4-20-1971

Congressional Record - Drug Abuse in the Military: Senator Hughes Remarks

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DRUG ABUSE IN THE MILITARY

Mr. HUGHES. Mr. President, inasmuch as the distinguished majority leader was speaking of “fragging” in South Vietnam, I would like to continue in that context for just a few minutes before I begin with the statement I prepared for this period.

As I listened to the distinguished majority leader this morning, I noted that the 209 reported incidents of last year in Vietnam, and later we developed in colloquy the fact that this figure undoubtedly did not include any of those incidents which may have taken place under actual combat conditions or conditions when combat troops were other than outer perimeter or central defensive troops, the thought occurred to me that in the study I am presenting this morning on drug dependence and drug use in the military we will see the causes behind many of those incidents of fragging or assassinations of American officers by others in the military, regardless of the circumstances.

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.

The President. Without objection, it is so ordered.

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 a distinguished member of that committee, Senator MARGARET CHASE SMITH.

The report does not purport to be an in depth analysis and investigation of this very large and complicated subject. 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 of the problem of drug abuse in the 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 unforeseen. 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 decision 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. As I have already stated, we 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. Unless such a 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 position or pay is withdrawn from a member who sought assistance as a drug dependent person or as a medically ill drug abuser, such withdrawal 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 have a more detailed report and will encourage us to take those actions legislatively that can undergird this plan.

The PENDING OFFICER. Without objection, Mr. Hughes.

(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 marijuana in combat areas than in rear support areas. Yet, some studies indicate a positive correlation between marijuana 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 one is never and is never far from 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 combat areas are available, there is ample reason to believe there is a close tie.

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

Press reports carry stories, one of which has been frequently presented here this morning, of widespread "fraggings" 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 that story.

Finally, we have the hideous picture before us of men, inflamed 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.

I have an opportunity to address the Congress of the United States to the conclusion of my remarks.

The PENDING OFFICER. Without objection, Mr. Hughes.
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-range 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 the development of programs for identifying drug abusers and potential drug abusers at the Armed Forces Examining and Entrance Stations and elsewhere in the military system. The General Accounting 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 such 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.

Exhibit 2

Staff Report on Drug Abuse in the Military

To: Members of Alcoholism and Narcotics

From: The Subcommittee Staff

I. Introduction

In the spring of 1970, the Subcommittee received an interim report on 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 that subcommittee were to: explore the extent and nature of drug and alcohol abuse in the military, and determine which this abuse is having upon individuals, the armed services, and American society as a whole; thoroughly investigate the areas of education, treatment, and rehabilitation, which the military is taking to meet the problem, and 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 state-wide 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.

The second attempt 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 returning to base). We visited bases throughout Southeast Asia, Europe, and 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, Malcolm Connel; Julian Granger, staff investigator; Richard J. Wise, Minority Counsel, and Jay B. Cutler, Minority Counsel. In Europe the above were joined by Nik Roes 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 adequate picture of either the extent of use or the nature of use, but it was available in all command situations. In addition to command discussions, we attempted, where possible, and when time permitted, 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 the personnel of the command 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 expansion of the military and increased the cooperation we received, particularly from the Provost Marshal General. In general we were satisfied with the truthful responses of those we contacted. The Army was more realistic in assessing the problem. When they seemed willing to recognize drug abuse as a problem and to take action both to prevent it and to help those who were addicted, we would rate the other services in the following order: the Air Force, the Navy, and the Marine Corps.

What follows is a synthesis of the staff's 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 use drugs, what drugs they use, when they tend to use drugs, and the circumstances of use and the reasons for use vary widely. However, the generalizations which we do draw from 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

The basic training period on which the emphasis was placed is a period of hard data on which to base an authoritative finding of the extent of drug use in the military. The few studies which have been undertaken have been reported by 11.6 percent (7.8 percent of married, less than high school personnel) of the men who are being held as draftees or non-career oriented enlistees, and are stationed on both overseas and stateside bases. It is primarily in the Two Northern Corps, Stan lion, 1969; (2) Marihuana In Vietnam: A Survey of Use Among Army Enlisted Men In the Two Southern Corps, Rozman, and (3) Marihuana Use in Vietnam: A Preliminary Study, 1969; and (6) A Study of Marihuana and Opiate Use in the Sixth Airborne Division, 1969. Of these, only the Stanton and Treanor-Skripol study included both officers and enlisted men; the others were concentrated on enlisted men in the lower ranks.

Patterns of drug use which Stanton found among soldiers leaving Vietnam 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 16.3 percent (11 percent casual users, 4 percent heavy users, 1 percent habituated users); (3) barbiturate use was reported by 11.6 percent (7.8 percent casual users, 2.7 percent heavy users, 1 habituated user); (4) heroin/morphine use was reported by 2.2 percent (1.4 percent casual users, 0.6 percent heavy users, 0.2 percent habituated users); (5) acid (LSD, STP, etc.) was used 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 time. At the same time, the first study was conducted, and that a growing proportion of servicemen are entering the service with some prior drug use experience. It is the job of the military, just as there is none in civilian society. We should mention that drug abusers are enlisted men of lower rank between the ages of 18 and 20, users may also be found in the non-commissioned and commissioned officer ranks; for example, a heroin hooked sergeant in 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, either draftee or non-career oriented enlistee, equally from field or support units on first overseas tour.

Other factors seem to be present in those who become regular or habitual users. These persons are often from broken homes, have a lower education (are high school drop-outs), have insufficient personality adjustive characteristics to deal with the pressures they are under (passive-aggressive personalities, immature, situational adjustment, lack of self-esteem, lack of long-term ambitions, etc.) and are likely to become involved in other behavioral groups such as the drug 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 require medical treatment are those which come 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 users. The Special Processing Detachment is primarily a holding unit for individuals apprehended anywhere along the East Coast for drug offenses. They are sent to Fort Dix until their records can be located and their proper unit determined.

An individual who has become a habitual user of drugs and who is going to become a problem for the military is either mentally or disordered, or an individual who has personality problems sufficiently serious that he would likely be called for 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 Fort Dix, New Jersey. There the drug users leave the post to congregate in pads rented by small groups for the purpose of taking drugs. These pads are characterized by psychedelic decorations, acid rock music, and by the most disastrous of all preparations. We were also told in several places that the figures on the extent of use were distorted depending upon which group an individual troop belonged to. If the person questioned
and in the use of various remedies. These are dispensed primarily by an organized network of Chinese operating in nearly all nations. In Vietnam and Thailand marijuana was freely available. In Thailand, the members of the staff had no difficulty in procuring "tailor-made" marihuana with some Air Force troops use. These were small apothecary shops which dispense the drugs they felt would solve the problem whatever he felt would solve the problem. The Southeast Asia marijuana is fresh and potent. Delta 9 Tetracannabinol (THC) is the active ingredient in marijuana. The average sample available in Southeast Asia contained 15 percent THC. This is much higher than the average 0.1 to 0.4 of 0.1 to 0.4 percent THC which U.S.-grown marijuana contains. The preference for marijuana in Southeast Asia among U.S. troops is ascribed to ready availability, inexpensiveness, ease of cachet, 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. A nongoing enlisted man in his sample, only 63 percent reported having used opium before their arrival but 74 percent reported doing so on the day before their departure. The question has been raised as to whether these trends really know what they were used for. Stanton's findings are as follows:

1. There is a growing trend among U.S. troops in Vietnam toward the use of marijuana. This is available in liquid or powdered form.
2. A nongoing enlisted man in his sample, only 63 percent reported having used opium before their arrival but 74 percent reported doing so on the day before their departure.
3. The question has been raised as to whether these trends really know what they were used for.

As noted above, the use of drugs at Ft. Bragg, takes ability to deal with raised "pains" away from the base and on-duty hours. In Vietnam and Thailand, it is likely that the most use takes place away from established posts because of availability of drugs and the likelihood of nondetection off post. As for Vietnam, Stanton found that the probability was 0.03 that this was going to start using marijuana there, he would begin in the first three months, or certainly in the first year. The use of amphetamines showed the opposite trend, with more enlisted men beginning use as their time in service increased.

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 can be grouped into several general categories. First, there are those which lie with the drug. Second, there are the external factors which arise in the individual's environment. The former are related to his ability to deal with environmental stresses and the latter are those which place burdens upon him which he must deal with. If his ability to deal with these stresses is inadequate, or if the burdens of stress which the environment places upon him are unusual, the individual is one of the drug uses available to help him cope with the situation.

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 marijuana.

C. When and where drugs are being used

It is difficult to form the impression of an Army psychiatrist who says that "the use of drugs and alcohol can occur anywhere and under any circumstances." However, it is our general impression that it is more likely to occur on off-duty hours whether in the United States or in Vietnam. 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." However, there is evidence to contradict this. While he did not approach the question head-on, Stanton's findings on the positive correlation between marijuana use and combat exposure. While this shows that combat conditions have been those who had the greatest marijuana experience, it does not necessarily indicate that they used marijuana after combat. Postel's study, also indicates the same thing but adds that the drug is "dosed down" after combat. Tresner and Skripol-like-wise found apparently spaced usage with field-type duty. Far greater numbers reported usage at large and small "LZ forward areas" than in the "rear support areas." Reinforcing this was their further finding that an overwhelming majority of regularly used (and more frequently) thought that marijuana should be permitted on fire-bases either during or after duty hours. Others indicated in person to the staff that they had used marijuana in combat situations.
Other factors lie with the environment in which the young soldier finds himself. Pressures such as boredom are difficult to cope with. Prime among these is the lack of sense of value which many soldiers feel about their job. (Skripka) found that job dissatisfaction seemed to correlate with marihuana use. This factor was also cited by Green by returned troops who have several months of stateside duty left. Factors such as boredom are given as 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 relatively little例行 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 major reason for marihuana use. This was used drugs, particularly marihuana, to unwind or relax after combat. This is accentuated when the soldier finds himself in a situation, seeking to establish his own identity, looks to join a group in which he will get support. They may be trying to free themselves from their Alice of his elders' authority and so when the group pressures him to conform, he feels he must do so or be left out. We heard reports of individuals being threatened if they did not conform to drug usage. This was especially true in units that were able 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 with the young soldier with the older, non-commissioned officers. Contributions of the Non-Commissioned Officers (NCOs) seem to be interpreted as coming from a sub-culture in civilian life which accepts the use of drugs. They not only want to perpetuate their life style but would resistent 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 more improved for the young soldiers but an obvious problem exists for blacks who are also barred from certain German clubs. (Niemeyer) In Vietnam, recreational facilities are generally unavailable and are advocated as an alternative to drug use. There is no question that if these would be used, since in Germany we were told that there is a general lack of troop recreational activities available-playing basketball, skiing, scuba diving, even three-day expense-paid excursions.

In contrast to this picture is the experience of the Air Force. In Vietnam and especially in Southeast Asia, Command In Thailand claimed that the cream of the Air Force core was highly motivated and had initial identification with the "Establishment." Also advanced as operative to keep Air Force units prepared for combat is the fact that by the Air Force that it gets a better grade person both in motivation and ability than does the Army in preparing non-commissioned officers. The Air Force also contends that further selectivity operates within its ranks in determining the kind of duty given to non-commissioned officers. This is a positive variation of a higher caliber. (In Southeast Asia. Command In Thailand military. We looked at the opportunities most attractive to drug abuse. However, it is also true that they did not conform to drug use. The effects of drug use are different in the military. The American Medical Association has little or no correlation between marihuana use and opiate use, most habitual opiate users in the present study had also used marihuana."

Another study 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 marihuana users first. Another important factor which was reported to us is 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 serious than the cases in other locales including some in the continental U.S. This was true even though the general impression was that the amount of hashish used was considerably less than that needed to cause hallucinations. The belief that marijuana is less dangerous is a dangerous one in that it is a drug that can be used with no apparent ill effects. This belief may lead to a greater degree upon the subjective state of the user. If he goes into the experi-
Senecio expecting and desiring a pleasant, mild, conscious experience with no negative effects and he is doing this in a social setting with fellow users who are compatible and with whom the user has had previous experiences. His expectations will likely be realized. In addition, because the active ingredient is taken in its purest form, it is likely to get into the bloodstream, the user is able to control or “fine tune” his level of intoxication, and he is 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 user in Nissan 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 rather than in straight marijuana.

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 many reports to the severity of the heroin problem and reported that they saw very few cases of classic withdrawal symptoms in patients who claim the use of heroin. The sniffers of Red Rock mine reported not to have become severely addicted to heroin. However, the heroin of 97 percent purity available in Vietnam is of such poor quality that in all but one case observed by an experienced military psychiatrist, the patient was not ill. The exception involved an individual who had taken 2 cc intravenously about 4 times a day and whose abstinence-withdrawal period bore serious problems. There were no other significant 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. Of these, 3 from hashish and cocaine, 3 from barbiturates, 4 from heroin, and 3 from barbiturates. In early October, however, the number of deaths has more than doubled to 34: 2 from chloroquine (used to prevent malaria), 4 from barbiturates, 3 from Darvon, 3 from morphine or heroin, 1 from opium (a drug native to Vietnam) and 1 from barbiturates. The increase in deaths in Vietnam is also likely to lead to secondary medical complications such as serum hepatitis from needle users.

The opium native to Vietnam is of such poor quality that in all but one case observed by an experienced military psychiatrist, the patient was not ill. The exception involved an individual who had taken 2 cc intravenously about 4 times a day and whose abstinence-withdrawal period bore serious problems. There were no other significant 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.

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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 drug users themselves and the military community itself. Smoking marijuana and hashish are social activities which tend to bring individuals together for the purpose of drug use. The illegality of drug use and the moral implications involved in the procurement of drugs and drug use is more likely to have to face legal or disciplinary action.

While the individual who becomes a heroin user, even if physically habituated to drug use may come to the attention of military authorities, it is the conclusion of the Sub-culture Group that “Illegal” marijuana use does not have a significant impact among the great majority of marijuana smokers in the military. Partly this is because it is usually not a drug that can be used in a social setting with fellow users. In addition, it is not as popular as a drug among the military. However, the military community itself is affected by the fact that the military drug user is often a member of a counter-culture of drug users who tend to seek out their own company.

One of the major threats of military drug education is that the user sees his time in the military as a time when he can engage in activities which were not possible before. He may use this time in the military to try drugs or to engage in activities which were not possible before and which he would not have engaged in if he had remained at home. It is likely that this will be particularly true of members of the military who are not assigned to drug enforcement duties.

In effect, the user sees the military as a “safe area” where he can engage in activities which were not possible before. He may use this time in the military to try drugs or to engage in activities which were not possible before and which he would not have engaged in if he had remained at home. It is likely that this will be particularly true of members of the military who are not assigned to drug enforcement duties.

The existence of a sub-culture problem has been identified by the example of a general in Austria in the late 1960s who reported to a conference in Germany. This general said that the national drug problem in Austria was not seen as a major threat, but that the problem was seen as a major threat in the military. The general said that the problem was seen as a major threat in the military because it was perceived as a threat to the military mission of the Armed Forces.

The military mission of the Armed Forces is to protect the country, to protect the population, and to protect the government. The military mission of the Armed Forces is not to combat drug abuse, but to protect the country, the population, and the government from the effects of drug abuse.

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upon military doctors, particularly psychiatrists, to estimate, monitor, and participate in drug abuse education programs. The military psychiatrists must make evaluations of mentally ill persons who are engaged in the use of drugs. In addition, military doctors are scheduled for orientation in the drug abuse 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 other segments of the military structure, particularly the command personnel and the judge advocate staff. The question usually becomes that of the cases of accused drug users and also an integral part of the military drug abuse education activities. These activities will be shown in greater detail later in the report.

C. The impact upon American society

The Staff believes that the greatest impact upon society as a whole lies in the integration of military drug users into their former places of service. While the indications of drug abuse are not significantly different in the military or in civilian society, the identification of drug users in the military is greatest. 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 "chronic drug ineffectiveness" rose 119 per cent from fiscal year 1966 to 1970, from 12,726 to 27,837. Many of these separations were for drug use. In addition, the Veteran Administration has indicated that there are sharp increases in the number of veterans, particularly under age 20, who are being treated for non-military drug dependency problems. Since much of the serious drug abuse is accompanied by emotional or psychological problems, 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 agencies, the local and state political organizations, the judicial systems, and the like. Therefore, it appears that their actual use of drugs, but unrehabilitated, is not very efficient. Whenever we asked to see a dog we ran the risk of encountering the law enforcement agencies, the local and state political organizations, the judicial systems, and the like. Therefore, it appears that their actual use of drugs, but unrehabilitated, is not very efficient. Whenever we asked to see a dog we ran the risk of encountering a large group of drug users and their associates. The command training and two-way cooperation in setting up covert activities aimed at penetrating illegal drug groups in Vietnam, the BNDD agent has worked closely with the military and the AID agencies to eradicate drugs and destroy marijuana crops. This has included the training of Vietnamese police in drug activities and the apprehension of special narcotics police in the Vietnamese police force. The program consisted of helicopter reconnaissance of marijuana growth. After the discovery of a field, Vietnamese police would move into the area and destroy and burn the plants. In 1969, 100,000 plants were eradicated in Vietnam under this program. The program was conducted due to what Ingersoll called "higher combat priorities." He said, in addition, that the Army felt that the existence of marijuana in Vietnam was already known. It was not the same degree of success as only 68,000 plants were destroyed through most of 1970. More recently, the military has undertaken photo detection of marijuana plants, with the goals of detecting 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 use of drugs by the natives, their feeling that marijuana is not their problem, local political involvement, and other factors. The current "systems" approach of the BNDD is aimed at major intermediate 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 September 1970, BNDD assigned a senior official to serve in the position with the Department of Defense. According to BNDD Director Ingersoll, this agent participated in all agency 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 stationed at the U.S. Embassy in 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.

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material to more imaginative give-and-take "rap" sessions. In many commands the Drug Suppression Team does the orientation to the program, or a former user to the Team. From what little feedback is received on the command level, this approach has been effective. This was affirmed by individual soldiers who complained that the presentations tended to be too formal and too "classroom." It is our impression that the presence of the Provost Marshal on the team, while meritorious in a situation where command influence 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. This conclusion, 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 programs was talked to was generally negative. In one command 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 previously served in Vietnam. The author and producers of the play were genuine impressed by the emotional impact of this production. It utilized rock music and songs with which the young soldier 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 in and out of the military about marijuana has undermined the military's credibility and by making scientifically accurate efforts being made now. However, this is being overcome with valid information by military medical officers.

C. Treatment and rehabilitation

Treatment and rehabilitation of drug abusers in the military cannot be discussed without reference to the official 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 problem.

Experimentation with amnesty programs in the Army began as long ago as February, 1966. A program was established by the 4th Infantry Division in Vietnam. Others were established on a command level, all under the aegis 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 actions for any action taken prior to 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, but in a total population of 185,000 Army troops of which 60% are overseas, 2% 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 il­prepared to accept—"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 which can be rehabilitated from; (3) a view among the troops that there are no inducements to join, no incentives, and no punishment; the fact that a commanding officer has "opened-ended options" to withdraw a man from the amnesty program; (4) an absence of pressure, including threats or actual bodily harm, by "hard" drug users against those who 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 see 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 is confidential in the drug service and that the communication privilege is gone. The troops know that the doctors are required to provide medical information concerning to the Army regulations. This means that the doctors are required to come forth and reveal their drug abuse. Another factor which may ac­count for less participation is the fact that the availability of adequate treatment for users has been limited in the war zone. Our impression that this is a major problem is borne out in our conversations with military personnel 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 may return to his unit as fit for duty; he may or may be not 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 questionable. 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 have other priorities. The activities related to Drug Suppression Teams and in providing psychiatric evaluation of accused drug users will be implemented elsewhere.

In short, the staff feels that the amnesty program is based on a sound principle, in that it offers a system which will get drug users into facilities for treat­ment. Each year, however, indicates that the program is not motivating the target group to volunteer for treatment and that even when 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 guidelines for medical personnel is to re­tain in the military medical systems only those drug abusers who are expected to return to full military duty within a reason­able time. What this means depends upon the particular case and the individual case. The staff also heard many expressions of the positions that the military is not a social welfare agency, and that 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, seems to be approaching 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 carried out by Gen. Hayes indicated that as projects are de­veloped and prove to have some efficacy, they will be employed. This appears to be the way things will be handled. It is likely that the individual services are authorized, but not required, to initiate these programs. In­asmuch as the Maritime 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 ac­tions that meet a broader, and more civilianized, type of treatment. One is "Operation Awareness," a new program to be carried out under the Uniform Code of Military Justice and other admin­istrative processes, rather than court­martial, in the handling of drug cases. A general court martial for drug offenses is not only summary courts martial and 43 special courts martial, while there were 315 Article 131 cases involving marijuana, narcotics convictions in general courts mar­tial in that division in either 1969 or 1970. The DOD has begun a program to reverse this trend: (1) the considerable investigation and paper work required to prepare for a gen­eral court martial, (2) overworking at the Long Beach jail; (3) the requirement that a man, if convicted, be subjected to a complete drug rehabilitation treatment. This is a long-term treatment. Most Staff Judge Advocates that young officers sitting on administrative boards are reluctant to approve an undesirable discharge for a drug offender; (4) a 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 marijuana convictions also present a problem. We were told that it is automatic to withhold security clearances from former drug users, even those who have been am­nestied. We are aware of no complaints with this procedure. However, there seems to be no legal basis for withholding the restoration of a security clearance to a drug user once he has been rehabilitated. When a secu­rity clearance is lost or denied, it can be restored after rehabilitation, but as one witness testified, "Outliving a reputation may well be 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. These dependents are exposed to many of the same environmental pressures that the young military man must face. The availability of drugs, combined with the local culture, and the absence of alternative activities, can lead to drug abuse. Many of the psychiatrists in Germany report that they see young dependents who are experimenting with drugs. The psychiatrists believe that these dependents have difficulties similar to those that might be found among young people back home.

We feel that our findings, although limited, are suggestive of the factors that may be involved in drug use by military dependents. We were attempting to gain an understanding of the types of factors that might encourage drug use among dependents, and we hope that our report will encourage others to look more closely at this problem.

B. Issues relating to the prevention of drug abuse

The discussion of the factors relating to drug use among dependents is completed. We have attempted to approach this problem from the point of view of the character of individuals, the reasons why drug using practices have increased in recent years, and the potential drug abuse problem. We believe that there is a need for a comprehensive approach to drug abuse prevention, and we hope that our findings will be useful in developing such a program.

1. Prevention—Individual Factors

In the last section we dealt with the characteristics of the typical user and the reasons why young soldiers engage in drug use. Some common personal factors seemed to be present. There were also indications of factors common to the heavy or chronic user who was most likely to continue to use drugs. These factors include: (1) early drug use; (2) drug use as an escape; (3) drug use to escape pressures; (4) drug use to escape boredom.

In the sections concerning the Armed Services we shall discuss certain issues, questions, and program areas which we feel are suggested by our findings, conclusions and impressions set out in this report. We believe that the factors discussed above are common to the heavy or chronic user who was most likely to continue to use drugs. They are: (1) early drug use; (2) drug use as an escape; (3) drug use to escape pressures; (4) drug use to escape boredom.

In addition, a number of factors were cited by the Air Force, Navy, and Army concerning the factors that might lead to or foster drug abuse among military personnel. These include: (1) lack of satisfying work; boredom; stress from combat; peer group pressure; development of a sense of anti-social behavior; a desire to fit in with the military; (2) a division between young enlisted men and "lifer" NCOs and officers; (3) lack of acceptance in the civilian world. These factors are common to the heavy or chronic user who was most likely to continue to use drugs.

In addition to these factors, some of which are common to individual drug users who are heavy drug users, there are some factors that are common to individual drug users who are heavy drug users. These include: (1) early drug use; (2) drug use as an escape; (3) drug use to escape pressures; (4) drug use to escape boredom.

In conclusion, we believe that there is a need for a comprehensive approach to drug abuse prevention, and we hope that our findings will be useful in developing such a program.
should be strengthened. In addition, it is our impression that present educational activities in the services themselves are not effective in preventing the desire to use drugs and should be evaluated.

In line with the thinking that the Subcommittee on Alcoholism and Narcotics had, the Committee immediately undertook 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 methods and consequences. As noted above, the current laws relating to the use of drugs (particularly marijuana) and their enforcement are not a deterrent. The control of the supply and distribution of drugs, both to the military and civilians, is difficult. It is not possible to operate enforcement programs in lawless areas where the manufacture of drugs is available. 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 in a memorandum of law and order 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 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 problem with which we are dealing in this 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 resolved. We are dealing here in the context of the military or civilian communities. As regards the drug abuser in the military, the question is to what extent, if any, should the military treat a drug abuser found in its ranks. As previously noted, forces have taken the position that they should undertake treatment programs for drug abusers only if he can be restored to duty within a "reason­able" time. The general position of medical personnel is that it is not consistent with the mission of the military to undertake long-term treatment programs.

The treatment which is now provided in the military services seems to be limited in scope and extent. A long-term rehabilitation program in the military is "Operation Awareness" at Fort Bragg where the program is expected to be expensive and minimal program is attempting to deal with hard narcotics 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 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 leaving combat duty.

This would be particularly true if, as some have proposed, a central treatment facility were to be established. Medical personnel also have pointed out that a centralized facility would come from a therapy point of view in that it removes the patient from his natural environment and ignores the importance of integrating him into any kind of military unit.

Adding to the complexity of the treatment problem is the fact that there are inadequate 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 required to fully develop any treatment program.
4. As to the shortage of trained medical and mental health personnel, it was told that in September, 1970, there were only 13 Army psychiatrists in Vietnam, and only one Army and one psychiatrist in Thailand. In Europe we were told that the Army has more psychiatrists 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 seeks to seek assistance under an amnesty program.

The Department of Defense did not address this issue. 30 U.S.C. § 3602. However, the Air Force, in its amnesty program, will grant "tantamount, limited privileged-exemption rights."

Under current military practice, there is generally no confidential communication between doctor and patient. This is based upon the Department of Defense policy that patients 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 is prohibited in the untenable position of having little or no idea as to the physical or mental condition of any members of the service.

Obviously, this rule gives rise to conflict when the subject matter of the privileged communication is related to the use or abuse of drugs. This point was particularly acute in the context of the amnesty program policy of encouraging drug users to seek treatment of drug abuse without fear of being 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 seeking medical assistance under the program, it is clear that it is not intended to prohibit the use of information for such administrative action as removal from flying status or the revocation of a security clearance. The Air Force has already indicated that such a decision could be used under its amnesty program. The administration of an amnesty program will not change a drug user under honorable conditions. It also has indicated that in the case of a temporary suspension of 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 reinstatement 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 abusers whether those participating in amnesty programs or those apprehended for drug abuse violations presents several other issues.

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 psychiatric dependence upon the drug.
5. The evaluation of the severity of any underlying psychological problems.

6. Whether it is a first offense 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 characteristic 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 person (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 dependents 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 to the retention of drug dependent 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 privileges, 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 elements 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.

Mike Mansfield Papers, Series 21, Box 47, Folder 32, Mansfield Library, University of Montana