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REPORT TO THE CONGRESS

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BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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Alcohol Abuse Is More Prevalent In The Military Than Drug Abuse

Department of Defense

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Actions are needed to improve the Department of Defense's management of its drug and alcohol programs. This report should help the Congress assess the adequacy and effectiveness of the military's efforts to reduce drug and alcohol abuse.

Defense has made progress in coping with the drug and alcohol problems of military personnel. Problems persist, however, which require additional action.

--Defense has not sufficiently recognized the severity of its alcohol problem; too little is being done to correct it.

--Defense's approach to the drug problem is not as effective as possible.

--Defense needs an information system to enable it to accurately gage, on a continuing basis, the size of its drug and alcohol problems and the effectiveness of its actions to correct them.

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APRIL 8, 1976

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(2)

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses how the Department of Defense has managed its drug and alcohol control programs. The report cites the progress the Department has made in coping with the drug and alcohol problems of military personnel and actions needed--especially in the alcohol area--to improve overall control.

Title V of Public Law 92-129 requires the Department of Defense to identify, treat, and rehabilitate military personnel who have become dependent on alcohol or other drugs. This report should help the Congress assess the adequacy and effectiveness of the Department's efforts.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Defense.

Comptroller General
of the United States

Contents

ABBREVIATIONS

DOD Department of Defense

GAO General Accounting Office

GLOSSARY

Abuse--drugs/alcohol	Any irresponsible use of drugs or alcoholic beverages which leads to misconduct, unacceptable social behavior, or impairment of an individual's performance of duty, physical or mental health, financial responsibility, or personal relationships.
Addiction--drugs/alcohol	A physiological condition in which consuming drugs or alcohol is necessary to prevent withdrawal symptoms.
Alcoholic	One who has the illness of alcoholism. The alcoholic has lost the ability to control his consumption of alcohol.
Alcoholism	A progressive chronic illness characterized by habitual excessive consumption of alcohol which impairs the individual's physical and mental health, personal relations, social conduct, and job performance.
Detoxification	The process of establishing physiological equilibrium, including eliminating alcohol from the body. Detoxification is the first step in the treatment process.
Drinking problem	Drinking which frequently impairs the drinker's health, personal relationships, social conduct, or job performance. The problem drinker has not lost the ability to control alcohol consumption.

Drug dependency	A state of psychological or physical dependence, or both, on a drug, arising in a person after receiving that drug on a periodic or continuing basis. The characteristics of such a state vary with the drug involved.
Classes of drugs	Stimulants--stimulate the central nervous system--produce excitation, increased activity, and an ability to go without sleep for extended periods of time. Examples: amphetamines, cocaine. Depressants--depress the central nervous system--reduce restlessness and emotional tension and induce sleep. Examples: barbiturates, sedatives, hypnotics, alcohol, methaqualone. Hallucinogens--distort the perception of reality--produce illusions and hallucinations. Examples: LSD (lysergic acid diethylamide), marihuana, hashish. Narcotics--among the drugs used medicinally to relieve pain. Examples: opium and the drugs made from opium, such as heroin, codeine, and morphine.
Intoxication	A state of impaired mental and/or physical functioning resulting from the presence of alcohol in the body.

Physical dependency	A state in which withdrawal symptoms occur when a person stops taking a drug or stops drinking alcohol.
Recovered alcoholic	A person whose alcoholism has been arrested. Normally this is accomplished through abstinence.
Urinalysis program	This program consists primarily of random, worldwide testing of urine samples to detect the presence of opiates, barbiturates, and amphetamines. Methaqualone is also detectable but is not tested for regularly on a worldwide basis. Tests are conducted (1) when certain events, such as entry into active duty, occur (2) at the direction of commanders who suspect drug use in their units, and (3) as a means of monitoring personnel and patients involved in rehabilitation programs.
Use--drugs/alcohol	Use of drugs or alcohol which may or may not be illegal or improper.
Withdrawal symptoms or syndrome	Drugs--a characteristic cluster of reactions that begin when a person stops taking a drug on which he is physically dependent. Alcohol--a potentially serious complication of detoxification. It includes intense anxiety and degrees of mental and physical impairment and may progress from tremors and convulsions through hallucinations and delirium to death.

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

ALCOHOL ABUSE IS MORE PREVALENT IN THE MILITARY THAN DRUG ABUSE
Department of Defense

D I G E S T

From fiscal years 1972 through 1976, the military services allocated about $336 million for drug control programs and about $57 million for alcohol control programs. (See p. 4.)

Major problems persist, however, and effective action is needed to correct them.

ALCOHOL PROGRAM

GAO found that alcohol abuse is more prevalent than drug abuse among military personnel and impairs the effectiveness and efficiency of military performance more than illegal drug use does.

DOD is aware that it has a severe alcohol problem but it is not doing enough to correct it. (See ch. 2.)

DOD should:

--Increase its alcohol education efforts.

--Reduce or eliminate practices which encourage alcohol consumption.

--Provide alternatives to alcohol consumption by encouraging and supporting activities that do not center around drinking.

--Direct the services to (1) strengthen their programs for identifying individuals with alcohol problems and (2) provide additional resources as needed for treatment and rehabilitation. (See p. 39.)

DRUG PROGRAM

DOD has placed much more emphasis on its drug control program than on its alcohol control program; funding levels for fiscal years 1972 through 1975 were over six times greater for the former.

Despite the larger resources made available to it, the drug control program has some problems. (See ch. 4.)

DOD needs to:

--Reevaluate the desirability of its present random worldwide urinalysis (a method of identifying drug users) program. The program's potential positive results, such as deterring drug use, should be weighed against such other factors as its high cost and the problems in administering the random tests.

--Provide more education on the intent of the drug user exemption policy (another method of identification) and thereby improve the policy's credibility and success.

--Instruct the services in the proper levels of rehabilitation services necessary to treat particular problems, especially the marihuana problem, which represents about 70 to 90 percent of the drug use among service personnel. (See p. 58.)

NEED FOR RESPONSIVE INFORMATION SYSTEM

GAO believes DOD could better (1) gage the size of its alcohol problem, (2) recognize the problems affecting the operation of both the alcohol and the drug control programs, and (3) direct the services on actions needed to improve their respective programs, if its management had better information in these areas. (See p. 62.)

AGENCY ACTION AND UNRESOLVED ISSUES

DOD agreed with the general thrust of GAO's recommendations and shared GAO's concern about the prevalence of alcohol abuse and its impact on military personnel.

It questioned whether alcohol abuse was a more serious problem than drug abuse and disagreed with GAO's recommendations on the need to (1) increase alcohol education efforts, (2) reevaluate the desirability of the present urinalysis testing program, and (3) improve the management information system. (See pp. 24, 39, 58, and 67.)

GAO believes that its review, coupled with studies performed for DOD by independent consulting firms, supports the need for DOD action in these areas. (See pp. 26, 27, 40, 61, and 68.)

CHAPTER 1

INTRODUCTION

This report considers the impact both drug and alcohol problems have upon military effectiveness and performance. Viewing both problems in the same report yields a broader perspective for evaluating program priorities and the management of resources in dealing with the problems. The report refers to drugs and alcohol separately in discussing the difficulties they cause and the programs established to deal with them; however, scientific definitions treat alcohol as a drug.

PREVIOUS REPORTS

We issued two earlier reports to the Congress on drug and alcohol problems in the military. "Drug Abuse Control Activities Affecting Military Personnel" (B-164031(2)) was issued in August 1972, and "Alcoholism Among Military Personnel" (B-164031(2)) was issued in November 1971.

In the drug abuse report, we discussed what the Department of Defense (DOD) had done to control and reduce drug abuse by military personnel. We recommended that DOD develop a system for evaluating its drug abuse treatment, rehabilitation, and education activities. Military service representatives generally agreed with our recommendation.

In the alcoholism report, we pointed out that no DOD-wide alcoholism prevention and rehabilitation program existed and recommended that the Secretary, DOD:

--Make a study to determine more precisely the incidence of alcoholism and problem drinking.

--Make rehabilitation available to all military personnel with alcohol problems.

--Establish educational programs to inform military personnel of the dangers of alcohol abuse.

DOD concurred with these recommendations and stated that DOD-wide policies would be established to implement them.

APPROACH TO THE PROBLEMS

DOD has made progress in coping with its drug and alcohol problems. DOD and the services have issued regulations providing guidance on (1) preventing these problems through education, law enforcement, and community action and (2)

identifying, treating, and rehabilitating individuals afflicted by them.

DOD awarded two contracts to evaluate the military's drug and alcohol programs--an $876,500 contract to Arthur D. Little, Inc., in June 1973 to evaluate drug programs and to develop a program evaluation system and a $616,681 contract to System Development Corporation in June 1974 to evaluate the alcohol programs. The Army and Navy have also funded studies to determine drinking practices and problems in their respective services.

The drug program

In October 1970, DOD issued a directive acknowledging its responsibility for (1) counseling its personnel on drug abuse and protecting them from it, (2) disciplining personnel who use drugs or promote their use illegally or improperly, and (3) attempting to restore to duty and otherwise rehabilitate drug users. The military departments were directed to:

--Develop screening programs to (1) prevent drug addicts from entering the services and (2) identify drug users already in the military.

--Establish trial amnesty programs under which drug users who voluntarily sought help might be exempted from punitive action. If rehabilitation or restoration to full duty was precluded, a discharge under honorable conditions was to be considered.

--Develop programs and facilities to restore to duty and otherwise rehabilitate drug users and addicts willing to undergo rehabilitation.

--Educate all military members in the hazards and consequences of using drugs.

The President issued a directive in June 1971 calling for a drug counteroffensive. In the same month the Secretary, DOD, told the military departments to give urgent priority to developing a comprehensive drug program to deal with the problem of heroin use among service personnel in Vietnam.

In July 1971 the services established an exemption policy (formerly called "amnesty"); they also began implementing screening, rehabilitation, and education programs in 1971.

The alcohol program

In March 1972, DOD issued a directive to the services stating it had responsibility for counseling personnel on drug abuse, protecting them from it, preventing and deterring alcohol abuse, and attempting to restore to duty and otherwise rehabilitate members who abused alcohol or were alcoholics. DOD directed the services to:

--Develop screening programs to prevent individuals who were alcohol dependent from entering the services and to promptly identify and refer individuals with alcohol problems to treatment and rehabilitation.

--Integrate, as practicable, the alcohol program with the drug program.

--Establish education and training programs to prevent alcohol abuse.

--Avoid practices which tended to encourage or glamorize excessive use of alcohol.

According to DOD, the services had begun individually to implement alcohol programs at several bases before this directive was issued. The Air Force opened an alcohol rehabilitation center at Wright-Patterson Air Force Base in 1966. The Navy organized a clinic for treating alcohol-related problems in 1967 and issued a Navy-wide directive on August 22, 1971. The Army published an alcohol and drug abuse prevention and control plan on September 3, 1971. After the issuance of the March 1972 directive, alcohol programs began to be implemented servicewide.

FUNDING

DOD provided us with the information on page 4 regarding the funding levels to support the services' drug and alcohol programs.

The ratio of drug to alcohol funds was about 14 to 1 for fiscal year 1972 and approximately 4 to 1 for fiscal year 1976, on the basis of estimated funding. As shown in the following table, the general trend in the Navy and the Air Force has been a decrease in drug funding and an increase in alcohol funding. The Army, on the other hand, has continually increased its drug funding and has made small increases in alcohol funding. The Army did not agree with the DOD-provided breakdown of its drug and alcohol funds. The Army felt it would be more appropriate to calculate its alcohol funding level by (1) eliminating the cost of

	Funding for fiscal years 1972-76 (note a)					
	1972	1973	1974	1975 (note b)	1976 (note b)	Total
			(millions)			
Drugs:						
Army (note c)	$31.9	$37.7	$38.2	$40.5	$43.2	$191.5
Navy	9.0	17.8	17.3	16.6	15.7	76.4
Marine Corps	.8	1.0	.4	.5	.6	3.3
Air Force	15.7	15.8	12.6	10.0	8.4	62.5
Office of Information, Armed Forces (note d)	1.3	.7	-	-	-	2.0
Total	$58.7	$73.0	$68.5	$67.6	$67.9	$335.7
Alcohol:						
Army	$ 1.9	$ 1.5	$ 2.0	$ 2.0	$ 2.0	$ 9.4
Navy	[e] 1.9	4.6	8.1	8.0	8.8	31.4
Marine Corps	-	.3	.5	.5	.5	1.8
Air Force	.5	1.6	2.7	4.4	5.4	14.6
Office of Information, Armed Forces	-	.2	-	-	-	.2
Total	$ 4.3	$ 8.2	$13.3	$14.9	$16.7	$ 57.4

[a] The funding information for 1973-76 was prepared by DOD in January 1975. The funding data for 1972 was provided by DOD separately.

[b] Estimated obligations.

[c] The Army operates a single integrated alcohol/drug program at its field installations worldwide. The Army drug funding totals include some inseparable funds that are used to operate the alcohol program as part of the integrated program.

[d] Buys pamphlets, brochures, advertisements, and films on drugs and alcohol.

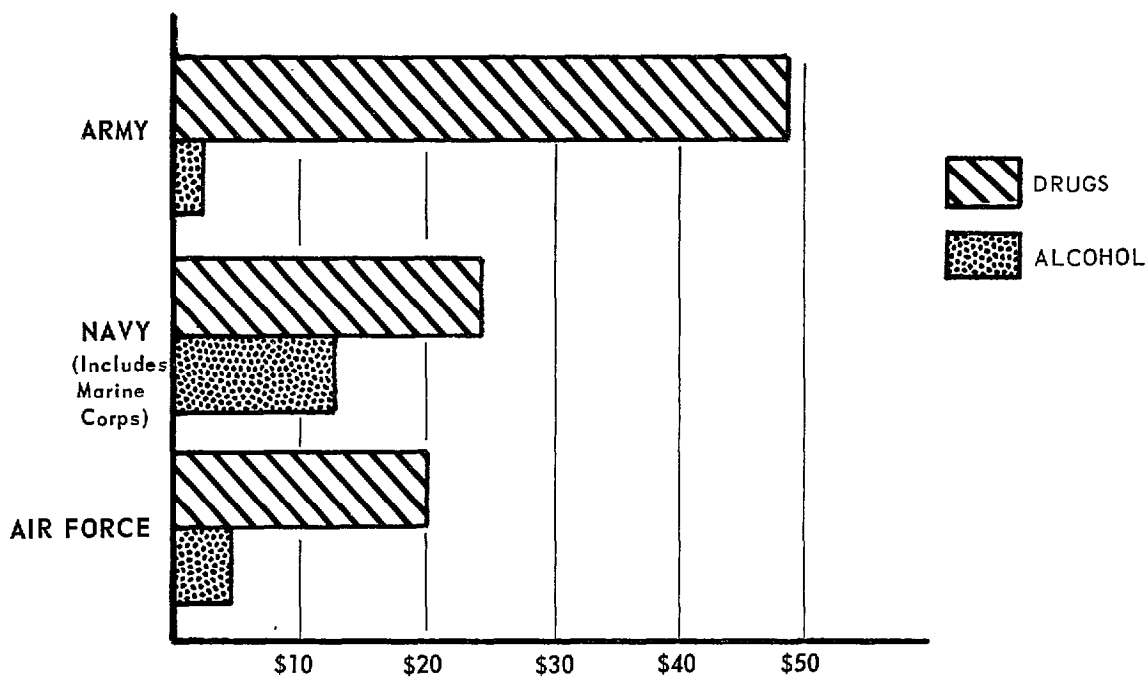
[e] Includes funds for the Marine Corps.

administering its urinalysis program from the total drug and alcohol budget and (2) multiplying the remainder by 42 percent (the proportion of alcohol clients in the combined program, according to the Army).

The Army, unlike the Navy and the Air Force, has a combined drug and alcohol program which involves some commingling of drug and alcohol funds. Also, according to statistics developed by the services, the Army has identified, treated, and rehabilitated more individuals with drug problems than the other services have. (See p. 54.)

The following illustration, based on the troop strength of each service as of June 30, 1974 (see p. 31), and its fiscal year 1974 funding level for drug and alcohol programs, shows the per capita funding for each program.

FUNDING PER CAPITA



PROGRAM COMPONENTS

The components of the military drug and alcohol programs which directly affect military personnel are preinduction screening, education, identification of problem personnel, and treatment and rehabilitation. Within DOD, each service

is responsible for developing its own programs. An organizational chart showing the breakdown of responsibility within each service is included as appendix II.

Preinduction screening

The services screen prospective recruits for prior drug use and alcohol problems. Before enlistment, each recruit is physically examined by a physician who may reject the recruit for such reasons as chronic alcoholism or drug addiction. Recruiters also interview prospective recruits about possible drug use and review recruit responses on recruiting forms which ask specific questions about prior drug use or related criminal arrests or incidents. If prior drug use is uncovered, enlistment is denied unless the drug involved was marihuana; in that case a waiver may be given. The Army and Navy may also grant waivers for experimental use of other drugs, such as amphetamines and barbiturates, but they generally do so only after thoroughly investigating the background, including any police records, of the prospective recruits.

In addition to requiring a physical examination, each service tries to determine if a prospective recruit has an alcohol-related problem. Checking police records--which each service generally does--may indicate a prior alcohol-related offense such as drunken driving. However, recruiters say they do not generally investigate or specifically discuss alcohol problems unless the recruits voluntarily provide information concerning previous or existing problems. Normally recruiters evaluate such disclosures, sometimes with the aid of police records, to determine their seriousness. Each service is willing to waive certain alcohol-related offenses and misdemeanors.

DOD believes a previous offense of alcohol intoxication in a public place cannot be equated to the illegal use of drugs; the first is a misdemeanor, while the second is a felony.

Education

The military drug and alcohol education efforts are essentially uniform, although instruction methods and frequency vary. The Air Force requires all its personnel to receive 2 hours each of drug and alcohol education annually. The Army provides 2 hours of combined drug and alcohol education during basic training, after which base commanders are responsible for continued education at their discretion. According to the Navy, varying amounts of combined drug and alcohol education are provided at Navy enlisted and officer

service schools. Additionally, each major command develops its own requirements for drug and alcohol education. For example, one command at the U.S. Naval Station, Rota, Spain, established a training course which devoted 2 days to drug and alcohol education.

Identifying problem personnel

Each military service uses various methods to identify drug and alcohol abusers. These methods include self-referrals, commander referrals, medical referrals, and law enforcement referrals. However, because of the urinalysis program, the identification measures for drugs are more costly and extensive than those for alcohol.

The main objective of identification is to identify individuals in the early stages of their drug or alcohol problem so they can be promptly treated and rehabilitated. Drug identification has two additional objectives:

--Deterring drug use.

--Providing data on the prevalence of drug use.

Exemption policy

The exemption policy was promulgated to encourage individuals with drug problems to volunteer for treatment and rehabilitation by exempting those who volunteer from certain punitive actions, including discharge under other than honorable conditions. As amended January 7, 1975, the DOD exemption policy states that:

> "* * * a military member may not be subject to disciplinary action under the Uniform Code of Military Justice or to administrative action leading to a discharge other than an honorable discharge for drug use solely because he has volunteered for treatment under the drug identification and treatment programs of the Department of Defense."

However, according to DOD, such administrative actions as removal from flying status and restriction of access to classified material may be imposed on individuals under the exemption policy.

Urinalysis program

After establishing the exemption policy, the services began urinalysis testing of personnel serving in Vietnam in

June 1971 to identify drug users. The testing was expanded in January 1972 to make service personnel worldwide subject to random testing for drug usage.

The urinalysis program provides for:

--Testing when certain events, such as entry on active duty and reassignment from certain locations, occur.

--Commander-directed testing of an individual or an entire unit when drug use is suspected.

--Testing of program staff to insure a drug-free environment.

As in the case of those who volunteer for treatment and rehabilitation, individuals identified as drug users by urinalysis are also exempt from certain punitive actions under the exemption policy. DOD policy states that:

> "Evidence developed by or as a direct or indirect result of urinalysis administered for the purpose of identifying drug users may not be used in any disciplinary action under the Uniform Code of Military Justice or as a basis for characterizing a member's discharge as other than an honorable discharge."

The urinalysis program normally requires individuals to provide urine samples under observation by testing personnel. The samples are tested for opiate, barbiturate, and amphetamine use by 10 triservice regional drug screening laboratories.[1]

A service member who has a positive urine sample but cannot be medically confirmed to be an illegal drug user must be placed in a surveillance program in which urinalysis tests are administered two times per week for 4 weeks. The procedures generally employed in confirming drug abuse are illustrated in the chart on page 9.

The urinalysis program was temporarily suspended on July 18, 1974, when the Court of Military Appeals ruled that, since an order to produce a urine sample could lead to an administrative separation with a less-than-honorable

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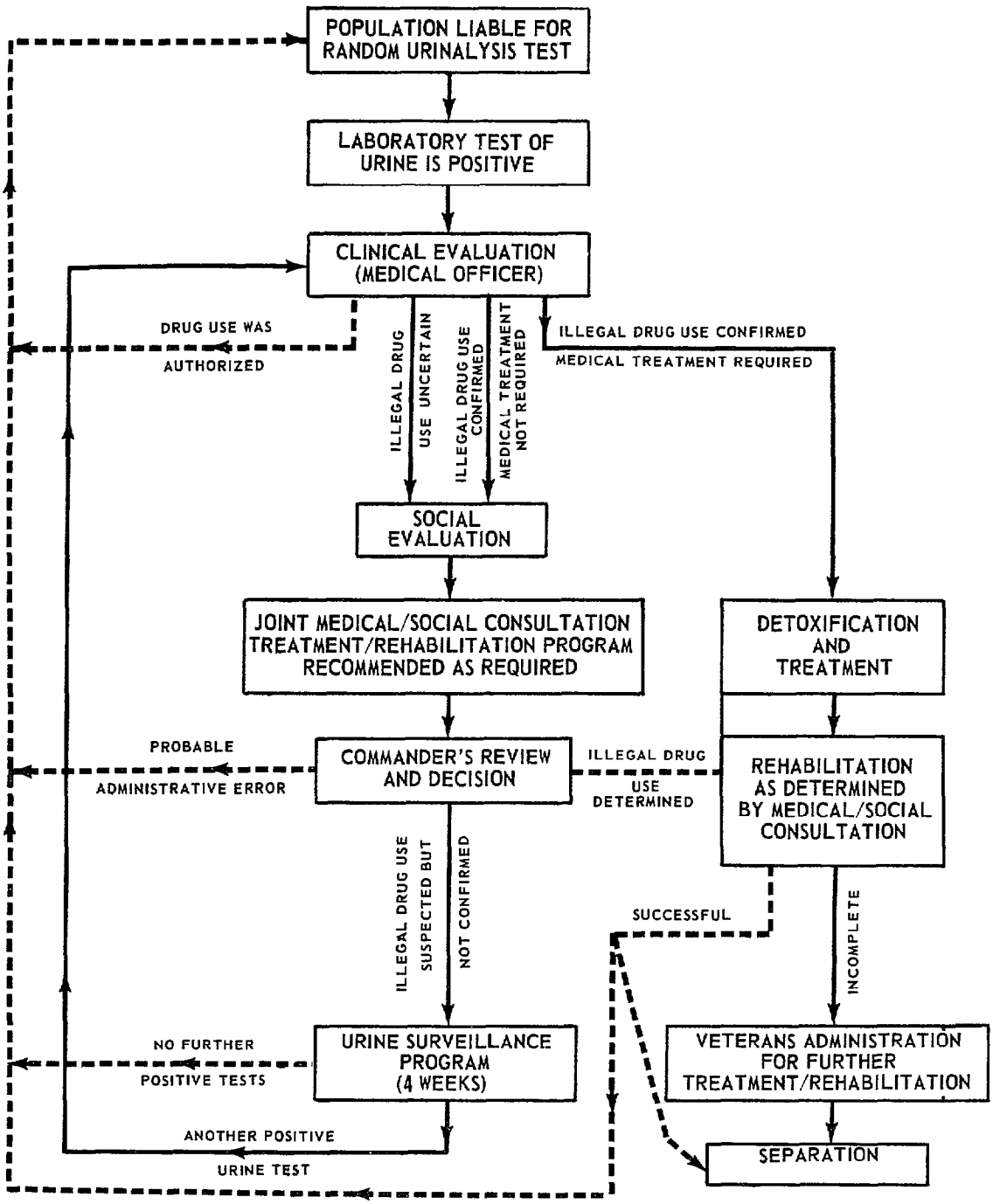
[1]On February 1, 1975, DOD instituted a new testing process called Radioimmuneassay, which can detect the sedative methaqualone.

CONFIRMATION PROCEDURES



1/ THOSE WHO REQUIRE LONG PERIODS OF REHABILITATION BUT HAVE NO FURTHER SERVICE POTENTIAL NOR TIME REMAINING IN THE SERVICES TO COMPLETE REHABILITATION ARE PHASED INTO THE VETERANS ADMINISTRATION PROGRAMS FOR TREATMENT, WITH SEPARATION EFFECTIVE 15 DAYS AFTER ARRIVAL.

discharge, such an order was unenforceable because it violated a service member's right to protection against self-incrimination.

DOD subsequently determined that the Court's decision did not rule out urinalysis testing and in January 1975 it reinstated the program because it believed the military still had an unacceptably high number of illegal drug users. However, test results could not be grounds for punitive or adverse administrative action, and an individual could not be separated with other than an honorable discharge if the only evidence of his illegal drug use was the urinalysis results.

Signs of alcohol abuse

DOD issued a directive in March 1972 which described the indicators of alcohol abuse as deteriorating job performance, errors in judgment, periods of absenteeism, unfitness for duty, and increasing or repetitive entries in service, health, or military police records related to alcohol abuse. Commanders and supervisors were instructed to make every effort to identify and refer abusers for treatment. Identification may also result from self-referral or peer observations.

Law enforcement

Since using alcohol is legal, the military's investigative law enforcement units, such as the Naval Investigative Service and the Army's Criminal Investigation Division, do not normally become involved with alcohol abuse until it is connected with illegal activities. However, illegal drug use, possession, or trafficking is actively investigated by these units. The only law enforcement units in the military we found concentrating on alcohol abuse were the military police units, which have law enforcement responsibility on and around military bases.

Treatment and rehabilitation

The Air Force, Navy, and Marine Corps have taken similar approaches in their treatment and rehabilitation programs. These services send personnel to central treatment and rehabilitation facilities from local commands. The Air Force, Marine Corps, and Navy also have local, on-base counseling and treatment programs to handle minor drug and alcohol problems. In addition, these local programs screen individuals so that only drug and alcohol addiction cases are directed to the treatment and rehabilitation centers. The Army, on the other hand, has a decentralized approach, with treatment

and rehabilitation facilities located on its bases. (See app. III for a more detailed description of the programs.)

CHAPTER 2

ALCOHOL AND DRUG ABUSE PROBLEMS IN THE MILITARY--THEIR PREVALENCE AND IMPACT

Precise measurements of (1) the size of the military's drug and alcohol problems and (2) the effect drug and alcohol use have on military performance are not readily available. On the basis of the information we gathered, however, we believe that (1) alcohol abuse is more prevalent among military personnel than drug abuse and (2) alcohol abuse impairs the efficiency and effectiveness of military performance more than illegal drug use.

SERVICES' STUDIES SHOW MUCH ALCOHOL ABUSE

The Army and Navy have either made or contracted with private organizations for studies on the magnitude of alcohol abuse among service personnel. The studies have ranged from servicewide surveys to local command inquiries. Most have shown that many service personnel have drinking problems.

A study by a private research organization on drinking practices and problems in the Army, based on questionnaires sent to 9,910 personnel and completed in December 1972, showed that:

--20 and 32 percent of officers and enlisted men, respectively, are heavy or binge drinkers,[1] and an additional 17 and 35 percent, respectively, have drinking problems.[2]

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[1]Classification of drinking behavior was based on responses to questions concerning the individuals' drinking behavior within the last 3 years. "Heavy drinkers" were defined as individuals who consumed five or more drinks on 4 or more days per week; "binge drinkers" were defined as individuals who had been drunk continuously for more than 1 full day at a time.

[2]Individuals with "drinking problems" were defined as those who, as a result of drinking, encountered serious difficulties in their personal relations or with their health, jobs, or the law.

--Army duty time lost in 1973 because of drinking was estimated to be about 2,200 staff-years and the cost was estimated to be about $17 million in pay and allowances alone.

--Most soldiers hesitate to seek help for a drinking problem for fear of damaging their careers.

--Enlisted personnel have a higher rate of heavy drinking and related difficulties (personal relationship, health, job, and financial problems) than do comparable civilians,[1] and officers drink slightly more but have slightly fewer difficulties than civilians of the same age.

--Over half of the nonsenior officers and over half of all junior enlisted men believed it was all right to get drunk once in a while as long as it did not become a habit, and 28 percent of the junior enlisted men believed it was all right to get drunk whenever one felt like it.

--Drinking is more prevalent overseas: More enlisted men abuse alcohol in Europe and Korea than in the continental United States.

--By any reasonable standard, the Army (as does any other large institution) has a serious alcohol abuse problem.

A semiannual opinion survey completed in Europe by the Army in February 1974 showed 27 percent of the 1,759 Army personnel sampled had a potential alcohol problem.[2] A similar survey had been performed in Europe in August 1973. The results of these two surveys are shown on the following page.

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[1]This conclusion was reached by comparing the Army questionnaire answers with similar civilian data contained in a 1972 study done by the Center of Alcohol Studies at Rutgers University.

[2]The National Institute on Alcohol Abuse and Alcoholism developed the questionnnaire which, on the basis of the number of affirmative answers, can detect if an individual has a potential alcohol problem.

Enlisted men by grade	Officers by grade	Percentage of alcohol use: Every day August 1973	Every day February 1974	Several times a week August 1973	Several times a week February 1974
E1 - E2	-	10	7	25	35
E3 - E4	-	7	9	31	35
E5 - E6	-	7	8	36	38
E7 - E9	-	2	6	34	41
-	01 - 03	7	3	46	53
-	04 and above	10	9	55	51

In the February 1974 survey, about 25 percent of the respondents, none of whom were officers, said they used hashish and 17 percent claimed daily use. About 15 percent said they used such drugs as barbiturates, amphetamines, hallucinogens, or opiates and about 1 percent claimed daily use. The survey also found over 90 percent of the respondents who had used these drugs were young and in the lower pay grades of E1 to E4. This contrasts with the high incidence of alcohol use in all ranks and the higher incidence of alcohol being used several times a week among officers as shown above.

Based on our analysis of the records of 1,534 patients at 22 facilities we visited, the profiles of individuals who have been through the drug and alcohol programs are shown below.

Average	Drugs	Alcohol
Age	20	30
Grade	E2	E5
Years of service	1-1/2	9

In March 1975 the Navy issued a report on drinking problems which was based on questionnaires sent to 9,508 Navy personnel. This study showed that:

--37 percent of the enlisted men, 26 percent of the male warrant officers, and 18 percent of the male commissioned officers had drinking problems[1] described as "critical," "very serious," or "serious."

[1]Drinking problems were considered to be any problems with jobs, the police, health, injuries, or interpersonal relations (with spouses, friends, or neighbors) connected with drinking within the last 3 years.

--19 percent of the enlisted women and 9 percent of the women officers had drinking problems[1] described as "critical," "very serious," or "serious."

--15.6 percent of the enlisted women and 24.3 percent of the enlisted men reported at least some lost work time or inefficiency at work during the 6 months preceding the study because of drinking or its after-effects. The percentages for officers were 17.5 for females and 17.7 for males.

--Lots of private parties and special celebrations were the reasons mentioned most often for getting inebriated.

Another Navy study, issued in April 1974, examined drug and alcohol use at the Naval Air Training Command, Corpus Christi, Texas. This study showed that 5 percent of the officers and enlisted men were using illegal drugs. It also showed that 32 percent of the officers and 37 percent of the enlisted men may have had drinking problems.[2] The study concluded that alcohol was the number one drug problem among sailors of all ages in the command and that far too little emphasis had been placed on prevention and early detection of alcohol addiction and remedial education and rehabilitation for it.

A study performed by the Navy Medical Neuropsychiatric Research Unit, San Diego, California, estimated that the Navy loses about $52 million annually from absenteeism, decreased efficiency, and poor decisionmaking due to drinking. This figure was computed using 5 to 6 percent[3] as an estimate of the Navy population with drinking problems. It did not include the costs of hospitalization, outpatient treatment, medications, or legal services for these individuals. On the basis of the higher rates of drinking problems found in other Navy studies and the exclusion of certain costs, the $52 million estimate appears conservative.

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[1]Drinking problems were considered to be any problems with jobs, the police, health, injuries, or interpersonal relations (with spouses, friends, or neighbors) connected with drinking within the last 3 years.

[2]Individuals with "drinking problems" were defined as those reporting something reasonably bad had happened because of drinking (such as not remembering events or passing out).

[3]According to the Navy, the percentage was obtained from our November 1971 report, referred to on page 1. In that report, the services' drinking problems were assumed to be at least as great as those of the civilian community.

In other studies, the research unit concluded that:

--Alcoholics have early deaths and high rates of accidents, suicides, respiratory disease, gastrointestinal illness, cancer, and cerebrovascular problems.

--The comparatively high rate of alcoholic hospitalization in the Navy may be attributed to such aspects of Navy life as separation from families, periods of boredom, inexpensive liquor, and social functions that invite drinking.

--A correlation exists between certain Navy occupations and alcoholism. Jobs associated with alcoholism tend to be nontechnical and filled by a relatively high proportion of older men with lower socioeconomic backgrounds.

--A dramatic decline in hospitalizations occurs after alcoholics return to sobriety.

MEDICAL REPORTS REFLECT ALCOHOL AND DRUG PROBLEMS

Physicians told us that alcohol abuse and alcoholism are seldom cited in the diagnoses of patients suffering from the effects of excessive drinking, such as cirrhosis of the liver, gastritis, ulcers, and pancreatitis. Some of the reasons physicians gave for this situation were:

--Physicians consider alcohol abuse more of a social problem than a medical problem and lack the interest to investigate if alcoholism is a patient's principal disease.

--The large volume of cases and related work pressures preclude efforts to deal with alcohol problems.

--An alcoholism diagnosis is largely subjective and physicians fear they might make a false one.

The services gave us statistics on the number of personnel who had a primary diagnosis of illegal drug use or alcohol abuse upon admission to or discharge from a military hospital and the number of related bed days they accumulated. With this data and DOD's average daily cost rate, we estimated the costs involved as shown on the following page.

BEST DOCUMENT AVAILABLE

Year (note b)	Admissions		Bed days		Estimated costs (note a)	
	Drugs	Alcohol	Drugs	Alcohol	Drugs	Alcohol
1972	7,639	6,641	93,450	103,830	$ 9,718,800	$10,798,216
1973	9,773	10,117	64,909	156,361	7,983,807	19,232,403
1974	1,674	3,150	21,455	62,213	2,703,330	7,838,838
Total	19,086	19,908	179,814	322,404	$20,405,937	$37.869,457

[a]Average daily cost rates: 1972--$104; 1973--$123; 1974--$126.

[b]Stated as fiscal year, except for Air Force data, which was available for only 6 months of 1972 and was not available for 1974.

As shown, alcohol abuse led to slightly more admissions than drugs did. Bed days were more numerous for alcohol abuse than for drug abuse, resulting in more expenditures of medical resources. Some of the extra bed days may have been attributable to the alcohol abusers' older ages. However, considering that physicians tend not to diagnose a patient's problem as alcoholism, these figures are probably conservative.

The greater cost of alcohol abuse was further attested to by physicians. They also told us alcohol does more physical harm than the drugs most commonly used by service personnel. Over 52 percent of the 196 alcohol rehabilitation patients who responded to our inquiries believed drinking was harmful to their health. About 37 percent of the 148 drug rehabilitation patients who responded believed the same about drugs.

Some of the statistics obtained on drug and alcohol deaths showed:

--Of the 289 Army personnel deaths in Europe in 1973, 24, or 8 percent, were drug related and 72, or 25 percent, were alcohol related, according to the results of autopsies. An additional seven were reported as both drug and alcohol related.

--For a 15-month period ending March 31, 1974, Air Force drug-related deaths (exclusive of suicides and deaths from prescribed drug use) numbered 12.

LAW ENFORCEMENT REPORTS REFLECT DRUG AND ALCOHOL PROBLEMS

Over 65 percent of the law enforcement officials we interviewed said alcohol is a greater problem to the military than drugs. Although these officials generally believed efforts to track down illegal drug use were worthwhile, several said illegal drug use was not as serious a problem as alcohol abuse. Most estimated that about 90 percent of the drug use in the military involved marihuana. Army data on law enforcement investigations and arrests involving drugs showed that over 70 percent of the cases closed during calendar years 1973 and 1974 involved marihuana. The chart on page 19 shows the number of marihuana investigation and arrest cases closed compared with those involving opiates, dangerous drugs, and hallucinogens. We also found that over 85 percent of the arrests and/or investigations at certain bases we visited involved marihuana use or possession.

The following statistics for calendar years 1972-73 show the number of service personnel arrested for drug- or alcohol-related incidents by civilian and military law enforcement authorities in the area of two military installations in California. 1/

Civilian and Military Arrests in 1972 and 1973

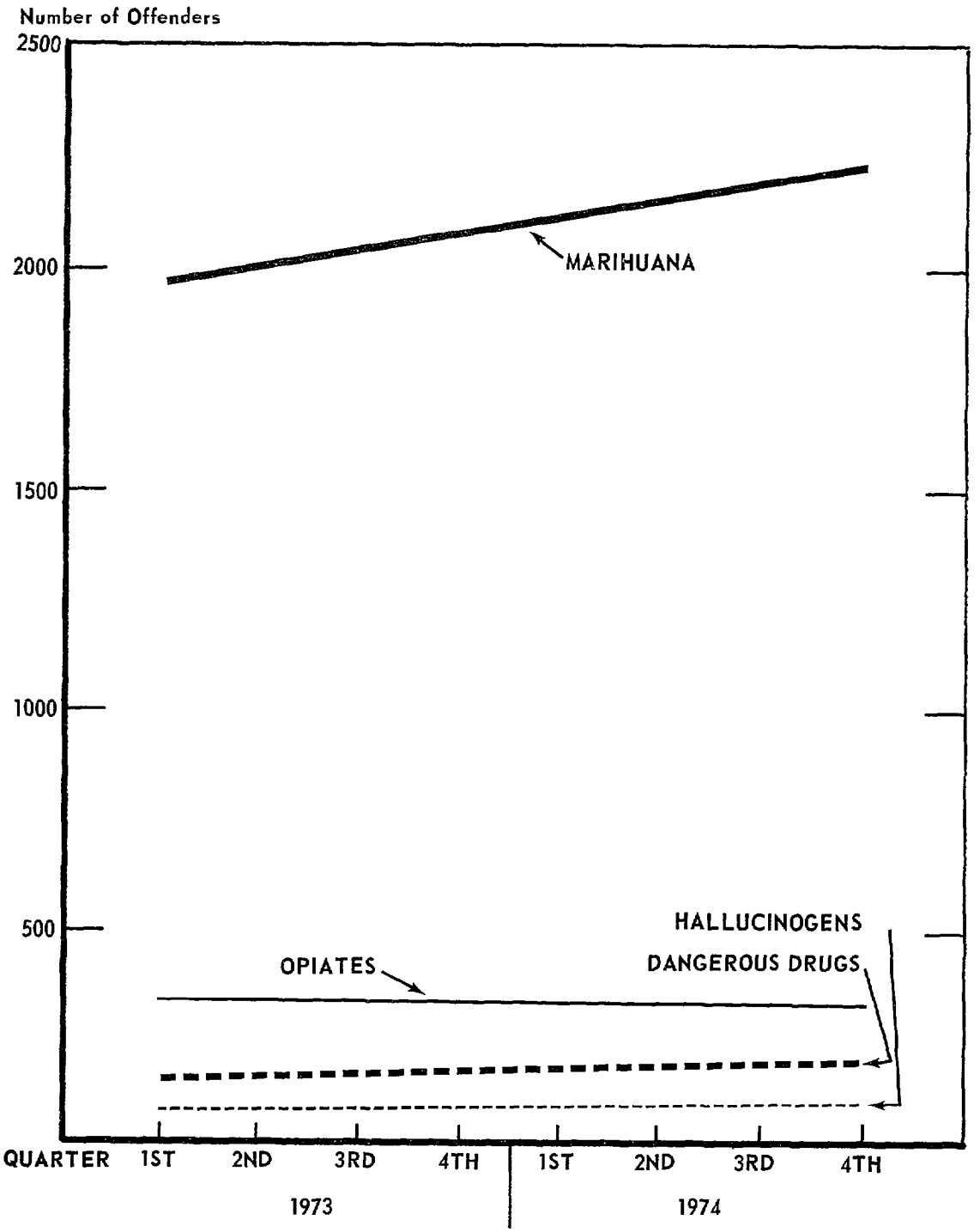
Location	Total	Alcohol-related	Drug-related			Percentage for	
			Marihuana	Other drugs	Total	Alcohol	Drugs
Long Beach	10,361	3,328	824	185	1,009	32	10
San Diego	42,820	15,596	3,322	889	4,211	37	10
Total	53,181[a/]	18,924	4,146	1,074	5,220	36	10

a/The Navy told us that base security forces data is not included in the above table but that the data shows an average of about 175 drunk driving and other alcohol-related offenses per month.

About 36 percent of these arrests were for alcohol abuse (drunk driving and intoxication) while 10 percent were for drug use or possession. About 80 percent of the drug arrests were for marihuana use or possession.

1/DOD-wide statistics for alcohol were not available because DOD does not require commands to report such data.

ARMY DRUG INVESTIGATIONS AND OFFENDERS' CASES CLOSED



Law enforcement officials told us that many additional arrests in such categories as felonies, morals, and disturbing the peace involved alcohol abuse. Drug involvement in these categories was minimal by comparison.

In Europe, Army law enforcement officials gave us 1973 statistics on such serious incidents as murder, rape, robbery, and aggravated assault. These statistics showed alcohol-related incidents ranged from 26 to 42 percent of all the serious incidents reported monthly. While drugs could have been a factor in some incidents, drug involvement was not reported in any of them.

Additional data provided on Army personnel in Europe showed:

--Alcohol-related traffic accidents ranged from 17 to 34 percent of the traffic accidents monthly during 1973.

--The number of drunk drivers apprehended in 1972 and 1973 was 2,140 and 2,446, respectively.

DOD compiles statistics on drug- and alcohol-related deaths but does not have overall statistics on traffic accidents involving alcohol use. However, the Air Force in Europe documented 55 alcohol-related traffic accidents involving 9 deaths during 1973. The Army's Schofield Barracks in Hawaii reported 22 alcohol-related traffic accidents involving 5 injuries during 1973. At Clark Air Force Base in the Philippines, autopsies taken during 1973 on 15 traffic-death victims showed 7 had more than the legal limit of alcohol in their bodies.

The commander of Army forces in Europe, concerned about fatal traffic accidents, directed in April 1972 that each subordinate command investigate every fatal automobile accident and determine the cause. These investigations showed that alcohol was the prime cause in 52 percent of the 58 fatal accidents which occurred during the 6-month study period. Drugs were not mentioned as a factor in any of the accidents. This investigation was discontinued after the inital study period because it was considered too laborious and time consuming.

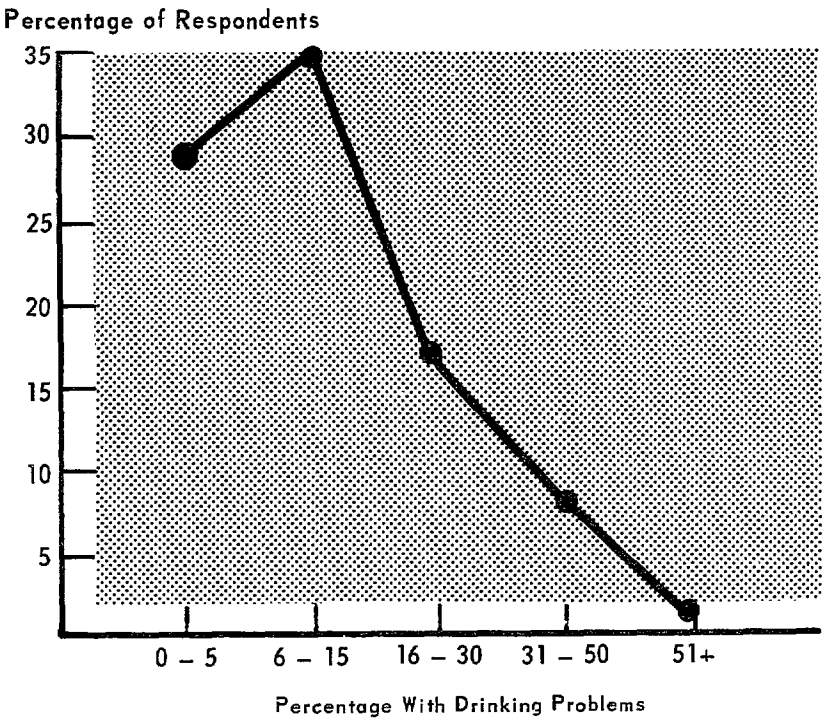
HOW MILITARY PERSONNEL VIEW THE PROBLEMS

We asked 665 military personnel their views about alcohol abuse in the military. About 70 percent indicated alcohol abuse was a major problem. When questioned on the relative effects drugs and alcohol have upon the military, about 56 percent believed alcohol use was a greater problem than drugs;

24 percent believed the problems were about the same; and the remaining 20 percent believed drugs were a greater problem.

Commanders are probably the best source of knowledge about service personnel's activities. The opinions of 263 commanders we interviewed worldwide about the percent of service personnel with drinking problems are shown below.

ESTIMATES OF SERVICE PERSONNEL WITH DRINKING PROBLEMS

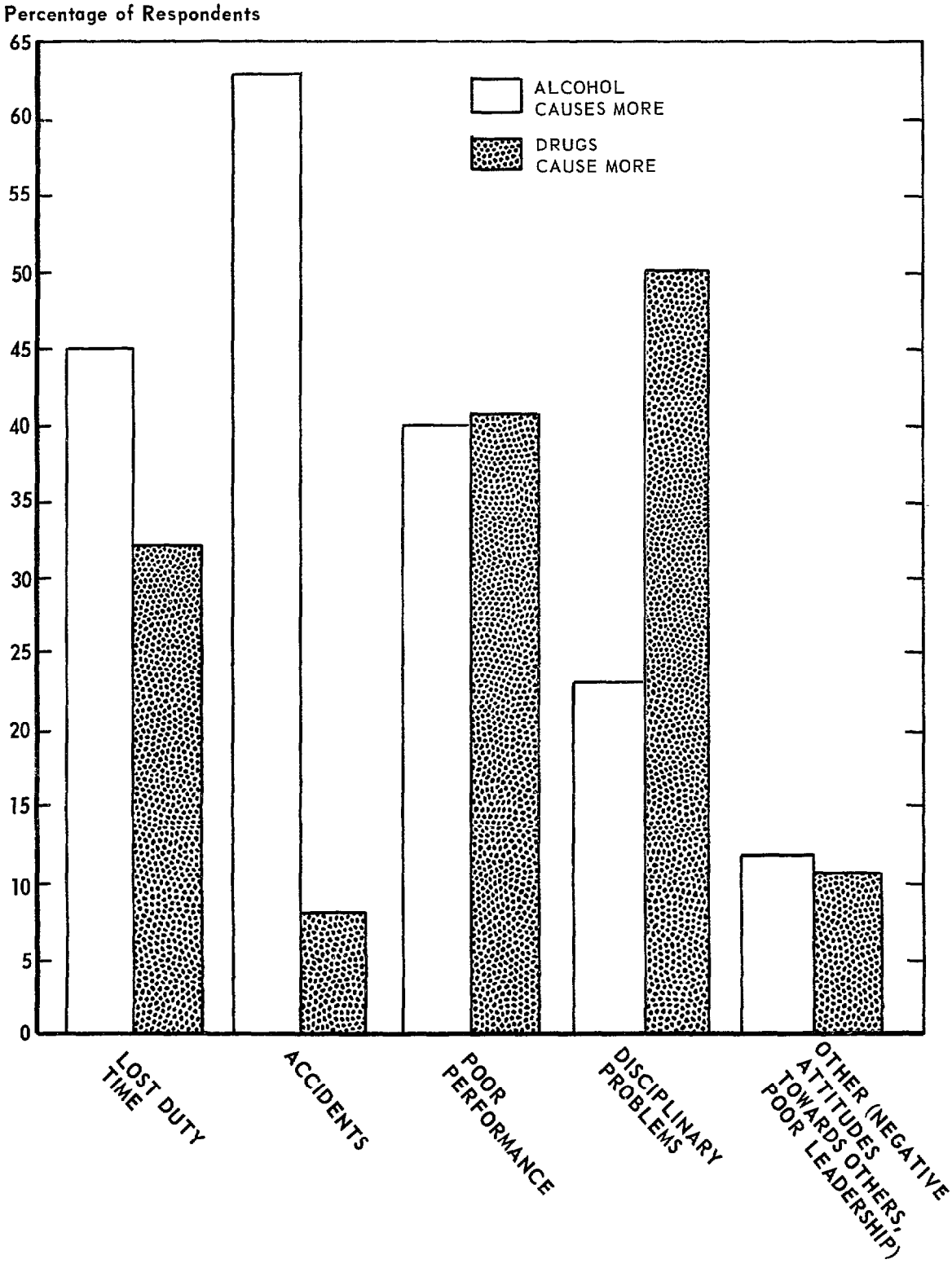


When questioned on the impact of drugs and alcohol on military life, command personnel generally believed alcohol had as much, if not more, adverse impact than drugs, as shown in the chart on page 22.

A majority of commanders and law enforcement officials commented that over 90 percent of the drug use among service personnel involves marihuana.

The Assistant Secretary, DOD, Health and Environment, has stated that drug use by service personnel in Germany is relatively serious but does not pose a threat to combat readiness.

COMMAND PERSONNEL'S OPINIONS ON EFFECTS OF DRUG AND ALCOHOL USE



About 96 percent of the medical authorities interviewed told us alcohol abuse does more harm to the health of military personnel than drugs, and about 75 percent believed alcohol abuse requires more medical resources for treatment than drugs. Several physicians cited examples which indicated over 50 percent of all trauma injuries (broken bones, contusions, etc.) are associated with alcohol abuse. The physicians indicated that service personnel were very seldom admitted to military hospitals for drug addiction.

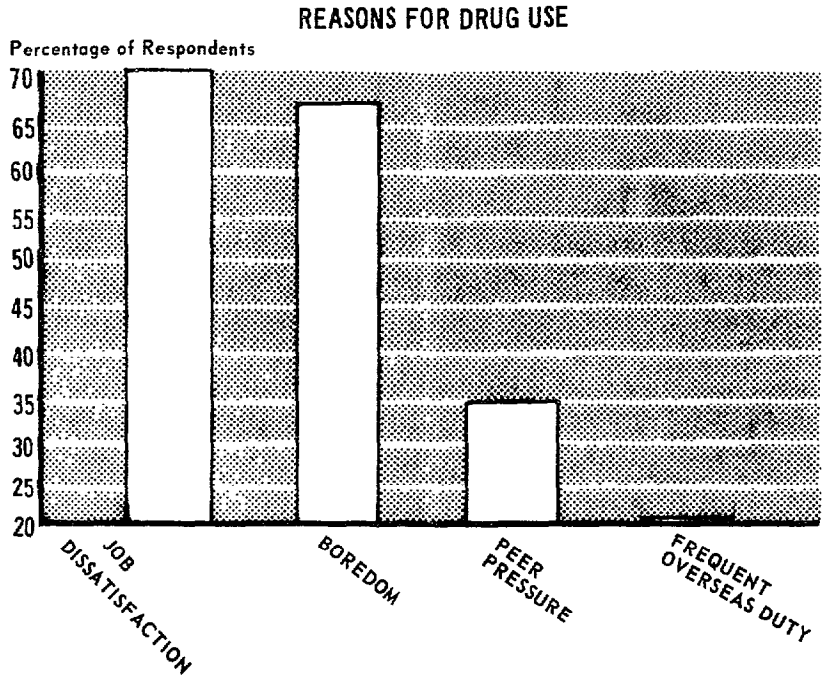
Following are other professional comments regarding the alcohol problem:

--Chaplains indicated alcohol abuse causes domestic problems, such as divorces and family separations.

--Drug rehabilitation officials said alcohol is a worse problem to the military than drugs, causing more problems to service personnel and duty performance.

--Alcohol rehabilitation officials indicated alcohol is a more severe problem than drugs.

On the question of the military environment's contribution to drug use, 128 of the 141 drug patients who responded, or 91 percent, believed it did contribute and cited the following factors.



About 85 percent of the 193 alcohol patients who responded believed the military environment contributed to alcohol abuse. The contributing factors they cited are shown on page 25.

CONCLUSION

Although DOD has one office--the Office of Drug and Alcohol Abuse Prevention under the Assistant Secretary, Health and Environment--responsible for setting policy on both drug and alcohol programs, neither it nor the services know which of the two problems is bigger nor which has the greatest effect on military performance.

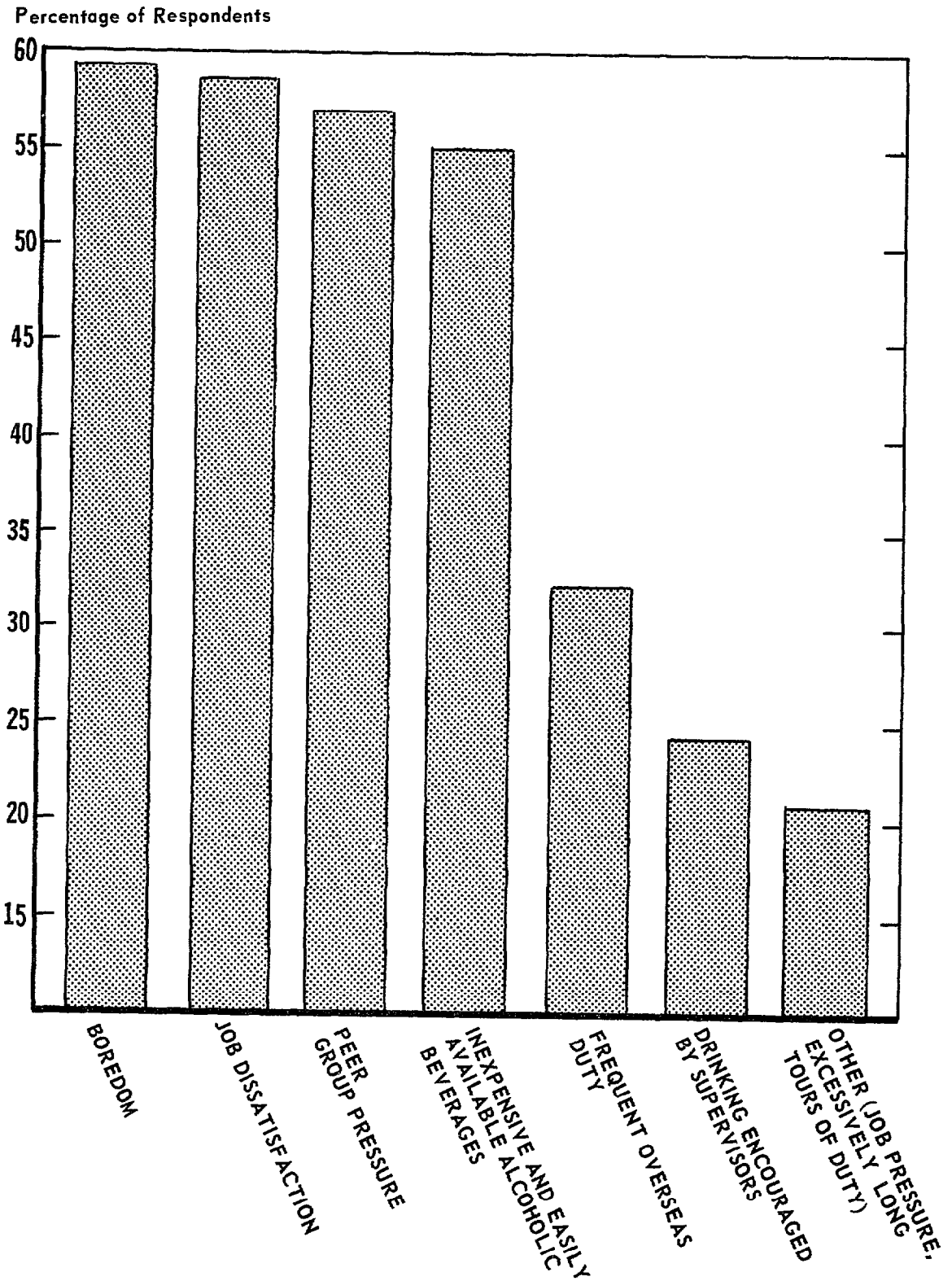
On the basis of the data we obtained, we believe alcohol abuse is more prevalent among military personnel than drug abuse and has a greater impact on military performance. In contrast, DOD has placed much more emphasis on its drug control programs than on its alcohol programs. One reason for this is that drug use is illegal while alcohol use is not.

AGENCY COMMENTS

In commenting on our report in a letter dated January 13, 1976 (see app. I), DOD stated that:

> "The report's chief conclusion is that within the Department of Defense, disproportionate attention and resources have been given to other drugs of abuse when compared with alcohol abuse. The Department of Defense shares GAO's concern about the prevalence of alcohol abuse and its adverse impact on our personnel; however, there is some question about whether alcohol abuse is the most serious drug problem. By their nature the number of drug and alcohol abusers defies precise quantification. Moreover, many young abusers are involved with both drugs and alcohol. Efforts to obtain precise measures of the extent of the problems have led to the conclusion that, in addition to imprecision, the numbers are highly influenced by the estimating methodology and can be misinterpreted if compared to estimates based on different methodologies. Reports now used, such as individuals in treatment and rehabilitation, deaths, law enforcement and investigative agency actions, urinalysis data, etc., are indicators of trends. These data indicate that there was significant improvement in drug abuse control during 1971-73, and that conditions have

REASONS FOR ALCOHOL USE



levelled off or become slightly worse in some locales in recent times. As regards alcohol, data would indicate increased abuse. However, it is not now known whether the situation is actually worse or appears so because of the increased emphasis being placed on alcohol abuse during the last several years.

"The important point is that OSD (Office of the Secretary of Defense) and the military services recognize that both drug and alcohol abuse are very serious problems and are pursuing active programs to identify, treat and rehabilitate abusers on a worldwide basis. Initial emphasis on DOD-wide programs were on efforts to identify and treat abusers of heroin and other illicit drugs. Meanwhile, recognizing the serious and difficult problem of alcohol abuse, and building on the experience of the Military Departments, a formal DOD program to deal with alcohol abuse was documented in 1972. Since that time, increasing resources have been devoted to preventing alcohol abuse and identifying and treating abusers."

We recognize that the presidential mandate in June 1971 (see p. 2) required DOD to place a high priority on developing a comprehensive drug program to deal with the problem of heroin use among service personnel in Vietnam. However, as discussed in chapter 4, the size of the problem was found to be far less than originally estimated and the major drug abused in the military appeared to be marihuana.

At the same time DOD was discovering that heroin abuse was not as widespread as it originally believed, studies by, or for, the services (see p. 12) were revealing serious alcohol abuse problems. However, the resources applied to the drug control programs continued to far exceed those applied to the alcohol control programs.

One reason DOD may not have emphasized its alcohol problem could be that alcohol abusers apparently can identify with the military environment whereas drug abusers cannot. The Army expressed this view when it commented to DOD on our report. Discussing the impact drug and alcohol abuse have on unit efficiency and effectiveness, the Army stated:

"Although alcohol abusers do not consistently contribute to the organization's mission at the same level as the "sober" soldier, they usually identify with the Army, its values, and its mission. Often, they out-perform other soldiers to gain favor with their supervisors--a social

> exchange in hopes of avoiding trouble in the event their abuse comes to the attention of the commander. On the other hand, the drug abuser frequently displays an attitude quite the opposite. He is anti-establishment; there is little identification with the unit, the Army, or its values. As a violator of the law, he is rejecting the societal norms. The danger of drug abuse is not simply physical damage to the body, or a less than satisfactory performance of a particular task. The drug abuser has a deteriorating effect on the moral strength of the unit."

The effect of alcohol abuse on job performance was addressed briefly in a study issued in September 1975 by System Development Corporation entitled, "A Study to Evaluate Department of Defense Alcohol Abuse Control Programs." System Development Corporation found a moderately positive relationship between the reported degree of alcohol use and reported job performance deterioration due to abuse. The Corporation recommended the relationships it found be tested more objectively but concluded that, "In the interim, it is probably safe to say that the reported relationship is real."

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The following chapters of this report set forth the specific actions we believe DOD needs to take to improve the overall management of its alcohol and drug control programs.

CHAPTER 3

MORE NEEDS TO BE DONE ON THE ALCOHOL PROGRAM

DOD needs to do more to reduce alcohol abuse and help service personnel with drinking problems. Specifically, we believe DOD needs to:

--Improve the education it offers on the dangers of alcohol abuse and do more to deemphasize and deglamorize alcohol.

--Improve its procedures for identifying personnel with alcohol problems.

--Improve its treatment and rehabilitation efforts.

NEED TO IMPROVE EDUCATIONAL AND OTHER MEASURES TO DISCOURAGE USE

Since observations by commanders and supervisors are a principal means of identifying alcohol problems in the military, education in behavior indicating alcohol problems is important.

The services' allocations of funds for drug and alcohol education are shown below for fiscal years 1973 and 1974.

	FY 1973		FY 1974		Total	
	Drugs	Alcohol	Drugs	Alcohol	Drugs	Alcohol
Army (note a)	$ 1,547	$100	$ 733	$ 40	$ 2,280	$140
Navy	4,379	190	2,664	141	7,043	331
Air Force	4,506	(b)	4,413	(b)	8,919	(b)
Marine Corps	539	(b)	150	53	689	53
Total	$10,971	$290	$7,960	$234	$18,931	$524

[a]Because the Army combines its drug and alcohol programs, some drug education funds were applied to alcohol education; therefore, the Army was unable to provide us with the specific allocations.

[b]Included in drug figure.

The potential benefits of alcohol education for military personnel were illustrated during our interviews with commanders. About 200 of the 276 commanders we interviewed had received alcohol education. About 54 percent believed the education helped them to better understand alcohol and its potential dangers.

About 64 percent of the individuals we interviewed who were in alcohol rehabilitation programs indicated their parent units did not provide alcohol education. Of those who did receive alcohol education, 62 percent indicated it helped them to realize and better understand the potential dangers of excessive drinking. In addition, about 69 percent of the commanders and 70 percent of the alcohol rehabilitation patients who offered suggestions for improving alcohol programs believed alcohol education should be expanded.

Regarding combined drug and alcohol education programs, some Army commanders believed that they were not sufficiently emphasizing alcohol abuse. Navy officials indicated the military services needed to provide more alcohol education.

More should be done to deemphasize and deglamorize alcohol

As DOD suggested in its 1972 directive, each service has issued directives and regulations discouraging immoderate and excessive alcohol consumption. However, these directives and regulations have not yet been universally implemented and DOD has not specifically directed which actions should be taken.

During our review, the Air Force instructed base commanders to thoroughly review base policies on selling and consuming alcoholic beverages, including (1) selling hard liquor in clubs during duty hours, (2) consuming alcoholic beverages at functions where food is unavailable, and (3) encouraging heavy liquor intake at purely social functions.

One of the few implementations of service directives we found was an instruction issued in March 1974 by the Commander-in-Chief, Pacific Fleet, which instructed fleet commanders and supervisors to establish an environment that not only discouraged alcohol consumption but encouraged abstinence. Immoderate consumption of alcoholic beverages was to be discouraged at such activities as ships' parties and picnics, happy hours, and "wetting down" (officer promotion) parties. Clubs and shore messes were directed to deemphasize such practices as:

--Selling two-for-one drinks to a single customer.

--Doubling the alcohol content of a drink without doubling the price.

--Stacking alcohol drinks for customers just before terminating happy hours or closing clubs.

--Serving alcoholic drinks to anyone who is or appears to be intoxicated.

--Holding alcohol-drinking contests.

--Coercing or influencing customers to drink alcohol.

Other efforts to deglamorize alcohol consumption which we noted in our visits to military installations included:

--Happy hours were changed to 1 hour on 3 days a week from 1-1/2 hours on 7 days a week at the officers' club, Osan Air Base, Korea.

--An Air Force noncommissioned officers' club in Hawaii stopped accepting credit purchases of liquor.

--Sunday morning "sick call," during which bloody marys and screwdrivers were provided, was eliminated at Osan Air Base.

--A Pacific Air Force Command message to Hickam Air Base in Hawaii and Osan Air Base recommended that Christmas season activities deemphasize alcohol.

--An Air Force installation in Thailand provided free Sunday dinners for airmen and their families instead of happy hours.

--A junior officers' club at Clark Air Base, Philippines, stopped serving free beer at its meetings.

--A drug-and-alcohol committee at Clark Air Base recommended that happy hour advertising be decreased and that pressure night activities, during which free drinks are provided for a $1 entrance fee until one person leaves, be eliminated.

--In Europe, the Army instituted recreational alternatives by encouraging participation in leagues for bowling, football, baseball, basketball, and other sports.

Many military installations we visited had not taken any action to deemphasize and discourage alcohol use. We found that (1) hard liquor was sold freely at noon in base clubs, (2) happy hours were widely advertised, (3) drinks were on sale at 25¢ apiece, (4) special low prices on "drinks of the week" were provided, and (5) free bottles of champagne were given on individuals' birthdays.

We also found instances where special committees recommended discouraging alcohol consumption by reducing happy hours at base clubs or reducing the number of drinks available for each individual; however, command personnel rejected these recommendations as too severe or unnecessary.

NEED TO IMPROVE PROCEDURES FOR IDENTIFYING PROBLEM PERSONNEL

The military installations generally lacked the aggressive alcohol abuse identification programs called for in DOD's directive and regulations. DOD's March 1972 directive instructed the services to:

> "* * * take cognizance of the signs of potential or actual alcohol abuse, such as deteriorating performance, errors in judgment, periods of absenteeism or being unfit for duty, and increasing or repetitive entries into service records, health records, or military police records relating to alcohol abuse."

By 1974, each service had issued implementing regulations citing the above factors as essential to identifying alcohol abuse. The services' identification efforts were basically the same.

As an indication of these efforts, the following table, based on DOD and service statistics, shows the troop strength and number of individuals who participated in the alcohol programs of each service during fiscal year 1974.

	Troop strength	Alcohol program participants	Percent of participants
Navy and Marine Corps	734,705	3,055[a]	.42
Air Force	643,970	2,725	.42
Army	783,330	6,250	.80
Total	2,162,005	12,030	.56

[a]According to the Navy, this number represents central treatment program patients only; it does not include participants in local command alcohol programs and individuals referred to Alcoholics Anonymous.

As shown above the military has treated and rehabilitated about one-half of 1 percent of its personnel. As indicated in chapter 2, military studies have shown that a much higher percentage of service personnel have drinking problems.

A report prepared for the Army Surgeon General on the effectiveness of the Army's alcohol and drug programs in identifying and treating individuals needing assistance was issued in September 1974. The report concluded that about 154,000 Army personnel required treatment for alcohol problems, while only 4 percent of these received it. The Army, however, did not agree with this estimate. It believed the contractor had misrepresented the problem by not distinguishing between occasional and frequent excessive use of alcohol.

Although the report for the Surgeon General concluded that a similar percentage (94 percent) of the individuals who use drugs are not receiving treatment, it assumed that anyone who used illegal drugs required treatment. Consequently, an estimated 137,000 service personnel were assumed to require treatment. The report also pointed out that many individuals interviewed believed that marihuana use does not affect performance to any great extent. The report made no attempt to distinguish drug abusers from drug users. In contrast, it concluded alcohol rehabilitation was needed in the case of excessive use of alcohol.

Attitudes toward the effects on an individual's career of participating in alcohol rehabilitation have resulted in minimal identification efforts. About 40 percent of the commanders and 66 percent of the professionals (chaplains, rehabilitation officials, and social workers) said that participation in a rehabilitation program would harm an individual's career. The report prepared for the Army Surgeon General concluded that such participation places a stigma on the participant.

Commanders indicated that participating in alcohol rehabilitation sometimes results in (1) a delay or denial of a promotion, (2) an undesirable assignment, (3) nonchallenging duty, or (4) other undesirable consequences, such as low ratings or a stigma.

Many commanders indicated that persons who drink excessively are generally not identified for counseling or treatment until the problem severely interferes with their duty performance or health.

Typical comments were:

--"A person must really become a burden or develop physiological problems before he is identified as a problem drinker."

--"There is a tendency to cover for and excuse alcohol abuse."

--"He's not an alcoholic, he's just a good ol' Navy man."

--"Alcoholism has not yet been openly accepted as a disease, thus social stigma and community pressure preclude an effective identification program."

Regarding the action commanders take when a subordinate abuses alcohol, most stated they usually talk with him or refer him to a counselor. About 24 percent indicated they initiate action under the Uniform Code of Military Justice or take some administrative action.

Less than 3 percent of the individuals in rehabilitation programs were officers. Rehabilitation authorities explained that this was because officers are protected by fellow officers. Several command personnel said many commanders cover up alcohol problems in their units, especially for officers and senior NCOs. The September 1974 report prepared for the Army Surgeon General commented that the alcohol program was strictly an enlisted men's program. Officers were simply not reached by the program no matter how serious their drinking problem.

Potential means to identify alcohol abuse

Greater use could be made of law enforcement and medical data to identify personnel with alcohol problems.

Numerous alcohol abuse cases come to the attention of the military medical community annually. However, most of these cases are neither identified as alcohol dependent or alcoholic nor referred to rehabilitation programs. For example, from reviewing medical files at Fort Bliss, Texas, we estimated, with the concurrence of Army physicians, that approximately 1,200 cases of alcohol-related diseases, accidents, illnesses, and deaths were treated at the base hospital during 1973. However, only 13 cases were referred to the base alcohol rehabilitation center. One apparent reason was the reluctance of physicians to diagnose an individual as an alcoholic or potential alcoholic. (See p. 16.)

At other hospitals we found similar situations; appropriate authorities were not being notified of alcohol problems.

As DOD's alcohol directive emphasizes, law enforcement activities are an important means of identifying alcohol abuse among personnel. At some bases commanders and rehabilitation and law enforcement personnel had established close working relationships. However, on other bases we found no system had been established to effectively use law enforcement resources to assist in identifying individuals with alcohol problems.

Some examples we found of local bases receiving law enforcement data were as follows:

--At Long Beach, California, Navy military police routinely sent commanders letters listing individuals who had had multiple arrests for or related to excessive drinking. They forwarded copies of the letters to rehabilitation personnel.

--At Osan, Clark, and Hickam Air Bases, commanders were notified by law enforcement personnel of individuals arrested for driving while intoxicated. Copies of the correspondence were forwarded to rehabilitation personnel at Osan and Clark if the individuals repeated their offenses.

--At Fort Sam Houston, individuals apprehended for alcohol-related incidents were required to attend a 4-hour alcohol education class, which was used as a screening device to identify individuals who needed rehabilitation.

--At Fort Bliss, after searching daily military police reports for alcohol-related incidents, Army rehabilitation personnel identified and referred individuals to 2-hour alcohol education classes.

At several locations the military services were experimenting with a program referred to as Alcohol Safety Action Projects. Under this program, which originated in the civilian community, alcohol-related traffic arrests were used as a means of early identification of persons with drinking problems. The civilian Alcohol Safety Action Projects reportedly increased alcohol abuse identification and the placement of drinking drivers in rehabilitation. The Army and Air Force, in a May 1974 directive on motor vehicle traffic supervision, encouraged active support and participation in Alcohol Safety Action Projects in neighboring civilian communities. The Navy had a pilot Alcohol Safety Action Project

program in Pensacola, Florida, and a Navy alcohol program official said the Navy plans to expand the program Navy-wide in January 1976.

As an illustration of the usefulness of law enforcement data in identifying alcohol abusers, over 90 percent of the alcohol rehabilitation patients at an Air Force installation we visited had at least one alcohol-related traffic violation or official reprimand relating to alcohol in their personnel file.

Use of law enforcement data as a means of identification was minimal at some military installations. For example, at Lakenheath Air Force Base, England, there were 45 alcohol-related traffic incidents and 15 violations for driving while intoxicated during 1973 and early 1974; however, no attempt was made to use this data to determine if the individuals involved needed alcohol rehabilitation.

MORE TREATMENT AND REHABILITATION CAPABILITY NEEDED

As shown in chapter 2, various studies by the services, law enforcement and medical statistics, and opinions of commanders and other service members indicate a large unmet need among military personnel for alcohol treatment. If the military services establish aggressive alcohol identification programs, additional resources will be needed to provide the necessary treatment.

The Navy has already experienced a shortage of alcohol treatment capability. In its fiscal year 1974 budget request for additional funds and manpower for alcohol programs, the Navy stated that "the demand for alcoholism treatment is approximately three times the treatment capacity available."

In May 1975 the waiting period for admitting individuals for treatment at the Navy alcohol rehabilitation centers was 4 to 8 weeks. Rehabilitation authorities indicated waiting periods can increase the chances of a return to heavy drinking.

The Army has no specific information available on the adequacy of its treatment capability. However, as previously mentioned, the report prepared for the Army Surgeon General concluded that about 96 percent of servicemen with drinking problems were not receiving treatment at existing facilities.

According to Air Force drug and alcohol program officials, as of March 1975 the Air Force's central alcohol rehabilitation facilities were operating at about 90 percent of their

340-bed capacity. The officials said that, if the trend in identifying problem drinkers continues as it has, the central rehabilitation facilities will have waiting lists by the end of calendar year 1975.

At the Alcohol Rehabilitation Center in Weisbaden, Germany,[1] in 1974, service personnel with drinking problems waited up to 2 months to be admitted.

Staffing problems

Alcohol program officials indicated that staff shortages necessitated borrowing staff from other units. For example, rehabilitation officials of a Marine Corps program in California told us their alcohol program could not operate if the commanding officer did not support it and did not assign personnel from other units to work in it.

Borrowing staff made turnover frequent. Program officials indicated experienced personnel were often transferred from a program when their parent units required their services and were replaced by inexperienced personnel. Some of the personnel transferred were filling essential program positions, such as counselor positions, which required training and on-the-job experience. According to program officials, reassigning these individuals adversely affected program continuity and effectiveness.

The September 1974 report prepared for the Army Surgeon General noted that:

> "Treatment staffs may fail to deliver competent therapeutic services for several reasons. First, they may be inexperienced. Even if they are experienced, they may fail in a counseling mode if clients are unwilling to unburden themselves because they fear the consequences of self-disclosure (as may be the case when the counselor is in the Army). Finally, they may fail to deliver the required services if they spend excessive amounts of time and effort on administrative and supervisory activities rather than a direct provision of services. In the present study, treatment programs in which a substantial proportion of the staff was relatively new to the program, active military personnel, or

[1]This Center services Air Force personnel stationed in Germany, the Netherlands, Italy, Crete, Greece, Turkey, and Spain.

occupied at least part of their time in administrative/ supervisory roles were found to be less effective-- presumably because required services were not reaching clients as effectively as at other programs."

Benefits of alcohol rehabilitation

We visited 22 alcohol rehabilitation programs worldwide. Seven of the programs had the following statistics available on the disposition of program participants.

	Number of facilities	Number of participants	Returned to duty	Discharged or retired	Dropped from program
Army	1	114	80	15	19
Navy	4	2,715	2,056	490	169
Air Force	2	343	336	4	3
Total	7	3,172	2,472	509	191

About 78 percent of the participants returned to duty and, according to followup data which some rehabilitation programs received from commanders, a large percentage of these were performing their duties satisfactorily. While not all individuals who successfully returned to duty abstained from alcoholic beverages, those who drank generally controlled their intake so it did not interfere with their performance. A similar result was mentioned in the report prepared for the Army Surgeon General, which concluded that alcohol rehabilitation substantially reduces alcohol consumption among service personnel with drinking problems.

Although the military has not comprehensively studied the cost benefit of alcohol rehabilitation, program officials indicated the alcohol rehabilitation programs appeared to be cost effective due to the large number of individuals who return to duty. In two limited studies, the Navy attempted to demonstrate the cost effectiveness of alcohol rehabilitation. In one study, the Navy estimated the savings in medical costs by comparing time spent in a hospital by 161 sailors 2 years before they were rehabilitated at a Center with the time they spent 2 years after. According to the Navy, the comparison showed the sailors spent a total of 4,251 days in the hospital before treatment and 1,985 days after treatment--a reduction of 2,266 days. The reduction was not compared with the costs of rehabilitation. However, if projectable to other rehabilitated servicemen, these reductions could lead to significant savings in hospital resources. Several hospital officials supported these findings, indicating service personnel with drinking problems have much higher rates of hospitalization than other personnel.

In a second study, the Navy estimated several million dollars have been saved in manpower costs and costs of training replacement personnel over and above the costs to rehabilitate personnel. Although this was a gross estimate, it indicated a potential major cost benefit of alcohol rehabilitation.

CONCLUSION

DOD needs to improve the services' alcohol education programs for both commanders and enlisted personnel. Education provided to commanders and supervisors in behavior indicating alcohol problems is especially important since observation is a principal means of identifying such problems. Educating service personnel is important in stressing the harmful effects of excessive drinking and in helping personnel recognize whether they have drinking problems.

We believe DOD should take the lead in issuing uniform, comprehensive directives on discouraging alcohol consumption and in providing alternatives to drinking. Each service has issued broad directives and regulations discouraging excessive alcohol consumption, and some commands have implemented these directives with specific actions. However, no DOD directive specifying actions to be taken has been issued.

If DOD requires the services to establish aggressive alcohol identification programs, a large number of individuals will be found to need rehabilitation and additional facilities and staff will be needed.

Services' internal studies show a substantial percentage of service personnel have drinking problems. In contrast, we found very few service personnel--about one-half of 1 percent--had received alcohol treatment or rehabilitation during fiscal year 1974. We believe one reason is that neither DOD nor the services have sufficiently emphasized the need for aggressive identification programs at the base level.

DOD's alcohol directive and the services' implementing regulations provide a broad framework within which each base commander can operate. However, DOD needs to more specifically direct the services regarding identification programs which should be established at the base level. One potential means of identification--which DOD should require each service to adopt--is the use of law enforcement and medical data. DOD should require medical and law enforcement personnel to report all alcohol-related incidents to appropriate base-level officials--either commanders or alcohol treatment and rehabilitation officials. These officials should, in turn, determine if the individuals involved need treatment and rehabilitation. Rehabilitation has successfully returned

individuals to duty; furthermore, it appears to be cost effective since it allows military skills and training to be retained and hospitalization to be reduced.

RECOMMENDATIONS

We recommend that the Secretary, DOD, direct the Assistant Secretary, Health and Environment, to:

--Increase alcohol education efforts to effect greater awareness and to change attitudes among military personnel.

--Reduce or eliminate practices which encourage alcohol consumption.

--Provide alternatives to alcohol consumption by encouraging and supporting activities that do not center around drinking.

--Direct the services to (1) strengthen their programs for identifying individuals with alcohol problems and (2) provide additional resources, as needed, for treatment and rehabilitation.

AGENCY COMMENTS

DOD agreed with the general premise that alcohol is a serious problem in the Armed Forces which requires intensified action by DOD and the military services. In addition, DOD agreed with all of the above recommendations except the one to increase alcohol education efforts to effect greater awareness and to change attitudes among military personnel.

Specifically, DOD stated:

"In the area of drug and alcohol abuse education, action was initiated in late 1974 to improve the overall education effort by forming a Media Support Committee with representation from the DOD and the military services. This committee reviews education materials and recommends those which should be used. To date this committee has been instrumental in procuring a substantial quantity of quality audio-visual and printed alcohol education materials, more in fact than is currently being purchased for drug abuse. In addition, emphasis has been placed on DOD and service policy regarding alcohol abuse as well as on drug abuse in the drug and alcohol education program for entry level personnel. Seminars, and special conferences and classes for leaders and supervisory personnel have been arranged which emphasize

methods of identifying and referring personnel with suspected alcohol problems, and of assisting such personnel when they have returned to duty after completing rehabilitation."

The Media Support Committee was established after we had completed most of our fieldwork. However, a study made by the System Development Corporation for DOD entitled, "A Study to Evaluate Department of Defense Alcohol Abuse Control Programs" was issued on September 22, 1975. This study, which included (1) visits to 30 military sites in January and February 1975 and (2) all branches of the service, found problems similar to those we found in the area of alcohol education/prevention. Some of the study's findings were:

--Detailed, operationally defined objectives written especially for a site's education/prevention program, for a series of education sessions, or for specific target groups were not found at the sites visited.

--Approximately 50 percent of the military personnel responding to a questionnaire reported they had not attended an alcohol education course during the past 2 years. System Development Corporation said the general objective of alcohol abuse education for all had not yet been attained.

--The effectiveness of special education programs aimed at helping individuals with alcohol-related problems and/or helping individuals help others prevent such problems has been limited.

--Education program staff saw a great need for more training of medical, nonmedical, and supervisory personnel in identifying abusers, but it appears such training was given only infrequently. Supervisors and commanders in particular indicated they did not know how to identify an alcohol abuser and were very interested in learning.

System Development Corporation made 10 specific recommendations to DOD on improvements needed in its alcohol education/prevention program which we believe support and reinforce our recommendation that DOD increase its alcohol education efforts to effect greater awareness and to change attitudes among military personnel.

CHAPTER 4

THE DRUG PROGRAM CAN BE IMPROVED

DOD has emphasized its drug control program much more than its alcohol control program. Since fiscal year 1972 the drug control program has received about six times more funding than the alcohol control program. For fiscal year 1976 the ratio of drug to alcohol funds is estimated to be about 4 to 1.

Despite its larger resources, the drug control program has some problems.

--Identifying drug users has been neither as effective nor perhaps as economical as possible.

--Treatment and rehabilitation varies in quality and lacks DOD-wide followup.

NEED TO IMPROVE PROCEDURES FOR IDENTIFYING PROBLEM PERSONNEL

DOD tries to identify drug users by (1) such investigative techniques as urinalysis and (2) persuading them to volunteer for treatment.

Need to reevaluate urinalysis program

The urinalysis program (see p. 7) consists primarily of random tests administered routinely to service personnel worldwide to detect the presence of certain drugs. In view of (1) the costs involved in identifying a small percentage of drug users, (2) problems in administering the tests, (3) the diversion of medical personnel required, (4) the tests' failure to detect the presence of commonly used drugs, and (5) the tests' uncertain deterrent value, we believe DOD should reevaluate the desirability of its present testing program.

High costs and low percentages of drug users identified

The military has spent a total of about $35 million for the urinalysis program. For fiscal years 1975 and 1976, the military budgeted $9.8 and $13.1 million, respectively, for this purpose. The cost breakdown, as provided by DOD for fiscal years 1972 through 1974, is shown on the following page.

Fiscal year	Expended (millions)
1972	$11.2
1973	11.5
1974	12.1
	$34.8

These costs represent, for the most part, laboratory costs to process the urine samples. There are additional costs that have not been included in the reported figures, such as the cost of lost duty time of the personnel giving specimens and the personnel witnessing the giving of specimens, the administrative cost for arranging the tests, and the transportation cost for shipping specimens from collection points to laboratories. DOD's new testing procedure, Radioimmuneassay, is expected to reduce the cost of testing by requiring fewer laboratory personnel to process the tests.

The unreported additional costs are not readily determinable and, in some cases, not easily measurable. One indication of how large these additional costs might be was shown in a 1974 study at Clark Air Base, Philippines, which estimated the program's additional costs would be double the reported costs. Also, military officials said the estimated time expended by service personnel waiting for urinalysis tests and giving specimens ranged from 15 minutes to 1 hour per individual. Applied to the approximately 2 million tests in 1973, this time range would amount to 500,000-2 million hours of lost duty time.

The following table shows the number of tests administered and the number which showed illegal drug use (confirmed positives), as reported by DOD.

Fiscal year	Number of tests	Confirmed positive	Percentage confirmed
1972	2,094,482	40,581	1.94
1973	1,932,589	19,022	.98
1974	1,627,129	13,766	.85
Total	5,654,200	73,369	1.30

As shown, about 73,000 tests identified illegal drug use. To obtain this identification, the military tested over 5.6 million personnel and spent about $35 million. According to officials, troop reductions in Asia were the principal reason for the decline in the drug detection percentages.

The fact that slightly more than 1 percent of the tests medically confirmed illegal drug use means that over 5.5 million personnel had to submit to procedures that some viewed as an insult to their integrity and personal dignity in order to uncover a relatively small number of illegal users.

Originally, the urinalysis program required testing of personnel of all ages. In March 1972, DOD excluded personnel 29 years of age and older because less than 1 percent of identified illegal drug users were in that age group. In October 1973, the minimum exclusion age was lowered to 27. DOD estimated such action would result in less than 2 percent of drug users escaping detection and would save $2.5 million in testing funds. In all, about 35 percent of the military population was exempted from the urinalysis program. Effective July 1, 1974, the minimum exemption age was lowered to 26.

As shown above, the percentage of illegal drug users identified by urinalysis testing has been declining and since 1972 has been, on the average, less than 1 percent servicewide.

About 55 percent of the command, medical, and other officials we interviewed believed urinalysis was not a cost-effective method of detecting drug use. A study at Clark Air Base also concluded that random urinalysis was not cost effective and recommended it be discontinued. DOD did not agree with this recommendation, however, because the study did not consider the cost of replacing drug abusers who cannot be rehabilitated and have to be discharged. Another study at the Naval Training Command, Corpus Christi, Texas, stated that "the Navy urinalysis program is a dismal failure as an identification device * * *." The study pointed out that, while 2-5 percent of the officers and enlisted personnel surveyed said they used illegal drugs, none of the officers and only 0.3 percent of the enlisted personnel tested were detected by urinalysis to have done so.

Problems in administering urinalysis tests

These problems have included:

--Many service personnel failing to report for scheduled tests and program officials failing to follow up on these individuals.

--Not insuring the reliability of test results by keeping information on dates and individuals selected for testing confidential.

--Not counteracting known means service personnel use to avoid identification, such as claiming inability to urinate at the time of the test, not returning later for testing as instructed, and supplying an insufficient quantity of urine.

--Not adequately evaluating service personnel with positive urine samples; for example, failing to maintain the required urinalysis surveillance. (See p. 8.)

--Not properly supervising and controlling the collection of urine samples.

After evaluating their testing programs, individual commands from each service issued reports indicating problems existed. We obtained reports from commands in the Far East, Europe, and the continental United States. Each report found problems similar to those cited above.

Diversion of medical personnel

Regarding the value of using urinalysis program resources for other medical purposes, over 75 percent of the medical authorities interviewed believed the resources could be used more effectively elsewhere.

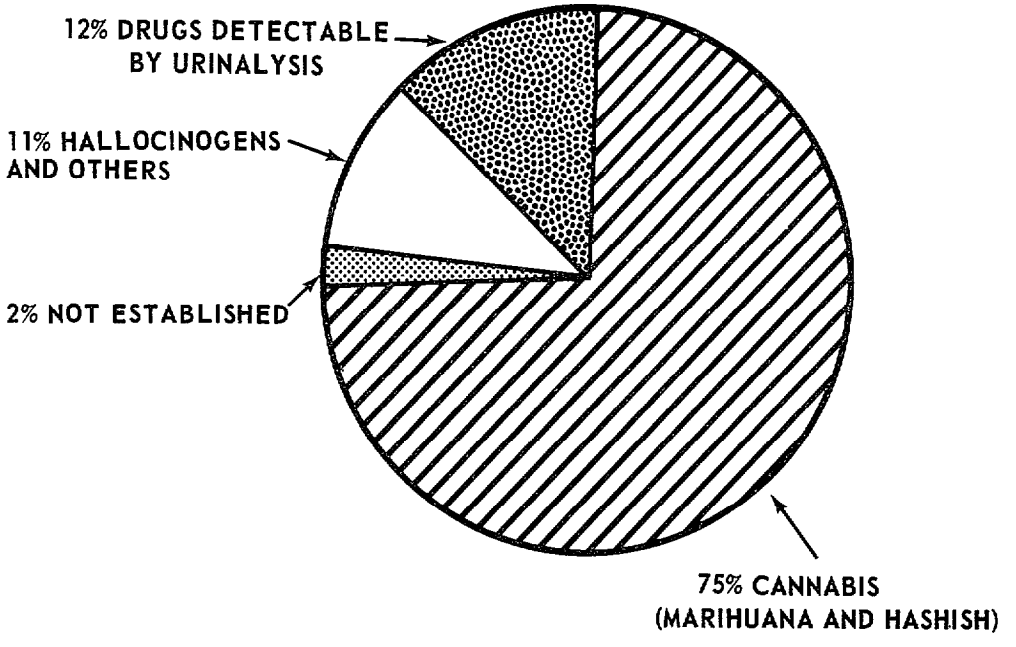
At two military bases, urinalysis program officials told us personnel important to the delivery of health care services were being diverted to process urine samples. On one large Air Force base, the chief of the medical laboratory had to spend most of his time processing and shipping urine samples to the regional urinalysis testing laboratory. As a result he had little time to supervise his laboratory and, according to him, quality slipped to the point that physicians complained about the laboratory's work.

The chief of a regional urinalysis testing laboratory said medical laboratories were generally understaffed and had to compete for personnel with urinalysis testing laboratories. As a result, medical laboratories' work suffered so urine samples could be processed.

Drugs commonly used by service personnel not detectable by testing

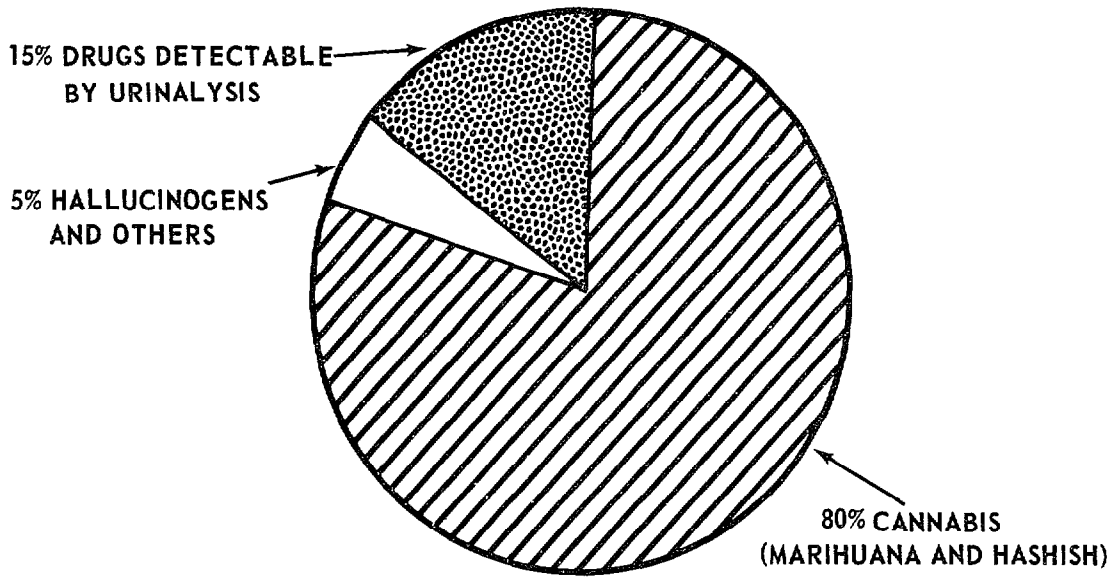
Urinalysis detects service personnel's use of opiates, barbiturates, and amphetamines. The military's law enforcement data, discussed beginning on page 18, shows that marihuana is the cause of most drug arrests and investigations. The following analysis of the Navy's law enforcement data shows percentages of service personnel arrests and investigations by types of drugs used.

NAVY LAW ENFORCEMENT ARRESTS AND INVESTIGATIONS JANUARY 1973 THROUGH OCTOBER 1974



DOD did not know the types of drugs used by service personnel entering rehabilitation programs. The Air Force did, however, and a compilation of its statistics showed the following.

AIR FORCE-TYPES OF DRUGS USED BY SERVICE PERSONNEL ENTERING REHABILITATION PROGRAMS OCTOBER 1973 THROUGH SEPTEMBER 1974



The Army gave us data on the types of drugs used by 48,599 individuals entering Army programs during the period 1972 through 1974. This data showed that (1) drugs detectable by urinalysis accounted for 32.6 percent of drug use, (2) hallucinogens accounted for 2.0 percent, (3) cannabis and poly-drug use (most of which involved cannabis) accounted for 59.0 percent, and (4) other drugs accounted for 6.4 percent.

A study of DOD drug abuse prevention and control programs, released in May 1975, also showed that marihuana is the drug most frequently used by service personnel. The study pointed out that, while overall drug use declined slightly from preservice to current use, marihuana use increased slightly.

Uncertain deterrent value of urinalysis testing

One objective of urinalysis testing is to deter drug use. We attempted to determine its effectiveness as a deterrent; however, no conclusive documentary evidence was available. We found that:

--Approximately 40 percent of command personnel doubted its effectiveness as a deterrent.

--The Army initiated a pilot study on April 1, 1974, at several military installations to determine deterrent value but, due to DOD's suspension of the urinalysis testing program, in July 1974 the study was discontinued with insufficient data having been obtained to draw valid conclusions.

--The Naval Training Command study at Corpus Christi found that urinalysis testing did deter some young personnel who were considered highly impressionable. Seventy-two percent of the young officers and 29 percent of the enlisted personnel 23 years of age or younger reported being deterred from drug usage by the threat of detection by urinalysis testing; however, no one over 23 reported any deterrence because of the tests.

--The Assistant Secretary, Health and Environment, acknowledged that many service personnel were beating the urinalysis program. He also said a system that can be beaten lacks credibility in the eyes of the target group and, therefore, lacks any deterrent effect it was intended to have

--In commenting on DOD's proposal to reinstate the urinalysis program after it had been suspended (see pp. 8 and 10), the Air Force recommended against reinstatement, the Navy did not take a position, and the Army suggested reinstatement under limited conditions. Also, two services indicated that, when urinalysis testing was suspended, drug abuse trends did not change significantly.

A study prepared on the military's drug programs by Arthur D. Little, Inc., in May 1975 found that about 18 percent of non-drug-using service members sampled indicated they did not use drugs because of the deterrent pressures from urinalysis testing, sniffer dogs, military police and special law enforcement investigative groups, other

service members, officers, and supervisors. The study found some positive deterrent value to urinalysis testing but concluded further controlled experiments would have to be conducted to establish the level and cost effectiveness of such value. If these subsequent experiments found insufficient deterrent value, the study recommended the program be permanently discontinued.

In its second report, the National Commission on Marihuana and Drug Abuse discussed social controls as deterrents to drug use among civilians. It stated many social controls interplay to affect individual decisions on drug use. The social controls considered most influential were family, peer, school, and church. In considering which deterrent factor influences an individual the most, his motivation and background must be considered in relation to the effect social controls have had on his past life.

Need to improve exemption policy

The exemption policy provisions, which encourage volunteering for treatment and rehabilitation, have contributed greatly to identifying service personnel using drugs. However, military officials indicated the exemption policy was not being implemented in full accord with its objectives. (See p. 7.)

The number of exemptions for drug abuse reported by DOD for 1971-74 is shown below by service branch.

Exemptions--1971-74

Calendar year	Army	Navy	Marine Corps	Air Force	Total
1971	28,412	4,084	3,053	2,466	38,015
1972	13,548	8,034	2,660	3,199	27,441
1973	6,513	3,938	1,831	1,944	14,204
1974	3,235	2,476	1,406	1,456	8,605
Total	51,708	18,532	8,950	9,065	88,265

Typical criticisms of the exemption policy were:

--Officials at the Pearl Harbor and Subic Bay Counseling and Assistance Centers believed most of the individuals volunteering for rehabilitation were penalized administratively. They cited an

example in which, after volunteering for exemption, a man was transferred from a staff command to the Pearl Harbor Naval Station and lost his security clearance and his occupational specialty. Moreover, an admiral tried to administratively discharge him without referring him to the Counseling and Assistance Center. The individual eventually received drug counseling at the Center but his security clearance had not been reinstated at the time of our visit.

--Attitudes toward drug users were negative and users' names were not kept confidential. For instance, on a Navy ship the names of those volunteering under the program were announced over the public address system.

--The officers responsible for enforcing the exemption policy at a command in Rota, Spain, said not one person within the last year had voluntarily asked for exemption. The officers said sailors previously used the program to get out of the Navy; however, since the Navy stopped discharging men for occasional or recreational drug use, users stopped resorting to exemption because they believed it would only label them as drug abusers.

--Army personnel at Fort Bliss, Texas, said personnel with drug problems hesitated to volunteer for exemption because they feared to lose their jobs, security clearances, and proficiency pay or believed their careers and promotion potential would be adversely affected.

Contribution of identification methods to rehabilitation program

Statistics showing the contributions various identification methods have made to referring service personnel to rehabilitation were not part of the information regularly accumulated by DOD. The Air Force compiled the information regularly and the Army compiled it at our request. The Navy, however, could not determine the methods by which service personnel were referred to rehabilitation. Based on Air Force and Army information, the principal methods

responsible for referrals and the number of referrals for calendar years 1972 and 1973 are shown below.

	Airmen	Soldiers	Total	Percent
Exemption program	5,147	8,927	14,074	39
Urinalysis	2,191	6,442	8,633	24
Incident to medical care	396	3,193	3,589	10
Law enforcement	4,364	892	5,256	15
Command referral	N/A	4,216	4,216	12
Total	12,098	23,670	35,764	100

On the basis of the above figures, about 24 percent of the service personnel referred to drug rehabilitation were identified by urinalysis testing. The exemption program, however, accounted for the highest percentage of identifications.

In calendar years 1972 and 1973, the Navy identified a total of 23,951 drug abusers. According to the Navy, about 50 percent of these were identified through the exemption program and about 16 percent were identified through the urinalysis program. About 44 percent, or 10,566 abusers, were referred to rehabilitation programs.

Our review at the Navy Drug Rehabilitation Center, Miramar, California, showed that 61 percent of the service personnel who entered rehabilitation entered through the exemption program, whereas only 8 percent of the referrals resulted from urinalysis testing. We also found from interviewing 156 drug patients that only about 8 percent entered rehabilitation as a result of urinalysis testing.

NEED TO IMPROVE TREATMENT AND REHABILITATION

DOD has not instructed the services in (1) how to assess the extent of drug use when identifying an illegal drug user or (2) what level of rehabilitation services to use to treat a particular problem.

As a result, service personnel who are experimental or casual users of drugs have often been placed in rehabilitation programs for drug-dependent personnel, and the degree of rehabilitation services provided has varied greatly from base to base.

In addition, DOD has not established a followup system to assess the effectiveness of its various treatment and rehabilitation programs. Without such information, DOD cannot properly direct the services as to the types of rehabilitation programs which should be used to treat specific drug problems.

Need to improve screening

Navy and Air Force local program officials were not adequately screening service personnel before referring them to the special rehabilitation centers which were established for service personnel with relatively severe drug problems.

Rehabilitation officials at the Navy's Drug Rehabilitation Center in California, the Air Force's Special Treatment Center in Texas, and several Army base facilities told us most service personnel in these facilities were experimental, casual, or situational drug users who were neither drug dependent nor addicted.[1] They said most of these personnel had behavior and character disorders which caused problems in their career and their personal lives but were not directly related to drugs.

Program officials said the counseling and assistance provided at the Centers helped resolve some of these other problems. As the chief psychiatrist at one Center explained, the word "drug" in "drug rehabilitation" could be deleted and the services provided at the Center would not change.

At a Marine Corps recruit depot in California, about 76 percent of the drug users who entered the local base program were referred to the Naval Drug Rehabilitation Center at Miramar. Our review of psychiatric evaluations of 291 of the 816 personnel that entered the local program over a 2-1/2-year period ending February 1974 showed that only 7 percent of the evaluations contained any evidence that the service members were drug dependent or addicted.

Despite the indications that only a few of the service members had severe drug problems, the Marine Corps discharged about 89 percent of the 816 service personnel after they were treated at the Center or in the local program. The Center's records did not show reasons for the discharges.

[1]Appendix IV explains the differences among these types of users.

Improper screening at the local command level prompted the Navy's Drug Rehabilitation Centers to send letters to its Counseling and Assistance Centers suggesting that more screening and evaluation of drug users locally could greatly reduce unnecessary Center referrals. The letters also suggested that more personnel could be handled locally.

In October 1973, the Air Force issued a revised drug control directive emphasizing the need for increased screening and evaluation of drug users at the local level to reduce unnecessary referrals to the Special Treatment Center at Lackland Air Force Base, Texas. The revised directive specified the base-level rehabilitation committees were to thoroughly screen and evaluate Center candidates so that only personnel who could substantially benefit from Center treatment would be referred. As a result, the Center experienced a decline in workload and had to close in April 1974. A Center official said, however, that treatment of drug users was as effective at the base facilities as at the Center.

Over three-fourths of the drug rehabilitation patients we interviewed said they were experimental, social-recreational, or circumstantial-situational drug users; less than one-fourth believed they were drug dependent or addicted.

Navy Drug Rehabilitation Center officials told us extreme cases of drug abuse were usually referred to the Veterans Administration.

Marihuana use

It appears that the military drug problem is largely a marihuana problem. Various estimates made by military officials and available law enforcement data show that about 70-90 percent of the drug use among service personnel involves marihuana.

--Most commanders and law enforcement officials believed that over 90 percent of drug use involved marihuana.

--Army law enforcement data shows that 70 percent of investigations and arrests involve marihuana.

--Navy law enforcement data shows that 75 percent of investigations and arrests involve marihuana or hashish.

--Air Force statistics on individuals entering rehabilitation programs show that 80 percent use marihuana or hashish.

--Navy officials said about 80 percent of the service personnel entering rehabilitation programs use marihuana.

When DOD established its drug program, it placed no special emphasis on marihuana. Therefore, the services have not done so either, nor have they instructed commanders or local program officials on how to treat or deal with marihuana use.

Decline of the drug program

The military planned a large-scale network of drug treatment and rehabilitation facilities on the basis of estimates that illegal drug use and addiction involved up to 30 percent of service personnel in Vietnam. Urinalysis testing has since shown that drug use was far less than the original estimates. Drug use was found in only 5 percent of the Vietnam service personnel tests and, in fiscal year 1974, was found in only .85 percent of the tests worldwide.

Since fiscal year 1973 funding of drug treatment and rehabilitation has decreased as follows.

	Fiscal year			
	1973	1974	1975 (note a)	Total
	(millions)			
Army	$22.4	$19.8	$17.6	$59.8
Navy	7.9	7.1	7.3	22.3
Marine Corps	.2	.2	.1	.5
Air Force	5.9	3.8	2.5	12.2
Total	$36.4	$30.9	$27.5	$94.8

[a]Estimated.

The services have reduced the number and capacity of their central treatment facilities and further reductions may by possible. For example, the Navy had planned 5 Drug Rehabilitation Centers but has only 2 in operation; their treatment capacity has been reduced from 300 to 200 patients. However, according to the Navy, the number of local Counseling and Assistance Centers has increased since the Navy Drug Abuse Control Program began. Also,

the Air Force closed its Special Treatment Center at Lackland Air Force Base, Texas, because of (1) increased capability and effectiveness of base-level rehabilitation programs, (2) declining numbers of drug abusers requiring central treatment, and (3) reduced cost effectiveness of the Center.

At some military bases, the programs had not yet been reduced. At Fort Bliss, Texas, for example, the combined drug and alcohol resident rehabilitation facility had a capacity of 20. Admissions to the program declined, however, to the point that the staff had extraordinarily light workloads. When we visited in June 1974, the program consisted of six full-time counselors and three drug and five alcohol patients. The program's director said the counselors were not being efficiently used. In addition, at Fort Sam Houston, Texas, the number of program participants declined approximately 65 percent from 173 in January 1973 to 60 in March 1974. Rehabilitation officials attributed the decline to counseling that commanders gave service personnel with minor drug problems at the unit level without sending them to the base program.

Disposition of identified illegal drug users

According to information from the military services, approximately 92,500 service personnel were identified, treated, and given rehabilitation services during a 28-month period ended September 1973. Approximately 48,600 of these servicemen returned to duty, as shown below.

Disposition of Identified Illegal Drug Users
June 1971 through September 1973

	Army	Navy	Marine Corps	Air Force	Total	Percent
Completed rehabilitation and returned to duty	33,281	8,525	1,918	4,947	48,671	53
Separated after rehabilitation	13,925	7,799	4,484	4,367	30,575	33
Transferred to Veterans Administration	5,368	142	104	122	5,736	6
Still in rehabilitation	7,142	257	59	89	7,547	8
Total	59,716	16,723	6,565	9,525	92,529	100

Note: The above figures represent totals for DOD's entire drug program. However, the amount and scope of rehabilitation services provided by the respective services differ greatly. Rehabilitation may involve counseling only or extensive Center treatment.

Varied services offered

The rehabilitation services offered locally to a service person vary, depending upon the base to which he is assigned. The various types of local rehabilitation services we found included the following:

--At Yongsam, Korea, the Army's resident rehabilitation program is the same for both alcohol and drug users. The inpatient program lasts 2 weeks and additional outpatient services are provided if necessary. Each patient receives about 3 hours of individual counseling per week. This amount can be increased if necessary. The program includes group sessions, lectures, and yoga.

--At Fort Bliss, Texas, required weekly activities of the inpatient drug programs include 8 hours of group therapy and 5 hours of individual counseling. The program lasts 6 to 9 weeks. Program counselors said, however, the program is ineffective because it is oriented toward military matters, such as proper saluting techniques and proper dress and appearance. They believed the program's 20-percent success rate could be improved by placing more emphasis on such rehabilitation activities as individual counseling, group therapy, and educational lectures.

--At the Navy Counseling and Assistance Center in Rota, Spain, individuals entering the program go through a 2-1/2-day screening. On the basis of the screening, they do one of the following: (1) return to the command for local counseling, (2) transfer to a Drug Rehabilitation Center, or (3) enter the Counseling and Assistance Center program. The Counseling and Assistance Center has two different programs. In one program the individual spends 4 hours a day at a unit to which he is temporarily assigned, spends 4 hours a day at the Center, and receives 5-6 hours per week of individual counseling. In the second program, individuals work at their commands, visit the Center three times per week, and receive about 4-1/2 hours of counseling per week.

Need for followup system

According to DOD, approximately 50 percent of the service personnel completing rehabilitation return to duty. (See p. 54.) However, DOD has not established a followup system to assess the effectiveness of the services' various rehabilitation programs.

Some bases had tried to assess this effectiveness. For example, followup studies by the Navy's Miramar Drug Rehabilitation Center showed the drug rehabilitation program had beneficial results but was not always successful in modifying drug-use behavior. A study completed in July 1973 of two groups of rehabilitated personnel who had been out of rehabilitation for 6 and 12 months, respectively, showed 67 percent were still using drugs. Some other findings were:

--55 percent of the rehabilitated personnel indicated the Center had helped them.

--12 percent indicated it had not.

--4.4 percent had been treated by the Veterans Administration for emotional problems, while 3.6 percent had been treated by the Veterans Administration for drug problems.

At its request, the Center received from commanders and supervisors of rehabilitated personnel the following followup showing whether the individuals:

		Percentage of rehabilitated personnel
1.	Got along well with their supervisors.	75
2.	Had been promoted.	20
3.	Received recommendation for reenlistment.	63
4.	Had no disciplinary problems.	95
5.	Were not using drugs.	91
6.	Were not using alcohol excessively.	98

The views of the commanders and supervisors differed from those of the rehabilitated personnel in the area of drug usage. While commanders and supervisors believed 91 percent of rehabilitated personnel were not using drugs, 67 percent of the personnel said they were still doing so. This disparity could be due to personnel using drugs that were not affecting their duty performance to an extent detectable by supervisors.

CONCLUSIONS

DOD needs to reassess its drug abuse control program. Specifically, it should reevaluate the desirability of using random urinalysis testing to routinely identify personnel with drug problems. The tests' substantial cost, low productivity, and demands on the short supply of medical personnel as well as the problems of administering the tests are several factors DOD should consider.

DOD has never established that random urinalysis testing actually deters illegal drug use. Two studies have alluded to possible deterrence value, however, neither of these studies was conclusive. As one study recommended, further controlled tests are necessary to accurately establish if urinalysis testing has deterrent value. This same study recommended urinalysis testing be permanently discontinued if these subsequent tests disclose insufficient deterrence. The three services were not enthusiastic about DOD's proposal to reinstate urinalysis testing after its temporary suspension in July 1974 and either did not support reinstatement or favored only limited reinstatement.

It seems that urinalysis testing when certain events occur and command-directed urinalysis testing (see p. 8), together with law enforcement and medical identification information, could provide a sufficient deterrent.

We believe the exemption policy has been reasonably effective in encouraging drug users to volunteer for treatment and rehabilitation. However, administrative actions have been taken against some volunteers and these actions have contributed to a reluctance on the part of more service personnel to volunteer. Minimizing the stigma attached to volunteers, placing more emphasis in drug education on the exemption policy's intent, and enforcing the policy, particularly in the area of confidentiality, could help improve attitudes toward the program as well as the program's success.

DOD has not instructed the services to assess the extent of drug abuse when referring an individual to a rehabilitation program. The extent of rehabilitation services provided varies greatly from base to base. In addition, service personnel who are experimental or casual users of drugs have often been placed in rehabilitation programs designed to treat drug-dependent personnel. Further, since the most frequently used illegal drug is marihuana, DOD needs to particularly emphasize the best approaches to deal with the marihuana problem.

Finally, to provide a basis upon which drug policy and program changes can be made, DOD-wide followup of rehabilitation programs is needed. Without followup, DOD cannot properly assess the effectiveness of rehabilitation efforts or direct the services as to the types of rehabilitation programs which should be used to treat specific drug problems.

RECOMMENDATIONS

We recommend that the Secretary, DOD, direct the Assistant Secretary, Health and Environment, to:

- --Reevaluate the desirability of the present urinalysis testing program.
- --Provide more education in the intent of the drug user exemption policy, thereby improving the policy's credibility and success.
- --Instruct the services in the levels of rehabilitation services necessary to treat particular problems; the best approaches to deal with the marihuana problem should be especially emphasized.

AGENCY COMMENTS

DOD agreed with the general premise that drug abuse constitutes a serious problem in the Armed Forces and agreed with all of the above recommendations except the one that it reevaluate the desirability of the present urinalysis testing program. One reason DOD cited for disagreeing with this recommendation related to a study conducted by Arthur D. Little, Inc., entitled, "A Study of Department of Defense Drug Abuse Prevention and Control Programs." Issued in January 1975, the study stated that, if questionnaire responses were considered at face value, urinalysis testing had the highest deterrent value among the various identification methods employed by the military. The study also pointed out, however, that responses by non-drug-using service members indicated that only 18 percent felt they were deterred from

using drugs because of urinalysis testing, military police, other service members, officers, and all other deterrents.

The study recommended that DOD consider three options for its urinalysis program:

Option A: Continue random urinalysis as well as commander-directed testing but discontinue "nonsurprise" testing.

Option B: Discontinue random testing but encourage commander-directed testing.

Option C: Conduct a controlled experiment to assess the true deterrent value of random testing.

After setting forth these options, the report stated:

"The following recommendation is made from the narrow vantage point of one whose mandate concerns the reduction of drug use, rather than evaluation of this issue within the broader context of ends and means. Now that urinalysis has been re-instituted, we recommend Option C * * *." If insoluble legal or constitutional problems again stand in the way of urinalysis, or if further analysis shows that urinalysis has insufficient deterrent value, then we recommend that urinalysis be permanently discontinued."

Another reason cited by DOD for disagreeing with our recommendations was a memorandum to the Secretary, DOD, from the Assistant Secretary, Health and Environment, dated December 11, 1974, which recommended reinstatement[1] of the urinalysis program for identifying drug abusers. This recommendation was based, in part, on the belief that:

--Drug abuse in the Armed Forces was increasing or holding steady at presuspension levels.

--The majority of commanders and staff officers felt reinstating the urinalysis program was necessary to successfully combat drug abuse.

A memorandum, which endorsed reinstatement of urinalysis, submitted by DOD's General Counsel to the Deputy Secretary,

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[1]Reinstatement of urinalysis is discussed on page 10.

DOD, on December 11, 1974, included a background paper which summarized the present status of the urinalysis program. The background paper stated that:

--"There is no hard statistical base whereby post-suspension drug incidency may be compared with the pre-suspension incidence rate."

--"The data tending to show increased drug use is fragmentary, misleading, and subject to differing interpretations as to its significance."

The background paper also set forth the principal arguments supporting resumption of the urinalysis testing program and those opposing resumption. Some of the supporting arguments were:

--Testing would identify drug abusers not being identified now and hopefully would lead to their rehabilitation and return to productive military service.

--A program of unannounced testing would deter the experimenter or infrequent drug user.

--Confirmed drug abusers frequently cannot perform their duties and thus can be discharged for reasons not associated with urinalysis test results.

Some of the arguments opposing resumption were:

--Granting an honorable discharge to military members who are unfit for military service because of drug abuse demeans the honorable discharge.

--Urinalysis testing is only useful in identifying certain drugs, and its validity as a testing device is by no means infallible.

--Random unannounced testing causes substantial administrative and logistical problems to commanders and lowers the morale of nonusers who are ordered to submit to testing.

--Through increased investigations, education, and personal involvement and observation by company commanders and their noncommissioned officers, casual drug users will be deterred and hard drug users identified without testing.

The services' positions on resuming urinalysis, as set forth in the background paper, were as follows:

Army--"[We] would be most unwilling to reinstate involuntary urinalysis testing at the expense of the honorable discharge certificate, or retention of confirmed drug abusers/rehabilitation failures in the service."

Navy--"There is no indication that drug abuse trends have changed significantly since urinalysis testing was suspended on 18 July 1974." (The Navy submitted no specific written position on resuming testing.)

Air Force--"In view of the questionable cost effectiveness of the urinalysis program, coupled with the problems created by [a recent court] decision, we recommend the involuntary testing program not be reinstated."

Accordingly, we believe:

--The results of our review, coupled with the recommendations in the Arthur D. Little, Inc., study and the views expressed by the military services, raise significant doubts about the effectiveness of DOD's urinalysis program.

--DOD should evaluate the deterrent value of its present urinalysis testing program.

--Commander-directed urinalysis testing together with law enforcement and medical identification information could provide a sufficient deterrent.

CHAPTER 5

NEED TO IMPROVE MANAGEMENT INFORMATION SYSTEM

In the previous chapters of this report, we discussed a number of management improvements which are needed in the administration of the military drug and alcohol programs.

The need for placing more emphasis on the alcohol problem has been recognized in studies conducted by or for the respective services but actions either have not been taken or have not been adequate.

We believe DOD would be in a better position to (1) gage the size of its alcohol problem, (2) recognize the problems of both the alcohol and the drug control programs, and (3) direct the individual services on how to improve their respective programs if DOD management had better information. Although DOD requires the services to submit reports, it has not required them to systematically compile uniform data on the size of the drug and alcohol problems or to measure the effectiveness of the programs established to deal with them.

DOD HAS PROVIDED GUIDANCE

The Deputy Secretary, DOD, issued a directive in 1970 assigning responsibility for administering and managing drug problems and programs to the Assistant Secretary, Manpower and Reserve Affairs. The assignment included overall responsibility for developing a coordinated drug abuse control program, including submitting appropriate reports to the Secretary and/or Deputy Secretary.

Some of the requirements outlined in the drug and alcohol directives have been fulfilled. However, DOD has not developed a system whereby it can monitor, on a continuing basis, the service programs, nor does it require sufficient data from the services to enable it to satisfy all of its responsibilities--particularly those relating to the alcohol program. DOD's oversight has consisted mainly of funding major research studies by private firms, making onsite visits to some programs, and analyzing urinalysis statistics. It appears that, for the most part, DOD's management has been concerned with the urinalysis testing program.

Because DOD established standardized testing and performance criteria and a standardized reporting system for the urinalysis testing program, it was able to recognize and support a reduction in the scope of urinalysis testing at an estimated savings of several million dollars.

Performance criteria and standardized reporting, however, have not been established for the other aspects of the drug and alcohol control programs, such as identification, treatment, and rehabilitation.

The military services individually reviewed and evaluated drug and alcohol programs but, generally, DOD had not received all of these internal evaluations.

In September 20, 1973, testimony before the Subcommittee on Drug Abuse in the Military, Senate Armed Services Committee, the former Assistant Secretary, DOD, cited as one of the problems of DOD's drug and alcohol programs a lack of standardized reporting which made comparisons of statistics unreliable.

In 1972 the Secretary, DOD, issued an alcohol directive further instructing the Assistant Secretary, Health and Environment,[1] to:

--Review, evaluate, and monitor, including making onsite inspections, the existing alcohol abuse control programs.

--Recommend new policies for more effectively identifying, evaluating, treating, rehabilitating, and disposing of service personnel with alcohol problems.

--Require DOD components to submit information for collation and dissemination to other DOD components concerning the causes of alcohol abuse, the methods of combating it, and the rehabilitation of abusers.

--Obtain reports and recommendations from DOD components responsible for programs.

--Exchange information on alcohol abusers with other Federal agencies and private organizations and disseminate information on research being conducted by other governmental and private organizations to DOD components.

--Recommend any needed additional research by DOD or outside agencies.

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[1]In September 1971 the Secretary, DOD, transferred responsibility for drug and alcohol control from the Assistant Secretary, Manpower and Reserve Affairs, to the Assistant Secretary, Health and Environment.

DOD IS NOT GETTING THE INFORMATION IT NEEDS

At various points in this report, we have referred to the nonavailability of data we considered useful in determining the scope and magnitude of the military's drug and alcohol problems and in assessing the status and effectiveness of its drug and alcohol control programs. As a result of the nonavailability of such data, we gathered statistics that would provide some indication or measurement of the problems and of the success of the control programs.

In reviewing overall program management and in attempting to obtain data, we found that the management information and evaluation system for the programs needed improvement, including improvement in carrying out certain administrative responsibilities set forth by DOD directives. More specifically, we found that:

--DOD did not have overall statistics on alcohol-related traffic accidents. (See p. 20.)

--Overall statistics for the number of alcohol-related arrests of service personnel by civilian and military law enforcement authorities were not available. (See p. 18.)

--DOD could not determine the total cost (including lost duty time, transportation, etc.) of the urinalysis program. (See p. 42.)

--The Army and Navy did not have statistics available on the contributions the various identification methods made in identifying and referring service personnel for drug treatment and rehabilitation. (See pp. 49 to 50.)

--DOD had not developed any statistical evidence establishing the deterrent value of urinalysis testing. (See p. 47.)

--DOD did not know the types of drugs used nor the extent of abuse by individuals in the drug rehabilitation program. (See p. 46.)

--DOD has not established a system to follow up on service personnel returned to duty after drug rehabilitation so it can assess the effectiveness of its rehabilitation. (See p. 56.)

--DOD had not comprehensively studied the cost benefit of alcohol rehabilitation. (See p. 37.)

Reports required by DOD

In May 1974, during our review, DOD issued an instruction to the services calling for drug and alcohol reports which provided:

--A measure of the magnitude of the problems.

--A measure of the success of the services' education, treatment, and rehabilitation programs.

--A source of data upon which to base replies to public, congressional, and government agency inquiries and to support budget requests for program funds.

--Trend data upon which DOD could prescribe policy and make indicated changes to reduce and ultimately eliminate the drug and alcohol abuse problems.

The reports received by DOD contained statistical information in the following areas.

	Drugs	Alcohol
Rejections at Armed Forces entrance examination stations for drug and alcohol abuse	X	X
Urinalysis testing of recruits upon service entry	X	
Urinalysis testing for drug abuse	X	
Service law enforcement statistics	X	
Service personnel volunteering for drug abuse exemption program	X	
Service personnel counseled by chaplains on drug and alcohol abuse	X	X
Service discharges for drug and alcohol abuse	X	X
Personnel in treatment and rehabilitation for drug and alcohol abuse (Includes drug- and alcohol-related deaths)	X	X
Veterans Administration report on treatment and rehabilitation of drug abusers	X	
Disposition of drug abuse offenders under the Uniform Code of Military Justice	X	

None of the reports gave DOD data sufficient to measure or to compare the magnitude of the drug and alcohol problems or to measure the success of the services' education, treatment, and rehabilitation programs. Further, only four reports related to the alcohol program.

Studies conducted by DOD and the services

During fiscal years 1972 through 1975, DOD and the services spent over $3.5 million for drug and alcohol studies, including:

--An $876,500 contract awarded to Arthur D. Little, Inc., by DOD in June 1973 to evaluate the effectiveness of the drug programs. (The study was released to the public in May 1975.)

--A $616,681 contract awarded to the System Development Corporation by DOD in June 1974 to evaluate the alcohol program. (This study was issued in September 1975.)

--A $130,000 study to determine drinking practices and problems in the Army.

--A $315,000 study to evaluate the Army drug and alcohol treatment and rehabilitation program.

--A $65,000 study to determine drinking practices and problems in the Navy.

--A $90,000 study to evaluate Navy alcohol treatment programs.

The studies which have been completed have indicated, for the most part, a substantial incidence of alcohol abuse among service personnel. (See also ch. 2.) Military funding and resources for drug control programs, however, continue to far exceed the resources applied to alcohol control programs. The use made of the drug and alcohol studies has not been apparent.

CONCLUSIONS

Overall, the Assistant Secretary, DOD, Health and Environment, could more effectively direct the services in (1) fulfilling the responsibilities set forth in DOD's drug and alcohol directives and (2) managing the drug and alcohol problems and programs. With the drug study by Arthur D. Little, Inc., and the alcohol study by System Development Corporation, DOD should have better insight into the overall effectiveness of the individual services' drug and alcohol

programs. However, DOD needs to establish a systematic reporting system to continually monitor the programs' effectiveness.

The Assistant Secretary, Health and Environment, needs to:

--Work with the services to identify needed information--such as arrest and hospital admissions information--and then develop a uniform reporting system. This information should then be analyzed by DOD and used to continually monitor and evaluate the drug and alcohol control problems.

--Obtain reliable and comparable information, including followup on rehabilitation efforts, and establish standard measures of performance for the services and DOD.

--Coordinate and monitor the drug and alcohol studies to prevent possible duplication and to standardize the methods of evaluation so comparable results are obtained when the services do independent studies.

RECOMMENDATIONS

We recommend that, to improve the overall management of drug and alcohol programs, the Secretary, DOD, require the Assistant Secretary, Health and Environment, to establish a DOD-wide system which:

1. Will provide, on a continuing basis, uniform and reliable data from the services on the size and impact of the drug and alcohol problems.

2. Can be used by DOD to evaluate the effectiveness of the various service programs and to direct the services on action needed to improve their respective programs. DOD should particularly emphasize evaluating and monitoring the effectiveness of rehabilitation programs by following up on service personnel who have undergone rehabilitation.

AGENCY COMMENTS

DOD disagreed with our recommendations and cited the establishment of a reporting system in 1974 to accumulate basic data on the alcohol and drug programs of the military services. Taken collectively, according to DOD, "these data provide a measure of the magnitude of drug and alcohol abuse problems and indicate trends of drug and alcohol abuse by service by geographical area." DOD further stated that:

"the search for new data for use in assessments of the situation has not stopped. Two new sources are being actively considered. One is the use of hepatitis rates as indicators of drug abuse incidence and the other is an expanded drug abuse law enforcement report requirement."

The reports required by DOD's reporting changes of 1974 are discussed beginning on page 65. We agree that these reports provide a collective measure of the extent of drug and alcohol abuse in the military. However, as pointed out in this chapter, we did not find that DOD systematically summarized and analyzed these reports to (1) evaluate the effectiveness of the services' programs or (2) direct the services on how to more effectively fulfill program objectives.

Our views on the need for a systematic approach to gathering and evaluating information at the DOD level were, to a large extent, substantiated by the System Development Corporation alcohol study. (See p. 27.) This study recommended that DOD establish:

--An evaluation system for its alcohol abuse control programs to determine their success and cost effectiveness.

--An ongoing research and research-review program to determine effective techniques of prevention and rehabilitation.

--Servicewide evaluation procedures.

Further, the Arthur D. Little, Inc., study on the military's drug programs also made recommendations for DOD and the services to improve program administration in the areas of planning and management. The study suggested that (1) DOD and the services develop criteria by which programs could be evaluated, (2) information needs be defined, and (3) a process and schedule be established to meet those needs.

In commenting on the extensive research studies made by or for DOD and the military services, DOD stated that:

"DOD receives copies of the bulk of service-initiated studies. The DOD does not evaluate the studies from the point of view of study coverage of findings -- that is a service responsibility. The DOD does review the studies to extract pertinent information of drug and alcohol abuse programs and problems for comparison against policy to see if changes or additions need to be made.

Data are also extracted which provide an indication of the magnitude of the problem. Finally, the study is retained as source material with which to answer future questions which fall within the study area of investigation."

We believe DOD must take a more aggressive role in evaluating and acting on many of these studies' recommendations for improving the services' alcohol and drug programs. To assume the services will appropriately modify their programs without DOD's encouragement or direction seems contrary to one of the primary missions of DOD--to oversee and to manage the various elements and activities of the military services.

Accordingly, we believe DOD's management information system needs the recommended improvements so DOD can more actively direct and evaluate the services' drug and alcohol programs.

CHAPTER 6

SCOPE OF REVIEW

We evaluated the management of the military drug and alcohol problems. The major areas examined were:

--The relative impact drugs and alcohol have on military performance.

--The services' compliance with directives and policies on identifying drug and alcohol abusers.

--The scope of treatment and rehabilitation services provided or made available to individuals with drug and alcohol problems.

We visited 36 military bases, including some in the Far East and Europe, to get a worldwide view of the problems and programs. We interviewed 276 commanders, 41 law enforcement officials, 107 medical authorities, 357 patients in drug and alcohol rehabilitation programs, and 194 other officials and professionals who were involved with the drug and alcohol programs. We also talked to DOD, service, and medical officials at headquarters in Washington, D.C.

We examined each service's compliance with applicable DOD policies, practices, and procedures. We reviewed records, including patient files, relating to the management and administration of the programs and obtained statistics on the impact of drugs and alcohol on the military.

Military bases and facilities visited are identified below.

Name of facility and location	Type of facility at time of our visit (note a)							
	Local program	CAAC	HRMC/D	ARC	ARU	ARD	DRC	Medical
Navy								
Training Center, San Diego, Calif.	X		X					
Balboa Hospital, San Diego, Calif.					X			X
Medical Neuropsychiatric Research Unit, San Diego, Calif.								X

Name of facility and location	Type of facility at time of our visit (note a)							
	Local program	CAAC	HRMC/D	ARC	ARU	ARD	DRC	Medical
Navy								
Air stations:								
Miramar, Calif.							X	
Corpus Christi, Tex.		X						
Bases or stations:								
Norfolk, Va.		X	X	X				
Long Beach, Calif.	X	X		X				X
Pearl Harbor, Hawaii		X	X			X		
San Diego, Calif.				X				
Naples, Italy		X			X			X
Rota, Spain		X	X			X		X
Subic Bay, Philippines		X	X		X			X
Ships:								
USS Ramsey, Long Beach, Calif.	X							
USS Long Beach, Long Beach, Calif	X							
Marine Corps								
Recruit Depot, San Diego, Calif.	X							
Base:								
Camp Lejeune, N.C.	X				X			X
Multiservice								
Armed Forces Entrance and Examining Center, Los Angeles, Calif.	X							
Armed Forces Recruiting Center, Los Angeles, Calif.	X							

Name of facility and location	Type of facility at time of our visit (note a)								
	CDAAC	SAO	ATC	STC	ADCO	RC	RRF	ARC	Medical
Air Force									
Bases:									
Edwards, Calif.		X							
Travis, Calif.		X	X					X	X
Lackland, Tex.		X	X	X					X
Hickam, Hawaii		X				X			
Clark, Philippines		X	X						X
Osan, Korea		X							
Wiesbaden, West Germany		X	X					X	
Lakenheath, England		X						X	
Alconbury, England		X							
Army									
Fort Bragg, N.C.					X	X			
Schofield Barracks, Hawaii						X			
Seoul, Korea						X			
Fort Sam Houston, Tex.					X	X			X
Fort Bliss, Tex.						X			X
Fort Lee, Va.						X			
Tripler Medical Center, Hawaii						X			X
Headquarters, U.S. Army, Europe, Heidelberg, West Germany					X				
Hanau, West Germany		X							
Frankfurt, West Germany	X		X						X
Nuernberg, West Germany	X		X				X		X
Ludwigsburg, West Germany	X					X			
Crailsheim, West Germany	X								
Wurzburg, West Germany									X

[a]ADCO - Alcohol and Drug Control Office or Drug and Alcohol Abuse Control Office (in Heidelberg, Drug and Discipline Division)
ARC - Alcohol Rehabilitation Center
ARD - Alcohol Rehabilitation Drydock
ARU - Alcohol Rehabilitation Unit
ATC - Alcohol Treatment or Rehabilitation Center

CAAC	-Counseling and Assistance Center
CDAAC	-Community Drug and Alcohol Assistance Center
DRC	-Drug Rehabilitation Center
HRMC/D	-Human Resources Management Center or Detachment
Medical	-hospital, medical center, and/or urinalysis laboratory
RC	-Rehabilitation Center (halfway house)
RRF	-Resident Rehabilitation Facility
SAO	-Social Action Office
STC	-Special Treatment Center

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AND
ENVIRONMENT

January 13, 1976

Director
Manpower and Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Sir:

On behalf of the Secretary of Defense, we are responding to your request for comments on GAO Draft Report, "Comparison of the Military's Drug and Alcohol Programs Shows Need to Recognize Alcohol Abuse as the Number One Drug Problem" (OSD Case #4144).

The report's chief conclusion is that within the Department of Defense, disproportionate attention and resources have been given to other drugs of abuse when compared with alcohol abuse. The Department of Defense shares GAO's concern about the prevalence of alcohol abuse and its adverse impact on our personnel; however, there is some question about whether alcohol abuse is the most serious drug problem. By their nature the number of drug and alcohol abusers defies precise quantification. Moreover, many young abusers are involved with both drugs and alcohol. Efforts to obtain precise measures of the extent of the problems have led to the conclusion that, in addition to imprecision, the numbers are highly influenced by the estimating methodology and can be misinterpreted if compared to estimates based on different methodologies. Reports now used, such as individuals in treatment and rehabilitation, deaths, law enforcement and investigative agency actions, urinalysis data, etc., are indicators of trends. These data indicate that there was significant improvement in drug abuse control during 1971-73, and that conditions have levelled off or become slightly worse in some locales in recent times. As regards alcohol, data would indicate increased abuse. However, it is not now known whether the situation is actually worse or appears so because of the increased emphasis being placed on alcohol abuse during the last several years.

The important point is that OSD and the military services recognize that both drug and alcohol abuse are very serious problems and are pursuing active programs to identify, treat and rehabilitate

abusers on a world-wide basis. Initial emphasis on DoD-wide programs were on efforts to identify and treat abusers of heroin and other illicit drugs. Meanwhile, recognizing the serious and difficult problem of alcohol abuse, and building on the experience of the Military Departments, a formal DoD program to deal with alcohol abuse was documented in 1972. Since that time, increasing resources have been devoted to preventing alcohol abuse and identifying and treating abusers.

[See GAO note.]

GAO note: Deleted comments relate to matters which were presented in the draft report but have been revised in this final report.

[See GAO note, p. 75.]

We agree with the general premise that alcohol and drug abuse constitutes a serious problem in the Armed Forces and requires intensified efforts on the part of the DoD and the military services. Further, except as noted in the enclosures hereto and in the enclosures to the 12 December 1975 letter of Mr. E. D. Schmitz of this office to Mr. Thomas P. McCormick of the GAO, we generally agree with the thrust of the report recommendations.

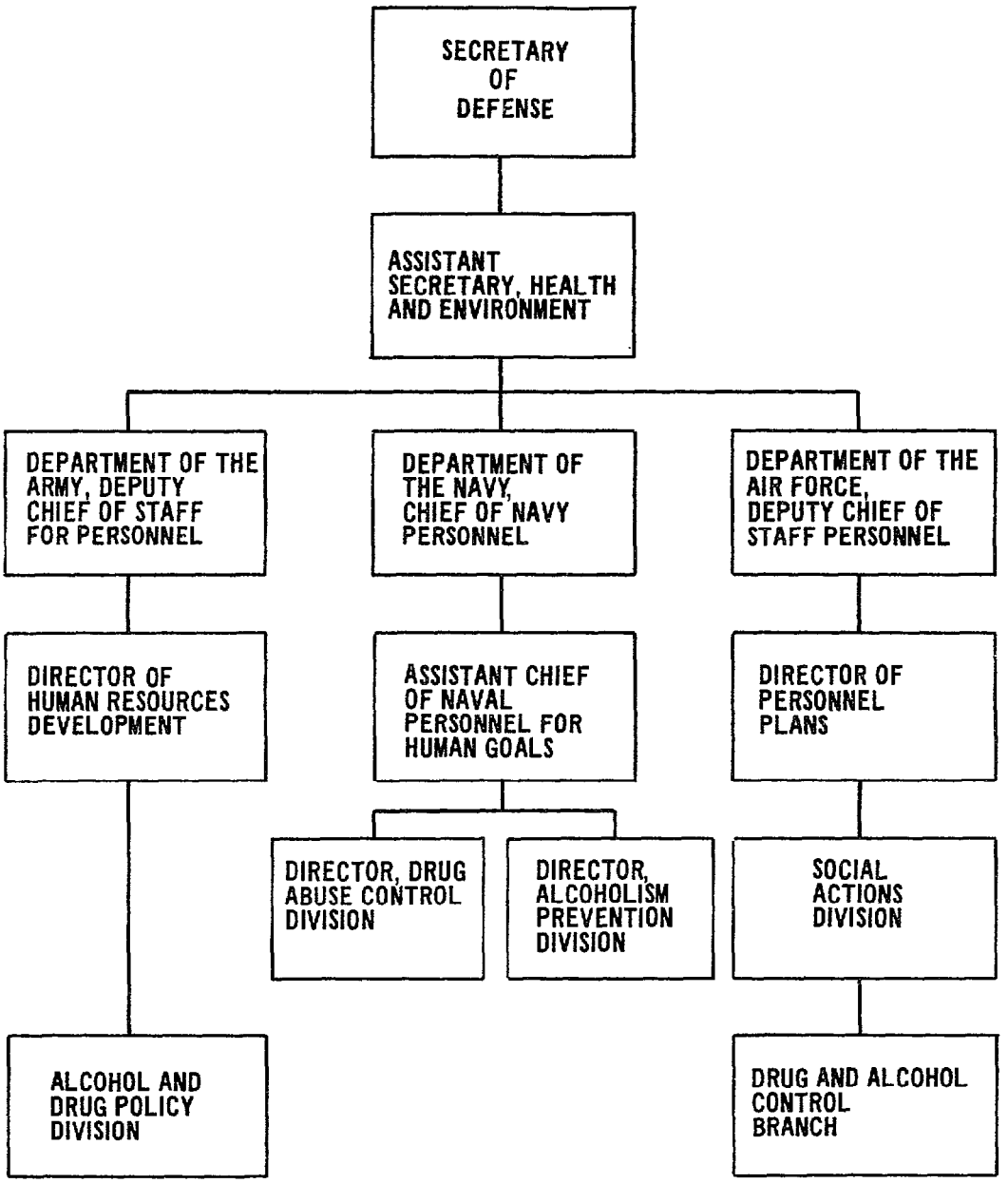
Sincerely,

James R. Cowan, M.D.

2 Enclosures

APPENDIX II

ORGANIZATION CHART SHOWING PROGRAM RESPONSIBILITY



FACILITIES AND SERVICES AVAILABLE TO SERVICE PERSONNEL WITH DRUG AND ALCOHOL PROBLEMS

DOD facilities and services available to service personnel with drug or alcohol problems vary, depending on the service. Each service has local rehabilitation programs; however, the rehabilitation methods differ. Navy, Marine Corps, and Air Force illegal drug users and alcohol abusers who require treatment beyond the capability of a local facility are sent to special centers. The Army has no special centers; instead, after detoxification in a hospital, a soldier with sufficient service time remaining goes to his base for rehabilitation.

DOD policy provides only for short-term treatment and rehabilitation. Individuals who cannot be rehabilitated within this time are phased into Veterans Administration programs.

Each service administers its own treatment and rehabilitation program under the broad guidance of DOD. A summary of the facilities and services of each follows.

ARMY

The Army's treatment and rehabilitation program operates on a decentralized basis at installations throughout the United States and overseas. Following identification, an individual is treated locally either at his unit or at a halfway house, depending on his need and the availability of treatment facilities. A "halfway house" is a place where soldiers in the drug and alcohol program may stay, usually after leaving the hospital and before returning to full duty. They may either live-in full time for a short while or perform regular duty in the unit and return to the halfway house in the evening. A "rap center," a place where personnel can talk in informal groups or individual sessions, may be provided within the halfway house. The staff of the rap center provides information, referral, crisis intervention, and counseling.

As of July 1974, Army facilities consisted of 50 halfway houses, 128 rap centers, and 73 hospitals in the United States and overseas.

When necessary, a soldier undergoes detoxification in a medical center. After detoxification, his treatment needs are determined by halfway house staff. He then enters a rehabilitation program involving either (1) direct return to the unit or (2) return to the unit by way of a halfway house.

Soldiers who do not require a period of residence (the vast majority) are those who (1) do not need the more structured environment of a halfway house or (2) are so resistant to therapy that forced participation in a halfway house program would be useless. These individuals are then entered in a 60-day active rehabilitation program during which they live and work with their unit but receive frequent counseling at a halfway house.

Some individuals in the active program spend a transitional period in a halfway house. Such a period, which lasts no more than 2 weeks, may involve either a highly structured, 24-hour day regimen or a less structured approach in which the soldier works in his unit during the day and returns to the halfway house for counseling and supervised residence during nonduty hours. Variations are tailored to the needs of the client. During the remainder of the 60-day active program, the soldier lives and works with his unit and visits the halfway house for counseling sessions only.

Soldiers who are functioning effectively on full duty at the end of the active phase and who have apparently stopped abusing drugs or alcohol are considered interim rehabilitation successes and enter a followup phase. They are followed up for 300 days, while living and working with their units. During this time they receive less frequent and less intensive counseling sessions and are given urinalysis tests two times a month.

At the installation level the program is principally coordinated by a staff, with an Alcohol and Drug Control Officer responsible to the commander. The Control Officer usually heads the installation's Alcohol and Drug Dependency Intervention Council, which advises the commander on the program. The Control Officer also monitors the progress of soldiers in the 300-day followup program.

The Army's program also includes an Alcohol and Drug Prevention and Control Team, which works in education and rehabilitation at the local level. Each team is authorized 15 positions, including a physician, a chaplain, a social worker, a psychologist, 10 paraprofessionals with appropriate training in drug and alcohol work, and a clerk-typist. The team members may work as counselors in halfway houses, hospitals, or rap centers. As preventive measures, team members distribute information, give talks, lead group sessions, man "hotlines," and provide other services through the rap center. Army policy states that the civilian counselors, whenever possible, should include ex-addicts and recovered alcoholics.

In Europe, the facilities and services available to soldiers with drug and alcohol problems include the following:

1. Community Drug and Alcohol Assistance Center: Helps commanders manage and monitor the rehabilitation of illegal drug users and alcohol abusers in the community in close coordination with medical treatment facilities until the individuals are either rehabilitated or discharged from the service.

2. Drug and Alcohol Treatment Center: Provides--in addition to medical supervision of withdrawal from drugs or alcohol--medical, psychiatric, psychosocial, and physical therapy services The Center is an extended care facility involving intensive therapeutic services up to, but not exceeding, 60 days from identification to disposition.

3. Resident Rehabilitation Facility: A regional residential, full-time, intensive therapeutic facility where an illegal drug user or alcohol abuser resides and participates in structured rehabilitation. The facility is staffed by professionals and paraprofessionals supplemented by training and administrative personnel. The facility is operated by a command and is not considered a medical facility. Personnel do not stay more than 4 weeks.

NAVY

The Navy, which also serves Marine Corps and Coast Guard members at its facilities, treats and rehabilitates illegal drug users and alcohol abusers separately. If an individual is found to be drug dependent, he is sent to one of the Navy's two Drug Rehabilitation Centers. These Centers are live-in facilities which are professionally staffed and have a bed capacity of 200. They provide professional treatment, counseling, orientation, and evaluation programs for up to 120 days. When an individual completes treatment, a Navy Drug Rehabilitation Center review board examines his past performance, progress during rehabilitation, and potential for further Navy service. The board may then recommend that he return to duty, be discharged, or be transferred to a Veterans Administration facility for continued treatment.

Sailors who do not show dependency or who are labeled as experimenters are rehabilitated locally at one of the

Navy's 31 Counseling and Assistance Centers or are counseled within their units. These individuals maintain their jobs while attending counseling sessions at the Center.

The Navy's alcohol abuse treatment and rehabilitation program includes:

1. Local rehabilitation programs: Established with command assistance, they are assisted by a "volunteer referral network" comprised of more than 1,500 recovered alcoholics who work part time. These volunteers also help establish local prevention and education programs.

2. Human Resource Management Centers and Detachments: Operate on a regional basis. Alcohol program specialists are assigned to them and, under the commanding officer of each Center, they assist in education and training, patient referral, and statistical reporting. Five Centers and eight Detachments were operating at the time of our review.

3. Alcohol Rehabilitation Units: Established in 14 naval hospitals throughout the world, they have a capacity of up to 15 patients. The Units are managed by the Bureau of Medicine and Surgery (the other Navy alcohol program facilities are managed by the Bureau of Naval Personnel and OCO Commanders) and treament includes medical and educational services and individual and family counseling. The program lasts about 6 weeks and relies heavily on such outside resources as Alcoholics Anonymous.

4. Alcohol Rehabilitation Centers: Handle those individuals needing more specialized care. These 5 Centers have a 75-bed capacity and provide medical treatment, group therapy, education, and individual counseling as needed. This program lasts about 8 weeks and is also tied closely to Alcoholics Anonymous.

5. Alcohol Rehabilitation Drydocks: Local semi-halfway-houses designed to help individuals whose problems are not too serious and individuals who are waiting to get into an Alcohol Rehabilitation Unit or Alcohol Rehabilitation Center. As of August 1975, the Navy had 35 Drydocks in operation and an additional 15 were scheduled to be operating by December 31, 1975.

AIR FORCE

The Air Force treats illegal drug users and alcohol abusers separately, using a centralized treatment and rehabilitation approach. Illegal drug users who could not be rehabilitated locally were sent to the Special Treatment Center at Lackland Air Force Base, Texas, until it closed in April 1974; its workload was transferred to Lowry Air Force Base, Colorado. Treatment and rehabilitation of illegal drug users in the Air Force consists of five phases:

1. Phase I--Identification: Accomplished through urinalysis testing, law enforcement, or the Limited Privileged Communication Program (exemption) or occurs incident to normal medical care.

2. Phase II--Physiological detoxification: Involves placing an individual in a patient status at a medical facility for withdrawal. During this phase the level of treatment is determined. The cases involving dependency or addiction are referred to the Treatment Center; other cases may be treated locally.

3. Phase III--Psychiatric evaluation: Involves evaluating the individual to determine such things as (1) extent of dependence, (2) motivation to quit, (3) type(s) of drug(s) taken, and (4) willingness to continue in treatment. An individual who chooses not to volunteer for treatment is discharged or sent to the Veterans Administration for treatment before discharge.

4. Phase IV--Behavioral reorientation: A non-medical approach using group interaction and counseling. At the completion of this phase, the individual may be returned to duty, discharged, or transferred to a Veterans Administration facility. If returned to duty, the individual enters Phase V.

5. Phase V--Followup support: May receive patients directly from Phases I through IV. This phase involves monitoring and facilitating the reentry of rehabilitated servicemen into military life. Each serviceman in Phase V is evaluated quarterly for 1 year by a subcommittee of the installation's Rehabilitation Committee on his ability to perform his duties. Failure to do so is a basis for separation from the Air Force. By showing

continued progress and satisfactory job performance, the individual may be removed from Phase V in less than a year, with restrictions to assignments or reenlistment lifted.

The Air Force program for rehabilitating alcoholics is similar to the Navy's, but not as extensive. If an individual requires treatment beyond local capabilities, he is sent to one of nine Alcohol Treatment Centers located at or in an Air Force medical center or hospital.

The treatment at these Centers consists of 28 days of in-house group living and education. The patients live together in a psychiatric wardroom of the hospital. They participate in recreational and occupational therapy or work in one of the hospital's industries. They are also required to attend Alcoholics Anonymous meetings.

A Social Actions Officer is responsible for managing the drug and alcohol control programs on Air Force bases. His responsibilities are, among other things, to:

--Identify and organize base resources to provide counseling and education programs to prevent illegal drug use and alcohol abuse.

--Coordinate, with the medical services, activities required by the drug and alcohol programs.

--Screen law enforcement actions and reports to identify individuals with drug and alcohol abuse problems.

--Help the commander administer the drug and alcohol abuse control committees.

--Establish cooperative programs with local civilian community.

--Identify programs that offer alternative activities to drug and alcohol use, such as Special Services programs, chapel activities, and educational programs.

--Formulate specific goals for managing the base-level drug and alcohol abuse control programs.

DRUG USE PATTERNS

The National Commission on Marihuana and Drug Use has divided drug use into the following five definitional categories.

EXPERIMENTAL USE

Experimental use is the short-term, nonpatterned trial of one or more drugs, either concurrently or consecutively, with a variable intensity but at a maximum frequency of 10 times per drug. Experimental use is primarily motivated by curiosity or the desire to experience new feelings or moods or to assess drug effect. It most often occurs in the company of one or more drug-experimenting friends or acquaintances and is generally viewed in the context of social activity.

Experimental use generally does not result in long-term or permanent physiological, psychological, or social impairment; however, lack of familiarity with the drug or drugs and their effects may occasionally produce acute adverse or even fatal reactions. Thus experimental drug use is not risk-free, but the risks are ordinarily low.

SOCIAL-RECREATIONAL USE

Social-recreational use occurs in social settings among friends or acquaintances who desire to share an experience they perceive to be acceptable and pleasurable. This use tends to be patterned but varies in frequency, intensity, and duration.

The most distinguishing characteristic of such use is that it is voluntary and, regardless of its duration, tends not to escalate in either frequency or intensity to patterns of uncontrolled and uncontrollable use which is personnally rather than socially motivated. Nor is it sustained by virtue of the dependence of the user, in any meaningful sense of that term.

The risk posed to the individual and to the community by social-recreational drug use is ordinarily low. This is largely attributable to (1) the user's familiarity with the effects of the drug used at given dosage levels and (2) the self-control ordinarily exercised by the user. The degree of risk, however, differs with the drug used. For example, the risks of escalation to more intensive and frequent use is greater for the heroin user than for the social users of marihuana.

CIRCUMSTANTIAL-SITUATIONAL USE

This is generally specific, self-limited use which may be variably patterned--differing in frequency, intensity, and duration. Its distinguishing feature is that it is motivated by the perceived need or desire to achieve a certain effect in a specific, sometimes recurrent, situation or condition of a personal or vocational nature. Users in this category include students preparing for exams, long-distance truckers who want to extend their endurance and alertness, military personnel in stress and combat situations, athletes who want to improve their performance or extend their endurance, and people giving themselves medication. As when an individual goes on an occasional alcohol binge when a particular stress situation becomes unbearable, circumstantial drug use can be episodic but intense and enduring.

Generally users in this category do not exhibit impairment or dysfunction except perhaps during such spree use as an alcohol binge, and they generally discontinue use without experiencing physiological or psychological impairment or reduced individual or social functioning.

Circumstantial-situational drug use poses some risk to both the individual and the community, particularly when high doses are involved. Public safety is most likely to be threatened when individuals under the influence of a drug such as an amphetamine exhibit impaired judgment or extreme fatigue and a concomitant decrease in psychomotor functioning while operating a motor vehicle or other dangerous machinery for a long period of time without rest. A great danger in such drug use is that the user will become accustomed to a drug-using response, receive reinforcement from achieving expected effects, and may ultimately escalate use.

INTENSIFIED DRUG USE (DEPENDENCY)

This is generally a long-term, patterned use of drugs at a minimum level of at least once daily and is motivated by (1) a perceived need to achieve relief from a persistent problem or stressful situation or (2) a desire to maintain a certain self-prescribed level of performance. Use occurs in both social and nonsocial settings but often takes the form of recurrent self-medication. The latter includes regular and/or heavy consumption of barbiturates, tranquilizers, and alcohol.

A distinguishing characteristic of this pattern is the regular use of one drug or a combination of drugs escalating to patterns of consumption which could be defined as dependence. For individuals who adopt this pattern, drug use becomes a normal and customary activity of everyday life. However, such individuals generally remain both socially and economically integrated into the life of the community; no substantial change in their major behavior patterns or key interpersonal relationship occurs. Some decrease in functioning may be apparent, however, depending on the frequency, intensity, and amount of use.

COMPULSIVE DRUG USE (ADDICTION)

Compulsive use is patterned at both high-frequency and high-intensity levels of relatively long duration, producing such physiological or psychological dependence that the individual cannot discontinue such use at will without experiencing physiological discomfort or psychological disruption. It is characterized by significantly reduced individual and social functioning.

Motivation to continue use at this level stems primarily from the need to elicit a sense of security, comfort, or relief related to the initial reasons for regularly using the drug; that is, such use is psychologically motivated and reinforced. When the individual depends psychologically upon a drug such as alcohol, a barbiturate, or heroin--all of which also have physiological dependence-producing characteristics--his dependence is reinforced by his desire to avoid the pain and distress of physical withdrawal.

Compulsive use may be characterized by preoccupation with obtaining adequate and sufficient amounts of the drug in order to forestall the abstinence syndrome. By no means do all persons clinically categorized as compulsive users fit the description of the street junkie or skid-row alcoholic, nor is total involvement with an underworld supply network or life style inevitable. Compulsive users might include such "hidden" drug-dependent persons as opiate-dependent physicians and alcohol-dependent white-collar workers. Compulsive drug use poses the highest risk to the health, welfare, and safety of the public and the community.

PRINCIPAL OFFICIALS OF DOD AND THE MILITARY DEPARTMENTS RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
DOD		
SECRETARY, DOD:		
Donald H. Rumsfeld	Nov. 1975	Present
James R. Schlesinger	July 1973	Nov. 1975
William P. Clements, Jr. (acting)	May 1973	June 1973
Elliot L. Richardson	Jan. 1973	May 1973
Melvin R. Laird	Jan. 1969	Jan. 1973
ASSISTANT SECRETARY (Manpower and Reserve Affairs):		
John Ahearne (acting)	Mar. 1976	Present
William K. Brehm	Sept.1973	Mar. 1976
Carl W. Clewlow (acting)	June 1973	Aug. 1973
Roger T. Kelley	Mar. 1969	May 1973
ASSISTANT SECRETARY (Health and Environment) (note a):		
Dr. James R. Cowan (note b)	Feb. 1974	Mar. 1976
Dr. Richard S. Wilbur	July 1971	Sept.1973
Dr. Louis H. Rousselot	July 1970	July 1971
DEPUTY ASSISTANT SECRETARY (Drug and Alcohol Abuse) (note c):		
Maj. Gen. Frank B. Clay	July 1973	June 1974
Brig. Gen. John K. Singlaub	Sept.1971	July 1973
CHIEF, OFFICE FOR DRUG AND ALCOHOL ABUSE PREVENTION:		
Ellsworth D. Schmitz	July 1974	Present
DEPARTMENT OF THE ARMY		
SECRETARY OF THE ARMY:		
Martin R. Hoffman	Aug. 1975	Present
Norman R. Augustine (acting)	July 1975	Aug. 1975
Howard H. Callaway	May 1973	July 1975
Robert F. Froehlke	July 1971	May 1973
Stanley R. Resor	July 1965	June 1971

THE SURGEON GENERAL		
Lt. Gen. R. R. Taylor	Oct. 1973	Present
Lt. Gen. H. B. Jennings, Jr.	Oct. 1969	Sept. 1973
DEPUTY CHIEF OF STAFF FOR PERSONNEL:		
Lt. Gen. H. G. Moore	Dec. 1974	Present
Lt. Gen. B. W. Rogers	Nov. 1972	Nov. 1974
Lt. Gen. W. T. Kerwin	Aug. 1969	Oct. 1972
DIRECTOR, HUMAN RESOURCES DEVELOPMENT (note d):		
Maj. Gen. K. E. Dohleman	Aug. 1975	Present
Brig. Gen. J. H. Johns (acting)	June 1975	Aug. 1975
Maj. Gen. R. G. Trefry	Jan. 1975	Present
Maj. Gen. M. C. Ross	June 1973	Dec. 1974
Brig. Gen. R. G. Gard, Jr.	June 1971	May 1973

DEPARTMENT OF THE NAVY

SECRETARY OF THE NAVY:		
J. William Middendorf II	June 1974	Present
J. William Middendorf II (acting)	Apr. 1974	June 1974
John W. Warner	May 1972	Apr. 1974
John H. Chafee	Jan. 1969	May 1972
THE SURGEON GENERAL:		
Vice Adm. D. L. Custis	Mar. 1973	Present
Vice Adm. George M. Davis	Mar. 1969	Mar. 1973
CHIEF OF NAVAL PERSONNEL:		
Vice Adm. James D. Watkins	Apr. 1975	Present
Vice Adm. David H. Bagley	Feb. 1972	Apr. 1975
Vice Adm. Dick H. Guinn	Aug. 1970	Feb. 1972
Vice Adm. Charles K. Duncan	Apr. 1968	Aug. 1970
ASSISTANT CHIEF OF NAVAL PERSONNEL FOR HUMAN RESOURCES DEVELOPMENT (note e):		
Rear Adm. Charles F. Rauch, Jr.	Feb. 1972	Present
Rear Adm. David H. Bagley	Jan. 1971	Feb. 1972
COMMANDANT OF THE MARINE CORPS:		
Gen. Louis H. Wilson	July 1975	Present
Gen. Robert E. Cushman, Jr.	Jan. 1972	June 1975
Gen. Leonard F. Chapman, Jr.	Jan. 1968	Dec. 1971

DEPARTMENT OF THE AIR FORCE

SECRETARY OF THE AIR FORCE:		
Thomas C. Reed	Jan. 1976	Present
James W. Plummer (acting)	Nov. 1975	Jan. 1976
John L. McLucas	July 1973	Nov. 1975
John L. McLucas (acting)	May 1973	July 1973
Robert C. Seamans, Jr.	Feb. 1969	May 1973
THE SURGEON GENERAL:		
Lt. Gen. G. E. Schafer	Aug. 1975	Present
Lt. Gen. Robert A. Patterson	Aug. 1972	July 1975
Lt. Gen. Alonzo A. Towner	May 1970	July 1972
Lt. Gen. K. E. Pletcher	Dec. 1967	Apr. 1970
DEPUTY CHIEF OF STAFF FOR PERSONNEL:		
Lt. Gen. K. L. Tallman	Sept. 1975	Present
Lt. Gen. J. W. Roberts	Oct. 1973	Sept. 1975
Lt. Gen. R. J. Dixon	Aug. 1970	Sept. 1973
DIRECTOR OF PERSONNEL PLANS:		
Maj. Gen. B. L. Davis	July 1975	Present
Maj. Gen. K. L. Tallman	July 1973	July 1975
Maj. Gen. J. W. Roberts	Aug. 1971	July 1973

[a]This position was formerly entitled "Deputy Assistant Secretary (Health and Medical)" under the Assistant Secretary (Manpower and Reserve Affairs). The change was effective in June 1970. Dr. Rousselot occupied the position under both titles.

[b]Dr. Wilbur remained as a consultant from his resignation of August 31, 1973, until Dr. Cowan's confirmation on February 11, 1974.

[c]This office was abolished effective July 1, 1974, and was replaced on that date by the Office for Drug and Alcohol Abuse Prevention.

[d]This position was formerly entitled "Director of Discipline and Drug Programs."

[e]This position was formerly entitled "Assistant Chief for Personal Affairs" and "Assistant Chief for Human Goals."

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