans to deal there on an international level are getting much more active in the whole area of exchange of information and supportive programs that can ultimately, we hope, do something about this.

At the local level, we are finding that there is a tremendous amount of cooperation with their own local law enforcement people, dealing with us in helping to get on with this project. As a matter of fact, more recently, they have been willing to put up some of the advance money that you have to have if you are trying to trap large-scale peddlers. So we think their cooperation is very good.

I have had occasion, as I go around the command and visit the various communities where we have soldiers, to go in to talk to mayors and deputy mayors. In every instance, we end up with some type of a conversation about this subject and this issue. The knowledge is there today that it is a very distinct problem for them. And we note that they are anxious to cooperate with us on it.

We find, beyond that point, that we move to a couple of other things in terms of suppression. Our CID folks have largely had this mission for a long time. And that is and must continue. Beyond that, though, we are coming to realize that we can make greater use of our MP's at the local level who are part of the separate structure, as you know, to deal with the small cases that we have. And so we are employing them to a greater degree than we have before.

In addition to that, we have recently reinstituted in Europe a form of unit testing. It is selected, and we base it on what we would

perceive to be probable cause that a unit commander, if he thinks he has got a problem that would warrant testing his entire company or battery, can get permission to do it, and it will be done.

At our level, as we administer the program, we can follow indications of apprehension and abuse and go back down the chain and have that unit tested.

We have done some of that with six of our companies within the last several weeks. And we think that that is going to be a very helpful thing for us as well in terms of making the troops understand they will be subject to some accountability in that area, at least as far as urinalysis can do it for us.

In the final analysis, we get to the whole matter of abuser identification. And we talk to the wide range of how that is done. We think that we are getting to a significant proportion of the real abusers with the program that we have over there.

I think all of our commanders—and I share this view—think people have gotten rather smart about their drug use, that it is largely a recreational thing that occurs off duty, off base, in many cases on weekends. We note that in Europe today, the commanders within the companies and batteries are pursuing a very good policy as far as they can control their own domain.

But when the individuals are off post, they can't do much about that. I think we understand that. We think that one of the big problems that we have over there is the whole question of wholesome alternatives and lack thereof for these kids that go off base. We note that there is an awful lot of shortfalls in terms of the quality of life in Europe that they are permitted to experience.

In many cases, they aren't living in very good facilities. In many cases, the normal outlets that you could expect at a CONUS post don't exist for them in terms of gymnasiums, libraries, craft shops, that whole range of things that are ordinarily available either on post or off post in CONUS.

In that context, they feel shorted. In many ways, they don't truly understand why they should pay some unusual price to serve with the Army in Europe. If they really believed what the recruiters told them when they enlisted them originally to come over there, they are going to be disappointed concerning the good life and be able to travel.

The thing we discovered is that the money, as Mr. Skubitz has indicated, is not ordinarily available to underwrite that for the lower grade people. And on that basis, we are discovering that only about 45 percent of our troops are taking any kind of leave among the lower grades. And within that group, only about 50 percent of them ever leave their immediate area when they do go on leave.

So I think we have got the whole problem there of boredom. We have got the problem of what we would call the barracks rat because he can't do anything else with his time. In our mind, that causes an awful lot of acting out in ways that may ultimately lead to drug abuse.

So it is a big problem for us as we see it. We do have mandatory educational programs for all of the commanders and all of the troops that come into Europe on the dangers that we perceive that exist from drug abuse. And certainly, we share the view that the whole area of the use of cannabis, it is against the law, it is against

what we want, and ultimately it can have no good effect for the units. And that is stressed.

I think in the area of hash, though, we do have a problem because a lot of these kids don't really believe that. They don't really think we are leveling with them about the difficulties that can be created as a result of hash.

I would just expect, as General Johns has indicated, that any great thought that it ought to be decriminalized—exacerbate our problem and we are concerned about that as an issue.

In the area of rehabilitation, we do have 80 counseling centers throughout the Army of Europe. We have five resident extended-care facilities which are part of our five major hospitals over there.

In 1977, we had 6,100 people that entered into the program for counseling at the local level. About 3,600 failed, did not successfully get through it. And another 3,600 in our judgment were rehabilitated.

In the extended care facilities, we had 284 that entered that program in 1977.

That in general is our program, Mr. English. I would be glad to try to answer any questions that you might have about what we are doing there.

Mr. ENGLISH. Chairman Wolff would like to ask a question.

Mr. WOLFF. Thank you, Mr. Chairman.

General, can you give us an idea of what division strength is over there? What is the size of it?

General FITTS. The basic division itself would be somewhere between 15,000 and 16,000.

Mr. WOLFF. I understand we have about 300,000 people over in Europe today; is that correct?

General FITTS. Sir, among our military strength, and we don't want to get too deeply into this because it is classified, but as a round number, officers and enlisted, we would be talking about up to 200,000 people.

Mr. WOLFF. If we take the figure 300,000 and your figure of 7.8 percent and extrapolate from that, we have got about 2,400 hard drug abusers.

General FITTS. That is exactly the way we would calculate it.

Mr. WOLFF. Am I correct—they are abusers of hard drugs?

General FITTS. Who are using drugs based on their admission, at least monthly.

Mr. WOLFF. There is no such thing as a use of hard drugs. We might differ that any hard drug is used. You may differ with the question of soft drugs. But any use is abuse of hard drugs.

Now, when we were over 18 months ago, of the figures that were given to us is the fact that the number of people that were abusing hard drugs at that time based upon your analysis figures were 1.2 percent to 3 percent on a blank basis.

Now, that doesn't jibe with the information you have of leveling off of figures. Because after all, if you are going to use random urinalysis on the basis of determination of the number abusers you have, it is one benchmark we can't use.

Now, this shows a very decided increase in the drug abuse sector. And I would say—not that I am trying in any fashion to take an adversary position here—that your figures today are perhaps a lot

more indicative of the problem than they were before. And perhaps we didn't have the information before that was indicative of the overall problem.

But one aspect of this that seems to bear witness to what you have said about the German authorities is the fact that we have positive proof that where you have increased availability, you have increased abuse. If it is more readily available, it is a more abused substance.

We have that on our overall figures here in the United States. We cut off the Turkish supply, we reduced the number of addicts here in this country just on that one indication alone.

There is increased availability over there. We know it because we wouldn't get the German authorities to cooperate with us if there wasn't a problem they were having with their indigenous population. Therefore, there is an increased availability.

On that basis, it would seem that with the increased availability, there would be increasing numbers of people in the drug scheme.

The point that I want to make here is I think that it is the major thrust of this committee. We are not here to prove a point. The only thing we are trying to do is to find some measure, some way, of cooperating with you and engendering cooperation of marshaling the resources that are available in this country to try to help you do your job more efficiently. It is on that basis that we are questioning.

I think I can speak for this committee. This committee is not antimilitary by any means. To the contrary. We find the fact that there is not the support given to our military today that is necessary in this country. That is the major point of contention that we do have as a committee.

And unfortunately, even in our city schools in New York, teachers, rather than stigmatize the students with the drug abuse will neglect to mention or push off into another statistical chart the amount of abuse that exists within a particular facility because they feel that if they do not, they can either stigmatize the institution or they stigmatize the individual.

What we should like to see is a greater concentration of effort.

Now, you did mention the question of Turkish opium coming in. I would like to pin that down because it is an important factor with us and does not jibe with the information we are getting from other of our resources—namely, DEA—that no Turkish opium is being diverted into legal channels. Do you have any indication that that is not accounted for?

General FITTS. I am a little surprised they would give you that kind of information. It is my belief that, for instance, they are represented in West Berlin.

Mr. WOLFF. I don't mean the Turks. I am not talking about the Turks, but Turkish opium.

General FITTS. I am with you, sir. Prior to 1977, heroin seized in the Federal Republic of Germany (FRG) was primarily of the Southeast Asia variety. Southeast Asia heroin was handled primarily by Oriental traffickers in the Netherlands and transshipped throughout Europe. Beginning in 1977, most heroin seized in the FRG appears to be of Mideast origin. Opium is converted to heroin in numerous laboratories located in the Mideast countries, where it

is transshipped through other countries and into Germany. The majority of third country nationals apprehended are of Turkish or Middle Eastern descent.

Mr. WOLFF. On that score, would it be heroin that is processed in Turkey around either Pakistan or Afghanistan?

General FITTS. There is a possibility of that combination.

Mr. WOLFF. What I am getting at is the fact that we have some very serious problems with Turkey, and we are anxious to control the oversupply, as you have indicated, the overplanting that has occurred in Turkey. They tell us that they have heavy control of this and no longer is there a chance of this opium being diverted to illegal channels. There was, however, one refinery recently discovered in Turkey.

I think that requires some clarification. And I would make this request, you give us something definitive on this because it does have a very definite bearing upon some of our relationships with the Turks.

General FITTS. I would be very glad to do it.

And we also believe that some of the heroin is in fact transshipped through Turkey into Germany.

Mr. WOLFF. Now, could you give us an idea of the number of dependents that are in Europe today?

General FITTS. I think dependents would probably run upwards of 170,000 without being too precise.

Mr. WOLFF. Could you give us any information on the number of dependents that have had to be rotated as an ultimate drug abuser?

General FITTS. No, sir; I have no data on that. But it does occur.

This is a very interesting area, by the way. And we don't believe that we have been doing as much in that area as probably we should have been. There are some limitations there because with the dependent or even with the civilian employee dependent, it is more of a voluntary type thing. With our military ones they have identified, we can pretty well direct them into one of these programs and keep them there. With the typical civilian, that is not quite so easy. They are volunteer, and they can leave when they elect to.

And it has not been a very active program in Europe.

Mr. WOLFF. Can you venture any opinion as to the qualitative aspects or the quantitative aspects, that is to say, of the number of dependents at all being on the rise? Is there rising dependent drug abuse, do you know?

General FITTS. I don't know the answer to that.

Mr. WOLFF. Well, again, based upon availability, you seem to have a potential for increases there.

I have only two more questions, Mr. Chairman.

I don't want to make this a leading question, but how do you consider the intelligence risks that we do have as a result of offbase abuse of drugs? Could you consider that as backing into any problem at all?

General FITTS. You mean in terms of——

Mr. WOLFF. Are these people potential intelligence risks or are they an intelligence risk if they abuse drugs offbase as well as, of course, abusing it onbase.

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General FITTS. I think that is an area where if the individual was very deeply into the drug scene and where he as a result of that then becomes subject to some type of blackmail, he could in fact become an intelligence risk. That would be my basic judgment.

And beyond that, though, it also strikes me that if he is into it that deeply, he is probably one of those individuals who is going to surface at a very early date. And it brings the whole matter of his security status into focus. And there would have to be judgments formed.

Mr. WOLFF. One aspect of this, since there was indication that much of drug abuse occurs offbase, I just wanted to factor that one element into the intelligence risk category.

What brings people into the drug scene in the first place or the second place? Why are they using drugs?

Now, you have addressed yourself to one part of this. Are there insufficient resources available for either the entertainment or the offduty time of the individual?

There is also another factor involved here—the length of tour, and the fact that many of these people are unable to get off base because of the costs that are involved in outside entertainment today. And I understand dependents have to go to the military mess in order to be able to eat. They couldn't hack it on the local economy. They can't.

I know that during certain periods of the Vietnam war, there were special provisions made for special tours for the military. Do you have any such programs over there now? Do we not have the airlift capacity, for example, within the military to provide this sort of thing for some of the people over there to reduce the boredom that is attached to service at a particular facility?

General FITTS. Mr. Wolff, concerning the basic question about the tour length, we have for at least the last 2 years strongly advocated that the tour be reduced.

General Blanchard feels, and has felt intuitively for a long time, that about 18 months was really the maximum length you could expect an unaccompanied young man to serve over there before he starts acting out in some pretty weird ways and decides he is going to get out of that type of environment.

I might say I transferred to Germany from Hawaii, and I didn't find that soldiers there reacted differently to those in Europe. There is just so much a typical young single man, even in a place like Hawaii, can do with sunshine and all of that beautiful area; 3 years is a terribly long time to him.

Within the last 2 months, we have had a study completed by the Army Research Institute looking to the matter of tour length. We have verified to our satisfaction that when you expect him to serve more than about 2 years, then all sorts of strange things start happening. Article 15's and drug abuse increase. A whole range of bad things start occurring within that range of 18 to 24 months if you are expecting him to stay around at least 3 years.

So our position is and has been that the length should be reduced. To the Department of the Army, this is creating a terrible problem because there is an awful lot of money involved with the whole matter of personnel change of station and rotation. We are coming to believe, however, with this study that the typical young

soldier who comes over there and has 3 years ahead of him fairly early in the game decides that this is not for him and that he will act out in some way to cut back his tour.

And first off, it seems that he will act out in any honorable way he can. He will try to get a hardship discharge or something along that line. And if that doesn't work, then in fairly large numbers sooner or later, they will turn into some sort of abuse, either through disciplinary actions or drugs or something like that.

And by the time they arrive down to approaching that 24 months, they will be separated because of their desire and what they decided they wanted pretty early in the situation. We have gone formally to the Department and are recommending that this tour be changed.

Mr. WOLFF. What about the airlift capacity? Do you have the ability to perform in this fashion at all to see to it that there is some sort of R. & R. that is provided for these young people?

General FITTS. Sir, we do not. And I have not seen or heard of that being addressed over there. I think it would be a matter that would have to be studied.

We don't have that kind of airlift ourselves within our capability.

Mr. WOLFF. Thank you.

Mr. ENGLISH. Thank you very much.

General Fitts, I would like to ask a couple questions with regard to the issue of where these drugs are coming from. You were talking about Turkey and various areas. But you also mentioned that these drugs were coming in usually, some instances, through East Berlin. Can you tell us with regard to heroin, as such, what percentage of the heroin comes into Germany, comes in through a Communist country.

General FITTS. I have no data with me to support that, although it might very well be that we can develop it for you, Mr. English.

Mr. ENGLISH. Have you seen any figures or any indications at all of that percentage? Surely, the military intelligence over there would have some indication as to where those routes are and how heavily traveled they are and what percentage is coming. Obviously, you indicated you knew something about——

General FITTS. I think they do, but I must confess to you I didn't ask them to supply me that level of detail for the presentation. But it might very well be we could get it for you and would ge glad to do it.

I would like to make one point if it is not clear for the record, if I might, that we are not only talking about Turkey, but also Afghanistan, Pakistan, and probably——

Mr. ENGLISH. The question I had was not so much point of origin as it is the route that was traveled and the routes that are being used. And the point I am trying to make and the issue I am trying to get to is a question of some obviously, the Communist countries are well aware their countries are being used for this purpose.

Obviously, they are aware that drugs are moving through East Berlin into West Berlin and I would assume through East Germany into West Germany. And there, it is much easier for them to act in shutting down such routes if they so cared.

But getting into the whole issue of—and correct me if I am wrong, but I believe that from the military standpoint, it is always

preferable to wound someone than it is to kill them, simply because when you wound him, that ties up personnel involved in transporting that individual to a medical facility and ties up personnel involved in medical facilities.

And we have already pointed out, I think, that our medical situation in Europe leaves something to be desired and that we have got an overburdening there. So it would seem to me that probably it would be in the best interests of any potential enemy of ours to overburden our medical facilities even further by the making of drugs readily available to our servicemen.

And that would in effect carry out the same purposes without anything showing for it. Would that be correct?

General FITTS. I think that is a fair statement.

Mr. ENGLISH. Has there been any study you are aware of or any work being done in that field in Europe to answer that type of question?

I am not asking you for results; I am asking, to your knowledge, has work been carried out and has this flaw been discussed as far as those that have that responsibility in Europe?

General FITTS. I believe that it has. Certainly through our intelligence channels and also this area has gotten to be a topic of discussion at the Federal Republic levels on the international working group they sponsored from this level.

Mr. ENGLISH. Would it be a fair statement to say Communist countries are promoting a ready and free highway for drugs to move into Western Europe, particularly in West Berlin and West Germany?

General FITTS. I would be reluctant to state that categorically. What I have been exposed to indicates to me that there is a belief that this is occurring from a couple of countries over there; and that probably beyond that, it is more than a belief with the materials coming out of Berlin into the Federal Republic.

Mr. ENGLISH. So as far as Berlin is concerned and particularly in West Germany is concerned, that could almost be categorized as a certainty.

General FITTS. I believe that is the way we would see it in Europe.

Mr. ENGLISH. I think that is a very important point and one that I am hopeful you will pursue further and give us some kind of estimate, particularly as far as West Berlin and West Germany is concerned, the approximate percentage of hard drugs, particularly heroin, that go flowing through Communist countries into those areas. I think that would be most enlightening.

No. 2, with regard to the issue you were making that pertained to the servicemen who used drugs in Europe and the point that you were making with regard to the fact that you, too, feel a great deal of faith with regard to the survey you carry out over there as well as, and I think you placed a great deal of weight with regard to the opinion of the officers who are in charge of those men and their observations.

And with regard to that, I would like to point out to you again—this comes from General Johns' addendum and with regard to the Walter Reed study that we quoted earlier from, and one of the quotes was—

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

In conjunction with the latter findings, these "good soldiers" did not usually involve themselves in behavioral indiscretions which drew the attention of their commanders. Essentially, they functioned quite well within their units surrounded by a "mantle of invisibility".

Would you agree with that?

General FITTS. I wouldn't argue with that point at all.

Mr. ENGLISH. So basically, what we are talking about is that probably the principles of the commanding officers with regard to their people that they supervise is quite likely to be distorted and perhaps greatly distorted as far as the amount of drug abuse that is taking place within those units, simply because of this very fact of the so-called "good soldier mantle" that descends upon them.

In other words, they perform the job well, they are military in their bearing and give no indication of being otherwise, there is no reason for their commanding officer to suspect them.

And it appears, then, from this study that goes back to 1975 those who do use drugs within the Army encourage their fellow drug users cloak themselves in that mantle of good soldierism. Is that correct?

General FITTS. I wouldn't argue with that point. I think the point I would have made about that is that in the final analysis, we must rely upon that young captain in his company or the lieutenant colonel in his battalion to look at the entire range of issues that affect whether or not he is able to take that organization into combat.

He is the ultimate in our judgment in that regard. And what he is telling us is that he sees this as a problem.

We didn't ask him for the percentage that might be abusing in that context. That came from our own personal opinion survey.

Mr. ENGLISH. The point I am trying to make is this, and it is obvious, if you agree with that statement and you agree with that if a young man cloaks himself and becomes a model soldier or good soldier in the eyes of his commanding officers, he is not going to be suspect. As far as that commanding officer's judgment about how great a problem drug abuse is and how it affects the combat readiness of the unit is going to be tremendously affected and obviously it is going to be completely out of whack as far as an accurate perception. And he is not going to learn of that perception until he takes that unit into combat. And it is going to be a bit too late then.

Mr. BEARD. Would the gentleman yield?

Mr. ENGLISH. Happy to.

Mr. BEARD. I wonder how many unit commanders have written a report to their unit commander and said, "hey, this bunch is not ready to go, the equipment is not ready, the men aren't ready, the quality isn't there, I have problems and there, a horrendous drug problem that is affected."

How many times has a commander, battalion commander or company commander, ever written that or committed a report such as that?

General FITTS. In Europe, about 1,000 times a month because that is how many companies we have that are assessing their

readiness and shortfalls. And these reports reflect major proportions of problems as they see them.

Mr. BEARD. So they are not just saying they are not ready?

General FITTS. They tell us what their deficiencies are and what would prevent them from accomplishing their mission in their judgment every month.

Mr. BEARD. So every month. I just wonder of the 1,000 how many are saying, "We can't handle it. We are not combat ready to conduct and accomplish our mission as so set up, ready to go, readiness aspect."

We are getting over into a classified area which I don't think that we can discuss here. Maybe we could if we ended up going into executive session.

Mr. BEARD. That is always a problem when we try to get into that.

General FITTS. But I can assure you in our judgment, these commanders are pretty candid, and the validity of their comment has been an area of concern in the Army for a long time. Are they and would they be candid?

Mr. BEARD. Some commanders tell us they have always had the feeling, if a guy goes down and takes over a unit, he gets out and says: "I want to tell you something. If I catch anybody smoking pot or any indication of anybody stepping out of line, I am going to bust you, run you out." And the next thing, he feels that maybe he is not receiving the support he should.

Of course, it is easy for me to sit here and say, but the problem that some of the guys have said is that it could be a reflection on their professional capabilities and leadership if they so indicate they have got a real, critical problem.

Is that something that is perceived in this mind?

Mr. ENGLISH. Could I interrupt? Mr. Guyer.

Mr. GUYER. Mr. Chairman, I think it is in order, and I do make a motion, since we do have to go to the floor, we go into executive session by rollcall for the purpose of admitting documents and not for an overhearing; and to call the roll and let the rollcall be for the next 10 minutes, which is admissible in other committees.

Mr. ENGLISH. And the purpose of examining classified documents.

Mr. GUYER. The Clerk will call the roll.

Mr. LAWRENCE. Mr. Wolff.

Mr. WOLFF. AYE.

Mr. LAWRENCE. Mr. Rodino.

[No response.]

Mr. LAWRENCE. Mr. Rogers.

[No response.]

Mr. LAWRENCE. Mr. de la Garza.

[No response.]

Mr. LAWRENCE. Mr. Mann.

Mr. MANN. Aye.

Mr. LAWRENCE. Mr. Murphy.

[No response.]

Mr. LAWRENCE. Mr. Rangel.

[No response.]

Mr. LAWRENCE. Mr. Stark.

[No response.]
Mr. LAWRENCE. Mr. English.
Mr. ENGLISH. Aye.
Mr. LAWRENCE. Mr. Evans.
[No response.]
Mr. LAWRENCE. Mr. Zeferetti.
[No response.]
Mr. LAWRENCE. Mr. Akaka.
[No response.]
Mr. LAWRENCE. Mr. Burke.
[No response.]
Mr. LAWRENCE. Mr. Railsback.
[No response.]
Mr. LAWRENCE. Mr. Frey.
[No response.]
Mr. LAWRENCE. Mr. Beard.
Mr. BEARD. Aye.
Mr. LAWRENCE. Mr. Gilman.
Mr. GILMAN. Aye.
Mr. LAWRENCE. Mr. Guyer.
Mr. GUYER. Aye.

Mr. LAWRENCE. Sir, that is six ayes and no noes. We need additional votes for the executive session.

Mr. ENGLISH. Without objection, the record will be held open. We will leave the record open for 30 minutes.

Well, it appears we are going to have a vote. We will resume the questioning, and the record will be left open for 30 minutes. At that point we will determine whether or not we go into executive session.

I would like to resume the questioning of General Fitts with regard to the issue of—I believe this is in your statement— USAREUR personnel opinion survey which you were discussing. And I believe on item No. 2, there is a statement that the rise in cannabis abuse is probably related to visible movements to legalize or decriminalize a drug. Would you care to elaborate on that?

And I would assume that what you are telling us is that the moves within this country, both by States and by some within the Federal Government, to decriminalize marihuana is primarily what you are getting at.

General FITTS. That is essentially true. I think the thing that we discover is that young soldiers read headlines, and they don't ordinarily get into the depths of what the follow-on story is or the iffy things or the caveats that are down in there.

And in our minds, I think many of them have in fact concluded that that makes it OK. And I think many of them, before they came to Europe or even before they came into the Army, came out of a society that largely seemed to be thinking it wasn't a bad thing for many of them.

So I think, yes, that is what we are saying.

Mr. ENGLISH. Would you care to elaborate with regard to the President's statements pertaining to decriminalization of marihuana?

General FITTS. I am not completely familiar with the President's statements on that subject.

Mr. ENGLISH. Have you seen indications that that statement has had an effect with regard to younger soldiers and the question of whether or not they should use marihuana?

General FITTS. I think the material that I have been exposed to probably was an assertion by Dr. Bourne in some way or another in this area. But I am of a mind that at this point, many of the young soldiers, you have to be very careful when you ask them a question about something such as drug abuse, because in many cases they wouldn't even include hash or marihuana in that. And they honestly will just eliminate that as a consideration.

So it is that type of a thing in my judgment that we are faced with.

And then, if there is some position taken by someone in authority here in this country that maybe it should be decriminalized, it seems to me that kind of aids that kind of thing.

Mr. ENGLISH. Also in that statement, and I quote:

> Yet, individuals' hard drug use is probably related to the discontinuance of random urinalysis testing in October of 1976.

Are you stating there that you feel that some of the hard drug use is a result of that discontinuation of random urinalysis.

General FITTS. I think we felt at that time that that was a possibility, and that what we are saying is, in our judgment, in the long run, that even if we did get a slight rise on that basis, that to suggest that that is the way we really want to go in 1978 is not, in our judgment, the way we really want to go.

Mr. ENGLISH. That is what I would like to clarify, because your statement was kind of going in both directions. Would you care to tell us which way you really think we ought to go.

General FITTS. I will to a point, because I think the thing that strikes us is that in the long run, that type of negative system tends to pull the soldier away from his commander and the leadership role and that whole thing begins to be somewhat of a problem.

In the long run, it also occurs to us we are dealing with some pretty smart young people. And to the degree that these things are detectable, it would occur to us that the tendency would be to move into areas that were not so susceptible to testing by a random analysis situation.

The other thing about this is that we find it to be extremely expensive with very little result per thousand.

Mr. ENGLISH. Would you agree, though, that as far as comparisons of random versus command-directed, that a command-directed urinalysis would drive a much larger wedge between a commanding officer and enlisted man even without random?

General FITTS. No, sir; I don't believe that I do. Because the thing we are discovering with the five or six that we have done so far is that with every single person in that company or unit taking it, including the commander himself, that if we are careful about the way it is administered and if we make every effort to preserve dignity with what they can do in that situation, if we put it under the right kind of supervision, it doesn't seem to be a big problem. That is our experience with the first five or six we have had.

Mr. ENGLISH. You are saying when a commanding officer says, "Joe Soldier out here, GI Joe, I think you are using dope, you go

take a urinalysis test," you are telling me that doesn't drive a larger wedge between he and that commanding officer when the order comes down that this unit today, everybody in this unit, is going to take a urinalysis test, or everybody on this post is going to take a urinalysis test?

General FITTS. Mr. English, what I was referring to was the new approach where we can command direct a unit at a time.

Mr. ENGLISH. That is exactly right. Isn't that a move in the direction of the old random urinalysis.

General FITTS. I don't see it that way, because in the first place, what we are seeking is not to do that unless we have probable cause to believe that there is a reason to in that unit, that we have some evidence or that the commander does, that there is a problem and that we deal with it then on that basis.

I see that considerably distinct from the old approach where we just did it on a broad case basis without having any reason to think we should.

Mr. ENGLISH. When did the so-called new version of the urinalysis test start?

General FITTS. It started about 30 days ago.

Mr. ENGLISH. Is that when you received the authority to do so?

General FITTS. Yes, sir.

Mr. ENGLISH. Is it not true that the reason that authority was given was a result of the efforts of this committee?

General FITTS. I don't honestly know that, but I can tell you this: If that is the reason, I want to thank you, because it is something we were seeking.

Mr. ENGLISH. We appreciate that. That directive that was sent out said it was, so I would assume that was the case.

Would you then disagree with the proposal from the White House that this committee has heard, that reinstituting the old random urinalysis—and we used to know it as the, quote, "magic answer to solving the drug problem within the military"——

General FITTS. We don't agree with that.

Mr. ENGLISH. I would simply like to state for the record that I agree with you on that.

And I understand it now in the new proposals that are coming forward, the discretion is left so that in areas such as Berlin or Germany or whatever section of the world it might be in which there is a great deal of evidence that some type of opiate is being used, a type of drug that could be detected by urinalysis, that under those circumstances, the new directive now is, the commanding officers of those bases, in fact, the whole continent over there, the authority to go in and say, "We are going to take urinalysis tests every day this week," if he wants to. Isn't that correct?

General FITTS. No, sir; that is not correct.

Mr. ENGLISH. That is not?

General FITTS. The final authority still rests with General Blanchard. And if a commander wants to do his unit either once or on a composite basis, he must come up individually and ask for that authority.

On the other hand, if we detect from our level he has a problem and he hasn't come up, by all of the things we are able to develop, we can go down and direct it without his having asked.

Mr. ENGLISH. I realize that. But I am talking about a commanding officer.

General FITTS. Yes, sir.

Mr. ENGLISH. If he decided he has reason to suspect his unit is using some type of opiate——

General FITTS. He has to request it.

Mr. ENGLISH. He must make that request?

General FITTS. We haven't turned down one.

Mr. ENGLISH. That was the point I was going to make. For all his purposes, you can direct him to take them every day of the week unless he gets harassment from his people and has some point of objective.

I would agree that is a good approach to it and I think you are to be commended on the record. I think that is what was requested of this committee when we were overseas by a number of people. And I hope it will be beneficial.

I think it is very important to state for the public that the urinalysis case, the perception that the reinstituting of that test as a means of eliminating drug abuse within the Army or anything else, it is simply not valid. Urinalysis tests, at least the general test that is normally used, will pick up only opiates. And the new drugs such as PCP or marihuana or hashish and a lot of other drugs simply are not detectible; and that this test is good for only 72 hours. Is that not correct?

General FITTS. The test, as we understand it today, depending on individuals, is good probably up to 7 days. However, it will detect amphetamines, barbiturates, and methaqualone as well as opiates.

But we don't see it as the end-all. We see it as a piece of a kind of multidimensional problem and solution.

Mr. ENGLISH. Excuse me.

If the clerk will call, how was Mr. Burke recorded?

Mr. LAWRENCE. Congressman Burke is recorded as aye.

Mr. ENGLISH. Now, we will continue.

Are there any other testing devices that the Army is now working on to detect other types of drugs, drugs that are not detectible through urinalysis?

General FITTS. We recently have been exposed to the EMIT, enzyme multiplied immunoassay technique, that is used in some places in the Navy today. And on that equipment, which I guess gives you a capability at the unit level with rapid turnaround of making some assessments, we have looked at that on a very limited base in Europe. And we feel it is probably worth going into some type of a pilot program to see what it ultimately could mean for us.

Now, that equipment to date, as we understand it, does have some limitations in terms of its current investigations. It is not clear enough in terms of the results that you get out of it whether you could use it to take a definitive action, say, against a soldier. But you can get a general impression or sensing of what is going on in a unit.

We are led to believe that down the road there are some versions of this which will be more sensitive and more to the point of being able to identify perhaps even such things as marihuana.

We have asked the U.S. European Command to secure authority to purchase four of the existing sets so that we could get them out

there and develop reasonable procedures as to how we might ultimately get the most payoff out of it. And then, if the newer equipment shows up and if it is validated that it can do all the things that have been promised, then we would want to consider going into a much wider program.

Mr. ENGLISH. Approximately how far away are we from perfecting this new equipment? Can you tell us?

General FITTS. I am not an authority on this subject, and I wouldn't want to represent myself as such. I am told it is possible some time in the next several months we might see something like that.

Mr. ENGLISH. Colonel, would you like to respond with regard to that?

Colonel KARNEY. There is one generation of equipment that is currently available. The enzyme technique is not a new item of technology. Just using it for this particular purpose is.

It is possible to test this system now with equipment that is available. It is somewhat more expensive to do it.

The proposed equipment that the company says that can be available, talking about a couple, at least 2 or 3 months down the pike, possibly 6, that equipment would be available for testing at that time. A number of additional reagents would become available.

The equipment is reasonably inexpensive, simple to operate. The reagents to run the tests, however, are as expensive as our current methods. And the specificity of the procedures is such that we would still need a confirmation procedure in order to back them up.

So we have some equipment that is available now. I understand from DOD information that we can use equipment to test the procedure with this equipment. But we still are some distance away from the final version.

Mr. ENGLISH. I would like to know how is Mr. Railsback recorded?

I assume Mr. Railsback is recorded aye.

Mr. RAILSBACK. Aye.

Mr. ENGLISH. One observation I make in behalf of the task force on the drug procedures that has been working, I would like your opinion on and particularly with regard to the experiences you have had as to the validity. One point that I repeatedly make is that the military, and talking about foreign communities in which the military is located, does not cause drug abuse problems in the civilian community

On the contrary, it is the civilian community that is likely to influence the military that is located in that area. And primarily what I am looking at is this issue of the type of drug that is used in the community. Whatever is available in the civilian community in the way of drugs is the drug that will be used most likely on the post, regardless whether it is Army, Navy, Air Force, or whatever. And, therefore, if you have the civilian population, say, in Europe, Germany, or East Berlin using a great deal of heroin, for instance, that heroin then is going to be carried into the military sector with the military population, regardless of whether it is the dependents of the military or soldiers themselves; and that this has as much to

do with the amount of drug abuse that we are likely to find within the military as any other factor.

Would you care to comment on that?

General FITTS. Well, I have a hunch that, first off, there is something to be said about usage by class. And I would expect in a very general way that the user would be looking very hard for something within the range or class of what he would ordinarily be inclined to use anyway.

Beyond that, though, I think that a person would be pretty hard put to deny that if there was a major influx of, say, heroin into Frankfort and if it became cheap enough and people were pushing it hard enough, that ultimately, you would get some significant increase in its usage. That would seem to be a reasonable statement.

Mr. ENGLISH. Would it also be, according to your experience, accurate to say, for instance, if a young person who went into the Army was used to segment one and went into, say, Singapore, where he had Thai sticks, that he is most likely going to be messing with Thai sticks?

General FITTS. I think that is correct.

Mr. ENGLISH. Would it also be accurate to say the same would hold for hashish or anything else, and that if you are dealing with a polydrug user here in the United States and he gets overseas and the polydrug—amphetamines and barbiturates—aren't readily available, he may turn to some other type of drugs than amphetamines and barbiturates, as opposed to the polydrug users? And many times, this is where I believe the check was made between alcohol and drugs. Many times, you may find an individual who has been using drugs may switch over to alcohol if alcohol is what is available, and vice versa. And this is where you get into the polydrug use.

Wouldn't you agree with that assessment?

General FITTS. That would be a reasonable assumption.

Mr. ENGLISH. Would it not be logical, then, that within the military, in addressing this problem that your primary key to what you are looking for within the drug use on the particular military installation should be primarily what is used in the civilian community? In other words, what law enforcement officials in that community are finding, that is what is being sold, that is what is on the streets, that is what is available. Would that not be the case?

General FITTS. We certainly would take that into account. And I think we do.

Mr. ENGLISH. Would this not be the real tipoff whether or not, for instance, urinalysis testing, a great deal of urinalysis testing, would go into certain posts as opposed to another post, simply because of the availability of opiates?

General FITTS. That is exactly what we are driving at, Mr. English, when we say we wouldn't rely only on the unit commander to say he would like to be tested.

Mr. ENGLISH. This is drawing the line, the difference between the old random urinalysis approach, as opposed to—and I think it is still random, even though you don't want to call it that—the new approach that is being taken. It is that it is directed toward what is

available locally regardless of what is being shown as far as the commanders saying, "We don't think our guys are using heroin."

If you have heroin all over the place outside, they better start running some urinalysis tests. Isn't that correct?

General FITTS. I think what we would want to do, I think in the typical community, one thing we want to keep in mind is, we are talking about ordinarily company-level testing. We are talking company-level testing. And in a given community we may have 100 companies. And I think our conception is what we want to do in that area is, No. 1, yes, see what kind of abuse is prevalent there.

Beyond that, let's start seeing what we are picking up in terms of who is being apprehended for what type things.

As we see a pattern developing in that way, then we move to have these units looked at more closely through this directed urinalysis. That is the way we kind of look at it.

Mr. ENGLISH. Counsel has a question.

Mr. NELLIS. General Fitts, on page 4 of your statement, there is a discussion of the impact of drug abuse. And you say it is expressed in a number of ways.

Your conclusion is, in the first paragraph of your statement on page 4: "The impact on the overall effectiveness of preparedness of the command is judged to be minimal."

Can I ask you the basis on which that judgment is made?

General FITTS. It is based on, I suppose, a number of things.

No. 1, as I have indicated before, our commanders have never seen fit to identify drugs on any readiness report as being an issue. It is based on the fact that ordinarily these units that we are most concerned about are rather constantly out on maneuvers. And we have never seen one of our units fail in accomplishing its mission in a field environment under those circumstances.

It is based on the testing of these units under the Army technical evaluation system to see if they can accomplish their mission, and do they have the willpower and ability to do so.

And finally, it is, I think, based again on our latest look at the commanders, as to how they say drugs in terms of the overall range of things that bothered them about getting the unit ready to go to combat.

Mr. NELLIS. General, wouldn't it make sense to analyze the instances of drug abuse by determining the military occupation specialty of the individual who is the abuser? For example, you have a unit that has some sort of secret device, nuclear device. You have 15 men in that unit. And it happens that the two people that are in charge of triggering the device are drug abusers. Don't you have a much more serious problem on impact than if the quartermaster type is using hash?

In other words, wouldn't it make sense in terms of impact to determine what the military occupation of the individuals who are using and abusing drugs, determining in that way whether or not you are impacting combat readiness or just impacting some support system that could be used alternatively? That is to say, quartermaster unit or a truck driver, something of that nature?

Do you feel what I am getting at?

General FITTS. I do. And I think I would have the same kinds of concerns for the type units that are involved. And when you talk

think we would probably like to see some people with more clinical training than we have and that kind of thing.

Generally speaking, it strikes me that our individuals are not failing to get treatment in this area because of some major shortage of medical people at this point in time.

Mr. RAILSBACK. Putting myself in their shoes, I am wondering what I would do if I had a drug problem and needed help yet I knew that if I were to turn myself in to submit to military medical care, there might be sanctions imposed against me or I might be courtmartialed.

I am curious whether there is that kind of a deterrent and whether some of our people may be going to private doctors rather than using our medical to avoid that kind of a stigma.

General FITTS. I don't really believe that is going on in Europe.

You know, I am struck with the young soldier, that he generally knows faster than his officers what avenues are open to him. It seems to me he has that kind of a capability. I think with the typical young man, the word gets around fairly quickly there is an exemption policy; that should he turn himself in, he will not be subject to the sanctions you are describing.

I think that becomes known pretty early in the game to the typical young soldier. He may not understand all the nuances of an exemption policy.

Mr. RAILSBACK. I didn't understand the exemption policy, either.

General FITTS. It may very well be, if he has already committed some major offense and wants to get exemption by applying for this, it wouldn't really apply to him.

Mr. RAILSBACK. That is different.

OK. Thank you.

Mr. ENGLISH. A vote is being taken, and the committee does have a quorum. The committee has voted to go into executive session to consider classified material.

I would request that General Johns and General Fitts and Colonel Karney would remain in the room, if all the visitors would please be so kind as to be excused for a few minutes.

How does Mr. Rogers vote?

Mr. ROGERS. Aye.

[Whereupon, the committee went into executive session.]

Mr. ENGLISH. If there are no further questions, this hearing is adjourned subject to the call of the Chair.

The resolution, a copy of which will be provided, was passed.

[The resolution follows:]

RESOLUTION OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL, U.S. HOUSE OF REPRESENTATIVES—ADOPTED MAY 24, 1978

Whereas H. Res. 77 vests the House Select Committee on Narcotics Abuse and Control with the authority to conduct a continuing comprehensive study and review of the problems of narcotics abuse and control including drug abuse in the Armed Forces of the United States;

Whereas the House Select Committee on Narcotics Abuse and Control has designated a special task force on Drugs and the Military which has intensively studied the subject for over a year;

Whereas the task force on Drugs and the Military has uncovered a wide range of unresolved problems, including the high levels of drug abuse reported by the Armed Forces services, and the questionable efficacy of attempts by the Department of Defense and the Armed Forces services to combat drug abuse;

think we would probably like to see some people with more clinical training than we have and that kind of thing.

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Mr. ROGERS. Aye.

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The resolution, a copy of which will be provided, was passed.

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Whereas the task force on Drugs and the Military has uncovered a wide range of unresolved problems, including the high levels of drug abuse reported by the Armed Forces services, and the questionable efficacy of attempts by the Department of Defense and the Armed Forces services to combat drug abuse;

Whereas the House Select Committee on Narcotics Abuse and Control is seeking a greater understanding of the effect of chronic drug abuse on job performance, morale, discipline, and the overall combat readiness of the Armed Forces of the United States;

Whereas various allegations have been made against the Department of Defense by witnesses appearing under oath before the House Select Committee on Narcotics Abuse and Control;

Whereas the House Select Committee on Narcotics Abuse and Control has on several occasions requested that the Secretary of Defense appear before the Committee to present testimony on the issue of drug abuse in the Armed Forces of the United States;

Whereas the Secretary of Defense has consistently refused to appear as a witness before the House Select Committee on Narcotics Abuse and Control; and

Whereas the refusal of the Secretary of Defense to appear as a witness before the House Select Committee on Narcotics Abuse and Control severely inhibits the Committee in its investigation of drug abuse in the Armed Forces of the United States as authorized in H. Res. 77: Now, therefore, be it

Resolved by the House Select Committee on Narcotics Abuse and Control that the Secretary of Defense be directed to appear as a witness before the House Select Committee on Narcotics Abuse and Control to present testimony with respect to drug abuse in the Armed Forces of the United States.

Mr. LAWRENCE. The committee went into executive session; and the resolution was passed unanimously and will be delivered to the Secretary.

[Whereupon, at 1:10 p.m., the hearing was adjourned.]

END