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CR 4/20/71

April 20, 1971

CONGRESSIONAL RECORD —

Mr. President, I herewith transmit to the Senate a comprehensive report on drug abuse in the Armed Forces prepared by the staff of the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare. I ask unanimous consent that the report be printed in the RECORD at the conclusion of my remarks as exhibit 2.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 2.)

Mr. HUGHES. Mr. President, this report is the result of an extended study by the subcommittee which began a year ago with the approval of the distinguished chairman of the Committee on Armed Services, Senator JOHN STENNIS, and the distinguished ranking minority member of that committee, Senator MARGARET CHASE SMITH.

The report does not purport to be an indepth analysis and investigation of this very large and complicated subject field. It is, rather, an inclusive, preliminary, base-level survey. Its tone is dispassionate and objective, reflecting a conscientious, bipartisan effort on the part of the staff. It represents, I believe, a valuable and necessary first step in realistically facing a very large and compelling national problem.

I believe no one can read this report, low keyed as it is, without feeling the urgency, the magnitude, the pervasiveness, and the peril of the infiltration of our Armed Forces by the drug epidemic prevalent throughout our civilian society.

The report will be used primarily as a working tool in discussions with the appropriate military authorities to identify those actions which can be taken under existing administrative framework and those that may require legislation for achieving solutions. The primary intent of the subcommittee from the beginning has been to explore a serious problem and to help find effective remedies for it, not to sensationalize the subject matter or to try to affix blame. Our approach is from the health standpoint, rather than from the law enforcement standpoint, although in some respects the two approaches overlap somewhat.

Mr. President, in all fairness, it must be recognized that the sudden explosion of the drug epidemic in our armed services, as in our civilian society, was not foreseen. The Armed Forces were understandably not equipped to handle it. The principal business of an army is to fight, not to treat and rehabilitate drug addicts. Yet, the problem is upon us and the Armed Forces, like the rest of our society, must face it realistically. And here we are talking about a matter that has a profound bearing on our national security as well as on the health of the personnel involved and the well-being of the civilian society to which they will eventually return.

The dilemma our military leadership faces is the same dilemma that confounds the civilian sector of American society. That dilemma flows from a conflict between laws based on traditional moralistic attitudes and, on the other hand, a very real American desire to aid the afflicted. Boiled down to its simplest terms, that dilemma is this: Shall the person who abuses drugs be treated punitively or as someone who needs help?

In a limited attempt to resolve that question, the Defense Department last October authorized the military services to establish amnesty programs on a trial basis. Essentially, this policy permits the individual services to offer treatment without punishment to any drug user who asks for it.

So far, only the Army and the Air Force have adopted implementing policies. Neither is consistent with the other. Indeed, as the distinguished Senator from Pennsylvania (Mr. SCHWEIKER) has pointed out, the Army policy permits a unit commander to determine in the final analysis whether to execute the policy. The Air Force policy—much in the pattern of its policy toward alcoholics—seems to discourage those of its members on flying status or in sensitive positions from even volunteering for treatment.

Although 6 months have elapsed since the Defense Department amnesty policy was announced, the Navy and the Marine Corps have not yet implemented it. I understand that such a policy instruction in draft form, however, is working its way through the Pentagon mills.

My primary recommendation, therefore, is that the Defense Department should establish a comprehensive, integrated, and mandatory policy under which service members who are drug dependent or who are medically ill drug abusers are provided the same opportunity for treatment and rehabilitation as would be afforded to any military person who is ill.

Such a policy would include the following principles:

First. A member who is a medically ill drug abuser or a drug dependent person should be summarily discharged from the service only if he has refused to accept appropriate treatment as shall be offered by the service.

Second. A member who is identified as a drug dependent person or a medically ill drug abuser as a result of his arrest for a drug-related offense should be dealt with through normal military judicial or disciplinary processes. In determining how to handle an individual case, primary emphasis should be given to how best to treat and rehabilitate the individual. It may be useful, for example, to consider postponement of the trial or disciplinary proceeding, suspension of sentence, or other devices commonly used in civilian courts in order to effect rehabilitation.

Third. A member with drug abuse or drug dependence problems should be encouraged to seek medical or other assistance and, when he does so, should not be subject to disciplinary or other punitive action—administrative or otherwise—based on information he has given in seeking or receiving such assistance. The military does not now recognize confidentiality in the doctor-patient relationship. Under this recommendation, absolute confidentiality would be preserved unless competent medical authority determines that the patient is a danger to himself or others; however, no information divulged by the patient in confidence should be admitted into evidence in disciplinary proceedings against him without his consent.

Fourth. A member who seeks such assistance should be offered every opportunity to be restored to useful military service with the Armed Forces. This contemplates that such persons may be offered temporary sick leave or given tasks they are capable of performing while undergoing treatment and rehabilitation.

Fifth. When security clearance, flying status, or other classification affecting job position or pay is withdrawn from a member who sought assistance as a drug dependent person or as a medically ill drug abuser, it should be reinstated within 6 months after his treatment has been completed unless he fails during this period to perform at the level at which he was performing prior to his request for treatment.

Sixth. A member who has sought or accepted treatment and rehabilitation should be separated only when such treatment and rehabilitation has repeatedly failed and competent medical authority has determined that he cannot be restored to useful military service.

These, Mr. President, are some recommendations I would make in the treatment and rehabilitation area. But there are other problem areas demanding attention if we are to prevent present and future generations of military personnel from abusing drugs and if we are to bring into treatment programs those who already have drug problems no matter where they surface in the military system.

One finding in the staff report is that a significant proportion of drug users, including those on "hard" drugs, are being admitted to the service because of inadequate preinduction screening. In my opinion, the Armed Forces should not only give special priority to developing reliable methods of identfying actual and potential drug abusers at this point in the system; they should also create a mechanism whereby those rejected for military service because of drug problems are referred, with their consent, to civilian prevention and treatment facilities.

It is also clear from the report that the military's drug abuse prevention-education programs have failed to teach commanders to understand the causes of drug abuse among their troops or how to deal with it in other than a punitive way. These programs have also failed to motivate service personnel effectively against the use of drugs.

I recommend that the Armed Forces—

in consultation with the Office of Education, the National Institute of Mental Health, the Bureau of Narcotics and Dangerous Drugs, and outside experts—carry out a massive upgrading of its present prevention and educational efforts with the objectives I have outlined in mind.

These efforts should present factual information in an unbiased way, encourage individual discussion and participation, and include discussions both of alcohol and alcoholism together with nonchemical alternatives to drug use and abuse. It is extremely important that these efforts reach every level of the military structure—commanders as well as troops.

In some segments of the Armed Forces, special traveling drug abuse teams with expertise in effective educational techniques and with knowledge of the legal, medical, and social ramifications of drug use and abuse are already being used effectively. These teams should be given additional support, and this program should be expanded.

Perhaps most importantly in the prevention area, the Armed Forces should give greater attention to providing more recreation, entertainment, physical activity and meaningful work in order to abate those conditions—particularly boredom and "make work" jobs—which appear to be conducive to drug abuse.

This need is already apparent among our troops in Germany, and it is becoming increasingly apparent in Southeast Asia where many towns are off limits, our troops have less to do, and a vast assortment of potent drugs—marihuana, virtually pure heroin, stimulants, and depressants—are readily and inexpensively available.

In the training area, two categories of military personnel demand special attention. One group, as I have indicated, includes those involved in screening candidates for induction into the Armed Forces. The other group includes those who are involved in day-to-day interpersonal dealings with drug abuse problems—unit commanders, noncommissioned officers, chaplains, medical and social workers, law enforcement personnel, and the like. Both of these groups require specialized training not only in detecting actual and potential drug abusers but, more importantly, in dealing effectively and humanely with the consequences of their abuse.

As for those drug dependent individuals or medically ill drug abusers who are separated from service for those reasons, I propose that they be granted a nonpunitive discharge and be afforded the same opportunities for treatment and rehabilitation afforded all persons discharged as physically or mentally disabled. Their drug-related actions should be not regarded as the result of intentional misconduct or willful neglect. In this connection, the Veterans' Administration should give priority to increasing its capacity to care for drug-dependent persons or medically ill drug abusers.

These are the highlights of my own recommendations. I have a more detailed list, and I ask unanimous consent that this list be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. HUGHES. Mr. President, the drug epidemic has reached a point that is no longer acceptable in our civilian society. It is even more unacceptable in the armed services entrusted with the defense of our country.

As the report shows, the subcommittee staff did not find factual evidence that would establish drug usage as a significant factor in actual combat. In Vietnam, commanders told the staff that, because of the personal danger involved, there was far less smoking of marihuana in combat areas than in rear support areas. Yet, some studies indicate a positive correlation between marihuana usage and combat exposure. In any event, one cannot believe there is anything less than immense danger in the use of dangerous drugs in a war theater, as we have heard stated on the floor of the Senate today.

After all, this is a guerrilla war, a war of infiltration in which the ambush and the booby trap figure largely. A lapse of vigilance or judgment could easily mean the loss of life—even in rear support areas.

We know the relationship between violence and drug addiction here at home. While no reliable studies on the relation of drug abuse and violence in battle areas are available, there is ample reason to believe there is a close tie.

While we have no hard evidence that drug abuse contributed to such incidents as My Lai, there is that possibility.

Press reports carry stories, one of which has been elcquently presented here this morning, of widespread "fragging" in Vietnam—the assassination of American officers by our own troops in the field. If a man will go to the extent of rolling a fragmentation bomb under the flap of an officer's tent, it is reasonable to suspect that drugs may and probably do figure in the story in some way.

Finally, we have the hideous picture before us of men, inured to violence and addicted to drugs, returning to civilian society from the war area compelled to use the skills of violence they have learned as soldiers in criminals acts here at home in order to support their habit.

Mr. President, I believe it is imperative that strong measures be taken to stem the rapidly growing drug epidemic in our armed services. I believe the Armed Forces are in a unique position to move out on this and to assert national leadership in the drug abuse prevention, control, treatment, and rehabilitation field. I feel confident that we in Congress will give them our full support in these endeavors. It is mv hope that the public release today of this staff report will encourage those in the highest positions of our military leadership to accept the challenge, will encourage those of us in the Congress of the United States to support the military leadership in the initiation of programs that are absolutely essential to the military of this country, and will encourage us to take those actions legislatively that can undergird and support, so that we can begin to alleviate the great dangers from these problems.

Mr. President, there are many ways in which we can begin. Just a few weeks ago, for example, I had the opportunity to stop by the Glasgow Air Force Base in Montana, where there are excellent facilities for long-term usage, fully and completely built, with excellent hospital facilities already existing, yet standing idle. We are talking about the need for long-range of rehabilitation and treatment, and for feeding back into our society those men who are the responsibility of our society, and have served our country in combat. Certainly, at this critical time, we must not be said to lack the initiative to accept the challenge or the innovative ability to adopt the programs that can begin to resolve these issues.

EXHIBIT 1

IDENTIFICATION OF DRUG ABUSERS AND DRUG DEPENDENT PERSONS

The Armed Forces should give special priority to developing reliable methods of identifying drug abusers and potential drug abusers at the Armed Forces Examining and Entrance Stations and elsewhere in the military system.

The General Acoounting Office (GAO) should be asked to undertake a study to determine whether entrance examinations can and should be made more effective in screening out drug abusers and those who are prone to drug abuse. Such a study should include an analysis of the techniques which can be used to screen such individuals, a cost-benefit analysis of such techniques, and recommendations of those techniques which can and should be used by the Armed Forces.

Individuals who are rejected for service in the Armed Forces because of drug abuse or drug dependence should, with their consent, be referred to appropriate civilian prevention and treatment facilities. This would apply to candidates for induction as well as to in-service personnel.

The Armed Forces should establish a system for evaluating the performance of each AFEES station in screening out drug abusers. Such a system should seek to identify those AFEES stations where significant numbers of individuals have been admitted to service with undetected drug abuse and drug dependence problems which subsequently interfere with their military performance.

PREVENTION

The Armed Forces, in consultation with the Office of Education, the National Institute of Mental Health, the Bureau of Narcotics and Dangerous Drugs, and outside experts, should carry out a massive upgrading of its present efforts toward preventing and educating against drug abuse and drug dependence. These efforts should present factual information in an unbiased way, encourage individual discussion and participation, include discussions of alcohol abuse and alcoholism, and include discussions of non-chemical alternatives to drug use and abuse. It is extremely important that these efforts be tailored to and reach each level of the military structure.

Special traveling drug abuse teams with expertise in effective educational techniques and a knowledge of legal, medical and social ramifications of drug use and abuse are being effectively in some segments of the Armed Forces. Additional support should be given to these teams, and this program should be expanded.

The Armed Forces should give greater attention to providing more recreation, entertainment, physical activity and meaningful

work in order to abate those conditions, particularly boredom and "make work" jobs, which appear to be conductive to drug abuse.

An intensive evaluation of all prevention efforts in this area should be carried out to insure their effectiveness.

TRAINING

Specialized information and training in the recognition of drug abuse and drug dependence should be provided to personnel involved in screening candidates for induction into the Armed Forces.

Additional emphasis should be given to providing specialized information and training to personnel involved in dealing with drug abuse problems, including unit commanders, noncommissioned officers, chaplains, medical and social work personnel, law enforcement personnel and the like.

An intensive evaluation of all training efforts in this area should be carried out in order to insure their effectiveness.

TREATMENT AND REHABILITATION

A. The Defense Department should establish a comprehensive, integrated, and mandatory policy under which service members who are drug dependent or are medically ill drug abusers are provided with the same opportunities for treatment and rehabilitation as would be afforded to any military personnel who are ill. Such a policy should include the following principles:

1. A member who is a medically ill drug abuser or a drug dependent person should not be summarily discharged from the service, unless he has refused to accept appropriate treatment as shall be offered by the service.

2. A member who is identified as a drug dependent person or a medically ill drug abuser as a result of his arrest for a drug-related offense, should be dealt with through normal military judicial or disciplinary processes. In determining how to handle an individual case, primary emphasis should be given to how best to treat and rehabilitate the individual. It may be useful, for example, to consider postponement of the trial or disciplinary proceeding, suspension of sentence, and other devices commonly used in civilian courts in order to effect rehabilitation.

3. A member with drug abuse or drug dependence problems should be encouraged to seek medical assistance and, when he does so, should not be subject to disciplinary or other punitive action based on information he has given in seeking or receiving such assistance. Absolute confidentiality should be preserved unless competent medical authority determines that the patient is a danger to himself or others; however, no information divulged by the patient in confidence should be admitted into evidence in disciplinary proceedings against him without his consent.

4. A member who seeks such assistance should be offered every opportunity to be restored to useful military service within the Armed Forces. This contemplates that such person may be offered temporary sick leave or given tasks they are capable of performing while undergoing treatment and rehabilitation.

5. When security clearance, flying status or other classification affecting job position or pay is withdrawn from a member who sought assistance as a drug dependent person or a medically ill drug abuser, it should be reinstated within six months after his treatment has been completed unless he fails during this period to perform at the level at which he was performing prior to treatment.

6. A member who has sought or accepted treatment and rehabilitation should be separated only when such treatment and rehabilitation has repeatedly failed and competent medical authority has determined that he cannot be restored to useful military service.

B. The present amnesty program should be totally re-evaluated in the light of the above principles and objectives.

C. A study should be carried out to determine whether treatment and rehabilitation efforts should be carried out in Armed Forces-wide central treatment facilities or, rather, in local settings.

SEPARATION

A member who is a medically ill drug abuser or a drug dependent person should be granted a non-punitive discharge and should be afforded the same opportunities for treatment and rehabilitation afforded all persons discharged as physically or mentally disabled. His drug-related actions should not be regarded as the result of intentional misconduct or willful neglect. Such a person should retain the same rights and benefits as any other person afflicted with serious illnesses, and should not lose pension, retirement, medical or other rights because he is a medically ill drug abuser or a drug dependent person.

The Veterans Administration should give priority to increasing its capability to care for drug dependent persons or medically ill drug abusers. In doing so, it should consider entering into contractual arrangements with such facilities as have demonstrated their effectiveness in the treatment and rehabilitation area.

MISCELLANEOUS

In general, the Armed Forces should recognize their unique position to assert national leadership in identifying drug abusers and drug dependent persons; in developing and evaluating effective treatment and rehabilitation, research, prevention and education programs; and making a distinct contribution toward the abatement of this national problem.

The Armed Forces should consider ways by which they can have an affirmative impact on the abatement of the drug epidemic in civilian society. The most obvious contributions would include sharing information and data relevant to the drug problem, and the donation or sale at present value of surplus equipment, facilities and the like that might be useful in combatting the drug problem.

The Armed Forces should establish a special program to provide prevention, treatment and rehabilitation services to dependents of military personnel.

Special consideration should be given to insuring that continuity is preserved in all prevention and treatment and rehabilitation programs. This should apply to personnel operating these programs. It should also apply to those receiving the benefits of treatment and rehabilitation programs.

The Congress should authorize and appropriate sufficient funds to carry out the above recommendations.

A special impacted aid program should be created to assist communities whose drug problem has been aggravated by the prevalence of drug abuse among military personnel stationed nearby.

The Armed Forces should provide written reports, at six-month intervals, on their progress toward achieving the objectives outlined above.

EXHIBIT 2

STAFF REPORT ON DRUG ABUSE IN THE MILITARY

To: Members of Alcoholism and Narcotics Subcommittee.

From: The Subcommittee Staff.

I. INTRODUCTION

In the spring of 1970, the Subcommittee staff began an investigation of drug abuse in the military. This was undertaken by authority of an April 16, 1970, letter from Senator John C. Stennis, Chairman of the Armed Services Committee, to Senator Hughes, Chairman of the Subcommittee, as well as under the Subcommittee's own authority to act in the drug abuse area. The objectives of the investigation were to explore: the extent and nature of drug and alcohol abuse in the military; the impact which this abuse is having upon individuals, the armed services, and American society as a whole; the measures, particularly in the areas of education, treatment, and rehabilitation, which the military is taking to meet the problem; and the areas in which further investigation or action might be taken.

In carrying out the investigation the members of the staff attempted to cover the problem from two approaches. First, we attempted to look at the problem from a geographical point of view. We looked at stateside bases (primarily in the Eastern United States), Southeast Asia and the Far East (Hong Kong, Thailand, South Vietnam, Japan, and Korea), and Europe (Germany and England). We visited Southeast Asia and the Far East in September, 1970, and Europe in January, 1971. In order to cover the broadest possible ground in the short time we had available, we split into teams in both Southeast Asia and Europe.

Second, the staff also attempted to visit examples of installations covering the entire range of the military system: induction, basic training, advanced training, support troops, and combat troops (in the field and returnees). We concentrated primarily on the Army for two reasons: it has the largest number of personnel and it has nearly all of the draftees. However, in Southeast Asia and Europe we also looked at the other branches in the same environment to determine what contrast, if any, we would find.

Members of the staff were: Southeast Asia: Robert O. Harris, Staff Director; Wade Clarke, Majority Counsel; Julian Granger, staff investigator; Richard J. Wise, Minority Counsel, and Jay B. Cutler, Minority Counsel. In Europe the above were joined by Nik Edes of Senator Williams' staff.

Our primary method of investigation was discussion with and collection of data from the members of command at each facility visited. At virtually every installation, we discussed the problems with groups composed of command personnel, the provost marshal, the medical officer, the judge advocate, the chaplain, and, on occasion, the information officer. In most installations, command relied most heavily on the data supplied by the provost marshal and the medical officer to answer our questions. This data does not give an accurate picture of either the extent of use or the nature of use, but it is the best available in most command situations. In addition to command discussions, we attempted, where possible, and within the limited time available, to interview individual enlisted men and junior officers. We also collected data in written and oral form from other agencies and individuals associated with the military.

On all of our visits we made it clear to those contacted that we were interested in low key, informal discussion and that our primary interest was in the health and prevention aspects of the problem. The staff believes that this allayed some of the fears that we were attempting to gather data for an expose or criticism of the military and increased the cooperation we received, particularly from the Army. In general we were satisfied with the truthfulness of those we contacted. The Army was more realistic in assessing their problem. They seemed more willing to recognize drug abuse as a problem and to take action both to prevent it and to alleviate its effects. In this regard, we would rate the other services in the following order: the Air Force, the Navy, and the Marines.

What follows is a synthesis by the staff of its findings and recommendations based upon its investigation.

II. THE NATURE AND EXTENT OF DRUG USE

The staff has attempted to ascertain who the military drug users are; how many of them there are, where they use their drugs, what drugs they use, when they tend to use drugs, and why they use drugs. While we make some conclusions about these factors, they are by no means applicable to all military drug users. The nature of drug use, the circumstances of use and the reasons for use vary widely. However, the generalizations which we do draw indicate the direction in which drug abuse appears to be going and suggest the areas in which further action might be taken in order to meet the drug abuse crisis.

A. The users: Who, and how many

There is a paucity of hard data on which to base an authoritative finding of the extent of drug use in the military. The few studies which exist have been made exclusively among Army populations and are severely limited both in numbers and in scope. This void was recognized when Department of Defense witnesses disclosed plans for a worldwide epidemiological survey of drug use among all members of the armed forces, to be undertaken this year.

Nevertheless, certain insights may be gained from the available studies. It should be noted that these studies generally reveal drug use of a greater amount than do the medical and law enforcement figures given the staff. However, they seem to be lower than the subjective assessments of command particularly at junior levels. Among those studies most heavily relied upon in this report (all cited in the hearings record) are the following: (1) Patterns of Drug Use: A Study of 5,482 Subjects, by Black, Owens and Wolff, Fort Sill, Oklahoma, 1970; (2) Drug Use in Vietnam—A Survey Among Army Personnel in the Two Northern Corps, Stanton, 1969; (3) Marihuana in Vietnam: A Survey of Use Among Army Enlisted Men in the Two Southern Corps, Roffman and Sapol, 1967; (4) Marihuana in a Tactical Unit in Vietnam, Treanor and Skripol, 1970; (5) Marihuana Use in Vietnam: A Preliminary Study, 1968; and (6) A Study of Marihuana and Opiate Use in the 82nd Airborne Division, 1969. Of these, only the Stanton and Treanor-Skripol studies used samples which included both officers and enlisted men; the others concentrated on enlisted men in the lower ranks.

Patterns of drug use shown by the most recent studies seem to be consistent with the findings from what is considered to be the most scientifically valid study of them all, the one by Stanton. He grouped nonusers, (1–20 times used), heavy users (21–199 times used), and habituated users (200 or more times used). He also sampled both incoming and outgoing troops. Overall, he found that 53.2 percent of enlisted men had used marihuana at least once in their lives. He also found a trend toward more frequent usage in Vietnam than had been reported two years earlier. Of the 50.1 percent who reported using marihuana in Vietnam, 20.5 percent were casual users, 11.9 percent were heavy users, and 17.7 percent were habituated users; in other words, heavy and habituated users were more numerous than casual users.

Patterns of other drug use which Stanton found among soldiers leaving Veitnam included the following: (1) opium use was reported by 17.4 percent (9.8 percent casual users, 5.8 percent heavy users, 1.8 percent habituated users); (2) amphetamine use was reported by 16.2 percent (11 percent casual users, 4 percent heavy users, 1.2 percent habituated users); (3) barbiturate use was reported by 11.6 percent (7.8 percent casual users, 2.7 percent heavy users, 1.1 habituated users); (4) heroin/morphine use was reported by 2.2 percent (1.4 percent casual users, .6 percent heavy users, .2 percent habituated users); (5) acid (LSD, STP) use was reported by 5.3 percent (3.2 percent casual users, 1.6 percent heavy users, .5 percent habituated users).

In general, it can be concluded from all these studies that drug use, at least among Army members, has been increasing with the passage of years since 1967, when the first study was conducted, and that a growing proportion of servicemen are entering the service with a history of drug use.

There is no pure stereotype of the drug user in the military, just as there is none in civilian society. While the great bulk of drug abusers are enlisted men of lower rank between the ages of 18 and 25, users may also be found in the non-commissioned and commissioned officer ranks; for example, a heroin-hooked sergeant at Fort Bragg was "the outstanding NCO in his company" or a colonel in Vietnam who became a "speed freak" from taking amphetamines to stay awake on long patrols and then used other drugs to get to sleep. While these extremes do exist, the age group of the typical user is much the same as it is in civilian society.

From the studies and from our on-site investigation we would ascribe the following characteristics to most drug abusers in the military: age 19–22, rank E–4 or below, unmarried, less than high school graduate, either draftee or non-career oriented enlistee, equally from field or support unite on first overseas tour.

Other factors seem to be present in those who become regular or habituated users. These persons are generally from broken homes, have a lower education (are high school drop-outs), have insufficient personalities to deal with their fears and stress (passive-aggressive personalities, immature, situational adjustment problems, low-self-esteem, lack of long-term ambitions, etc.) and are likely to become involved in other behavioral problems within the military society. In Vietnam, we were told that nearly all of the arrests for drug offenses were incidental to arrests for other violations, such as uniform violation, curfew violation, off-limits violations, etc. The cases which required medical treatment usually were those with these kinds of negative behavior patterns and with psychological problems which went beyond their drug use. At Fort Dix, New Jersey, many of those who were being held in the Special Processing Detachment were also drug abusers. The Special Processing Detachment is primarily a holding unit for individuals apprehended anywhere along the East Coast for being AWOL. They are sent to Fort Dix until their records can be located and their proper unit determined.

This individual who is going to become a habitual user of drugs and who is going to become a problem for the military—in either medical or disciplinary terms—is an individual who has personality problems sufficiently serious that he would likely become a problem in whatever societal structure he is in.

It should be emphasized that the drug user—particularly the heavy user—is likely to be a member of a peer group or sub-cultural group in which the taking of drugs plays an important role. For example, we were told that in Germany most arrests for drug abuse were made in groups. These arrests by the Criminal Investigation Division were usually the result of the infiltration of a group by an agent and when the arrests were made the entire group was taken.

The sub-culture is best illustrated by the experience at Ft. Bragg, North Carolina. There the drug users leave the post to congregate in pads rented by small groups for the purpose of off-duty relaxation through drugs. These pads are characterized by psychedelic decorations, acid rock music, and by the mod dress of the participants. We were also told in several places that the figures on the extent of use were distorted depending upon which group an individual trooper belonged to. If the person questioned was a non-user, he associated with other non-users and tended to view all use in terms of his group; his estimates were usually low. The user on the other hand associated with other users and tended to feel that everyone used drugs.

B. The drugs being used

The kinds of drugs being used in any particular area depend to a large degree upon the extent to which they are locally available. In Thailand and Vietnam, there are few effective controls on the availability of any drug. Because of a lack of doctors, apothecary shops dispense virtually every manufactured drug and many herbs and other types of remedies. These are dispensed without a prescription to any buyer. Also in Thailand and Vietnam, as in most Southeast Asia nations, opium, particularly among the Chinese populations, has been the drug of choice of the natives. This and its derivatives, morphine and heroin, were reportedly supplied primarily by an organized network of Chinese operating in nearly all nations.

In Vietnam and Thailand marihuana was freely available. In Thailand, the members of the staff had no difficulty in procuring "tailored" marihuana cigarettes with filter-tips. These cost $1.50 for 15. In the United States a similar amount would cost at least five times as much. They can be procured from or through bar girls, taxi drivers, and even young children on the street. In Nakhon Phanom, Thailand, we were shown apothecary shops which dispense the various amphetamines and barbiturates which some Air Force troops use. These were small shops with an open front and shelves loaded with bottles and jars. Drugs were dispensed either by name or by describing a set of symptoms which led the shopkeeper to dispense whatever he felt would solve the problem.

The Southeast Asia marihuana is fresh and potent. Delta 9 Tetrahydrocannabinol (THC) is the active ingredient in marihuana. The average sample available in Southeast Asia contains between 3.5 and 4.0 percent THC. This is much higher than the average ½ to ¾ of one percent THC which U.S.-grown marihuana contains. The preference for marihuana in Southeast Asia among U.S. troops is ascribed to ready availability, inexpensiveness, ease of cachement, non-addictiveness and the quality of the intoxication produced.

Stanton found a growing trend among U.S. troops in Vietnam toward the use of opium. This is available in liquid or powdered form. Among the departing enlisted men in his sample, only 6.3 percent reported having used opium before their arrival but 17.4 percent reported use upon leaving. However, the question has been raised as to whether these troops really know what they were using was opium. We also heard of opium being available in the form of "OJ's"—marihuana cigarettes dipped in liquid opium.

Stanton's 17.4 percentage figure for opium use in Vietnam places that drug ahead of amphetamines, or "speed," in popularity among the troops. The incidence of amphetamine use among outgoing enlisted men was 16.2 percent, up from 12.4 percent usage before their arrival in Vietnam. Barbiturates were favored by 11.6 percent. Other drugs used were heroin, morphine and "acid" (LSD, STP), with the use of "acid" actually showing a drop in the before and after figures.

We were regularly informed that there was an increase in the availability, experimentation with, and use of heroin. There seemed to be an increase in the hospitalizations for heroin withdrawal. Heroin is available in two forms: "Red Rock" heroin from Thailand (reportedly brought to Vietnam by Thai troops) and refined heroin. Red Rock is generally 3–4 percent heroin, 3–4 percent strychnine, and 32 percent caffeine. The refined heroin is in 100- and 300-milligram capsules containing 97 percent heroin as compared to

the 5 or 6 percent heroin usually available in the U.S.

The two most commonly used amphetamines come in liquid form. They are Maxitone Forte and Obesitol, both of French manufacture. Maxitone Forte is taken orally mixed with Coke or used intravenously. Obesitol is taken orally. The barbiturates most commonly used in Southeast Asia are Binoctal and Aminoctal, also of French manufacture.

In Germany, there is a plentiful supply of hashish, amphetamines, and barbiturates, and U.S. troops and their dependents have easy and inexpensive access to them. Hashish is by far the drug of choice and is in widespread use. It is reputedly brought in by "guest worker" nationals from growing countries such as Turkey, Pakistan, and Lebanon and by a number of criminal syndicates. We were told it is distributed by German nationals, by American military personnel and former servicemen who were discharged in Europe. "Uppers" and "downers"—amphetamine preparations, Librium, Valium and Darvon—may be purchased inexpensively over the counter, without prescription, in any German drug store.

LSD is also used in significant amounts by troops in Germany. This is either brought in from the U.S. or made in illicit laboratories in Germany. We had very little indication of heroin or cocaine use. Both the law enforcement personnel and the medical personnel had had very little contact with these drugs.

Regardless of location, marihuana and hashish usually is smoked in pipes or cigarette form. In Vietnam, the marihuana cigarettes are sometimes filled with Red Rock heroin and smoked. The amphetamines and barbiturates are generally taken orally but occasionally they are injected intravenously. Heroin is generally smoked (sniffed) by beginners and injected by heavy users.

It is important to note that most of the regular or heavy users are multiple drug users. They will substitute one drug for another if availability is a problem or will use a variety of drugs to meet their emotional needs. The takers of amphetamines will use barbiturates to come down off their high. Most of the users of hallucinogenic drugs such as LSD or STP also used marihuana.

C. When and where drugs are being used

It is difficult to disagree with the impression of an Army psychiatrist who says that "the use of drugs and alcohol can occur anywhere at any time." However, it is our general impression that it is more likely to occur on off-duty hours whether in the United States or abroad. It is also likely to occur away from the military post.

The most crucial question on time and place of use concerns the use of drugs in combat. In Vietnam, commanders universally told the staff that, because of the personal danger involved, there was far less smoking of marihuana in combat areas than in rear support areas. The same was stated by commanders to the Department of Defense Drug Abuse Control Committee Task Force headed by Jerome A. Vacek of the Marine Corps during its visit there in the fall of 1970. We were told that there was considerable self-policing among the troops while in combat areas because they did not want to endanger themselves or be endangered by another who might be "high" at a critical moment. However, there is evidence to contradict this. While he did not approach the question head-on, Stanton found "a slight positive correlation . . . between marihuana use and combat exposure." While this shows that combat experienced troops probably were those who had the greatest marihuana experience, it does not necessarily indicate that they used it while actually in combat. Postel's study also indicates the same thing but adds that the usage came after combat "to calm down." Treanor and Skripol likewise found apparently increased usage with field-type duty; far greater numbers reported usage at large and small "LZ forward areas" than numbers reporting usage at "rear support areas." Reinforcing this was their further finding that an overwhelming majority of regular users (once weekly to once daily or more frequently) thought that marihuana should be permitted on fire-bases either during off-duty hours or whenever the individual chooses. Other individuals indicated in person to the staff that they had used marihuana in combat situations.

As noted above, the use of drugs at Ft. Bragg takes place primarily in rented "pads" away from the base and on off-duty hours. In Vietnam and Thailand, it is likely that most use takes place away from established posts because of availability of drugs and the likelihood of nondetection off post.

In the career context, Treanor and Skripol found the highest incidence of marihuana usage during the first two or three years of a soldier's military service. They also reported that apparently there is a slight increase in usage as the first tour progresses, but not with those on extensions.

As for Vietnam, Stanton found that the probability was greatest that if a man was going to start using marihuana there, he would begin in the first three months, or certainly in the first six months. Conversely, amphetamines showed the opposite trend, with more enlisted men beginning use as their tour progressed.

D. Why drugs are being used

The reasons which have been presented to us as to why drugs are being used by young men in the military fall into two general categories. First, there are those which lie with the individual himself. Second, there are the external factors which arise in the individual's environment. The former are related to his ability to deal with his situation and the latter are those which place burdens upon him which he must deal with. If his ability to deal with environmental stresses is inadequate, or if the burdens of stress which the environment places upon him are unusual, the individual user will take one of the drugs available to help him cope with the situation.

As mentioned earlier, the habitual drug user is likely to be young, have a low education, come from a broken home, and have psychological and emotional problems which lead him to conflict in whatever society he happens to be in. These are individuals with a low self-esteem who are unable to meet most life situations. Other individual reasons presented to us are related to the attitudes held by many of the age-group from which the typical drug user comes. These include the following: (1) youth, being "now" oriented, are impatient and frustrated by the gradual process of social change; (2) middle-class youth reject the life goals of affluance and prestige held by their elders; (3) lower-class and minority youth are impatient and frustrated with the disparity between their goals and perceived opportunities to attain them "now," and they see the Establishment as trying to block them; (4) young people "get hung up somewhere along the developmental line" toward maturity, with a conflict developing between dependency and autonomy; (5) drugs are a means of acting-out behavior disapproved of by parents or the senior generation and thus help to concretely distinguish the "self" from Establishment norms. The latter point seems to be particularly valid in regards to the troops in Germany. There we found, to a greater degree than in Vietnam, an attitude of division between the enlisted or drafted lower rank soldiers and the "lifer" NCO's and officers. Perhaps these troops are using drugs as a means of setting themselves off from the older and higher-ranking personnel who use alcohol as their social drug.

Other factors lie with the environment in which the young soldier finds himself. Pressures are put upon him which are difficult to cope with. Prime among these is the lack of sense of value which many soldiers feel about their job. Treanor and Skripol found that job dissatisfaction seemed to correlate with marihuana use. This factor was also cited among many of the returned troops who have several months of stateside duty left before discharge. These men are given unfulfilling tasks to do while waiting out their time. This factor appeared to be particularly acute in Korea and Germany where there is little or no actual combat. Since the troop units there must be combat-ready, there is apparently much routine work aimed at preparing for inspections. A jeep driver in Germany, for example, told us that his only consistent job during the three months in advance of a unit-wide vehicle inspection was to "maintain" his own vehicle. A platoon leader said the only time the morale of his troops seemed to lift was when they were preparing to go on a tough training exercise, which was infrequently. There was widespread griping about the many "make work" jobs that troops were being given to do.

In Vietnam, stress from combat was cited as a factor. It was felt that some troops used drugs, particularly marihuana, to unwind or relax after combat. This is accentuated when the soldier moves from a stressful situation to a combat lull where only routine work is required of him.

Another important external factor is peer group pressure. There were indications that peer group pressure "to be one of the boys" was strong. The young man, placed in a new situation, seeking to establish his own identity, looks to join a group in which he will get approval and support. He may be trying to feel independent of his elders' authority and so when the group pressures him to conform by trying drugs, he finds it hard to resist. We heard reports of individuals being threatened if they did not conform to drug usage patterns but were unable to verify any of these.

We learned of several factors which tend to enhance the peer group situation. We were told that the non-commissioned officers generally did not live among their troops in barracks areas. The older "lifer" non-commissioned officer was regarded very negatively by the young soldiers. There was apparently little identification of the young soldier with the older, non-commissioned officers. Contributing to this problem is the fact that many of the young soldiers were coming from a sub-culture in civilian life which accepts the use of drugs. They not only would want to perpetuate their life style but would resent and resist those who might prevent them from living it.

Another factor is the lack of acceptable alternatives to drug use to meet either stress or boredom. The soldier in Vietnam has little or no way of dealing with his frustration in any constructive fashion. Most towns are off-limits and those that are not are limited in what they have to offer. The primary activity when they are permitted off the post is drinking in the local bars and meeting with local women, most of whom are prostitutes. In Germany, the opportunities for meeting local girls are somewhat improved for white soldiers but an obvious problem exists for blacks who are also barred from certain German-operated "white only" discotheques. In Vietnam, recreational facilities are generally unavailable and are advocated as an alternative to drug abuse. However, it is questionable if these would be used, since in Germany we were told that there is a general lack of troop interest in recreational activities available—playing basketball, skiing, academic courses, even three-day expense-paid excursions.

In contrast to this picture is the experience of the Air Force in Vietnam and especially in Thailand. The extent of drug use was reported to be decidedly lower among the Air Force men at the four bases we visited in Thailand. The command personnel gave evidence that both arrest and medical statistics were much lower. The reasons which they gave for this lower use might be instructive: they stated that the typical airman tends to be older than the soldier; nearly all are high school graduates with a significant number having some college experience; they tend to identify with the military; they have good self-esteem; and they feel that they have something to lose if they use drugs. They also said that in Thailand, airmen were working a 12-hour-a-day, 7-days-a-week schedule and were doing tasks of a higher caliber. (In Thailand much of the more menial-type tasks are performed by local natives.) The Air Force personnel are said to have a high sense of job satisfaction whether they are flying or are engaged in maintenance work: the flight crews feel more worthwhile because they are engaged in a task they feel is significant.

Other factors cited by the Air Force include a higher ratio of officers and noncommissioned officers to enlisted personnel. This is said to give the airman a closer identification with the "Establishment." Also advanced as operative to keep Air Force usage down is the selectivity factor. It is felt by the Air Force that it gets a better grade person both in motivation and ability than does the Army. The Air Force has no draftees. The Air Force also contends that further selectivity operates within its ranks in determining the kind of man who is sent to Southeast Asia. Command in Thailand claimed that the cream of the Air Force crop was being selected to serve in Southeast Asia because of the importance of their mission there. The Command in Thailand also attributed their reputed lower incidence rate to the easy accessibility of alcohol and local women. It appeared that while the drug use rate might be low, the V.D. rate was high.

Another factor which may militate against drug abuse in some situations is the so-called "buddy" system. The Marines and Navy command personnel we spoke with in Vietnam and the Army in Thailand felt that the encouragement of close ties with another individual for the purpose of mutual support and concern helped stop drug abuse before it began. This is a positive variation of the peer-group pressure factor. In this instance a peer situation with anti-drug use values is encouraged. If one individual in the pair is suffering unusual stress or boredom, he has another individual with whom he can share his burden. This gives some relief so that crisis can be met without resort to drugs. We did not have an opportunity to look at this system directly and hence cannot give any independent evaluation. It does, however, appear to have at least theoretical value in terms of action to be taken to combat drug abuse.

III. THE IMPACT OF DRUG ABUSE

The staff has attempted to access the impact or effect which drug abuse is having upon the individual military man, upon the Armed Services, upon American society as a whole and upon the various relationships that exist between individuals and groups in the military. We looked for signs of breakdown which would point to remedial measures and looked for trends or directions which would suggest preventive actions which might be taken.

A. The impact on the individual

The medical effects of drug abuse upon the individual in the military do not seem to vary substantially from those reported in the civilian community. Marihuana produces a range of effects which include mild euphoria, mild time-space distortions, hallucinatory episodes and delusion ideation. Those who are turning up at medical facilities with adverse reactions to marihuana are generally those who suffer anxiety reactions when they first use the drug. Their condition lasts for a very short period and is normally cleared up in 24–72 hours. The reaction seems to be dependent upon the state of mind of the user rather than upon the effect of the drug. It is likely to occur in an individual who has guilt feelings about the use of marihuana and is apprehensive about being arrested or caught. A very few instances of persistent conditions, psychotic states and violence were also reported. However, these seem to involve individuals with deeper, more long-standing psychological conditions of which drug abuse is merely one manifestation of the problem. Many of these situations involved persons who were using marihuana on a heavy basis every day over a considerable period of time. The number or the nature of these cases did not seem to be sufficient to justify a conclusion that marihuana causes lasting psychosis or violence in users.

An interesting phenomenon reported was the "marihuana flashback." A flashback is commonly associated only with LSD usage. Several doctors reported that they had had patients who claimed having flashbacks after use only of marihuana. These flashbacks were described as being reoccurrences of prior experiences while under the influence of the drug. They were described as occuring in moments of stress as if the mind was involuntarily reaching back for a pleasant experience while under intolerable pressure of the moment. However, the subject can apparently be brought out of the flashback by someone talking to him and telling him to return to the present moment. There were no reports of deaths or permanent physical damage from the use of marihuana among military personnel. The military medical personnel also regularly reported that marihuana is non-addictive in terms of physical dependence but that users could and did become dependent upon its use in the psychological or behavioral sense. Medical officers also felt that marihuana does not in itself lead to the use of harder drugs. This is supported by the Black, Owens, and Wolff study which reported: "It should be noted that, although initial experiences with marihuana tend to lead to continued use, marihuana usage does not lead most individuals into experimentation with heroin. The belief that marihuana use is dangerous because it predisposes toward heroin is fallacious, although it is true that nearly all the heroin users in the present study had also used marihuana." Other studies also support this conclusion and indicate that while there is no causal relationship between marihuana use and opiate use, most habitual opiate users have been heavy marihuana users first.

Another important factor which was reported to us is that the effects of hashish use in Germany do not seem to be any more severe or extreme than the effects of marihuana smoked in either the United States or in Vietnam. The medical staff of the hospitals we visited in Germany reported that the cases involving marihuana which required medical or psychological treatment were no more severe than they had seen in other locales including some in the continental U.S. This was true even though the general impression is that the THC content of hashish is higher than marihuana alone.

The reason for this may be in the psychological state of mind of the users and in the setting in which marihuana is used. Also important is the ability of the experienced smoker of either marihuana or hashish to control his level of intoxication. To explain further, the effects of cannabis use seem to depend to a great degree upon the subjective state of the user. If he goes into the experience expecting and desiring a pleasant, mildly euphoric experience with no negative effects and he is doing this in a social setting with fellow users who are compatible and who desire the same kind of experience, his expectations will likely be realized. In addition, because the active ingredient is taken in through the lungs the quickest way to get it into the bloodstream, the user is able to control or "fine tune" his level of intoxication. When he feels himself getting too high he can relax for a while and not smoke any more until he starts to come down. This control by the smoker enables him to keep the intoxication within a manageable range and avoid adverse reactions. Neither the military nor the Bureau of Narcotics was able to supply us with an analysis of the hashish being used in Germany. It is possible that the product bought by the consumer is so cut with adulterants that the THC content is lower than in straight marihuana.

One of the drugs with the greatest impact upon individuals, in medical terms is heroin. It is physically addicting when taken regularly and in sufficient doses. However, we received mixed reports as to the severity of the addiction. Many doctors reported that they saw very few cases of classic withdrawal symptoms in patients who claim the use of heroin. The sniffers of Red Rock heroin were reported not to have become severely addicted. This was also true of some of the injectors of refined heroin. However, the heroin of 97 percent purity available in Vietnam is particularly dangerous, inasmuch as it will likely lead to frequent occurence of overdoses and death even in experienced hands. Heroin use is also likely to lead to secondary medical complications such as serum hepatitis from unsterile needles.

The opium native to Vietnam is of such poor quality that in all but one case observed by an experienced military psychiatrist, withdrawal symptoms were mild. The exception involved an individual who had taken 2 cc. intravenously four times a day and whose abstinence-withdrawal presented serious problems. Another serious result of opium use which occurs occasionally comes from mixing it with marihuana in cigarettes. This synergistic or multiple effect of the two drugs together can exceed the expectation of the user and present him with a reaction with which he cannot cope.

Deaths from heroin abuse or overdose in Vietnam are increasing. For the entire calendar year of 1969, only 16 deaths from drugs were reported: 5 from chloroquine (used to prevent malaria), 4 from barbituates, 3 from Darvon, 3 from morphine or heroin, 1 from opium. During the nine-month period January-October 1970, however, the number of deaths had already more than doubled to 34: 2 from chloroquine, 5 from barbituates, 3 from Darvon, and 26 from heroin-morphine. It will be seen that heroin or morphine has become the most frequently used lethal agent.

One additional significant effect which drug abuse may have on an individual soldier is the role which drugs may come to play in his life. Those individuals who are unable to cope with life and turn to drugs may end up relying on drugs as the core of their life. When this occurs the individual loses interest in other aspects of his life and devotes most of his time to the procurement of drugs and to their "enjoyment." This modification of behavior will likely lead this type of user into conflict with the military community and consequently he is likely to have to face legal or disciplinary action.

While the individual who becomes a heavy user or is psychologically or physically habituated to drug use may come to the attention of legal authorities, it is the conclusion of the staff that the illegality of marihuana use does not have a significant impact upon the great majority of marihuana smokers in the military. It clearly does not

have a deterrent effect. The illegality of marihuana use has been widely publicized within and without the military. Indeed, one of the major thrusts of military drug education is to stress the legal consequences of marihuana use. We believe that the lack of deterrent effect exists for several reasons. First is the basic attitude of young Americans toward marihuana use. Unlike many of the senior generation, many young Americans including those in the military do not regard the use of marihuana as a moral question. They do not see the user of marihuana as a "bad" or "immoral" person. They believe that marihuana should be legalized and its use left up to the individual. They also do not regard the effects of marihuana as detrimental to their health or to their functioning. Many of them regard marihuana as a social drug to be used for relaxation and as superior to alcohol for this purpose because it does not leave the user with a hangover.

B. The impact upon the military

We did not find that the use of drugs has a significant direct impact upon the military mission of the Armed Services. While we were made aware of rare, isolated instances where marihuana had been used in combat situations in Vietnam, we saw no evidence that any mission or operation had been jeopardized by drug use. Virtually every commander to whom the Subcommittee staff put the question stated unequivocally and categorically that drug use has not adversely affected military effectivenes or the military mission of his unit.

However, it is clear that drug abuse does impose an indirect but significant burden upon the entire military community and organization. There is a relationship between drug use and manifestations of social and behavioral disorganization such as AWOL, sleeping on the job, failure to appear for duty, disrespect, indebtedness, and unhealthy and unclean living habits. Of these, General John J. Tolson, the Commanding General of Fort Bragg, singled out AWOL's saying, "It is bound to cut down eventually in your strength figures." although he added that the problem at his base had not reached such proportions "that as units they are not capable of performing their job."

The military community is also affected by the fact that the military drug user is often unable to pay for his habit from his normal income. While this is not often troublesome in Vietnam where all drugs are available at low prices, at continental United States bases, crime to support drug abuse is a problem. Theft of Government property, including weapons, to support habits is known to occur. "Today," General Tolson observed, "you have to secure your arms rooms and supply rooms on a scope that you never had to do before . . . and still, if you don't have guards actually there, thieves will break into them."

One of the most critical effects of the growth of drug abuse among the military is in the growth of a counter or sub-culture within the military centered around drug use. This affects both the individuals involved and the military community itself. Because smoking marihuana and hashish are social activities, the users tend to group together for the purpose of drug use. The illegality of drug use also tends to force the user into a particular group of his drug using peers. This is true whether the use is occasional or is on a regular basis. Part of the mystique of smoking "grass" is to gather together with others to enjoy the experience. The illegality of use, in effect, cuts off the user from legitimate sources of support and help with his problems—whether directly connected with drug use or of another nature—and he can, therefore, look only to those in his peer group for emotional support.

This is aggravated because so many of the young military men coming into the services today, do not identify with the value system of the senior generation. They tend to form peer groups for all activities rather than interact with command personnel. This is further enhanced in the military because it is organized upon a hierarchial basis. In Germany more than in Vietnam the sense of separation between the enlisted man of lower ranks from the non-commissioned officers and the commissioned officers was apparent. In fact, in Germany we felt a great hostility between the one-tour soldier and the so-called "lifer." In Vietnam this was less so, probably because of the common sense of urgency faced by both groups. However we were told in several places that young troopers had a more positive relationship with NCO's and officers of their own age. This was attributed to the fact that these individuals, while occupying positions of authority over the troops, shared many of the same values of the enlisted men, particularly in regard to the smoking of marihuana as a social activity. Some senior officers felt that some of the junior officers right out of college share those values and hence did not take action on marihuana use among their troops.

Another manifestation of the sub-culture problem is illustrated by the example of a second lieutenant at the Wildflicken outpost in Germany. This platoon leader told a Subcommittee investigator of his fears of venturing into the barracks at night, where he might be slugged if he came upon a "pot party" (as had happened to a fellow officer.) The existence of a sub-culture also causes general disruption. A squadron commander at Bad Kissingen, Germany, reported, "It's not the smoking that causes military ineffectiveness; it's the ramifications of the distribution system—the competition among pushers who fluctuate the price, put guys in debt, and cause disciplinary problems, commit assaults and so on."

A more tangible impact upon the military caused by the increase in drug abuse is the burden which it places upon the various elements of the military society. Because of the illegality of drug abuse the primary burden is placed upon the law enforcement branches of the military. The allocation of manpower and monetary resources by the provost marshal to drug problems is significant. For example, in Fiscal Year 1970, 27 per cent of all Army CID investigations in Europe were "drug-related." However, while the law enforcement branches have devoted a significant amount of their resources to stopping drug abuse, we were universally told that their activities were limited and not sufficient to make any significant impact upon illegal drug activity. Their operations are hampered by difficulties in teaching command personnel to make legal searches and seizures, by the length of time necessary for laboratory verification of illegal drugs, and by the difficulty in establishing a legal chain of custody.

Because of the difficulty in enforcing the law, particularly with regard to marihuana use, the law does not have any effective deterrent effect and the impression is given to the users that use is tacitly accepted by command. This leads to disrespect for the law and in effect crates a double standard. While we were not made aware of any cases, we do note that the inability to enforce the law in all cases gives rise to the possibility of selective enforcement for reasons unrelated to drug abuse.

The medical personnel in the military are under many of the same pressures as those in the law enforcement branch. There has been an increased case load upon all military doctors. A number of senior doctors are unprepared to deal with drug abuse because they were trained in an era when it was much less common. The activities of the military doctor include many duties other than treatment. A heavy demand is made upon military doctors, particularly psychiatrists, to establish, promote, and participate in drug abuse education programs. The military psychiatrists must make evaluations of many troopers charged with crimes and this includes evaluations on the users of drugs. In addition, military doctors are scheduled to play a large role in the amnesty program which will be discussed later in the report. These functions place a burden upon doctors who are already overburdened because of a reportedly inordinate reduction of medical personnel in relation to the reduction of other U.S. military personnel. This is a serious problem because military doctors are faced with an increase in drug abuse for which there are few, if any, proven methods of treatment available.

The increase in drug abuse has placed a concomitant load upon all other elements of the military structure, particularly the command personnel and the judge advocate staff. They are called upon to process the cases of accused drug users and also are an integral part of the military drug abuse education activities. Their specific activities will be shown in greater detail later in the report.

C. The impact upon American society

The Subcommittee staff believes that the greatest impact upon society as a whole lies in the integration of military drug users into their local communities upon release from service. While the indications of drug abuse are not significantly different in the military or in civilian society, the likelihood of identification of drug users in the military is greater. Many drug addicts and users with maladjustment problems are being returned from military service identified as drug users, but unrehabilitated. For example, administrative separations for "characterologic ineffectiveness" rose 119 per cent from fiscal year 1969 to fiscal year 1970, from 12,726 to 27,837. Many of these separations were for drug use. In addition, the Veterans Administration has indicated that there are sharp increases in the number of veterans, particularly under age 26, who are being treated for drug addiction and dependency problems.

Since much of the serious drug abuse is accompanied by emotional or psychological problems requiring lengthy treatment, those released from the military with histories of drug use will have to find treatment sources in civilian society. If they are unable to do so, they will place an obvious burden on other segments of society, particularly the law enforcement segment. Returning veterans with drug histories also have difficulty in finding employment. Fifty business firms who were asked by Fort Bragg officials about their policies toward a man with an undesirable discharge or a known drug abuser replied universally that neither would be considered favorable for employment.

IV. HOW IS DRUG ABUSE BEING HANDLED

The question of how to handle drugs and drug users in the military is primarily being met with a law enforcement approach. This effort is aimed at reducing the supply of illicit drugs, at eliminating drug pushers and users where detected, and at providing a negative incentive for the use of drugs. Second priority is given to treatment and rehabilitation of those using drugs. The lowest priority is given to activities which would lead to reduced demand for drugs.

A. Law enforcement

The prime objective of the law enforcement efforts is to identify drug pushers and traffickers and therefore halt or diminish the supply. As noted above, there is little indication of concerted efforts to seek out and arrest users or possessors. In Vietnam and Thailand most possessors were initially picked up for other disciplinary violations. In Germany command indicated that while most drug arrests were for possession or use, they were not specifically looking for users.

There, the greatest number of arrests of users were made as a result of infiltrating a whole group of users and not just arresting individuals.

Because of their relatively small numbers and for jurisdictional reasons, military law enforcement personnel often must rely upon other agencies in trying to shut off the supply of drugs to U.S. forces. The principal agency relied upon for overall activities, both here and abroad, is the Bureau of Narcotics and Dangerous Drugs. Insofar as military bases in this country are concrened, BNDD Director John E. Ingersoll told the Subcommittee "The current 'systems' approach of BNDD is aimed at major interstate and international drug traffickers, and hence, the drug problem on large military reservations such as Fort Bragg is left largely to the military and local authorities concerned." In the U.S. the BNDD forces provide information and support rather than actual enforcement for military bases.

In the U.S., coordination with local and state authorities is essential because apart from those pushers or dealers apprehended on the military base, military law enforcement personnel do not have jurisdiction off base. However, we found good two-way cooperation in gathering and supplying information so that illegal activities that cross jurisdictional lines could be halted.

In September 1970, BNDD assigned a senior official to a permanent liaison position with the Department of Defense. According to BNDD Director Ingersoll, this agent participates in all Defense Department activities concerned with drug abuse and support to the military needs. Overseas, a BNDD senior agent stationed at MACV Headquarters in Saigon works directly with the military and a similar agent more recently was assigned to Frankfurt, Germany. In addition BNDD has regional supervisors in Bangkok, Thailand and Paris, France. Other agents are located in other countries such as Hong Kong, Japan, Turkey and Lebanon. These agents work with military police agents in exchanging information and in setting up covert activities aimed at penetrating illegal drug groups.

In Vietnam, the BNDD agent there has worked closely with the military and the AID agency to establish a program to locate and destroy marihuana crops. This has included the training of Vietnamese police in drug activities and the development of a squad of special narcotics police in the Vietnamese police force. The program consisted of helicopter reconnaissance flights to locate marihuana growth. After the discovery of a field, Vietnamese police would move into the area and destroy the plants by uprooting and burning. In 1969, some 500,000 plants were eradicated in Vietnam under this program. The program decreased in 1970, due to what Ingersoll called "higher combat priorities." He said, in addition, that the Army felt that surveillance which had to be conducted at low altitude and slow speed was too hazardous in areas of potential hostility. While bounties are now paid for reporting marihuana growth, the program has not had the same degree of success as only 68,000 plants were destroyed through most of 1970. More recently, the military has undertaken photo flights with fixed-wing aircraft that can detect growth at safe speeds and safe altitudes.

Local cooperation with native police, particularly in Vietnam, is another activity of the military law enforcement agencies. This does not seem to be a successful program because of the acceptance of opiate drug use by the natives, their feeling that marihuana is not their problem, local political involvement and corruption, general antipathy toward cultural change, inadequate legislation, and the local economic situation. In Vietnam for example, the average daily wage is about $.85 American. If a Vietnamese sells two packages of prepared marihuana cigarettes at $1.50 each, he will have made over 3 times the local daily wage. This makes it difficult for local enforcement agencies to take action.

In Germany, the cooperation with local police seems to be satisfactory. However, there appears to be less than close liaison between the CID and the BNDD agent in Frankfurt. Local command was attempting to overcome this problem by developing closer ties on that level. The CID in Germany makes great use of undercover or covert agents. This has led to the arrest of several large groups of pushers and users. The CID estimates that it is intercepting 20 percent of the illicit trafficking in drugs bound for American troops in Germany.

Also used by military law enforcement authorities are marihuana sniffing dogs. On the Asia trip, we heard quite often about the marihuana dogs and their value. However, it appears that their actual use is limited and not very efficient. Whenever we asked to see a dog we ran into scheduling difficulties or were told that the dogs had worked their allotted time (usually one-half to one hour) and were unavailable. While we suspect their actual detection value, they are probably justified by the deterrent effect their reputation has.

Because of the great amount of drugs available, particularly in Southeast Asia, we do not feel that the law enforcement activities mentioned above will be able to make any significant impact on the drug distribution system. However, we do feel that continued efforts aimed at pusher and major trafficking organizations are necessary and should be continued.

B. Education efforts

Education activities in all commands fall into two categories, command training and troop education. The command training activities center around giving command personnel sufficient factual information to enable them to carry out their legal and disciplinary functions. Emphasis is placed on detection of drug use and subsequent disciplinary action. Command education is generally carried out through Drug Suppression Teams, consisting of medical, legal, law enforcement and perhaps chaplain officers. Primary importance is placed on the identification of drugs, drug paraphernalia, drug use symptoms, and drug user behavior patterns. Command personnel, particularly the junior officers and senior non-commissioned officers are instructed in the techniques of proper searches and seizures, maintaining the chain of custody, and the action to be taken upon apprehension of offenders. While this educational approach may be useful in meeting the legal responsibilities of the military, we feel that it does little toward achieving true prevention of drug abuse.

Education which will enable command personnel to understand the causes of drug abuse and to deal with the troops before they begin drug abuse is generally lacking. Senior officers and NCO's appear to be the groups most needing this type of education. General Tolson of Fort Bragg stated, for example, "It appeared obvious to me at the very beginning that if we were going to get anywhere in our education, in our dialog with the young soldier, the man we were really interested in, there had to be a real understanding by the senior officers and non-commissioned officers on the drug culture and its problems. They were my number one target to educate."

Military regulations, including those issued by the DOD and the various services require that all military personnel periodically receive orientation concerning drug abuse. The form and substance of this orientation varies from unit to unit and, to the knowledge of the Subcommittee staff, has never been evaluated, except informally, for its value in deterring drug use. This orientation runs the gamut from the showing of a film and the reading of prepared lecture material to more imaginative give-and-take "rap" sessions. In many commands the Drug Suppression Team does the orientation to the troops, occasionally adding a former user to the Team. From what little feedback is being received on the command level, this approach was generally not effective. This was affirmed by individual soldiers who complained that the presentations tended to be too legalistic and used scare tactics. It is our impression that the presence of the Provost Marshal on the team, while meritorious in a situation involving command personnel, is not warranted when the target group is younger officers or troops. In fact, the presence of the "cop" on the team acts to turn the young troops against the panel's activities. Surprisingly, this view was accepted by several of the Provost Marshals we talked with.

Other educational activities include radio and T.V. spots and films. The evaluation of these troops we talked to was generally negative. The best educational device we have seen was a training road show in Germany. This play was written by enlisted men in the language and style of enlisted men and performed by enlisted men, most of whom had previous show business experience. The staff was genuinely impressed by the emotional impact of this production. It utilized rock music and visual effects with which the trooper could identify. Because of this we felt its credibility and value was outstanding.

The credibility problem underlies all of the military educational efforts directed toward the young soldier. The conflicting information presented both in and out of the military about marihuana has undermined the credibility of the better prepared and scientifically accurate efforts being made now. However, this is being overcome with valid information presented by medical officers.

C. Treatment and rehabilitation

Treatment and rehabilitation of drug abusers in the military cannot be discussed without considering the so-called amnesty program. This program, in what ever form it may take in any particular command, is a combination of legal, medical and administrative approaches to drug abuse. Its general purpose is to provide an atmosphere in which a drug abusing soldier can feel free to come forth and get medical and psychological help to overcome his drug use.

Experimentation with amnesty programs in the Army began as long ago as February, 1968, when such a program was established by the 4th Infantry Division in Vietnam. Others were established on a command level, all of which were in violation of existing Army regulations. One of the most noteworthy of these is "Operation Awareness" at Fort Bragg which was begun in May 1970, and undertakes to treat and rehabilitate the users of hard as well as soft drugs. Regulations have now been established by the Army and DOD encouraging the establishment of amnesty programs. The Air Force has indicated its intent to establish such a program in a letter to Chairman Hughes. However, the Navy and the Marine Corps have not yet implemented the DOD directive.

The various amnesty programs all include provisions which allow a drug user to make his use known to the chaplain, doctor, or his commander; a guarantee of no disciplinary action if the user is not under investigation and so long as he stays clean; and some treatment for his drug use. The response to the program is mixed. In Europe, only 140 users per month have responded since June, 1970, out of a total population of 185,000 Army troops of which at least 10 percent are said to be chronic users.

The apparent reasons for the minimal response in Europe are several: (1) failure of unit commanders—many of whom were ill-prepared in the first place—to convey the concept of amnesty to their troops, and thereby signal their support of it; (2) a

widely held feeling among drug users, especially hashish smokers, that there is no wrong—physical moral or otherwise—in such use and hence nothing to be rehabilitated from; (3) a view among the troops that there are no inducements to join, no incentives, and no rewards, coupled with the fact that a commanding officer has "open-ended options" to withdraw a man from the amnesty program at any time for any reason; (4) pressure, including threats or actual bodily harm, by "hard" drug users and pushers against those who may wish to seek help under the program; (5) a reluctance on the part of some commanders to devote the considerable amount of time required to provide the soldier with the supportive help he needs; and (6) the fact that many who do participate are subjected to harassment within their units upon their return and that some commanders and top NCO's seem disposed to permit this activity.

The response in Vietnam is also limited. There, many of the medical personnel we contacted felt that the program was not being received as well as it should be among the troops because of the lack of a true guarantee of amnesty. The troops realize that only the chaplain has a true confidential communication privilege. The troops know that the doctors are required to provide medical information to command and therefore are reluctant to come forth and reveal their drug abuse. Another factor which may account for the apparent lack of effectiveness is the unavailability of adequate treatment for users in the war zone. Our impression is that the amnesty program often operates this way in Vietnam. The heavy user comes to official attention when he seeks medical help after an overdose or other condition related to his drug taking; he undergoes detoxification, and within a matter of days is returned to his unit as fit for duty; he may or may not be offered follow-up psychiatric assistance; and no punishment occurs unless he is later caught taking drugs. The extent of treatment which war zone doctors can realistically offer under the current manpower situation is detoxification. There is an insufficient number of psychiatrists to treat the characterological disorders which may underly the drug abuse. Those doctors who might otherwise be available for such treatment are primarily engaged in activities related to Drug Suppression Teams and in providing psychiatric evaluation of accused persons for disciplinary action.

In short, the staff feels that the amnesty program is based upon a sound principle, in that it attempts to provide a system which will get drug users into facilities for treatment. Early evidence, however, indicates that the program is not motivating the target group to volunteer for treatment and that even if they did volunteer, the treatment available is not adequate to solve the drug problems of most users.

The medical treatment provided by the military must be viewed in light of the attitudes of the services toward providing this type of treatment. Brig. Gen. George J. Hayes, Principal Deputy in the Office of the Secretary of Defense (Health and Environment) told the Subcommittee that the general guideline for medical personnel is to retain in the military medical systems only those individuals who could be expected to return to full military duty within a reasonable time. What this means depends upon the circumstances of each individual case. The staff also heard many expressions of the positions that the military is not a social welfare agency, that the long-term treatment and rehabilitation of drug abusers is in conflict with the basic military mission, and that such persons should be removed from the sphere of military influence.

However, the military, particularly the Army, appears to be experimenting and trying to find such clinical approaches as will be effective within the scope of the military missions. We saw examples of this approach in Operation Awareness at Fort Bragg, and group therapy sessions at other bases. General Hayes indicated that as projects are developed and prove to have some efficacy, they will be implemented elsewhere.

D. The administrative process

Of particular importance is the way the problem of drug abuse and drug abusers is being handled in the administrative sense. At the highest level—policy development in DOD—the major effort to date has been the issuance of the DOD directive on amnesty programs. While this effort is much needed, the lag of three years from the time of the first command level amnesty program to the issuance of the broad directive is regrettable. Even that order is not mandatory in that the individual services are authorized, but not required, to initiate these programs. Inasmuch as the Marine Corps and the Navy have not instituted an amnesty program, the young soldier and airman are given greater opportunities to overcome their drug problem than are the young sailor and marine.

The DOD has also recently initiated action to get a broad understanding of the problem. Of importance here are the studies undertaken by the Mack Task Force and the team headed by Jerome Vacek. These studies cover DOD drug abuse policy and programs. There does not exist any service-wide data on drug abuse at the present time, but it is our understanding that such a survey is under consideration. We noticed the lack of hard data at all levels of command. No hard statistics as to the extent of use or the profile of typical users or the reasons for use are available on a broad scale.

At the command level, there seems to be a growing trend toward the use of nonjudicial punishment under article 15 of the Uniform Code of Military Justice and other administrative processes, rather than courts martial, in the handling of all but the most serious drug cases. A general court martial for a drug case is almost unheard of, and Special Courts Martial and Summary Courts are used infrequently. A typical illustration is provided by the experience in the First Air Cavalry Division in Vietnam, in the disposition of marihuana cases. During 1969, there were no general courts martial, only 11 summary courts martial and 43 special courts martial, while there were 131 Article 15 cases involving marihuana. Nor were there any narcotics convictions in general courts martial in that division in either 1969 or 1970. There seem to be several reasons for this trend: (1) the considerable investigation and paperwork required to prepare for a general court martial; (2) overcrowding at the Long Binh jail; (3) the requirement that a man punitively discharged be escorted back to the United States; (4) a feeling among Staff Judge Advocates that young officers sitting on administrative boards are reluctant to approve an undesirable discharge for a drug offender; (5) a further feeling among Staff Judge Advocates that an individual must be apprehended actually in possession in order to sustain a guilty verdict in a court martial; (6) improper search and seizure procedures and failure to maintain a proper chain of custody by unit commanders.

Drug users with security clearances also present a problem. We were told that it is automatic to withhold security clearances from known drug users, even those given amnesty. We are aware of no complaints with this procedure. However, there seems to be no effective policy concerning the restoration of a security clearance to a drug user once he has been rehabilitated. When a security clearance is withdrawn from a drug user, it may be restored after rehabilitation, but as one witness testified, "Outliving a reputation and proving oneself as trustworthy may be difficult indeed."

A special problem has arisen in those overseas areas where there are heavy concentrations of military dependents, particularly in Germany. The dependents are exposed to many of the same environmental pressures that the young military man must face. The availability of drugs, the conflict with the local culture, and the absence of alternative activities are some factors cited by military psychiatrists in Germany as to why dependents might use drugs. The psychiatrists informed us that their efforts at combating the problem were primarily in the educational area. They were trying to develop curricula for the dependent's schools which would provide students with the information necessary to make mature decisions on drug use. They also were attempting programs of early identification of personality problems so that they could get emotional support to youngsters before they became victims of drug abuse.

The military has apparently resorted to another approach in dealing with drug abuse among dependents. Information received by the Subcommittee staff, principally letters from servicemen, indicates that transfer is a commonly used device to remove uniformed fathers whose teen-aged dependents have become involved with drugs. Reports have been received of threats to a father's career as being used to remove families with teenaged users from an overseas post. A civilian counselor for the Army said he had dealt with eleven cases since the summer of 1970 by use of forced retirement and reenlistment (so that return to the United States is immediate). He reported that the tactic was successful since he had had no drug problems among dependent children since September. He did acknowledge, however, that in none of the cases was the next duty station given full particulars about the real reason for reassignment, nor was help requested for the family.

V. DISCUSSION

In this section, we shall discuss certain issues, questions, and problem areas which we feel are suggested by our findings, conclusions and impressions set out in the sections above. While we recognize that the scope of our investigation was limited and that we do not have expert knowledge of statutes, policies, and regulations relating to the Armed Services and the Veterans Administration, we believe that the following discussion will be useful in forming the further consideration of these problems by the Subcommittee, the Armed Services Committee, or the various military branches.

A. Lack of hard data relating to the extent and nature of drug abuse

It is our conclusion that there is a definite lack of hard, scientific data which shows the nature and extent of drug abuse in the military. This lack has been recognized by the DOD. It has indicated to the Subcommittee that an epidemiological study of broad scope will be undertaken in the near future. We believe that such a study would be helpful for several reasons:

1. It would show the extent and nature of drug abuse activities of young men entering the military service.

2. It would show the nature and extent of drug abuse activities engaged in by servicemen while members of the Armed Forces.

3. It would indicate the personal characteristics and the external circumstances common to individuals who abuse drugs.

4. It would indicate those personal characteristics and external circumstances which are common to individuals who refrain from or cease using drugs.

This information would be extremely valuable in determining the more precise allocation of resources and the design of programs to meet specific needs as revealed in the study. We urge that this study be begun as soon as possible and on as broad a basis as possible.

B. Issues relating to the prevention of drug abuse

The discussion of the factors relating to the causes of drug abuse suggested two approaches to the programs designed to prevent drug abuse in the military: one is related to characteristics of individual drug users and the other concerns the circumstances which are present in the user's environment.

1. Prevention—Individual Factors

In the sections concerning the characteristics of the typical user and the reasons why young soldiers engage in drug abuse, some common personal factors seemed to be present. There were also indications of attributes common to the heavy or chronic user who was most likely to come to the attention of command either medically or legally. These common attributes included: age 19–22, rank E–4 or below, unmarried, low education, draftee or non-career oriented enlistee, from a broken home, and personality or characterological disorders. The most recent studies which have been done to date indicate that a significant proportion of the drug abusers being identified in the Army had engaged in drug abuse before entering the military, including some individuals who had used heroin. For example, the survey among 82nd Airborne Division troops showed: "Approximately one half of the marijuana users (who represented 64 percent of the total sample) began use prior to coming into the Army while approximately 4 out of 10 of the opiate users (who represented 17 per cent of the total sample) first used opiates prior to entering the Army. Further, there is evidence that a majority of those in the sample that are heavy drug users began their drug habit in civilian life."

This suggests that the incidence and impact of drug abuse in the military could possibly be reduced significantly by eliminating, in the induction process, those indivduals whose personal characterstics indicate that they are "drug-prone" or who are most at risk when exposed to drugs. Obviously, this approach is not without difficulty. Some candidates for induction may attempt to use alleged drug abuse to escape their obligation. Others may attempt to conceal their habits so that they may join hoping to be cured. A special problem is presented by the drug abuser in civilian life who enlists in the Army when given the choice of military service or jail by his local judge.

In addition, there are few, if any, reliable tests to determine actual drug use or those most likely to become drug abusers. The medical officers at induction stations now consider individuals under the "whole man" concept and try to weigh all relevant factors in each case to determine an individual's potential as a military man. This is clearly a difficult task.

An additional problem arises in determining what should be done with an individual if he is rejected at the induction level as a known drug user or as likely to become one. This individual, while not a risk to the military community, may present difficulties for the civilian community. So far as the Subcommittee staff could determine there is no formal mechanism for referring to civilian treatment agencies those rejected at the induction station who may desire treatment. In contrast, however, under regulations governing the operation of these stations, a candidate for induction who is infected with venereal disease is required to obtain treatment at a U.S. Health Service Hospital before reporting back to the station for further examination.

In view of the foregoing, we recommend that the Alcoholism and Narcotics Subcommittee or the Armed Services Committee immediately undertake discussions with the military to determine the feasibility of taking appropriate action based on the following questions:

a. Whether the Armed Forces should give special priority to developing reliable methods of identifying drug abusers and potential drug abusers at the Armed Forces Examining and Entrance Stations and elsewhere in the military system.

b. Whether a study should be undertaken to determine if entrance examinations can and should be made more effective in screening out drug abusers and those who are prone to drug abuse. Such a study might include an analysis of the techniques which can be used to screen such individuals, a cost-benefit analysis of such techniques, and recommendations of those techniques which might be successfully used by the Armed Forces.

c. Whether individuals who are rejected for service in the Armed Forces because of drug abuse or drug dependence should, with their consent, be referred to appropriate civilian prevention and treatment facilities. Such a determination should include a consideration of the resources available in the civilian community at large.

d. Whether the Armed Forces should establish a system for evaluating the performance of each AFEES station in screening out drug abusers. Such a system might seek to identify those AFEES stations where significant numbers of individuals have been admitted to service with undetected drug abuse and drug dependence problems which subsequently interfere with their military performance.

2. Prevention-Environmental factors

In earlier sections, there was considerable discussion of environmental factors which might lead to or foster drug abuse among military personnel. These included: lack of satisfying work; boredom; stress from combat; peer group pressure; development of a sub-culture organized around values antithetical to the military; a division between young enlisted men and "lifer" NCO's and officers; and the lack of acceptable social and recreational alternatives.

In addition, a number of factors were cited by the Air Force, particularly in Thailand, as contributed to a low drug abuse rate. These included better caliber of personnel (higher education, bstter motivation); high sense of job satisfaction; high ratio of officers and non-commissioned officers to enlisted personnel; no draftees; selectivity in recruiting; and acceptable recreational alternatives. Another factor which was suggested as tending to prevent or reduce the desire to participate in drug abuse was the "buddy system."

While these were presented to the staff as possible factors affecting the rate of drug abuse, we do not feel that we have sufficient information concerning these assertions to make any firm recommendation as to their validity. However, they do point the way to possible approaches which would reduce the motivation to take drugs and thereby reduce the demand for illegal drugs.

Therefore, we recommend further study of these factors, both positive and negative, to evaluate the impact they have upon drug abusers and whether positive alternatives can be developed to reduce the impact of negative elements.

C. PREVENTION-EDUCATION

The education activities which the various military branches have been presenting fall into two categories, command training and troop education. As noted above, primary emphasis is being placed upon command training, the purpose of which is to enable the command cadre to carry out legal and disciplinary functions. Education which would enable command personnel to understand the causes of drug abuse and to deal with troops before they begin drug abuse is, in the opinion of staff, generally lacking and should be strengthened. In addition, it is our impression that present educational activities directed toward the troops themselves are not effective in preventing the desire to use drugs and should be evaluated.

In view of the foregoing, we believe that the Subcommittee on Alcoholism and Narcotics or the Armed Services Committee immediately undertake discussions with the military to determine the feasibility of taking appropriate action based on the following questions:

1. Whether to shift the priority of drug abuse education from command training to troop education.

2. Whether a more intensive troop education program and permitting individual participation, would be effective in reducing drug abuse in the military.

3. Whether "Drug Abuse Suppression Teams" with expertise in effective educational techniques and a knowledge of legal, medical, and social ramifications of drug abuse, are a useful tool in meeting the drug challenge.

D. PREVENTION-LAW ENFORCEMENT

The primary question in the law enforcement field relates to the relative priority of law enforcement activities as compared to prevention programs aimed at reducing the motivation to use drugs. As noted above, the current laws relating to the use of drugs (particularly marijuana) and their enforcement do not seem to be providing any significant deterrent effect. Other factors favor a shift away from a basically law enforcement approach, particularly in Southeast Asia. The control of the supply and distribution of drugs under the ecological, economic, and political conditions in those countries is difficult. Director Ingersoll testified that he thought American troops would be gone from Southeast Asia before any significant changes were made there. The total amount of drug supplies which can be stopped seems to be limited, regardless of manpower limitations. This was recognized by the CID of the 4th Infantry Division when it provided the main impetus in establishing its amnesty program in early 1968.

Specific problems affecting the legal and law enforcement process of the military in dealing with drug abuse include: improper search and seizures by unit command personnel; failure to maintain proper chains of custody in preserving evidence; and delays in getting laboratory analysis of suspected drugs. We suggest that further emphasis be placed upon developing procedures and training programs which would eliminate these problems.

E. PROCESSING OF DRUG ABUSERS—TREATMENT AND REHABILITATION

The issue of treatment and rehabilitation of drug abusers is the most complex and difficult of all those dealt with in our investigation. There can be little doubt that drug abusers, especially those who are addicted or dependent on drugs, should receive medical treatment whether they are in the civilian or the military community.

However, the questions as to how that treatment is to be delivered to the abuser, by whom it is to be delivered, the nature of the treatment necessary, and under what circumstances it should be delivered have not been definitively answered whether in the context of the military or civilian communities. As regards the drug abuser in the military, the most difficult question is to what extent, if any, should the military treat a drug abuser found in its ranks. As previously noted, the Armed Forces have taken the position that they should undertake treatment of a drug user in the military only if he can be restored to duty within a "reasonable" time. The general position of medical practitioners and command personnel in the military is that it is not consistent with the

mission of the military to undertake long-term treatment and rehabilitation.

The treatment which is now provided in the military services seems to be limited in scope and duration. The closest approach to long term rehabilitation in the military is "Operation Awareness" at Fort Bragg where the program is 12 weeks long. This experimental program is attempting to deal with hard narcotic addicts as well as those dependent on soft drugs.

Under the amnesty program, the treatment provided is minimal. It does not appear to go beyond detoxification, if necessary, and short-term psychotherapy or group therapy. This is particularly true for cases arising under the program in the Vietnam War Zone. There the conditions under which treatment is given make it extremely difficult to deal with any thing other than the acute effects of drug abuse. It would be nearly impossible to provide treatment of underlying psychological disorders while maintaining an individual in his unit under combat conditions. Another difficulty with treatment in the war zone is that any kind of treatment which would remove an individual from combat conditions would tempt many individuals to take advantage of the program solely for the purpose of avoiding combat. This would be particularly true if, as some have proposed, a central treatment facility were to be established there. Some medical personnel have also pointed out that a centralized facility is not satisfactory from a therapy point of view in that it removes the patient from his natural environment and increases the difficulty of reintegrating him into any kind of military unit.

Adding to the complexity of the treatment problem is the issue of whether or not there are adequate resources within the military to provide treatment, even under the limited responsibilities assumed by the Armed Services today. There are several factors which should be considered at this point:

1. The true extent of the drug abuse problem is unknown.

2. There is a current shortage of trained medical and mental health personnel.

3. The rotation of military personnel usually militates against the overlap of key people and the retention of personnel in a single position long enough to fully develop any treatment program.

As to the shortage of trained medical and mental health personnel, the staff was told that in September, 1970, there were only 13 Army psychiatrists in Vietnam, and only one Army and one Air Force psychiatrist in Thailand. In Europe we were told that the Army has more psychiatrists than in Vietnam, on the ground that there is a greater spread of individual installations in Europe.

The present normal tour of duty for physicians and psychiatrists in the Army is three years at one duty station except in Vietnam where it is one year. We were told, however, that DOD was contemplating recommending a five-year normal tour of these personnel.

Another issue relating to treatment and rehabilitation is whether confidentiality of communications should be preserved in all treatment and rehabilitation relationships involving the drug user who elects to seek assistance under an amnesty program.

The Department of Defense did not address this issue in its Directive 1300.12. Nor did the Army in AR 600-32. However, the Air Force, in its amnesty program, will grant "certain limited privileged communication rights."

Under current military practice, there is generally no guarantee of privileged communications between doctor and patient. This is based upon the Department of Defense position that "a military service must have, or be able to obtain, full and complete information at any time as to the physical or mental capacity of its members. A rule providing otherwise would place the military in the untenable position of having little or no idea as to the physical or mental conditions of the members of the service."

Obviously, this rule gives rise to conflict when the subject matter of the privileged communication is also illegal. It becomes particularly acute in the context of the amnesty program policy of encouraging drug users to seek treatment. This conflict was repeatedly cited as discouraging drug users from seeking help even though they were otherwise motivated to seek it. The fear of prosecution on the basis of information divulged in the course of treatment has apparently not been overcome by the guarantee of amnesty established in the program.

Medical personnel did point out, however, that "often in treatment and rehabilitation it is very important that certain people who are in important social positions be notified in order to enlist assistance in helping someone. So in that sense strict confidentiality may not be something you want to maintain, but it is the illegality which poses a major problem."

Although the amnesty policy does preclude prosecution upon the basis of information divulged by an individual when seeking medical assistance under the program, it is clear that it is not intended to prohibit the use of such information for such administrative action as removal from flying status or the revocation of a security clearance. The Air Force also indicates that such information could be used under its amnesty program to administratively discharge a drug user under honorable conditions. It also has indicated that in the case of a temporary suspension or disqualification from flying status, a one year period of abstinence would be the minimum time before restoration of such status.

In the Army the security clearance of a drug abuser is withheld automatically upon disclosure. While this withdrawal is characterized as temporary, no specific guidelines have been established to permit reinstitution of the clearance.

It should be noted that if the drug abuser does not voluntarily seek help under an amnesty program there might be no knowledge of the drug abuse and therefore the individual would retain flying status, security, clearance, etc.

The administrative processing of known drug abusers whether those participating in amnesty programs or those apprehended for drug abuse violations presents several other issues.

A major question raised by the administrative processing of drug abuse offenders, whether by Article 15 action, administrative action, or through judicial action, is the relationship between the administrative action and treatment and rehabilitation. Regardless of whether punishment or separation of a drug abuse offender is administered, the offender in many situations has physical or mental health problems related to his use of drugs. Therefore consideration must be given to providing treatment or rehabilitation to the offender as well as to the individual who voluntarily seeks assistance under the amnesty program or otherwise. Factors which should be given consideration in determining the proper disposition of an offender include:

1. Whether it is a first offense.

2. The severity of the offense (pushing vs. use).

3. The willingness of the offender to accept treatment.

4. The degree of physical addiction or psychological dependents upon the drug.

5. The evaluation of the severity of any underlying psychological problems.

6. The length of service of the offender and the length of time left in his current obligation.

Another problem arises in the cases of those who have actually been separated from the military for drug offenses. We were presented with some evidence that those who are separated with anything less than an honorable discharge are subjected to discrimination when re-entering civilian life. This can be particularly difficult for the drug offender as he has characterological problems which make him a marginal individual in society anyway. A discharge other than honorable places one more barrier in his way. However, it was the position of some military personnel that the discharge is an assessment of the job performance of the individual in his military function and therefore no modification in policy would be appropriate to alleviate the burden of the drug offender.

Another issue worthy of mention is the military dependent and drug abuse. The primary place where we came into contact with dependent use was in Germany. We heard reports of administrative action (early retirement, transfer, loss of quarters) being taken against a parent because of his child's use of drugs. We learned of drug education and prevention efforts being made by dependent schools and medical personnel. We would recommend, however, that the problem of drug use among dependents and programs designed to combat that problem be given further study and evaluation.

Because of the interrelationship between treatment and rehabilitation, and administrative processing of drug abusers, we believe that the Subcommittee on Alcoholism and Narcotics or the Armed Services Committee should immediately undertake discussions with the military to determine the feasibility of taking appropriate action based upon the following questions:

1. Whether it is feasible for the Defense Department to establish a comprehensive, integrated, and mandatory policy under which servicemen who are drug dependent or drug addicts are provided treatment and rehabilitation within the military service.

2. Whether it is feasible for the Defense Department to establish a program whereby a drug offender who desires medical treatment can receive it within the military.

3. Whether a program can be developed whereby servicemen identified as drug dependent persons or drug addicts can be separated from the military and provided with treatment, if necessary, in the civilian community.

4. Whether it is feasible to consider such actions as postponement of trial or disciplinary proceedings, suspension of sentence, or other devices commonly used in civilian courts, as alternatives or in lieu of prosecution of drug depsndent persons or drug addicts.

5. Whether absolute confidentiality in privileged communications is necessary or feasible within the meaning of amnesty programs.

6. Whether guidelines can be developed to permit the restoration of flying status, security clearance or other privileged status, within a reasonable time after rehabilitation.

7. Whether treatment and rehabilitation efforts should be carried out in central treatment facilities, within the context of a local unit or both.

8. Whether drug dependent persons or drug addicts should be granted non-punitive discharges and be eligible for all or some veterans benefits.

9. Whether the Veterans Administration should give priority to increasing its capability to care for drug dependent persons or drug addicts.

10. Whether military medical manpower can be allocated so that continuity is preserved in treatment and prevention programs.

11. Whether it is feasible to allocate greater manpower and monetary resources to all ele-

ments of the military which deal with drug abuse.

12. Whether it is feasible to give priority to peer group participation and the use of ex-addicts in prevention, treatment and rehabilitation programs.

Mr. MANSFIELD. Mr. President, will the Senator yield?

Mr. HUGHES. I yield.

Mr. MANSFIELD. Mr. President, I commend the distinguished Senator from Iowa for once again taking the initiative in a field which is of transcendent importance.

We have been hearing a great deal from congressional sources about the rise in the drug problem in Indochina, and perhaps in Southeast Asia as a whole, and we are becoming aware of what this means to us in more ways than one.

I recall the interest of the distinguished Senator from Iowa in going down to Fort Bragg some months ago to look into the drug treatment program as it affected, I believe, members of the airborne troops at that base. If I recall correctly, the Senator was very pleased with the attitude of the commanding officer there, and the attempts which he was making to try to bring about rehabilitation of those who had become addicted to drugs—many of them to the hard-type heroin and the like.

The Senator has now become the chairman of a committee which will be able to look into this matter more thoroughly. I anticipate that the kind of job which the distinguished Senator from Iowa will do will be one which is long overdue, which will be welcomed by the Senate and the country as a whole, and which will help to point a way toward a solution of this problem, which is growing not better but worse with the passage of time, and which will affect not only the military, as it does at the moment, but in time will affect the population as a whole.

Again I commend the distinguished Senator for his initiative in this most important and delicate field.

Mr. HUGHES. I thank the Senator from Montana.

Mr. BYRD of Virginia. Mr. President, I wish to join with the distinguished majority leader in commending the thoughtful and able Senator from Iowa for his work in regard to the drug problem in our Armed Forces. I do not know of any subject more important for congressional consideration than the accelerated use of drugs in the Armed Forces. It presents a grave danger to our Armed Forces. As a Senator and as a citizen, I am very glad that the conscientious, dedicated, and able Senator from Iowa is chairing a committee to delve deeply into this problem.