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DRUG ABUSE AMONG U.S. ARMED FORCES IN THE FEDERAL REPUBLIC OF GERMANY AND WEST BERLIN

HEARINGS

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

SECOND SESSION

NOVEMBER 20 AND 22, 1978

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DRUG ABUSE AMONG U.S. ARMED FORCES IN THE FEDERAL REPUBLIC OF GERMANY AND WEST BERLIN

MONDAY, NOVEMBER 20, 1978

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Stuttgart, Germany.

The Select Committee met, pursuant to notice, at 9 a.m., in the NCO club room, Patch Barracks, West Germany, Hon. Glenn English (acting chairman of the Select Committee) presiding.

Present: Representatives Billy L. Evans, Benjamin A. Gilman, Cardiss Collins, and John W. Jenrette, Jr.

Staff present: William G. Lawrence, chief of staff; David Pickens, project officer; Elliott A. Brown, professional staff member; and Daniel A. Stein, researcher.

Mr. ENGLISH. The committee will come to order.

I have an opening statement that I would like to make and several of the other members have statements they would like to make as well. First of all I would like to place these hearings somewhat in perspective. Obviously, the committee has come to Germany to determine the extent of drug abuse. But we're also here to determine what assistance we can lend in fighting this deadly menace. There is no question that we have a drug oriented society. That is to say that in the American society there are some forms of acceptance of drugs in many parts of America.

It should also be kept in mind that the military is a part of our society. Soldiers who enter the service, young soldiers, are a result of 18 years within that society, and their values for the most part are formed before entering the service. I don't believe that there is any question that there are more hard drugs used in Germany than there are among comparable young people in the United States, and that is particularly true, I think, of young soldiers in the United States. The reasons, we believe, are because of availability, price and environment. By environment, I mean loneliness, peer pressure, quality of life, and the lack of a challenging job, et cetera. Also we find that hashish is in far greater usage than the so-called hard drugs, and we find that many of our young soldiers equate hashish with marihuana. There seems to be a lack of recognition among young people that hashish being used here in Germany is approximately 10 times stronger than marihuana used in the United States. I think it should also be stated, however, that from the indications we have seen in the past week, that an undetected addict is a very rare occurrence and that the rate of drug usage varies greatly from unit to unit. There is no question that leadership plays a major role, but it is not the only factor involved in determining the rate of use. The leadership and the chain of command are obviously for

the most part lame. They are doing a job that many professionals find extremely frustrating. The chain of command is also frustrated by the legal delays and by Department of Defense policy. I think it's reasonable to also state that we cannot expect these leaders to keep a lid on this problem without much better tools. Drug rehabilitation is obviously a desirable part of the arms program, however, we have found that it is only worthwhile for those who really desire help, and we find that for the most part, there is very little professional help. All of these points will be touched upon during the hearing and the testimony of the witnesses, as well as the questions from the members. I think it will further clarify this very difficult problem that we're facing. However, I would urge all to keep in mind that this very difficult problem is easy to sensationalize but is very difficult to solve. I believe other members of the committee also have statements that they would like to make. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman. Mr. Chairman I first would like to thank you for diligently pursuing the problem of drug abuse in the military and for arranging to bring the Select Committee on Narcotics Abuse and Control to West Germany to help us learn firsthand the magnitude of the drug problem amongst our military personnel that are stationed over here. Also I want to thank General Haig, Commander of the European Command and Supreme Allied Commander in Europe, Gen. George Blanchard, Commander of the U.S. Army in Europe, and their respective staffs for their assistance in helping us to dig into the facts of the drug problems among our soldiers and helping us to arrange these hearings. Of course, the narcotic problem is not unique to USAREUR or to West Germany. The supply of illicit drugs in West Germany, being readily available, narcotics and other illicit drugs are being used by our troops both on and off base. Drug abuse has accelerated to such a level that should no longer be tolerated. Our initial surveys and inquiries indicate that over 75 percent of our troops stationed here are using soft drugs and that over 15 percent are using hard drugs. I believe that those estimates are rather conservative.

It is important that we know the full extent of the drug problem among our troops and the drug problem in West Germany. We should be intensifying our efforts to interdict narcotics trafficking in and around our military bases. We should also be providing better facilities and more professional staffing to treat and rehabilitate those men and women who have become drug dependent or drug addicted.

I would like to point out that our committee isn't here to point a finger of neglect at anyone, we are here to listen, to learn and then to be able to go back to the Congress to present the facts and data that we have gathered, and I hope that our military personnel will be candid with us, that they'll level with us concerning the magnitude of the problem so that working together, we can hopefully turn this complex problem around.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. Thank you, Mr. Chairman.

Today we are going to hear testimony concerning drug abuse in the military forces of the United States stationed here in Germany. We are going to hear, of course, that many factors bear on this problem. You mentioned some—crowded barracks, loneliness, boredom, isolation,

long tours, dollar devaluation, all kinds of tensions which result from these things. We are also, I think, going to hear commanding officers state that they are concerned, and I know that they are.

There is one factor that you did mention that I think that without which these pressures would have some different consequences. That is, the ready availability of cheap heroin for these men and women who are here in this particular area. I do not believe that any factor is more important for us to examine and to correct. I represent a district in the city of Chicago where we see a lot of the same pressures which our people are experiencing here—we have underemployment, social isolation, relative poverty, and, of course, boredom. Law enforcement officials tell me that heroin is considered plentiful there as well as here, but it is nothing compared to the situation that I have seen here in Germany. Unhappily, there is very little that the U.S. Army can do about the smuggling of heroin in the Federal Republic of Germany, because I believe the problem has to be addressed by the German Government, as well as by those of us who are concerned about the problems. It seems to me that if it is perceived to be a direct threat to their people, that they are going to act with a great deal of confidence and vigor to see to it that this is the problem, one of availability and one which must certainly be diminished. I feel that without the cooperation of the German authorities, whatever steps that we attempt to take will surely fail, and our mutual security will remain threatened. More can and must be done about the problem. I'm also concerned about the situation with the black soldier. He is a soldier who experiences all the same problems as the white soldier, but also lacks even the opportunity to associate socially with women of his own race in this predominately Caucasion nation. I've heard of instances where he has been excluded from certain restaurants and discos because of his race, with certain of these establishments being placed off limits for that very same reason. Now many young black men have been reared in a city environment where it is not unusual for their peers to turn to drug abuse for relief of tensions of this kind. Is it any wonder then that when he gets over here in a different environment, where drugs are more readily available, that he does find it easy to resort to this for some kind of relief. I believe that availability is the key to any long-term solution to the drug problem and will state again that we alone will never be able to control it, but the only way is with the committee cooperation with the German law enforcement community will we reach the goal that we hope to find soon. Thank you, Mr. Chairman.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman.

This committee, I believe, has the responsibility to the American people to insure that our military is in a state of readiness and equipped to defend the American Nation. Along with that responsibility is to insure that our troops over here have the quality of life that is necessary to sustain them. I believe that in coming here we have exhibited not a desire to criticize or point a finger of blame at the military. We have received the highest cooperation from the military in our quest to find out exactly what the status of our troops is. I believe that we will continue to get that kind of help, because the military should know that we are on your side in that we want to provide the help,

whether it be negotiation with governments over here, to provide help, or whether it be by providing additional equipment or money to do away with some of the conditions that are causing the problem, whatever needs to be done. We need to take a message back to the American people and say, "yes there is a drug problem," or, "no there is not." We need to go back and say, "yes it does affect our troops overseas," or, "no it does not." We need to go back and say, "yes, our soldiers are having a hard time, they are turning to drugs on a monumental level," or, "no, they are not." Now, we cannot come here and be given just a standard answer. We have to do some investigations on our own, and I hope that this investigation has not caused any problems with the military. But I think that if we go back with an incomplete answer, or a canned answer, then we have gone back with no answer at all. So while we may seem to question at times what we are being told, we are doing so so that we can be better equipped to go back and do those things which are necessary to alleviate some of the problems and to work with the military for a better situation for our soldiers and, therefore, a better equipped soldier to do his or her job in times of combat.

Mr. ENGLISH. Mr. Jenrette?

Mr. JENRETTE. Thank you, Mr. Chairman. I would like to join with the chairman and other members of the committee on commending the general officers of this command for allowing us to have this hearing, but I would also like to go a step further and commend—and probably they will never even read the record—but commend the enlisted men who, while we were in the field last week, took the courage and guts at times to give us information relative to the situation that actually occurred or was occurring within their individual units. I believe that the peer pressure, as the chairman has mentioned, and others have mentioned, is a big part of the beginning of the problem; however, the availability provided by lax laws and a very lax enforcement by many of the allied countries in the NATO area, I think, is a matter that must be addressed and must be addressed soon. Rehabilitation will be the cure, education and the lack of availability will be the preventive measures that I hope that this committee will be able to say to this country, and to other countries within the command, and to the officers. We must move through law enforcement procedures aggressively to see that no young man, no matter how much peer pressure might be, is addicted to any narcotics that will not allow him to fulfill the mission for which he has been sent here to fulfill. I would say to our friends here in Germany that the drugstores or the apotheke stores that allow this so-called jet fuel and the syringes to be sold over the counter, that the government, this very fine government, should reevaluate the situation as it provides for the availability of much of the paraphernalia for our soldiers and their soldiers and their individuals to become addicted to narcotic drugs, and I just hope that this committee can take back to the Congress, as well as to the citizens of this great country, the concern for a problem that we have and a problem that is apparently spreading around the world, but it is essential that those of you in command positions be alert and take the immediate action necessary to see that our young men have the best proper protection available within your command. Thank you.

Mr. ENGLISH. Thank you very much. I would also like to state at this time that it is a tradition within the committee that each witness will be sworn before testifying. We will follow that tradition today. The chief of staff will call the first witness.

Mr. LAWRENCE. Brig. Gen. Grail L. Brookshire.

[General Brookshire was sworn.]

Mr. ENGLISH. I believe you have a statement you would like to give to the committee at this time.

General BROOKSHIRE. Yes, sir, I do have.

[General Brookshire's prepared statement appears on p. 149.]

TESTIMONY OF BRIG. GEN. GRAIL L. BROOKSHIRE, HEADQUARTERS, EUROPEAN COMMAND

Mr. Chairman, ladies and gentlemen, I'm pleased to be the headquarters, European command spokesman in addressing the issue of drug abuse within the command. Today I would like to outline for you the drug abuse problems and programs as we see them from a joint command viewpoint. The Washington based military service departments are charged with the overall responsibility of worldwide drug abuse programs within their services. These programs are directed through their respective service components, USAREUR, USAFE, and USNAVEUR, stationed here in Europe. However, we at the joint command level are concerned with all problems that affect the morale and readiness of our forces, and certainly drug abuse comes under that umbrella.

Our past interest in drug abuse within the command was one of providing maximum assistance to the service components in the execution of their programs. However, early in 1976 we became aware of the need to exchange ideas, concepts, problems and programs amongst the service components in the area of drug abuse. Therefore, we established a semiannual triservice drug and alcohol symposium that would provide us with a feel for the overall problem within the command and provide an open forum for drug and alcohol representatives to exchange information of mutual interest. We have since extended participation in the symposium to include dependent schools, the American Embassy, the Drug Enforcement Administration, and Office of the Secretary of Defense representatives. It also became apparent that this subject could not be considered in isolation, but was one aspect of the entire spectrum of human resources. We expanded the scope of the seminar to include race relations, equal opportunity and overseas living. Because of these changes, we renamed the symposium, "The Tri-Services Human Resources Symposium."

We have conducted four of these symposiums, and all who participated in them considered them to be very successful. However, one of the things that we had hoped to accomplish, gain a feel for the magnitude of the drug abuse problem within the entire command, was not in fact accomplished. This was because of a lack of standardization, both in reporting and in definitions. Following service regulations, each component was compiling and reporting drug statistics, but the procedures and categories did not permit a consolidation that would, in meaningful terms identify the command-wide problem.

This aspect gained added significance when indicators of increased drug abuse within the command surfaced in late 1977. Simply, we needed to know the magnitude of the drug abuse problem. In response, General Haig asked that action be taken to determine the magnitude of the problem, and take necessary corrective actions. Within this mandate, the component commands, in concert with this headquarters, considerably intensified efforts in the drug abuse prevention area.

First: To develop methods to identify the magnitude of the problem, we conducted a European command drug abuse seminar here at headquarters, USEUCOM, in April of 1978, to develop common procedures and techniques, and print a directive that would codify our efforts.

We did accomplish this and we printed a European command directive that standardizes definitions for common drug abuse terms, standardized methods for drug abuse reporting, and requires that component commands, using the new standardized procedures, provide this headquarters with a quarterly report. This report will permit us to measure the command-wide magnitude of the problem, and over time, direct our priorities and measure the effectiveness of the corrective drug abuse programs. The first two quarterly reports, April through June and July through September, have been compiled and copies of those reports were provided to the committee.

In summary, the report tells us that the European command has a drug abuse problem. We consider it a serious problem, as anything that adversely impacts upon the ability of this command to fight and win as serious. And we are equally concerned about the exploitation of young Americans and the destructive effect of drugs on their lives. Most important are the facts that you have identified as the problem and the considerable actions underway to address the problem, and have, through our new reporting procedure, established a baseline which will allow us to measure the results of our program.

As mentioned, our task was to identify magnitude, and develop necessary solutions. In an effort to get a feel for the nature of the drug problem so that we could work toward solutions, during August of 1978, we conducted a brainstorming session here at the headquarters in which general and other senior officers, primarily from command positions, participated. Some of the most interesting points developed during this session are:

Our commanders must intensify their efforts to keep our people productively occupied, especially during off-duty time.

Command presence must always be felt in the barracks.

We must work to eliminate negative peer pressure.

As far as use of drugs is concerned, off-duty activities are more important than on-duty. The depressed value of the dollar is making virtual prisoners of many of our young people on military kasernes. We must have morale, welfare, and off-duty recreational programs to offer them alternatives to drugs.

We must work to remove legal and regulatory constraints that currently inhibit our corrective efforts in the drug abuse area.

We must attack the total drug system from the source to the user. However, our primary emphasis must be on the source. To illustrate, we consider it easier to burn a bale of marihuana than to police up

5,000 marihuana cigarettes once they are distributed. Intelligence indications show that West Germany is targeted for a significant increase in narcotics during the next year. This further emphasizes our priority effort on the source.

Following the general officers seminar, we all went to work to translate the concepts and problem areas developed into action programs.

USAREUR has outlined their plans and programs in this area. However, since USAFE and USNAVEUR are not scheduled to appear at the hearings, I would like to outline some of their, of course, our, Headquarters USEUCOM plans and programs concerning drug abuse problems.

USAFE has launched a comprehensive drug abuse suppression program named "counterpush". This program is designed to thwart the transportation, sale, and use of drugs. In this effort, they have requested an additional 28 air policemen and 25 special agents and investigators who will be dedicated to drug abuse programs.

The program includes a considerable increase in the use of drug detection dogs. In their rehabilitative effort, USAFE is increasing their clinical and medical, their social actions, and their program control strength by 86 personnel. Overall, a comprehensive and, we feel, potentially successful program.

As you know, the Navy strength here in central Europe is almost nil. In addition, two-thirds of their assigned personnel are stationed aboard fleet units where shipboard control factors do reduce exposure. Nevertheless, in those countries in the European Command in which there is a significant U.S. Navy population, NAVEUR has active programs. They have recently taken action to increase their special agents and investigators by 20 percent, and their clinical and social action strength by an additional six personnel. In relative terms, sir, these are significant increases.

Both USAFE and NAVEUR have active liaison programs with the constabularies and local police and drug intelligence personnel of host nations.

In Headquarters USEUCOM we have taken, and will continue to take, extensive measures in our effort to get at the real problem—the source of the drugs.

First, we maintain an ongoing effort to solicit administration, congressional, Department of Defense, and Department of State support in having Government programs at the highest level directed to eliminate the source and interdicting the international movement of drugs.

General Haig has recently written to Federal Minister of Defense Apel soliciting his support in the development of a more intense program of cooperation within the Federal Republic designed to suppress drug sources and availability.

We are in the process of establishing a four-man drug enforcement cell working directly for CINCEUR, General Haig. The cell will act as an interface between the U.S. military law enforcement activities in Europe and drug investigator and law enforcement personnel of host nations and other U.S. activities in countries, such as drug enforcement agent, embassy narcotics coordinators, and U.S. Customs.

To underscore the degree of cooperation existing between all U.S. agencies in-country to get at the drug abuse problem, on June 9, 1978,

Ambassador Stoessel and Federal Foreign Minister State Secretary Van Well signed a U.S.-Federal Narcotics Control Agreement that will support our mutual efforts to check drug and narcotics abuse. The bilateral program calls for semiannual meetings and on a daily basis will address the entire spectrum of common drug abuse problems, and will enhance interoperability within the drug abuse area. There will be a subcommittee for police and customs enforcement on which CINCEUR will have a military representative.

In addition, there will be a military subcommittee that will concentrate on problems common to our military forces, The first meeting of the Narcotics Control Central Committee is scheduled for December 15 in Bonn.

I hasten to add that all aspects of the program mentioned are in agreement with the principles of and, in most cases, directly enhance the 12-point Department of Defense drug abuse program espoused earlier this year to Congress by Deputy Secretary of Defense Duncan.

We feel that the programs discussed, along with the very comprehensive USAREUR program you have heard, present a formidable challenge to drug abuse within the command.

Having outlined our plans, Mr. Chairman, there is, of course, an "oh, by the way" attached. It does involve a need for some increased resources and some congressional assistance.

We need to upgrade our morale, welfare, and recreational facilities in Europe. Over the past few years we have seen a trend toward reduced appropriated fund support for our essential morale, welfare, and recreational activities and facilities. The contention that funds can be generated from nonappropriated fund sources to support these essential facilities requires the charging the troops a fee to use gymnasiums, athletic courts, facilities, and equipment. These are precisely the facilities most useful in providing alternatives to drug abuse.

We need to reduce tour length of our young, first-term, unaccompanied Army soldiers in Germany to 18 months. Studies and commanders' experiences tell us that current tour lengths of up to 40 months for these young people are just too long, and are a contributor to drug abuse.

Next, personnel are needed to man our new programs, We've mentioned some requirements and the USAREUR presentation mentioned more. In sum, the European Command is requesting 439 additional personnel in the law enforcement, clinical and medical, customs and command and control areas. These requests have been forwarded through service and, in the case of this headquarters, the Joint Chief of Staff channels. Also, we've made our consolidated needs known to the Secretary of Defense.

Finally, we need legislative understanding and assistance in areas where U.S. law, and the U.S. Court of Military Appeals interpretation of U.S. law in those cases where decisions are founded upon evidentiary as opposed to constitutional principles, are major impediments to vigorous prosecution of drug abuse cases. Of specific concern are:

Removal of the effects of *U.S.* v. *Jordan*, which renders inadmissible in courts-martial such evidence collected by foreign authorities which does not conform to U.S. rules of evidence, even though they do meet host nation rules of evidence, and;

Removal of the effects of *U.S.* v. *Ruiz* which requires the military departments to separate an individual with an honorable discharge when the reason for separation is based on evidence developed as a direct or indirect result of a urinalysis test or by a servicemember volunteering for treatment for a drug problem.

This latter provision, allowing an individual to procure a drug related discharge, and thereby shirking an enlistment and overseas tour commitment while receiving an honorable discharge and subsequently the full range of veteran benefits, makes a joke of the concept of military justice and creates a severe creditability problem between the system and the people in the system.

We understand, Mr. Chairman, that you have expressed a willingness to support our additional resources needed in the Congress. Such support would be appreciated.

Sir, that completes my statement. Again, I would like to express my thanks for the opportunity to address the committee.

Mr. ENGLISH. Thank you very much, General.

With regard to the two proposals that you made as far as changes in the legal process, we have noticed also that there appears to be a tremendous delay once an individual has been charged with some particular violation that could bring on a court-martial, it seems to drag on for months and months. Have you got any comment that you would care to make with regard to that delay? Could you also tell us—I know that you may not be prepared for this—but could you tell us the amount of time on an average that it takes to go through this legal process of court-martial.

General BROOKSHIRE. Sir, addressing the second part of your question first, I could not. Perhaps the USAREUR representative could, but I am not that familiar with the amount of time it takes. As far as the delays, sir, some of the delays are caused by interdepartmental regulations, Department of Defense, or Army regulations. I do know that USAREUR is addressing these problems directly with Department of the Army, and, yes, there are delays. I don't consider myself the best qualified guide to discuss those with you as to what is causing those delays, but I know there are some regulatory problems. I have discussed those with the USAREUR representative but I think he could probably give you more details than I could.

Mr. ENGLISH. To your knowledge, are there any recommendations being drawn up to change those regulations?

General BROOKSHIRE. Yes sir, there are. I do not know the details of them, but I know that USAREUR has made recommendations to the Department of the Army to change those.

Mr. ENGLISH. Also, during these months of delay that take place between the time an individual is actually charged with the evidence and the time that he finally goes to a court-martial, there seems to be an indication that these people are left in the same units, in the same barracks, and, on many occasions, have done the same duty that they have done in the past. For instance, what I'm getting at, you may have an individual who was caught selling heroin. That individual remains within that unit, he remains within that barrack, he remains within that environment in which he was selling drugs, and it even had some indication that that person even continues to sell after he's been

charged, and after he has been caught, mainly to pay for any legal fees that he may have. And this seems highly questionable, particularly when we are talking about a situation in which young soldiers are in an environment with such tremendous amount of peer pressure. And many times this is seen as an indication that if you do violate the rules, regulations, and laws dealing with drugs, that nothing happens to you. Have you any comment on that, and do you know of any plans that are being set forth to remove those individuals during that period, getting them out of that environment and preventing this type of contamination from taking place?

General BROOKSHIRE. Sir, as far as comment is concerned, I would certainly agree it's a most undesirable situation. I can only harken back to my experience when I was commanding a U.S. unit, but I commanded it in the States; not here in Germany. When faced with similar problems within the restrictions that we had, we were located at the same base, same post, unlike here in Germany where we're spread out quite a bit, we did move people around within the units pending final disposition of their cases. I know there are constraints on the commands, legal constraints, regulatory contraints; again I'm simply saying this is undesirable. I would refer to the USAREUR representative who I'm sure is much more knowledgeable in that area.

Mr. ENGLISH. But as far as you know there is no proposal that is underway that would say at least remove these individuals from that barracks?

General BROOKSHIRE. No sir, I do not know of any. I would think most desirable, but I don't know of any proposals.

Mr. ENGLISH. Do you know if this is brought about by DOD policy or is it——

General BROOKSHIRE. I don't sir. I would think it would be brought by either Department of the Army internal regulations or perhaps by just the nature of the fact that the investigations going on, the man needs to be kept available for the investigation, and that it may be a small unit on an isolated location. Because of the other contraints, that's considered the best solution. It's not a very good answer to your question.

Mr. ENGLISH. I'd simply like to say that the units in which we found this were very large units; they weren't small units.

General BROOKSHIRE. Yes, sir.

Mr. ENGLISH. Excuse me, my time is up. Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman.

General, we certainly welcome hearing the attitude that the European Command has taken with regard to this serious problem. I know that you have been studying the problem now at length. What do you estimate to be the extensiveness of the drug problen in your command?

General BROOKSHIRE. Sir, the figures that we provided are based on an examination on reports that we've received, and we've received at this time two of them, and your committee will have a copy of this. This is based on a variety of methods of coming up with the indicators of drug abuse when you—and you understand sir, I'm speaking now of all three services rather than just the Army, although they are broken out by individuals. But, for example, the command directed urinalysis testing program for the April through September period. In the target group, the figure that came up was 19 per thousand as far as positives

were concerned in the target group. This was a combination of narcotics and dangerous drugs.

Mr. GILMAN. What does that boil down to percentagewise?

General BROOKSHIRE. Sir, that comes out to about 1.9 percent of positives. Now, understand that a urinalysis is a one-time thing and does not give you a rate of everybody that's abusing drugs. What it gives you is an example of what—it will give you a reading of those who have used drugs within about the last 72 hours.

Mr. GILMAN. How extensive was your urinalysis testing at that time?

General BROOKSHIRE. Sir, that was a test of 93,000 persons over that period of time.

Mr. GILMAN. What period of time was involved, General?

General BROOKSHIRE. April through September of this year.

Mr. GILMAN. Besides the urinalysis, I'm sure the command must have undertaken some other studies and surveys. What is your best estimate of the use of hard drugs in the command?

General BROOKSHIRE. Sir, our best estimate would be the estimate that is provided by USAREUR. They have a combination——

Mr. GILMAN. What's that estimate, General?

General BROOKSHIRE. That's about 7.8 percent are using hard drugs, sir.

Mr. GILMAN. And what's your estimate of use of soft drugs, hash, and marihuana?

GENERAL BROOKSHIRE. We do not have as good a figure on that sir, but that would be something over about 20 percent.

Mr. GILMAN. 20 percent of the troops?

General BROOKSHIRE. Yes, sir. Now when I say troops, sir, I'm not talking about the target group; I'm talking about all troops.

Mr. GILMAN. Do you feel that those are a fairly accurate estimate based on your own knowledge and based upon your review of the information that's been provided to you?

General BROOKSHIRE. Yes sir, I believe that those are reasonably accurate.

Mr. GILMAN. I must say that they are certainly in direct contrast to what this committee has been finding by way of our own survey. While we have not fully compiled our statistics, I think that I'm safe to say that our statistical information and our field surveys—and they have not certainly been extensive, they have only covered, I think, five, six, or seven hundred individuals that we have spoken to in the short period of time that we have been over here—the hard drug usage exceeds 15 percent and is, as a matter of fact, probably much higher than that, and that the soft drug usage exceeds 75 percent, and is probably closer to 80 to 85 percent. I am wondering why there is such a wide gap between what we are finding and what the command has been studying for the past 2 years? When we were here in 1976, there was a drug problem that was a growing problem. We are here now 2 years later and, while I certainly commend you for the recommendations that are being made, these same items were discussed 2 years ago, and I am wondering what is taking so long to address ourselves to these problems. We are certainly here to be supportive and want to help, but we can't help unless there is some real action going on on the battle lines. We are talking about doing something

about recreation and getting the men out of the barracks and helping them. I keep hearing from the men that there is still no programing down in the barracks, and they want to get out of the barracks and they are confronted with economic problems, the dollar situation, they are confronted with the language barrier, and they are confronted with the lack of adequate programing. Can you tell me what is being done in that direction?

General BROOKSHIRE. Sir, let me——

Mr. GILMAN. Now I have asked you two questions.

General BROOKSHIRE. Yes, I know.

Mr. GILMAN. Why the wide gap between the information that is being presented? I know my time is running here but I think the committee would welcome hearing that, and why is there such a lapse between, or gap between, what is recommended at the command and what is happening right down in the barracks?

General BROOKSHIRE. Sir, as far as the first part of your question is concerned, sir, I think I can address that only by saying that the figures that I quoted referred to the entire command, not just a target group, not just the troops in the maneuvering units, not just the troops under 25, and so forth. I believe that the thrust of your discussions have been toward younger soldiers, soldiers in the barracks. The figures I have given are an overall figure to include everybody, including the commands from the highest rank all the way down, and I think that would certainly account for some difference in the percentages.

Mr. GILMAN. Well, aren't most of your troops down in the barracks? Isn't that where most of your personnel are located?

General BROOKSHIRE. That is where a good deal of them are, sir. Yes, sir. I think that as far as the difference in the figures, I think that would be the only way to describe it. As far as what is being done in the programs——

Mr. GILMAN. General, I——

General BROOKSHIRE. I'm sorry, sir.

Mr. GILMAN. I'm frank to say that I don't understand that response.

General BROOKSHIRE. Sir, I think that the information that I am using will give you the response as based on percentage figures of the entire command's strength.

Mr. GILMAN. You told me that most of your strength is down in the lower areas in the barracks areas. I don't understand if you are saying that you're taking command figures, people in the command headquarters and using that as the reason——

General BROOKSHIRE. No, sir, I'm saying we are taking everyone, the figures of all of the members of the command. When you add all those up, and using the tools that the command, USAREUR used to evaluate, what you get, these are the figures that I just gave you, the figures that are our best estimates of the problem. What I did say was that in your discussions and your surveys, you have concentrated, I believe, strictly on what is referred to as the ones who are 25 years or or below, and those would tend to make the figures higher, because you don't have included in that the overall command figures which include a lot of people that aren't usually the ball of drug abuse.

Mr. GILMAN. General, I don't know that we limited ourselves to the age categories. I guess most of your people are younger people, but I

don't think we picked out any age categories, we just asked everyone that we could come into contact with as we made our spot visits. Can I just get into the other area. Why has there been such a gap between the recommendations for recreational activities and constructive activities to get the men out of the barracks? You've recognized the problem at command, most of the field commanders have recognized the problem, and yet I see very little being done about it. And a lot of these activites don't take a great deal of money to structure some sort of a reasonable recreational program. Yet we hear so little about that kind of programing throughout the command. Can you tell me why there has been a lack of activity in that direction?

General BROOKSHIRE. Sir, the only thing I can tell you is we think that the monetary constraint is a big part of it. For example, last year we lost 1,500 appropriated spaces to nonappropriated recreational activities. That was a big loss. Those do work against me.

Mr. GILMAN. Unfortunately, my time has run, but I don't think that many of these recreational activities take that much funding, and it would seem to me that with some initiative, you could stretch your dollars a bit and work out some programing. I am certain that our committee will go back to try to be of assistance in that direction, but I would hope that the command would take another look at what is actually being done at that level at getting them out of that barracks area in their spare time. They're crying for it, the commanders recognize it's in need, but it isn't being satisfied.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. Thank you very much, Mr. Chairman. General, I was interested in your figures here, but what did occur to us is that in talking to many of the young soldiers, they told us that urinalysis tests that the results can be changed in a number of ways. Are you aware of that?

General BROOKSHIRE. Yes, Mrs. Collins. The only thing I can tell you on that is that we are aware of that and the commanders have taken all the activities they can to assure that the urine samples they get are as accurate as they can possibly get them. I would not say that it's impossible for somebody to beat the system. Obviously, that is possible, but I would say that the command is aware there is an effort to do that and they try to structure the test to prevent that.

Mrs. COLLINS. Based on the fact that you know that, then you don't think these to be hard-found results from the tests?

General BROOKSHIRE. I take that to be the best figures that we've got. Certainly, they could be subject to manipulation.

Mrs. COLLINS. What sort of tests are you testing for when you do these tests?

General BROOKSHIRE. Narcotics.

Mrs. COLLINS. What kind?

General BROOKSHIRE. Heroin—all types of morphine based. I'm sorry, I can't give you the three dangerous drugs, I'll have to get that information. You know, we're capable of giving a total test for four type drugs, and of course, the morphine based is one, and the other three I'm not sure about.

Mrs. COLLINS. Is there a large number of drugs, including hash, that cannot be found using your urinalysis test?

General BROOKSHIRE. Hash is not tested for in that test.

Mrs. COLLINS. OK, thank you. I'm looking on page 5 of your testimony and you say that some of the interesting points you developed during these is that you needed more command presence in the barracks. We talked with some of these fellows, and it's my understanding that the command presence can also be negative. A lot of them felt that there was a lot of pressure from their commander, chain of command closest to them to in fact indulge in certain forms of drug usage. Are you aware of that sort of thing going on?

General BROOKSHIRE. No, I did sit in on a session that developed this discussion and the discussion centered around the fact that the command presence in the barracks was necessary to insure that you did not have negative peer pressure, or pressure for the abuse of drugs or the use of drugs.

Mrs. COLLINS. I think you're missing my point. My point is that some of the command pressure in the barracks, according to what I have been hearing, comes from those who are in charge of those soldiers, and that it is a negative impact that they are having on them, one conducive to the use of drugs, to be more explicit. Are you aware of that sort of thing going on?

General BROOKSHIRE. I was not aware of that.

Mrs. COLLINS. Well, I sure hope you will be looking at it as a possible help in the problem. You mentioned here that your command is requesting additional personnel in the clinical and medical fields. From discussions that we've had with the people who have been in CDAAC, do you think that these numbers are sufficient to handle the problem? Our problem seems to be that you have a number of people who are not professionals in these fields, and they, of course, can't get the amount of help needed to make it work. Do you think that this number is a sufficient number to help in domestic problems here?

General BROOKSHIRE. Yes, ma'am, I do.

Mrs. COLLINS. I have no further questions.

Mr. ENGLISH. Mr. Jenrette?

Mr. JENRETTE. Thank you, Mr. Chairman. General, the symposium that you've had were attended by officers and enlisted personnel, or sergeants or just general officers?

General BROOKSHIRE. I'm sorry, sir we referred it to—one was a general officer's get-together here at the headquarters, the other was a triservice symposium. Is that——

Mr. JENRETTE. Yes, but in the triservice symposium, that was general grade officers also?

General BROOKSHIRE. Sir, there is some enlisted participation, but that participation is usually just those that are involved in one of those areas. For example, race relations or drug abuse, not troops from the general population, no. It's mostly people that are involved in the programs.

Mr. JENRETTE. In the letter by General Haig to the Defense Minister you referred to on page 8 of your testimony, was there any discussion, or to your knowledge, has there been any discussion whereby the Federal Republic would ban or help us monitor the mandrax pill that can be purchased over the counter that, with a little class VI, puts a guy in space, or a girl. The jet fuel, which is a diet type drink that can be sold directly over the counter that does the same sort of

thing, and the ready availability of syringes and other paraphernalia that would probably take an act of the Government to ban or to make a little more strict. Has that been discussed in either of your symposiums?

General BROOKSHIRE. No sir, they were not. The thrust of General Haig's letter was more toward joint effort on the source of illicit drugs, rather than discussing the ready availability of drugs.

Mr. JENRETTE. And he wrote that, I assume, shortly after this committee came over here 2 years ago? Or was that just recently?

General BROOKSHIRE. No sir, this was relatively recent. I believe this was early in October.

Mr. JENRETTE. And the symposiums were when, sir?

General BROOKSHIRE. Sir, the symposiums were back in August.

Mr. JENRETTE. Of 1978?

General BROOKSHIRE. Yes, sir.

Mr. JENRETTE. And this committee was——

General BROOKSHIRE. No, I'm sorry sir, the General Officer's symposiums were in August 1978. The other symposiums had started in 1976, the triservice symposiums.

Mr. JENRETTE. Is my assumption correct that from 1976 until 1978 now, after the first symposium to the second symposium that you yourself, or your command, had seen an increase in the use of hard and soft drugs within the military forces?

General BROOKSHIRE. Yes, sir, we have seen an increase starting in early 1977, an increase in drugs.

Mr. JENRETTE. And that was after your symposium when you had all the men in?

General BROOKSHIRE. No, sir; that was after the beginning of the 1976 symposium. If I could, sir, I would like to emphasize that I'm speaking for the joint command, and there are other things that have been going on in this interim by the three services that I'm not fully prepared to speak to you. The triservice symposiums that I discussed—there have been four of them since 1976—it started off as an information exchange between the services. This headquarters efforts to get an exchange of what works between the services and what the situation is between the services. From 1976 forward, General Haig's personal involvement mostly concerned his discussion with the commander at his monthly commander's conference. The pace of this joint command's involvement in the program, which is run by the three services, picked up beginning in 1977, as we saw the increase in abuse and we feel the increase came about as a result of increase in availability. You see, this headquarters is getting more and more involved. There is still a lot of things going on in the three services' programs that they are much more capable of speaking to you than I am.

Mr. JENRETTE. I certainly hope so, and my point was to make sure that that was in the record that from 1976 to the present date that you had only two symposiums and obviously the——

General BROOKSHIRE. Four, sir.

Mr. JENRETTE. Four. Even that, it's been increasing and I think we both agree on that. Is that correct, sir?

General BROOKSHIRE. That is correct, sir.

Mr. JENRETTE. Realizing that, I want to go to two other subjects very briefly. One, you stated in your testimony that you wanted to

reduce the tour of duty of the first-term soldier, the young soldier, to 18 months.

General BROOKSHIRE. Yes, sir, that's Army, sir.

Mr. JENRETTE. Army. Would you include in that the individual soldier that is working with sensitive or classified weaponry?

General BROOKSHIRE. No, sir; we would say any first-term Army soldier. We feel that his tour should be reduced to 18 months.

Mr. JENRETTE. Thank you. I had some more questions but I see my time is up. Thank you Mr. Chairman.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman.

General Brookshire, I would like to thank you for your cooperation that the committee has received. I wanted to ask, in the connection with the 18-months tours that Mr. Jenrette has just referred to, in that connection, I know that the Army has looked at the 24-month optional tour. Is there any present move to drop down to an 18-month tour, or is this something you're thinking about at present?

General BROOKSHIRE. Sir, there have been several movements in this area. First, the Army has recently changed its policy to allow its 4-year enlistees to have to complete only a 24-month tour here. In the past, they completed whatever time was remaining after their technical training before they came over, so it could go up to 40 to 42 months. But that only accounts for 20 percent of their people. The Army informs us that they are studying a 2-year enlistment option—2 year overseas after training enlistment option—and several other options, as far as reducing tours, and I believe they are pointing this toward combat arms. Our concern that we have expressed to DOD and are expressing to the Army, head command of the Department of the Army, is that this still does not address 100 percent of the young first-term soldiers which we think is the problem, and General Haig's position is that the 18-month tour for all first-term Army soldiers is the desirable solution.

Mr. EVANS. Is there any study being made to provide some duty in the United States for the first-term soldier after basic and AIT before he is assigned overseas, where he has to deal with the language problems, social problems, and all other problems which bear and contribute to drug abuse?

General BROOKSHIRE. Sir, I don't know that that specifically is being studied. The thrust of our efforts has been toward holding the tour to 18 months for first termers. We have not addressed that aspect.

Mr. EVANS. If I might share with you, a great many of the soldiers that we talked to when we came over here, they felt that would be beneficial to them, that they were being thrown into a somewhat hostile environment before they had even gotten their feet wet on the grounds of the service. I would certainly encourage that to be considered.

General BROOKSHIRE. I saw a lot that would leave in 6 months.

Mr. EVANS. Well, they can under chapter 9, I think. On duty usage, I noticed in your statement that you placed more emphasis, of course, on the off-duty activities of the soldier in connection with drug abuse. If you had information which would indicate that there is a great deal of on-duty usage of drugs, would this cause you to also reevaluate your on-duty activities?

General BROOKSHIRE. Most certainly, sir.

Mr. EVANS. At the present time you don't have any such information, is that correct?

General BROOKSHIRE. Sir, at the present time my statistics don't break it down as on-duty, off-duty abuse.

Mr. EVANS. Are you handicapped in any way by the requirement that a certain percentage of the people in the military be less than so many years new soldiers as opposed to career soldiers? Is there a requirement?

General BROOKSHIRE. The age structure of the force, sir?

Mr. EVANS. Not the age structure, just the term of service structure.

General BROOKSHIRE. Sir, I can only give you a very general answer to that. Obviously, most of the drug abuse is in the younger troops.

Mr. EVANS. Yes, sir. I think maybe we will just pass that question. That's not really what I'm asking. What percentage of your troops are E–1 through E–4, would you say, or enlisted personnel?

General BROOKSHIRE. Sir, I'm sorry that I would ask that you ask the Army representative for that. I wouldn't know that. I know that overall living in the barracks here in Europe in all services we have something around 100,000 troops.

Mr. EVANS. Thank you very much, General Brookshire.

Mr. ENGLISH. Thank you very much, General Brookshire. Chief of staff will call the next witness.

Mr. LAWRENCE. Gen. George S. Blanchard, Commander in Chief, U.S. Army, Europe, and 7th Army.

Mr. ENGLISH. General, would you remain standing?

General Blanchard was sworn.

General BLANCHARD. May I bring up the other members of the panel, Mr. Chairman?

Mr. ENGLISH. Will they be testifying as well?

General BLANCHARD. Yes, sir, they will.

General Reid and General Fitts were sworn.

Mr. ENGLISH. Will you proceed with your testimony, General Blanchard?

TESTIMONY OF GEN. GEORGE S. BLANCHARD, COMMANDER IN CHIEF, U.S. ARMY, EUROPE, AND 7TH ARMY; ACCOMPANIED BY MAJ. GEN. SPENCER B. REID AND BRIG. GEN. WILLIAM H. FITTS

General BLANCHARD. Thank you, Mr. Chairman. On November 12, a week ago Sunday, several members of my staff and I presented testimony regarding the drug abuse situation in the U.S. Army, Europe. Since then, you have been traveling throughout the command visiting and talking with a cross section of our leaders and soldiers. I hope this has been a worthwhile experience for you. I am certain that your close contact with many of our fine young men and women has given you a better perspective, not only on the capability of our units to accomplish their mission, but also on the quality of life shortfalls that may contribute to drug abuse. We in USAREUR are proud of our command and hope that you, too, share that pride. Today, we are here to follow up on our earlier presentations and answer your questions. As a leadoff to our discussion, I would like to summarize some of the major points that we covered on November 12.

We recognize that we have a drug problem in Europe here in USAREUR, and I assure you that the availability of high-grade, inexpensive heroin is a matter of special concern. Further, we believe we are aware of the magnitude of the problem, and action is being taken at all levels to reduce the availability and abuse of drugs. Never in my 5 years in Europe have I witnessed the degree of awareness of the problem and the intense desire to do something about it which prevails today. Of course, you recognize that there are limits to the ability of the Army in Europe to solve this problem. Given the ready availability of hard drugs, and the ease with which this young group can be targeted, to solve this problem we need and solicit considerable additional help from the countries where our soldiers serve and especially from the countries which are interdiction routes into the Federal Republic of Germany.

At this point, I would like to emphasize my commitment to solving the problem in Europe. With your permission, I would like to read into the record two letters that I have dispatched to commanders down to and including company commanders in USAREUR. The first letter was disseminated on August 24, 1978, and reads as follows:

I am deeply concerned about the increasing availability and abuse of drugs in the U.S. Army, Europe. Drug abuse represents a threat to the readiness of U.S. Forces and affects the living and working conditions of every USAREUR soldier.

Recently we began selective unit urine testing for company-size units [SUUTCO] to determine the extent of drug abuse in USAREUR. This program will help to provide a drug-free environment. It is not harassment. In this regard, I expect commanders to supervise personally the implementation of SUUTCO to insure that all testing is conducted in a dignified manner and individuals' rights-of-privacy are not unduly infringed.

Challenging training, educational opportunities, and a variety of recreational activities are available as meaningful alternatives to drug abuse. Commanders and supervisors should emphasize these alternatives and provide effective counseling. We must also make every soldier aware of the dangers drug abuse poses to the individual and to USAREUR.

Together, we must minimize the effects of drug abuse in USAREUR by prevention, whenever possible, and provision of help for those who need it. I urge every member of this command to support the alcohol and drug abuse prevention and control program.

The second letter specifically addresses the issue of recognition for the commander or supervisor who has been particularly effective at dealing with the drug problem. On October 19, 1978, I dispatched the following communication also down to company level:

A vigorous program for identifying alcohol and drug abusers and reducing this abuse in USAREUR units is essential if we are to maintain our personnel readiness.

Commanders at all levels must be involved and committed to reducing the impact of alcohol and drug abuse in their units. USAREUR commanders have my wholehearted support in their efforts to reduce such abuse by pursuing a lawful and vigorous alcohol and drug identification and prevention program. I expect the chain of command to support these endeavors by all appropriate means, to include recognition of achievements in connection with this program.

Additionally, on August 5, 1978, I dispatched a message to all commanders, to include our community and subcommunity commanders, stating in part:

I want you and your NCO's to get thoroughly involved personally. Initially, our drug education programs need to be upgraded to insure that the young soldier understands the implications of the use, even though experimental, of hard drugs and the need to curb it. Second, our attempts to ferret out drug abusers must be

intensified. We have numerous resources to do this, including Provost Marshal activities, searches and seizures, health and welfare inspections, our various urinalysis programs, etc. I want you to become personally involved in using all the capabilities that we have. Third, I want you to insure that the CDAAC's are performing well. You need to make frequent visits to check on the quality of their people and the effectiveness of their counseling of your soldiers. Fourth, you need to crack down on the drug abusers themselves.

Our efforts to identify drug abusers must be intensified. Every legal and authorized means for accomplishing this effort should be utilized.

By cracking down on the drug abusers themselves, I mean for you to take whatever affirmative action is proper and appropriate to deal with each individual case. Where rehabilitation is deemed appropriate, it should be attempted. Where administrative disposition is deemed appropriate, the various administrative mechanisms at your disposal should be employed. If appropriate and warranted, article 15 or judicial action may be initiated against drug law violators. In each instance, you as commanders have freedom to select the appropriate disposition.

In the area of law enforcement, we already have taken a number of actions to strengthen our drug suppression effort.

First, we have emphasized that drug suppression is our No. 1 priority.

Second, we recently opened a drug suppression operations center which centralized our efforts in acquiring, analyzing, and disseminating all available drug data. The DSOC should provide for improved coordination of everyone working on this problem, a more rapid response to perishable drug intelligence, and better utilization of law enforcement assets.

Third, the cooperation and working relationship between the Federal Republic of Germany and all U.S. law enforcement agencies continues to improve. We have representatives participating in a number of host nation drug oriented law enforcement working groups on a regular basis.

Finally, the addition of CID and military police investigators, an already formidable force, enhances our capability to take more drugs off the street and out of our military communities.

Despite our intensified law enforcement efforts, we anticipate that the easy availability of drugs will continue to pose our most serious problem. Regardless of the level of effort the Army devotes to reducing the availability of drugs to our soldiers, the extent of success will be strongly influenced by the host nations' and other governmental agencies' ability to suppress drugs.

Our identification, treatment and rehabilitation program needs improvement. In the area of identification we have initiated several measures that will increase our ability to detect at the individual level and improve our capability to assess the overall magnitude of the problem. Our recently implemented selected unit urine testing for company-sized units and special surveys—in connection with the continuation of the USAREUR personnel opinion survey and our regular commander directed urinalysis program—have proved to be excellent assessment tools which provide us with useful estimates of drug abuse levels. Also, we are moving ahead in our bid to obtain additional resources to improve rehabilitation services. We recognize the shortfalls in our community drug and alcohol assistance centers, CDAAC, and plan to upgrade the quality of this program by providing a trained, experienced psychologist or social worker to the staff in each of our 80 CDAAC's and by hiring additional civilian counselors who possess the qualifications, skills, and maturity to deal with the complexities of

the drug situation in Europe. More professional CDAAC staffs and higher quality rehabilitation efforts will increase the confidence in our program at all levels. We also intend to tie-in the CDAAC to the quality of command in a greater degree than heretofore.

In short, we believe we are taking the kinds of action within our capability to combat the drug problem. We have used DOD's 12 points as a basis for developing a comprehensive plan for improving all of our drug-related programs and activities. It is my desire and my intent to take every appropriate action to reduce to the absolute minimum the availability of drugs to our soldiers, to minimize their abuse in our units and to either rehabilitate or eliminate the abusers in our ranks.

I would like to clarify one issue that was raised on the 13th of November when I submitted my statement to the committee.

That issue concerned the effect of drug abuse on the readiness posture of this command. I recognize the danger of drug abuse and the threat it poses to our readiness. In assessing the present effect of drug abuse as opposed to its potential ultimate effect, I weighed several factors.

First, I consider the view of my chief surgeon. He has told me that most drug abuse in this command is not the result of hardcore addiction. This view is reinforced by the drug abuse prevalence estimates drawn from our biochemical testing programs and our opinion survey data.

Second, I consider the substances abused, the frequency of their abuse, and the population engaging in that abuse. All prevalence estimates must be well defined in these three parameters in order to have real meaning. As I review these numbers I am, of course, very concerned about the soldiers who abuse drugs. We've worked very hard to understand the relationship between what our surveys show, what our urinalysis testing reveals, and what our soldiers tell us. The objective estimates that we receive from different sources seem to agree well. However, in dealing with subjective estimates from soldiers, we keep in mind that it is extremely difficult for one person to estimate the drug abuse habits of another. Further, soldiers seem to base their estimates of the whole on their preception of what their immediate associates are doing.

Third, I consider a number of indicators of effective unit performance; the results of training tests and exercises, the level of equipment maintenance, the level of physical fitness and appearance, and the results of inspections throughout the command. Our most recent reforger exercise provided, I believe, a graphic demonstration of the combat readiness of USAREUR and CONUS reinforcing units.

Fourth, I consider indicators of personal conduct and discipline such as military police reports, AWOL rates and accidents.

Fifth, I consider the views of my experienced subordinate commanders right down to the company level. Readiness is the No. 1 concern of all these leaders. They are continuously aware of a broad range of factors which can and do affect the readiness of their units. They tell me that drug abuse has less effect on readiness than a number of other factors, such as limited access to training areas, limited training funds, and the long tour for first term soldiers. In this context the effects of drug abuse on command readiness—serious though

they may be—do not loom large to them compared to a significant number of non-drug related issues.

Finally, I merge all of these considerations, indicators and views with my own judgment and observations. Having done so, I conclude that my command today is ready to fight and is better equipped and trained to carry out its combat mission than at any time in my experience—and that goes back here to 1973 in Europe. Having said that about the effectiveness of our units, let me emphasize to you that I know drug abuse degrades the personal readiness of the abuser, and that I am aware of the fact that we have many abusers in our units. We are working hard to determine some means to measure and assess the impact of individual abusers on our total combat readiness. We have not yet succeeded in that endeavor, even though everyone who looks at our units in training and in exercises comes to one view—that our force is ready to fight. Yet, we all know intuitively that fewer abusers in the command would make ours a better force, and consequently, a more combat ready force. Moreover, we believe that given the current availability of relatively pure heroin in USAREUR, our force will be in great jeopardy if our current intensified efforts are not successful.

We have attempted to develop precise, quantified measurements of our readiness—both individual and unit—and we will continue to do so. In the interim, we are open to any recommendations and we are prepared to support research into this difficult problem.

You have asked on several occasions what the Congress can do to assist us. You can help USAREUR by supporting our proposed program enhancements and requests for additional resources. If we are to succeed, our current and planned efforts to combat drugs must be complemented by attendant improvements in the general environment in which our soldiers live and work. The quality of life in USAREUR must become more nearly like that enjoyed by service members of the United States. Improved environment and quality of life, together with a shorter tour for the first-term, unmarried, unaccompanied soldier, will help to provide acceptable and attractive alternatives to drug abuse. I would also like to emphasize as I indicated previously, that we need all the assistance that this committee and the Congress can render to deal with the international traffic of drugs in areas where our soldiers are targets.

Mr. Chairman, I am very glad that I had the opportunity to be here today. This kind of situation doesn't often happen. You've had the opportunity to visit the various levels of my command in the past week, and I certainly hope that before the airplane leaves, we'll be able to take advantage of your findings and recommendations. Usually we have an opening statement, questioning, and evaluation made at home, and then a conclusion and recommendation without this kind of opportunity to see. I'm glad that this kind of change in procedure enables you to have a far better feel for what you see and can help us, and we hope to get as much as possible from your surveys, your ideas, your thoughts, and your recommendations. Thank you very much, Mr. Chairman.

[General Blanchard's prepared statement appears on p. 151.]

Mr. ENGLISH. Thank you, General Blanchard. There is one question that was raised by a previous witness that I would like to ask you in regard to USAREUR. What drugs are not tested by your urinalysis?

General BLANCHARD. Mr. Chairman, may I ask the doctor, or General Fitts, to identify specifically so that we have an authoritative answer?

Mr. ENGLISH. Certainly.

General REID. Yes sir, we test for barbiturates, opiates, and amphetamines. This means that we don't test for hash, marihuana, and a number of hallucinogens——

Mr. ENGLISH. Such as LSD?

General REID. Yes, we do not test for PCP, Angel Dust; the largest group that we are not testing for, I would say are the hallucinatives.

Mr. ENGLISH. Are you aware—I assume that you are—that there are indications in Berlin at least that there was a methadone lab that was discovered there, and will that be included on the test in the future? Do we have any plans——

General BLANCHARD. I do not know if we have any plans at this time. I must say that in addition to a single new test to the four, is a very complex and expensive operation. One test means about a 25 percent increase in the overall cost of the urine testing program.

Mr. ENGLISH. Among the enlisted personnel, General Blanchard, it is my understanding on the last USAREUR survey that came out, when it was balanced out, in other words, taking out the higher ranking officers and the more senior enlisted men, that it came out for the target age group, mainly the 25 years old and below, something like 12.5 percent self-admitted hard drug use. Is that correct?

General BLANCHARD. You have those figures right there. That is approximately correct, Mr. Chairman, but let me get it from the actual survey itself here if I may.

General FITTS. Yes, and to give you little pieces of it, military personnel age 25 or younger for narcotics and/or dangerous drugs is 6.1 percent, narcotics is 1.8, dangerous drugs 5.3, and cannabis 23. When you drop that down to look at the E–1's through E–4's, at that age it would be 8.3 percent that would tell us that they are on narcotics and/or dangerous drugs, 2.5 on narcotics, and 7.5 on dangerous drugs, and 31 percent on cannabis. Take that same group, E–1 through E–4, age 21 or younger in combat units, and it rises to 10 percent that would admit that they are on narcotics and/or dangerous drugs, 3.4 percent on narcotics, and 9.3 percent on dangerous drugs, with 34 percent admitting to cannabis.

Mr. ENGLISH. With regard to the urinalysis test, this is good only for a 72–hour period. In other words, it catches only those individuals who have used it within the last 72 hours, and this is not counting the various techniques that have been developed to beat the tests, so to speak. If that's the case, we've heard one estimate that taking the number of times that an individual most likely is going to be confronted with the test, which is a very rare thing unless he has been detected previously and goes on the program, that probably catches about one-third of the individuals who may be using it once a week, once a month, you know, very sporadically. Would this seem much in line with your observations?

General FITTS. We have taken the data that we have used on the urinalysis and then interpolated that back to what our personnel survey shows us, and what it tells us is that what we have is correlated pretty directly with the 7.8 percent we had in January, and what now

turns out in the October test to be 8 percent overall admission of use on at least a once-a-month basis. I don't know whether that is responsive to your question or not.

Mr. ENGLISH. Basically what I'm saying is, obviously with urinalysis tests, you are only catching those in the last 72 hours, that used in the last 72 hours.

General FITTS. That is correct.

Mr. ENGLISH. So, then, also I think you've got to take into account those who carry samples, clean samples, with them, and so on and so forth. But the point I'm trying to make is does the 72-hour picture represent at any one time approximately one-third? Does that seem to fit in with it?

General FITTS. The figures that our operations research people have worked out for us tell us that taking it from the view post back to a weekly figure that it would just about cut that in half. So if we're talking about 8.1 percent, the overall viewpoint from the post point of view, it would be about 4 percent on a weekly basis, and as you know, what our more recent unit tests are showing us is about 3 percent. So I think what we would have to say is that if we were to try to say what would that mean on a weekly basis, recognizing our 72-hour limitation, it would probably be 4 to 4.5 percent, somewhere in that range.

General BLANCHARD. Mr. Chairman, may I ask or add one thing there? I would hope that you would ask the panel of commanders, that you have later, about this business of carrying samples and so on with you. I am thinking in regards to the SUUTCO, the selective unit. You heard me in my testimony on the guidance to the commanders on SUUTCO. I have pretty good assurance that that's basically accurate in terms of present-for-duty personnel in that company at the time that company is asked for it, and that there is a very limited amount, if any, of the kinds of clean sample techniques you were talking about in that type of an environment. But I think you could get a better feel for them when you talk to those people at the lower level who actually have been there when those tests are administered.

Mr. ENGLISH. Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman. General Blanchard, I certainly am impressed with the concern that has been expressed by yourself and by General Haig and his officers with regard to the extensiveness of the problems and the recommendations being made. As I expressed before, I, too, am concerned about the gap that exists between your recommendations and General Haig's recommendations and what's happening down at barracks level and hoping that maybe some of these people will be able to take a harder look at that large gap and see what has taken place between the command and the implementation of the command. General, you've looked over the statistics, you've been aware of the problem now for a couple of years. What is your feeling with regard to the extensiveness of the use; that we're hearing here 7 to 8 percent, our surveys show a higher figure, the press reports much higher usage. What's your feeling about the extensiveness of the use in your command? You're familiar with the troops. You've been out and talking with them.

General BLANCHARD. Mr. Gilman, I'm trying to express that in my prepared statement with relation to the different categories and the way I have to look at it from all my different sources. And I come to

the conclusion that the combination of the selected unit urine testing and the personnel surveys which are not identified with the individual—is not identified in any way with that survey—it gives us a reasonably accurate figure in terms of a snapshot at that time of the situation of the present-for-duty personnel in that unit. As far as the SUUTCO is concerned, and I believe that the view post is given in such a way that there is a pretty good—I have a pretty good feeling that they are telling us what they believe in that survey. I feel that the combination of those two are good indicators of what overall drug abuse exists in Europe. Recognizing that it exists at a higher level in the particular target groups that you have had a particularly good opportunity this past week to inquire into and talk to.

Mr. GILMAN. Well, the groups we've talked to are essentially the field operation people; are they not?

General BLANCHARD. Yes, sir.

Mr. GILMAN. People out on the front line?

General BLANCHARD. Yes, sir.

Mr. GILMAN. Do you feel then that these figures of 9 to 10 percent—I guess they are the highest figures I've heard you say about drug usage, and some 30 percent in soft drug—are accurate? Do you feel that that's what the extent of your problem is?

General BLANCHARD. I think so. I would have to say yes, and I've looked at the USAREUR personnel opinion survey, November 1978 preliminaries, in which we asked the same definitional question that you were talking about in terms of weekly or more frequent use of drugs expressed as a percentage of our military population and then of our subpopulation.

Mr. GILMAN. General, based on those figures, I guess it's safe to assume you're saying to us that while it is a serious problem, it is not affecting the proper fulfillment of the troops' responsibilities and performance. Am I correct in that evaluation?

General BLANCHARD. Mr. Gilman, I'm saying that we've got a problem. I'm saying that there is no question but that it is a personal effectiveness degradation on the part of the individuals affected. I'm saying, though, also that this command can fight today, and I've seen them countless times proving that to me. I've also said in my statement that this is a very difficult thing to judge and that we don't have, really, from the total standpoint, a solution to it. We use these indicators to tell us the direction it's going, and it's going up, and I am very worried.

Mr. GILMAN. Would your opinion change, General, about the effectiveness on the battlefield if we were to find that some 75 to 80 percent of the troops were using hash daily, and many of them while on duty? If we were to find that the use of hard drugs were in excess of 20 percent and some of those used hard drugs on duty, would your thoughts about effectiveness of troop performance then change in any manner? Readiness to perform, not based on what you've seen, but in a state of readiness and alert.

General BLANCHARD. I would be very surprised, Mr. Gilman, and I have heard estimates that range from units, as far as the soft drug—marihuana, hashish—everywhere from 0 to 100 percent. In anecdotical instances by individual soldiers, I do not find that shared by my commanders. It is high. The 80 percent figure I would find very difficult.

to believe. I would think it would be less than that, and it varies from unit to unit, no question. Secondly, I would be very much surprised if—and I think I'm quoting you correct—in excess of 20 percent of the soldiers use hard drugs, both in a combination of on- and off-duty activities. I would be very much surprised if that were so. Certainly it is not reflected in those percentages on our surveys, and various and sundry evaluations.

Mr. GILMAN. Apparently, there is some discrepency in the information that the field commanders are getting and the information that we seem to be deriving from other sources. While our computation isn't completed at this point, and I've done some random sampling of it, it seems that our sampling is coming out much higher than information you're gathering. I'm hoping that maybe we could resolve that somehow and find out what the real situation is. It has taken us 2 years to get the studies going; I hope it won't take us 2 years to start implementing the recommendations. I do have some other questions, but I'll reserve that opportunity for when my colleagues complete their questioning.

Mr. ENGLISH. Mrs. Collins.

Mrs. COLLINS. Thank you very much, Mr. Chairman. I am a little bit confused here as to how you perceive the severity of the problem, especially when we get to talking about the hard drugs and the soft drugs. Now, would you mind telling me your view about the readiness of the soldier who has admitted the use of hash as opposed to the one who has talked about the use of marihuana?

General BLANCHARD. Are you asking hash versus marihuana?

Mrs. COLLINS. Yes. What do you perceive it to be?

General BLANCHARD. As I understand it, Mrs. Collins, is that hash and marihuana fall into the same general category.

Mrs. COLLINS. But at different strengths.

General BLANCHARD. Hash being a little stronger? I don't know whether——

Mrs. COLLINS. A little stronger?

General BLANCHARD. The definition? Can I ask the doctor if he would address that question?

Mrs. COLLINS. Yes, sir.

General REID. I am told that in Europe we probably have very little marihuana, and the reason for it is that you get more "bang for the buck" by buying hash. Hash is readily available in Europe, it is stronger and undoubtedly it represents more of a hazard than say just a street marihuana that you find in the States.

Mrs. COLLINS. How much stronger do you think that hash is than marihuana?

General REID. In the neighborhood of six times.

Mrs. COLLINS. Well we've heard it runs from 5 to 10 times, and that the "bang for the buck" is 10 times greater, to put it that way. I think that that's a serious problem. I think that—and I'm sure that you're not overlooking the fact—that even though you have a large number of soldiers who readily admit to the use of the so-called soft drugs, do have serious problems as well as those who use the hard drugs. I am interested, too, in some figures that you gave, General Fitts. You mentioned something about the younger soldier once before, that 10 percent readily admitted to narcotics or dangerous

drugs, 3.4 to narcotics, 9.3 to dangerous, and 34 to cannibis. Were those figures mutually exclusive?

General FITTS. No; the 10 percent certainly indicates the combination of the possibility of narcotics and dangerous drugs, and then I attempted to give you a figure which showed our best estimate of what it was of each.

Mrs. COLLINS. Would I be correct in saying that 10 percent of 34 percent, that roughly 44 percent is admitted to some kind of usage of drugs? Or would I be all wet on that assumption?

General FITTS. Well, the problem then you get into is the polydrug thing. Maybe another way of putting it would be this: We have looked within this population in terms of a monthly usage spector, which might get to the issue that we're talking to, and in that defined population, we would estimate that about 18 percent of the E–1's through E–4's, 21 or younger, are telling us that they are using a narcotic or dangerous drug monthly or more often, and that upwards of 40 percent are telling us that they have used cannabis monthly or more often, within that defined age group.

Mrs. COLLINS. Through your CDAAC programs, have you been able to determine whether or not these young people on this monthly or more often basis, can you determine how much more frequently in a month they are using it? When it comes to heroin, is this just a weekend recreational thing with them, or have you been able to define your statistics to that level?

General FITTS. It turns out to be primarily recreational. Doctor, would you——

General REID. My feeling—and this is having included practice in Washington, D.C., where we really saw addicts—we don't have the addict problem in Europe that you're accustomed to seeing in the United States. For example, if you take our diagnostic codes, those that are admitted to the drug program here, of all those admitted, those who are actually diagnosed as addicts are those who are drug dependent, hard drugs, which our definition includes opiates and cocaine, counts from 0.5 to 0.7 percent of those admitted to the program. If you take the dangerous drugs, which we include as barbiturates, the hypnotics, hallucinogens, methaqualone, amphetamines, if we take all of those, if you take what percentage of those admitted are addicted, then it is 0.2 percent, and the same figure is the dangerous drugs and soft drugs to include hash is also 0.2. The highest one, of course, is alcoholism.

Mrs. COLLINS. Thank you. General, I'm interested, too, you have certainly given me every assurance, some assurance at least, that your troops are combat ready, but I can't help but wonder just how ready they are when we know, and you know as well, that some of these men are using hard drugs and particularly hard drugs with such a high level of purity—thinking now of heroin. If a fellow does a recreationally chipping of these really harder drugs, he's chipping pretty good. I've heard estimates of the heroin here running as high as 40 percent purity, and even just a little bit of that ought to be enough just to knock everybody cold, as far as I'm concerned, but it seems to me if you have troops that are going in the fields using this kind of stuff, and they are near about as ready as you have led me to counterbelieve in your statement here, would you address yourself to that?

General BLANCHARD. I would, please. First of all, there is no question but the quality in terms of purity of heroin here in Europe today is far higher than it is in most parts of the United States. We recognize that it is a severe problem. I go back again to looking at it from a standpoint of the unannounced alerts and other tactical exercises conducted in the U.S. Army Europe, to insure our readiness. Each unit in Europe is required to undergo unannounced alerts in which the unit commanders do not know, nor do the troops, when that alert will be called. The requirements in those cases vary, and according to the type of alert from a mere assembling of the people and loading of the vehicles and tanks, and so forth, to actually moving out into the assembly areas and preparing for combat. In the time that I have had an opportunity to observe those alerts, I have never seen, nor have I heard of significant problems related to the issue you mention, and I think that comes reasonably close to what you are talking about. I might add that one of those alerts, about a year ago, or 9 months ago, was conducted on a Sunday afternoon, at a time when you would expect experimenters and recreational users, perhaps, to do that. I would ask you also if you would question the panel of commanders to follow us, looking at it from the standpoint of that type of requirement that doesn't give you any warning at all as to the unit, timing, or type of alert, or anything of that kind.

Mrs. COLLINS. Well, General, I appreciate that, and my time is up, but let me just say this: In talking to the young soldiers, I have asked how they and their young friends felt, if they were ready for active combat, and they said they didn't feel that they were ready at all. As a matter of fact, they felt they were a little bit shakey and that they had real reservations, based on the use of drugs. Thank you.

Mr. ENGLISH. Mr. Jenrette?

Mr. JENRETTE. Thank you, Mr. Chairman. General, I first want to thank you for allowing the individual officers to go with us. Our escort officer was extremely helpful, at least in the group that I led. They gave us full range to go where ever I wanted to, and I appreciate that. The gut reaction from 1973, when you were here before, to the present, on the question of drugs, has there been an increase or a decrease, in your opinion?

General BLANCHARD. There has been an increase, Mr. Jenrette.

Mr. JENRETTE. The surveys that you have alluded to on a number of occasions are based upon urinalysis tests and through company units, plus surveys, as I understand it, sir, that you send down to be filled out by the troopers. Will you tell me how you receive those surveys back? Will you tell me if they are sent through the chain of command? Does the company commander get it and send it through the battalion commander, and on up to you? How are the surveys conducted?

General BLANCHARD. Let me ask the man who does this to tell specifically how it is done. It does not come through the chain of command.

General FITTS. We primarily do those through the community process, and then directly from the community on a somewhat random basis directly to the companies. That fairly well bypasses the normal battalion and brigade structure, and the particular surveys that we are doing, Mr. Jenrette, involves about 10,000 individuals in the command out of a population of 190,000, and that makes it statistically relevant.

Mr. JENRETTE. You would provide for getting it down to the unit. Who provides for allowing it to——

General FITTS. Through the community command structure. They supervise it at both levels.

Mr. JENRETTE. The community command structure would be the full colonel or the general in charge of that community?

General FITTS. Yes, basically, and his staff.

Mr. JENRETTE. General Blanchard, you are sitting on a promotion board. You have a battalion commander who has a high degree of drug usage based upon the surveys and urinalysis tests. How does that affect you and your decision as to whether or not that LC shall be a colonel or that colonel shall be a general?

General BLANCHARD. It doesn't affect it, Mr. Jenrette. I am aware of the problem and what he is attempting to do about it. In other words, it relates—I tried to say in my prepared statement, and I hope you go back to that when you have the opportunity—there is an encouragement to identify. This is the policy of the command. There is no question in my mind that out of 1,200 companies there are going to be people who are going to perceive the kind of concern you have expressed. I do not perceive it that way. My corps commanders and division commanders do not perceive it that way, and the policy of the command is not to perceive it that way. Consequently, if they are perceiving it that way, it is an aberration and I need to understand it in your conclusions so that I can even more strongly emphasize it.

Mr. JENRETTE. I had a number of occasions to ask a number of your battalion commanders the same question in off-hand ways without trying to be as direct as I was, and that basically is the same answer, so I think maybe you got your message across to them. They encourage the company commanders and others to be as open as they can and that it would not go into their 201 file as an adverse document, but I can't help but wonder whether that in your surveys and your command, you are doing as we are, and I don't understand how the statistical data that we have prepared—and I know a number of Congressmen and staff people have gone out in the field in the pouring down rain, and we went into some, and your rain gear works pretty well.

General FITTS. I am glad to hear that.

Mr. JENRETTE. We went into some and sat them down and talked to them, and I would hope that they were honest and open when they filled it out. It was very confidential, and the figures that we are getting just aren't there. Now maybe we just picked out the son-of-a-gun troops, or whatever, but I think that some way, before this airplane leaves, if we can sit down and find out where that missing link might be, because the press apparently gets the same surveys that we do, and, believe me, we are in a position that we don't want the press talking about our troops any more than you do as head of the command. Somewhere—and I'm making more of a statement than a question, sir, and I apologize for that—somewhere there is a breakdown in the way you have administered it and the way we have administered it, and we do, sir, have a common goal. We have a common goal, and whatever we can do to help, it is both of our responsibilities to do it.

General BLANCHARD. Mr. Jenrette, may I comment on that?

Mr. JENRETTE. Absolutely.

General BLANCHARD. Your objective and our objective is totally the same. If anyone, I might be construed as being more interested in the combat effectiveness of this command than you. I am not sure that is true. I have certainly, as a professional military man, have been involved in this all of my life.

Mr. JENRETTE. Well, I don't want anything to happen, so I can't sit back and smoke my pipe and drink my beer and know that I am safe, so you might be more directly responsible, but I don't want anybody bothering me at home.

General BLANCHARD. I understand that, sir, and I appreciate that, and I certainly share your hope that together we can come up with more information that would be helpful. I know that is the intent of the committee. The chairman has assured us on a number of occasions, and I know that we do not have all of the answers.

General FITTS. Just to share the wealth a bit, you should know that we sometimes come across the same baffling thing that you have described. We certainly did in terms of the original estimates that we were getting out of Berlin. We went in and did the urinalysis, and we did not find it there. We had some estimates up in the 32nd Army Air Defense Command, which indicated one of our units was in terrible condition. We went in and we found we had a problem, but the point I would like to make to you is that this is the way we can get to some of this issue. I believe that we are operating a system here which is somewhat of an open book, and we would be quite willing to take our processing of urinalysis or any other means and do follow-ups in any area that you think would be worthwhile, and even under your supervision if you would like to do that to get to the truth of the issue, because we recognize there is a gap and we are prepared to do whatever we can to narrow that gap so that we are all speaking from the same sheet of music.

Mr. JENRETTE. Thank you. I think my time is up. While the command is here, I ran into some different situations with the CID and the MPI. In many instances, they work together, and there seems to be some instances in some areas some friction or lack of desire of working together as I thought they should, and I would appreciate it if you would look into that. The manpower is very short in those areas and I don't think we can afford to have any conflict between those two agencies that are so important to the control of these substances.

General BLANCHARD. I appreciate that comment, Mr. Jenrette, and I think the fact of the organization we have just set up will accomplish that in a better way than we have in the past.

Mr. JENRETTE. Thank you, Mr. Chairman.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. General Blanchard, I had some conversations with some of the local German officials, mainly police officials, and they seem to reflect an attitude that, here again, this is basically an American problem, as far as the soldiers are concerned, that the number of German addicts was very low, and that what they needed was to get rid of the addicts in Germany by curing them, building hospitals, and that there was not really that much of a police problem. With the emphasis on free trade and free access in all European countries, is there any way at all, without drastic change in governmental policy

on the part of our host government here, to control it or to reduce the supply of drugs, in your opinion?

General BLANCHARD. That is a very tough one, and I would hope that you will address that to the Ambassador and to the Minister when they testify. Our experience has been that the police chiefs—and I hope that you talked to some of them in Germany—are very realistic about the problem and, naturally, as you get up higher in the command, or higher in the political ranks, there is a differing perception. However, we are seeing more and more cooperation and understanding. We are also keeping additional efforts in resources being applied by the German authorities at various levels to this problem. We are finding that our cooperation with them is increasing. I understand what you are saying, and I believe there is gradually emerging a greater understanding of what the problem actually is within the population as well as the American population. There are a number of German officials who will tell you that the American Army is not the problem when you look at it from the standpoint of the total number of drug abusers. So there is this kind of differing comprehension at different levels.

Mr. JENRETTE. General, it is my understanding that because of certain legal proceedings, and so forth, that once you have identified a heroin user, or one who has used heroin, and he is returned to his unit, that he has to remain in that unit until such time as whatever action is going to be taken. Is that correct, sir?

General BLANCHARD. Unless, Mr. Evans, that individual is an individual who will not be available as a result of his own personal attitude, unless that commander is concerned that he will not be available for the subsequent process, if it is a judicial process, for example, we are, at the present time, constrained to keep him in a unit, or to put him in jail, to confine him. Now, I have a lawyer in the back of the room and I would be delighted to have him get up here and explain what that really means in terms of the judicial process and the rights of the individual, but it is an extremely important point to understand what those constraints are.

Mr. JENRETTE. I think I do understand. I am an attorney and am somewhat familiar with part of the military law and I think I do understand, but I am concerned as to the effect that this man has on the rest of the unit. My concern is the effect that a heroin user has on the armed services, and I would like for you to rebut any statement that I am about to make. In the first place, I don't believe that the Armed Forces is in the business of rehabilitation of hard drug users. I think that your primary purpose is to be combat ready to fight a war if necessary. I think that you have to maintain your men the best that you can, and I might request that General Reid respond to this, but once a person has become addicted to heroin, is there, practically speaking, any way the Armed Forces can rehabilitate that man and keep him in the armed services and make a useful soldier out of him? We already have a number of agencies in the U.S. Government doing this job. Should we remove this man from the armed services once we have established that he is a habitual heroin user?

General BLANCHARD. May I break that down into two parts, and General Reid will comment upon the first part. If the man is a confirmed addict, narcotics, and address that part of it in terms of reha-

bilitation, the Army is not that kind of an agency, but is there any expectation in our processes that we can use in terms of percentages of rehabilitates?

General REID. If there is any one group that I would like to move directly out of the Army, it would be the opiate addicted individual. Of opiate dependent individuals that we treat, we have in a neighborhood of 20 percent rehabilitation rate. It is too low, I believe, for the amount of effort that we put in. Now where we talk about just improper use of opiates, or even an opiate abuser, who is a little worse than that, we are talking about the neighborhood of 45 or 46 percent of those we rehabilitate. So the addict, yes, I would say that the ideal procedure would be to remove that individual from the Army.

General BLANCHARD. We feel that we have a responsibility, particularly among the other individuals than that hard drug individual who is not rehabilitatable in any kind of percentage, and our experience has been that we can rehabilitate a considerable number through education, through counseling, and through other means. Where the drug user is experimental, by convincing him that it doesn't make sense, and by other methods. The problem comes when the individual is not a rehabilitatable individual, and I would certainly share your view that we are not in the business to rehabilitate those kind of people who, by experience, medical, and knowledge, are not rehabilitatable within our capabilities.

Mr. ENGLISH. With regard to the same issue, doesn't it come down to basically what you are saying is that those people you are identifying as being rehabilitative are those people who go back to their jobs and aren't caught using it again?

General BLANCHARD. Yes, sir.

General REID. In fact, all of our statistics on rehabilitation have several fallacies immediately. One, is that we can only judge rehabilitation on the length of their tour, and when you judge an opiate rehabilitation failure or cure, I really believe it ought to be out farther than 1 year, and about half of our people only have about a year to go after they have been picked up.

Mr. ENGLISH. So the rate is misleading?

General REID. Yes, sir and it is also misleading, as I mentioned before in my previous testimony, it is also very misleading to compare our statistics to civilian statistics.

Mr. ENGLISH. Let me bring out one more point. Doesn't it also depend on whether the individual wants to be rehabilitated? If he does not, he is just an abuser, and the chances of saving him are very, very slim?

General REID. For all drugs.

Mr. ENGLISH. And that is a very small percentage we are talking about. Given that, the next point we are talking about is that a majority of the people identified as users are people who want to use it, that's what we are talking about, they are doing it because they want to use it and they are not going to be rehabilitated unless they want to be rehabilitated, and that's what it comes down to today. The question I had between the two different points, as far as information, you have other indications that we have received, that there seems to be a gap. Are we talking about the question of definition? I want to go a bit further. It is probably a very loaded question, and that is—and I think

it was summed up by an employee of the department along this line—if we went in and identified all the people who were using hash or heroin, or whatever, who, or by their own conscious decision, desiring the use, they are not drug dependent, they just want to use it, and breaking the law—if we removed all those people from the service, then we wouldn't have enough of an Army to do the job, and that being the case, that would mean a total failure of the all-voluntary service. I suppose the question I had is: How much of this definition, how much this question of removing someone who has decided in his own mind to break the law, to use drugs, to replace those people through the all-volunteer service?

General BLANCHARD. That is a tough one. Certainly from my standpoint, as the recipient of the people who come into the Army, no matter how they come in, I am interested in people who can perform. Where are those figures of the people who came in who have already used drugs? May I use this personal opinion survey of November 1978, the preliminary one, of personnel who experienced drugs expressing the percent of the population? If you go down to the E1–E4, age 21 or younger, in the combat units, this is the group that you really looked at, a lot of them, and a key group. The ones who have admitted percentagewise some narcotics and/or dangerous drugs prior to their coming into the service is 52 percent.

Mr. GILMAN. Would the gentlemen yield?

General BLANCHARD. And 20 percent of that relates to narcotics. The number who have used cannabis prior to coming into the service is 76 percent. Now that's E1–E4. Basically, all the commanders up and down the chain of command, even the enlisted personnel in the barracks, spend a tremendous amount of time, effort, money, all sorts of resources in the drug problem. Obviously, this detracts, it is resources taken away from working on combat readiness, preparing for combat, so it has got to have an effect. We have had company commanders tell us that 10, 20, sometimes 30 percent of their time is dealing with this problem, this problem alone, and that if they could put that time in with those soldiers who really want to soldier, who really want to get with it, then we would have a far different situation than we have now.

Mr. GILMAN. Answer, I couldn't disagree with those commanders. Well, then, it would seem to me that it would be in the best interest of the Army in doing its job, namely, in being combat ready, if they could simply remove those people who make the conscious decision, they are going to bring peer pressure to their peers to break the law and to use drugs, regardless of whether it is hash or whatever. Obviously, we are in a different situation from those people who are drug dependent, but as I see it, from what we have heard, we have had day after day, month after month, go by with those same people after they have been caught, pending court-martial, sitting in that same barracks, with those same soldiers, with the same influence, and the good soldier sit there and look at them, and those who are not using it. Nothing happens to them. It doesn't make any difference, and that is very frustrating to them as well. I think my time is up. Mr. Gilman?

Mr. GILMAN. General, if you are finding 50 percent of the men having had prior usage, it would seem to me that there is some pretty ineffective screening going on, both on admission and in training, not to be able to weed those out before they get into a field unit, and I

would hope that you could make some recommendations back to the Pentagon to do a little more effective screening on admission and better screening on training. It would seem to me that you could weed out a portion of those before they got out into the field. I would like to address my self to General Reid's suggestion that once you found an opiate, to get him out of the service. It's nice to wash our hands of that responsibility, but let's bear in mind that the Army has invited them to come over here as a voluntary force. Fifty percent of them were not involved in drugs before they came over, and I don't think we can wash our hands completely, but we should be making some effort to find some rehabilitation service and some unit maybe back in the States, or some unit back in the—they are not hard users. Fifty percent of them are starting their use over here, we ought to do something about proper rehabilitation, and I think we have the responsibility, since we brought them over here.

General REID. Yes, sir. I in no way implied that what I would say——

Mr. GILMAN. But, General, I will permit you to respond. You are sending them into CDAAC and 80 percent of the hard drug users going to CDAAC are getting discharges and being sent home, and then we get the complaints of what did the Army do to my son.

General REID. Well, there is a provision for those individuals. They may go directly from the Army to a VA center, and this is provided for by Congress.

Mr. GILMAN. They don't all end up in those VA treatment centers, unfortunately.

General REID. Once they go there, they are eligible to leave on their own and will and that is primarily the problem, many of them do leave immediately.

Mr. GILMAN. I had been informed that referral to those treatment centers has the services. I might, if I have some time remaining, General Blanchard, General Brookshire reported to us that commanders, after their seminar in August, said that their commanders should intensify their efforts to keep our people productively occupied, especially after off-duty time. What have we done down in the field to do that sort of thing?

General BLANCHARD. We have done a considerable number of things, Mr. Gilman. Unfortunately, we are resource-limited to a degree in that those funds are competitive for other uses as well. I hope you had an opportunity, for example, to take a look at some of the facilities in the community and that you recognize that they are facilities as a whole in terms of their effectiveness, in terms of the backlog, the essential maintenance, and so on. There is a great deal that can be done within the unit itself without a lot of facilities. The commanders down the line are encouraged——

Mr. GILMAN. But what are they doing? I saw very little of that frankly, General. Maybe you can tell us a little more about what they are actually doing to intensify the efforts suggested by the brainstorming session held in August of 1978.

General BLANCHARD. I would suggest that this is another appropriate subject to ask General Reid rather than asking me. The kinds of activities are largely physical activities, and they are activities that can be organized in terms of athletics of all different types, and they

are limited, of course, because of weather, particularly at this time of year. It is not very conducive to that type of thing. They are limited because our gymnasiums in terms of either numbers of quality of the type we would like. They have on post, however, a considerable number of recreational activities, not to the number or the quality we would like. We have submitted, and continue to submit, recommendations and requests for additional. We can make available our budget request, for example, which indicate what those requirements are. Each community commander has a community life program addressed specifically to this area, some of which can be done without a great deal of help, others which demand appropriational assistance in order to see that it gets done. The limitations are limitations in many cases of ingenuity on the part of commanders in order to accomplish these objectives. We do as much as we can in the area of tours and opportunities for travel of the soldier. We had been somewhat limited because that takes money, and then the dollar relationship has suffered in Europe, as you are aware.

The Germans themselves have helped in a lot of ways, the German military and the German civilians. In addition, we have at the Armed Forces Recreational Center, which is being better used than ever before, and which is able to keep its prices comparatively low, which helps the dollar-Mark crisis. Regardless of all those things, we don't have the facilities that we would like to, and I am afraid that people being people, we don't have it at the same level at every command for those activities. One other point, Mr. Gilman, and that is, there are a lot of soldiers who, no matter how much we encourage them, really don't want to participate. I have had people tell me," Sir, there is nothing to do," when I happen to know, as does his non-commissioned officers and his officers, that there are things to do. We have to do a better job in motivating these people ourselves, so we have a lot to do.

Mr. GILMAN. General, I am pleased with the attitude that you take and the high command takes, and again, I emphasize, apparently it is either a lack of communication or a lack of motivation of implementing their program down to the lowest level. I hope that the command will take a good hard look at that. The biggest complaint that we've received is that, "We can't get out of the barracks, and there is no place to go and we have no funds," and the language barrier, there is no structured activity, so if we can break through that barrier attacking a part of the boredom problem that is leading to the drug abuse.

General BLANCHARD. You are familiar, of how we tried to cope with that in terms of the young soldier that comes here, and the language problem does bother him, within the first month or so of his arrival he is—which addresses itself specifically to the common language situation of being in a Gasthouse and how you order, or being at the railroad station and how you conduct yourself in the normal type situation within the German community. There are other activities really designed to do this. We had not done as well as we should have and we will push that one harder.

Mr. GILMAN. My time is up.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. General, in talking about the usage, I wonder if your figures had been refined enough to tell me of what the percentages are of the usage in the non-high-school graduate?

General BLANCHARD. We have that information from one of our surveys. Let me dig it up. Has anyone in the back row got those basic factors? While we are waiting, it does appear from our statistical data that the non-high-school graduate has a greater proclivity to involved in drugs than the high school graduate. I refer here to table 8 of my personnel survey in April of 1977, which addresses a monthly or more frequent use of drugs expressed as a percentage of each educational level within the lower enlisted E1–E4 USAREUR population. For any hard drug, the percentage of use with less than high school comes out here at 15.9 as opposed to the high school graduate or GED or 8.6, so it's a little less than double. On the other hand, you come into the peculiar situation of 2 years college or more goes up to 13 percent. We are talking here of a sample size of nearly 700, less than high school, and nearly 3,000 high school graduates, and 450 2 years of college or more.

Mrs. COLLINS. You are talking about your enlisted men, though, aren't you?

General BLANCHARD. No, these are either E1's to E4's in the USAREUR population. We have a number of people with 2 years of college or more.

Mrs. COLLINS. These are the bulk of your enlisted men, though, aren't they?

General BLANCHARD. The bulk of them fall into less than high school or high school.

Mrs. COLLINS. You mentioned something about 50 percent of the personnel having used drugs before they came into the Army, a larger percentage used heroin.

General BLANCHARD. That's correct.

Mrs. COLLINS. That's correct to say. Do you have a program recognizing that 50 percent of them are coming into the Army—I know you don't have the training level back home, because your're not responsible for that—but knowing that this percentage is coming to you, 50 percent or above are coming to you, do you have any programs so that when they first step on European soil, are any corrective measures taken at that time, or is it just permitted to go on?

General BLANCHARD. No, we have a required orientation of the new individual of which drugs, and the use of drugs, and the prevalence of drugs, and so forth, plays an important part. So yes, we do look at that and attempt to insure that the newly arrived soldier is aware of, and understands the drug culture and its problems. May I address your specific question of your earlier one when you asked what about narcotics in terms of that 50 percent we referred to. Actual narcotics, we are talking about nearly 21 percent who have experienced drugs prior to their arrival. Of the dangerous drugs itself, 50 percent, when you combine that with dangerous drugs, 76 percent.

Mrs. COLLINS. Now your sample is beginning to meet ours a little bit better, I think.

General BLANCHARD. I suspect that a great many of the people that you talked to fell into the category that we are talking about right now.

Mrs. COLLINS. Thank you.

Mr. ENGLISH. General Fitts?

General FITTS. I think, we think, that it is a comparison between the people who have actually used it versus what the soldiers are telling you.

Mr. ENGLISH. Mr. Jenrette?

Mr. JENRETTE. I guess the statistical value of the non-high school graduate, the high school graduate, and those of 2 years of college, is that of teaching too little and teaching too much. Being in athletics most of my life, I know the cost of the facilities of the gymnasium, but the weather you have here, the gymnasium will accompany approximately 20 individuals playing basketball or whatever, only, and you have that at battalion level, and I think you are going to have to go more and more to this volkswalking, or whatever that is and I see that as a situation that I was very impressed with, that some of the units have begun annual military sponsored with the community.

General BLANCHARD. That's right, Mr. Chairman. Volksmarching is a very popular activity.

Mr. JENRETTE. You give a very brief course on how to order at a Gasthouse, or whatever it is called in German, and very little on how to ask a girl to go to dance with him. Maybe the volkswalking would be a combination of getting the local community involved with the military. Mrs. Collins was concerned about the black individual young man having the racial, as well as the language problems, and knowing the limited resources that you have, it seems to me that a vigorous military-local community program of volkswalking might get that barracks rat—and I use that with a great deal of deference to the individual—that kid that is not athletically inclined as his peer down the hall who might have had a very strong basketball background or something of that nature, but certainly if he is in the service he can walk.

General BLANCHARD. Yes sir, and I think you know that we go further than that and there are a considerable number of communities where there are teams that play the Germans, and use their facilities, basketball, volleyball, all kinds of activities in what we call soccer and they call fussball, and there are others, wrestling, boxing, and so on.

Mr. JENRETTE. Let me finish by going back to the education for just a moment if I might, and I ran into this by one of your commanders in that your company commanders are required to have a B.S. degree, a college degree equivalent to a B.S. degree, basically.

General BLANCHARD. Most of them do.

Mr. JENRETTE. The teaching corps, and I don't know all the background on the teaching corps here for the educational benefits for the soldier, those teachers have B.S. or above in educational background, I understand.

General BLANCHARD. Yes, I understand that, too.

Mr. JENRETTE. This particular commander had a novel idea, and I expect to talk with him about it, hopefully with your permission, later of course, corresponding through Washington, about these individuals that do not have a high school education, that are reserved in their athletic abilities or their self-motivation for activities, to have

the company commander—and I've been one, so I know what they have as activities—but this individual commander felt that his company commanders would enjoy a teaching course, and when I say enjoy, maybe I should put that in quotes, but it would make a better soldier and, therefore, easier to command, to allow that individual to be taught after regular duty hours, a course by the commander or his designee with a B.S. degree, and that credits toward high school education could be given to that individual through that teaching course. Now I know it is going to take a great deal of cooperation, but the activities that I've seen that your command had a number of days in the field are not conducive for the combat individual, and are not conducive for a regular scheduled schooling at some particular place within the community, and it has to be done at some other place. I would like, sir, if you would have someone in your command explore the possibility through the educational programs, allowing it. Naturally you are going to have to give them a test, and that test could be given by the educators as such, rather than the commander, but maybe that motivation would be one that would help this non-high school graduate, and I've never met one, sir, that after 6 months after he had dropped out, didn't have some regret of not going there. Maybe if we could help him, at least get some credits toward his certificate, it might be a motivation that would cut down that 15.9, and we would be doing a hell of a job if we could cut the 15.9 to 8.6 that are high school graduates.

General BLANCHARD. I think the idea is a good one. We do have what is called ACEP, the Army continuing education program. I'm sure you're familiar with that, which basically permits an individual who is not a high school graduate to get that kind of academic education that will assist in his particular specialty.

Mr. JENRETTE. But if he misses three classes he does not get a credit or a passing grade, isn't that right?

General BLANCHARD. You hit it on the head when you said the combat units have a great problem.

Mr. JENRETTE. You got a guy 90 days out in the field in the last 200 days. How can he possibly not miss the class?

General BLANCHARD. It does make it difficult.

Mr. JENRETTE. And this commander was willing to take that portion of the course and take it to the field, which I thought was a hell of a commendable thing to do.

General BLANCHARD. I think so, too, and we support that, and I would be very much interested in following up on that idea.

Mr. JENRETTE. I plan to contact him and I will send a copy of the letter to you to get to him, if you don't mind.

General BLANCHARD. No, you go ahead and write to him, but I would appreciate copies of the letter so that we can look at it from a command standpoint as well.

Mr. JENRETTE. Thank you, sir.

Mr. EVANS. General, just one last area. What is our Army policy about accepting people who have used drugs into the service, if they know about it?

General BLANCHARD. I'm not sure I can give you the best answer to that because I have been here a good bit of time and I'm talking about the people whom I receive.

General REID. To my knowledge, they're not acceptable.

Mr. EVANS. If that be the case, then who is doing the lying when they come into the service, the soldier, the recruiter, who? I think we need to find out who's doing that. I think if we recruit people that are not on drugs, that we'll be subject to get a heck of a lot less people on drugs in the service and have a lot less problem. I don't know who we need to address that to, I guess a number of people in Washington.

General REID. You see, we get that information two different ways. When a man comes into the Army, he goes on record as saying I am or am not. When we get this information, we get it either anonymously or by a urinalysis or by some other way.

Mr. EVANS. I understand very well how you get it. I know that once they are in the service, that you get a number of them admitting it at that point. Now I don't know whether it has been admitted, I would like to know if this all-volunteer Army is putting so much pressure on taking people that we are taking people that we should not be taking into the service, and that's part of the problem. I would like to have an answer to that if anybody could.

General BLANCHARD. I'm afraid we've got the wrong people here because we are in the business of taking what we have, and making combat effective units out of them.

Mr. EVANS. Yes, sir, I understand that. I think these are questions that need to be asked of somebody, thought, in charge of policymaking, whether it be the Congress or whether it be the Army, or whatever, but I certainly think that the incident of drug abuse would be much less if we had a ban on bringing people in the service who had used drugs.

General REID. Mr. Evans, we are committed to communicating back to headquarters, Department of the Army, on this issue of a much better screening approach for these people as they come in, and we would like to assure you that we will take that initiative.

Mr. EVANS. Thank you, sir. One other question that doesn't really get on the question of drug abuse. One of the things, General, that I ran into repeatedly, both in the maintenance units and in the actual cavalry units, tank units, and other units, was that of the state of the equipment.

Now I know about Reforger and I know most of the equipment made it back, but there seems to be a feeling on the part of the troops that this equipment would not stand up in combat purely because it takes so long for them to get replacement parts, necessary parts. This was true not only in the tank units, but also where the people working on the vehicles in the shops, and I might say that I certainly sympathize with what you are having to work with in the nature of some of the shops in some of the units because they can't even see in them without having the door open, and I think that's something we need to address, but I would hope that that would be communicated through the request for appropriations, and I hope that it gets through the chain of command to us so that we can address it, as well as the things that are lacking in the barracks and the recreational facilities.

General BLANCHARD. Sir, anything you can do to help us would be most appreciated.

Mr. EVANS. We are going to have to know.

Mr. ENGLISH. General Blanchard, you other gentlemen, we appreciate your candidness and your testimony has been most helpful. Thank you very much. Chief of staff will call the next witness.

[The prepared statements of Generals Fitts and Reid appear on p. 156.]

Mr. LAWRENCE. Major General Tice, Colonel Sunell, LTC Vanderploog, and Captain Davis.

[General Tice, Colonel Sunell, LTC Vanderploog, and Captain Davis were sworn.]

Mr. ENGLISH. I might say that we are running a bit behind. If you gentlemen would care to give a brief summarized statement, it would be most helpful. If you have a prepared written statement it will be included in the record.

[General Tice's prepared statement appears on p. 174.]

TESTIMONY OF MAJ. GEN. R. DEAN TICE, 3D INFANTRY DIVISION, 7TH ARMY; ACCOMPANIED BY COLONEL SUNELL, LIEUTENANT COLONEL VANDERPLOOG, AND CAPTAIN DAVIS

General TICE. Do you wish, Mr. Chairman, that I omit reading my prepared statement?

Mr. ENGLISH. If you could summarize it, it would be most helpful.

General TICE. I guess I would summarize it in this way, and since it will be introduced into the record, you will have it verbatim. I have been commander of my division now for about 13 months. I am starting on my 5th year in Germany. My perspective, of course, will be influenced by my assessment based on that going on 5 years of service here in Germany.

For the past fiscal year, it seems that one of the big debates is to try to arrive at a statisical analysis as to how deeply ingrained the drug abuse is within the U.S. Army, Europe. I must say that that has been very elusive to me in my role as the commanding general of the Berlin brigade in 1974 to 1976, as deputy chief of staff of personnel for USAREUR, and now as the division commander. The statistical information that I have indicates that over the past year in my division, that we had a low of 1.99 percent in the third quarter to a high of 2.58 percent in the fourth quarter that were identified as hard drug abusers within the division. In May of 1978, we started the SUUTCO program within the 3d Infantry Division, and to date we have found that 3.39 percent of the soldiers have been identified as abusing those drugs for which we test.

Now, when I eliminate those who are over 24 years of age, that statistic jumps to 7.61 percent, if you take the E1's through E4's, which includes most of those. I have got several areas I just briefly discussed as to some of the most common reasons that I've found as to why soldiers abuse drugs in the 3d Infantry Division. Many have experimented before they came into the service. Only last week I talked to a young soldier who had been apprehended by his platoon sergeant for smoking hashish, the young soldier indicated he had been smoking hash since he was 12 years old. Not only that, his folks smoked hash, and he said most of the teachers did in the high school where he attended school. He said, "but I want to stay in the Army."

Mr. English. Let me interrupt you just right there. General, are you saying that in high school they were smoking hash or smoking marihuana?

General Tice. He said hash and marihuana, mostly marihuana in the States. He said that his teachers even smoked marihuana or hashish, but he said, "I want to stay in the Army, but I also want to continue to smoke pot." That was a young 18-year-old soldier. So I conclude that there has been a lot of experimentation before they come in, as well as once you get in the Army, they seem to continue to experiment. Another area which we have touched upon in the hearing is boredom. Perhaps that is one of the greatest challenges for the young, single soldier who live in the kasernes most of which were built in 1937 and 1939, now find themselves located in the heart of the city. Where my division headquarters is, I have five separate kasernes in which we have troops stationed in the heart of the city of about 120,000. There are few options for them in the way of facilities. Unlike our sister service, with an airbase that has a fence surrounding it where you can have one facility to take care of all of the soldiers, then I'm challenged with the limited funds to try to provide some kind of athletic options available for those soldiers. To date, I have one lighted athletic field in that area. Another area, of course, is peer pressure.

The peer pressure comes in many ways. One, I think a young soldier is reluctant to admit that he has not experimented with drugs, because it is popular to say that you have, and how much that influences the responses that your committee finds in talking with the young soldier, I do not know. I know that there is a propensity for a lot of people to tell you what they think you want to hear as opposed to what you really want to derive at the facts. Like in some of the young soldiers in groups, in their comments to me and to my commanders of how many are involved in drugs, similar to being a young 18-year-old myself in high school, bragging about my sexual prowess, I was reluctant to say that I was still a virgin. I sense there is some of that in the questionnaires and the responses that you receive from young soldiers. The drug dependency? We do have soldiers that are using drugs. Twenty percent of the court-martials in my division for the past year were a result of individuals involved in drugs. I was privileged to be in the audience and heard the comment as to the delay in processing times. For general court-martials in the 3d Infantry Division, we processed them between 50 and 60 days, and that usually involves people who are peddling the hard drugs in the case of drug abuse. For bad conduct discharges under the special court-martial authority, it's about 45 days.

For other special court-martials, which would be in the drug area, those who perhaps are abusing it and are caught and would not be under the exemption program and would be prosecuted, it runs about 55 days. The things that we have done in the area from which I serve, first and foremost, I think that the single greatest thing to reduce abuse of drugs is to have a dynamic, a challenging, and a dynamic training program. In my division this has been passed down to the lowest levels within the division. I am absolutely convinced that such training would do a lot to limit or more to limit drug abuse than some of the clinical approaches. In the urinalysis testing program, it comes on a random

basis, and each day, of course, the commander can refer up to three individuals. The SUUTCO program which we started in May of 1978, I gave you those statistics to begin with. We have a very active health and welfare inspection program within the division that is executed all the way down throughout the units, and we are fortunate today to have one company commander from my division on this panel. Of course, we have the clinical evaluation for all of our surgeons and medical personnel are tuned to discerning possible drug abuse for soldiers who come in for other ailments. The one which I would hit hard upon is the recreational sports program which we believe in very strongly. We participate not only among the troops themselves but also in the German-American sports club. In fact, there are five athletic events that we participate in Schweinfurt community with the German-American sports club.

Another area, if you look at these old, run down buildings, and areas in which the soldiers live, in the past year I spent over a quarter million dollars in rehabbing and improving the club systems within the Wurzburg community, and that was renovation of three clubs, to improve enlisted NCO club atmosphere by putting in carpeting, kitchens, furniture, disco equipment in them. In addition we had one club which was located down in the city, which I suspected, and we reaffirmed this, a place that was trafficking in drugs and I closed that one down. One of the highlights is, I am always amazed when I hear the soldiers have nothing to do. We have international tours and travel offices in the Wurzburg city alone and over 2,200 soldiers in the last 3 months have visited at least eight other countries You ask me what we have done. There is one tour that goes to Spain for 5 days, includes three meals a day on the beach for $116, and I suggest a soldier can blow that much just on a weekend drunk. We try to push that they can participate in these kinds of programs. They can go to Copenhagen for 3 days, for $98, and over 2,200 soldiers in the division participated in that—not in the division, that was only the Wurzburg area in the last 3 months

We started about 6 months ago a covert drug suppression team made up of undercover agents in which I started working in a community at a time, and as you know, Mr. Chairman, in use of undercover agents, their discovery comes probably after about 45 days. Once that is done, then I pull them out and move them to another community and move them around. These are specially trained individuals where we marry up the MPI along with the CID and we go in and take a look. In one of our communities we are now prosecuting 11 soldiers, in another, 15, as a result of this suppression team. I guess I would conclude that by the actions that we are taking in the division is that every soldier who comes into my division, I talk to him personally as a welcoming part of my address, and we look straight on at drug abuse. I kind of throw out the challenge to the young soldiers themselves, that perhaps peer pressure from themselves will probably do more to stem the tide of drugs than all the law enforcement we might muster. I regret that I am not completely successful on that kind of an approach. Though we are taking steps within our NCO professionalism program and our basic leadership program, the NCO academy to alert our first line supervisors and our young NCOs to be concerned and help to identify drug abuse.

I guess before I would pass on for questions, when I was asked perhaps what the committee or Congress could do for us, I think first and foremost, it is important that we have sufficient funding capability to insure that the combat divisions in Europe can train to the level for which they are designed and know we must do in order to meet the challenge and the threat. I am perplexed by trying to discern the degradation in combat readiness when just in the last month I had two tank battalions who fired a very competitive course at Grafenwoehr in which 54 crews out of 54 in one battalion qualified with 15 distinguished, which is a damn tough competition. The other battalion, 52 out of 54 qualified. I am perplexed when I call an alert on Sunday afternoon and in 2 hours 72 percent of the troops are available to go fight. So I would suggest that one of the things that you can help is to provide sufficient funding so we can maintain that high state of training. That will stem boredom more than anything else.

I also would suggest that the committee can support us in the professional and the clinical help, in the form of counseling and having true professionals involved. I guess lastly, sir, there has to be some recognition of the high cost, with the declining dollar within Europe.

We made a lot of sacrifices over here, they are living in a different environment, but I think on the bottom line, we do have a lot of dedicated soldiers, and I don't propose that as a major general commanding a division that I hope to know the real answer, but we work damn hard at trying to ascertain what the soldiers' views are toward soldiering in Europe.

We are ready for your questions, sir.

Mr. ENGLISH. Thank you, General. We will go through all the panel members. Any statements they would like to make, it would be fine. If you don't have any statements, that's fine too, but before we begin the questions, I think it's best if we go through the panel.

Colonel SUNELL. I don't have any statement to make.

Mr. ENGLISH. OK. Colonel Vanderploog?

Colonel VANDERPLOOG. I would like to comment a moment, Mr. Chairman, and pick up on a point that the general introduced about being able to perform our mission. I command a battalion, transport battalion, 8th Infantry Division. Our wartime mission, essentially, is to preserve the combat power and operational range of that division in battle by feeding it, fueling its weapons system, equipping it, transporting the supplies, and servicing its soldiers. I have a luxury as battalion commander because my garrison support mission on a recurring basis, 365 days a year, patterns exactly what I am to do in combat. I have 379 soldiers, including myself, and they are dedicated to that mission. To give you an idea, 16.4 percent of my soldiers are females. How do I look on a racial composite? Fifty-four percent are white, 36 percent are black, 9 percent Hispanic, 1 percent native American. Seventy-one percent of those soldiers live in my dorms, 29 live off post, 16 percent Government quarters, and 13 percent on the economy. What does my average soldier look like in that battalion? Well, my average male soldier from E1 to E5, his age is about 21 to 23 years old, he has a GT score of 98.1, 59.4 percent of them are high school graduates, 23.7 percent, GED equivalent, 12 years, and another 28 percent of my males have some college. 30.4 percent of those soldiers are married, and they have been in my battalion about 13 months.

My female soldiers of the same grade are compatible, a little higher particularly because of the entry requirements for the female soldiers, and I won't belabor the point.

That's the average E1 to E5 bracket, whom we must depend on to do the job we have. Well, do I have a problem in my battalion? Certainly, I think it has been said time and time again, we are aware of it. We are doing something about it. But the real gut question, Mr. Chairman, is can our soldiers perform their mission? I would like to take this opportunity to offer some evidence, several factors. First, my battalion stood in the annual general inspection, the 3d through the 5th of October this year. Officers, senior NCO's, don't pass these type inspections, soldiers pass the inspection. I was very pleased. For 10 months that I have commanded the battalion, my soldiers have worked. They have passed every major area—training, operations intelligence, supply, logistic, personnel management, maintenance, the whole spectrum. There were 96 commendable ratings afforded my soldiers, the highest maintenance inspection in the last year in the division. Of 310 graded areas, 11 were in the red. You don't do that by peeking, Mr. Chairman, I would submit, and I would also suggest that's indicative of hard work over extended periods of time. To support that in the fiscal year 1978, what have my soldiers done? Can they do their job? Well, I submit, yes, and let me offer as evidence, in fiscal year 1978, my motor transport company, in direct support of the 8th Infantry Division, drove 1,038,000-plus miles, with six reportable accidents. That's an accident of over $250 cost of damage. In addition to that, my soldiers in my supply company, they serviced better than 6,500 soldiers in a troop issue subsistence activity. They receive, store, and issue food, gross sales of $3,872,000. My property warehouses, we received, stored, and issued in excess of $15,000,000 of property, to include the accountability of that proprety, by soldiers of the grade we just talked about.

We delivered 778 2½-ton truckloads of property to our customer units throughout the division area. We serviced 11,000 soldiers in our central issue facility, where our soldiers receive their equipment when they join our division. Petroleum, we issue better than 2 million gallons of fuel to our divisional customers. My truck company, in turn, moved 1,945,000 gallons in our 5,000-gallon tankers, 650,000 of that in the field and environment in support of the division's training exercises. Looking briefly to those areas, I would offer to you, and I think I can look you straight in the eye in good conscience and suggest, yes we have a problem, yes, I know what it is, and we are doing our best to improve our situation, but I can also state to you that I am sincerely convinced my unit is prepared to do its mission.

Mr. ENGLISH. Thank you very much. Captain Davis, do you have a statement?

Captain DAVIS. Sir, I have no statement, but what I would like to say is, that I am a combat company commander in the 3d Infantry Division and, particularly, the 1st of the 7th Infantry. It is my third command, and I have had a command in Vietnam, the States, and also in Europe.

Mr. ENGLISH. Thank you very much. I would like to lead off the questioning by simply asking of you your various functions in the chain of command. Each month, what percentage of the time do you

spend dealing with drug or drug-related problems? I am talking all the way from legal processing time to detection time, to classroom time, to just general planning time, and trying to combat this problem.

General TICE. As a general court-martial convening authority for a greater scope than just my division, approximately 25,000 soldiers fall within my area that I am responsible for and in that regard I spend about 6 hours a week on court-martial matters as the convening authority. I would say that probably 2 hours a week would be devoted to my review of those involving drug implications, as the division commander. I also spend an hour a week talking with all replacements, so a portion of that is involved with drugs. I spend at least 2 to 3 days a week in the field with the troops, and a considerable portion of that time is dealt in communicating with the soldiers. I fully recognize that in a subordinate-senior relationship, you don't always get the answers that are the truth, but perhaps what the general wants to hear, and that's the difficult thing to sort out, but that is a rough estimate, I would say.

Mr. ENGLISH. Percentagewise, what would you say that would run into?

General TICE. But, Mr. Chairman, when I talk about my energy exerted toward the total people programs, you know, it would probably—in the social kind of responsibility that you have——

Mr. ENGLISH. I am just talking about your total job. All the way through. All the things that you have to do, the whole spectrum. What percentage of the time is eaten up either directly or indirectly dealing with drugs?

General TICE. I would say probably 5 percent of the time.

Mr. ENGLISH. Five percent? OK. Colonel Sunell?

Colonel SUNELL. Well, I command a cavalry regiment, and I have approximately 9,000 soldiers and dependents and 385 kilometers of border for which they are responsible. That takes up the absolute bulk of my time. I would say 2 percent or less.

Mr. ENGLISH. Two percent or less? Colonel Vanderploog?

Colonel VANDERPLOOG. My battalion, all aspects, and in response to your question, approximately 10 to 15 percent of my time.

Mr. ENGLISH. Ten to fifteen! Captain Davis?

Captain DAVIS. Mr. Chairman, 5 percent of my time.

Mr. ENGLISH. How much?

Captain DAVIS. Five percent.

Mr. ENGLISH. Obviously, the point I am trying to make is all up and down the chain of command, there is considerable effect being exerted in this area and a considerable amount of resources being used. Obviously, there is a considerable amount of money. We are talking about urinalysis tests, detection, whatever, and one of the questions I would like to ask of you is, the point has been made, and I think that it is a valid one, the evidence that we have seen that I think would agree to the member that you probably can do your job. You can accomplish your mission. We didn't see any question of that. The question, I think comes down to is a matter of degrees. If you had these additional resources, if you had this additional time, if your troops were not using, recreationally or whatever degree they do use it, how much better would our people be? How much more time could be spent on training? How much more resources could go into these

areas of improving the quality of life of soldiers here? What impact do you think that that would have?

General TICE. I would hate to put that in a percentage kind of category, but you hit upon the thing that my young company commanders tell me when I talk to them about drug abuse, and with reference to combat readiness, it is that diversion of their energy to administer and follow up the drug and alcohol abuse program that could be devoted to training and some of those other things in a supervisory way.

Mr. ENGLISH. In your opinion, does it have a significant impact on the degree we are talking about?

General TICE. I would say that they spent 5 to 10 percent of their time in energies in that area. Certainly, it would impact upon it.

Mr. ENGLISH. Thank you. Colonel Sunell?

COLONEL SUNELL. Well, I think that the problem with my commanders is not how much time they actually spend on drug related problems, but the fact is, when you have a drug related problem, you spend a great portion of your time trying to solve that, and consequently you don't have the time to spend on the good soldiers. The soldier that has a very serious drug problem takes a lot of time, and you spend a lot of time on that individual which you probably should be spending with the soldiers that don't have that kind of problem. That's where it really eats up the time.

Mr. ENGLISH. Colonel Vanderploog?

Colonel VANDERPLOOG. Yes, sir, Mr. Chairman, I would echo the sentiments of those spoken before me. In my case, my time is a little higher. We have been working hard in this area. By so doing, I have been doing things in some cases that I would expect my unit commanders to do more frequently. My decision, though, has been to take some of that burden off their backs to get on about the business of training and preparing our soldiers to do the job. By splitting the workload, obviously we can devote the resources to things we need to do more of, that would show measurable improvements.

Mr. ENGLISH. Captain Davis?

Captain DAVIS. Sir, when I talk about 5 percent, it might seem low to the other company commanders, but I have been there 17 months. After you get the patterns established, and the identification process going, the process of rehabilitating the guy can come not only in an office commander-to-EM environment but also in the outside on the track, so that 5 percent is a large amount of your time to get that guy to open up. What I am saying is that maybe if the atmosphere is open maybe we can talk instead of wasting a lot of time by going about different directions to get that man to communicate direct to the point where we are frank about it.

Mr. ENGLISH. I believe my time has expired, Congressman Gilman?

Mr. GILMAN. Thank you, Mr. Chairman. Colonel, approximately how much of your time is spent on maintenance of equipment in your company?

Colonel VANDERPLOOG. My company sir, my battalion?

Mr. GILMAN. Your battalion.

Colonel VANDERPLOOG. My direct time, probably about 20 to 25 percent, because the backbone of my business is motor transportation,

and I do that through a hierarchy where I have a maintenance warrant officer that actually manages and makes these programs.

Mr. GILMAN. I see you spend about 15 percent of your time on narcotic problems. What do you translate that into hours per week, approximately?

Colonel VANDERPLOOG. Well, thinking in terms of the hours in the day are not—the point in hand will probably translate to about a day.

Mr. GILMAN. About a day a week. Can you tell us how you spend that day a week?

Colonel VANDERPLOOG. Well, equivalent, if you will. I'm not thinking in terms of say an 8-hour day.

Mr. GILMAN. How would you spend that time? Can you tell us how you break that up for narcotic problems?

Colonel VANDERPLOOG. All right, the biggest point I've been working on, in a related problem, I've been going after what is causing the narcotic problem in my soldiers. I've put a good deal of time into that.

Mr. GILMAN. What are you doing in that direction?

Colonel VANDERPLOOG. In what I've taken a look at, and if you will indulge with me, please, I would like to address that. A problem has been—I don't know what's turning my soldiers that way, but the problem is there. You've found it, we've found it. In a supply-type organization, some would say "Well, that's where it is more prevalent," or, "where you will find more of it." Why? Well, support soldier is not a soldier that has a peak period of training and comes back to his home area, refits, and goes again. It's a daily mission. It goes 6 to 7 days a week. Why do we get involved? So we have looked at that very very closely. We put a lot of time looking into it to find out the causes. I've looked hard and come up with the absence of knowledge very truthfully. We've looked in respect to drugs and in respect to his job. Again, training related. We've got to improve in this area to improve that professionalism.

Mr. GILMAN. Colonel, what I would like you to address yourself to is, I'm curious how you spend this time. Can you tell us directly how that 8 hours is spent each week on narcotic problems?

Colonel VANDERPLOOG. Yes sir, I'd like to break that up. We've done a lot in this area determining the causes. I have been having meetings with my commanders, my first sergeants——

Mr. GILMAN. How often do you have meetings with your sergeants on narcotics?

Colonel VANDERPLOOG. Among other subjects, weekly we have the first sergeants in.

Mr. GILMAN. You have weekly meetings on narcotics?

Colonel VANDERPLOOG. That is the topic of discussion, yes sir.

Mr. GILMAN. Pardon?

Colonel VANDERPLOOG. As a topic of discussion, yes sir, it's not solely focused at that.

Mr. GILMAN. Are all the sergeants included in that weekly meeting?

Colonel VANDERPLOOG. First sergeants, sir.

Mr. GILMAN. How else do you spend that time?

Colonel VANDERPLOOG. I spend the time by going out interviewing soldiers, where we have identified problems that come up in the workplace. I've made a significant effort to get out to find out the causes, where they are reportedly showing up in certain areas, predominantly

related to work hours. I spend the time in the investigative portion. I did a great deal of time substantiating cases to find out if, in fact, they are supportable. I spend time going through the barracks. I spend time visiting the barracks after hours.

Mr. GILMAN. How frequently do you go into the barracks after hours?

Colonel VANDERPLOOG. A minimum of three times a week, sir. My commanders and first sergeants do it daily.

Mr. GILMAN. When you go into the barracks after hours, how do you spend your time there?

Colonel VANDERPLOOG. I walk around and talk to my soldiers, sir.

Mr. GILMAN. Can you tell us any additional activities that you do?

Colonel VANDERPLOOG. Yes sir, I'm tied up with them with court-martial activity. At times, appear as a witness or as a character witness, or article 32 investigations ongoing for soldiers pending a court-martial action.

Mr. GILMAN. One of the problems that we found is that there has been a recommendation, I think General Brookshire mentioned, about command presence must always be felt in the barracks, and Major General Tice said today, "I think that the best pressure is peer pressure amongst the men." We find too little training and attention being devoted to the problem by the sergeants who are closest to the men. You talked about a meeting with your first sergeants. What about time spent with your other sergeants? Is it filtering down to them? What are they doing about the drug problem? Are they talking to the men about it? Is that message getting home to the men through the sergeant who they come in contact with? We found that in spot checking, it's not the situation. Maybe it's different in your unit. Can you tell us a little bit about that?

Colonel VANDERPLOOG. I don't believe it is, sir, to a degree. Let me explain. I don't have all the sergeants every week. I have my command sergeant majors and the first sergeants. We talk in the areas of concern. Passing down, when you look at who is the first line supervisor. In my unit, it's going to be a young E5 or a staff sergeant, E6. Looking at that on a profile, we don't have maturity that at one time we may have had in those ranks as far as hardcore years of experience. They are young, they are capable, but they need seasoning, and time in the supervisory position. Is it effective? Well, it is and it isn't. We can do better in this area. We must do better because, in my humble opinion, the first-line supervisor holds the best key to drug detection that we have available to us, bar none.

Mr. GILMAN. All of the fancy planning and all the talk about doing these things, how could it mean a darn thing if it's not trickling down to the men in the barracks, through someone with responsibility in the barracks, and if it's not getting through to the sergeant that comes into contact with the men, then you've got a weak link, it seems to me, and I would hope that maybe you could find a better way of addressing yourself to that problem. I'm afraid my time is running. You may want to respond.

Colonel VANDERPLOOG. I did not mean to convey that it is not, but there are degrees of effectiveness. I have some young sergeants that are super, they are involved, they're concerned. That's key. The soldier has to believe him and have involvement. We have noncommissioned

officer professionalism programs. They're actively addressing subjects such as how can that first-line supervisor truly become involved and concerned with soldiers? It's when those channels open up——

Mr. GILMAN. Colonel, is there any training program for that sergeant? Is there a training program for him to relate the drug message through to the line? Now the top command tells us it is very limited. Maybe you are doing a better job. Is there——

Colonel VANDERPLOOG. I'm not meaning to suggest that I'm doing better, but it's part of our noncommissioned officer professionalism programs, which you will find in all battalions.

Mr. GILMAN. How much of that program is devoted to drug training?

Colonel VANDERPLOOG. Well, it brings in all current subjects——

Mr. GILMAN. How much of it is devoted to drugs?

Colonel VANDERPLOOG. Well, of recent, I wouldn't want to be quoted off the top, but I would say there has been at least one session a month dealing with drugs or drug related type——

Mr. GILMAN. For all of your sergeants?

Colonel VANDERPLOOG. In their respective companies.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. Thank you, Mr. Chairman. Colonel, and Major General Tice, I'm interested in a number of things that were said here. Colonel, before we leave this question that has been raised by my colleague, I'm wondering—we were told by a number of groups, that as far as sergeants are concerned, they perhaps are some of those who are exerting the most pressure on men to use drugs. We asked the question of a number of these men if they knew of NCO's who were using the drugs and many hands were raised. We asked others if they knew of NCO's who were selling hash, in particular, and hands were raised. Now I'm wondering—talk about a weak link in a chain, that, to me, is the weakest of all. Have you looked into that problem?

Colonel VANDERPLOOG. Yes, ma'am, we have.

Mrs. COLLINS. What have your findings been?

Colonel VANDERPLOOG. I can speak for my battalion. We have found some evidence of lower grade, noncommissioned officers, that have participated in some cases in the use of a narcotic substance. I guess it's a matter of record, we did in fact court-martial a young sergeant here in the last month and a half. Those problems exist. Like I say, that is where our effort is being focused now trying to get to the bottom of this, and the only way we can do that is to keep working to develop their capabilities, to expand their knowledge and to weed out the ones that do not conform to accepted practices. There is no cure, right off the top, that you can identify the sergeant or supervisor that may be involved. You have to ferret it out.

Mrs. COLLINS. I'm sure that's true, but you talk about the magnitude of the problem. I think that the magnitude might be much larger than any of us are thinking if we have these types of things going on. I even heard from the same group, this particular group that I have reference to, that—and I saw here in the paper that the MP's are often the ones who find these narcotics on these people, or use of it, and even the MP's are selling the stuff, so it is a magnitude which I find mindblowing, literally. Major General Tice, I'm looking in your written statement at your three points here, your third point of action that you have

taken to prevent drug abuse, and I was particularly interested in your sports and recreation program, because I guess you're trying to get more of these kinds of programs here. That's what your implication is.

Major General TICE. Yes, ma'am, I perceive that the closest link to developing the kind of teamwork that is necessary to survive in battle, starts with sports. It has the closest correlation.

Mrs. COLLINS. How effective have you been in getting more of this here?

Major General TICE. We have, in the last year, had an increase in a magnitude way. For example, the German-American Club in Schweinfurt, which just started 7 years ago, in which we became full-fledged members of that German activity and we participated in five sports activities. We have a very active company level competition in five major sports.

Mrs. COLLINS. How many of your men participated in the sports and recreation programs?

Major General TICE. One hundred percent on the training schedule, during the training day.

Mrs. COLLINS. And what about just in off-training time?

Major General TICE. In off-training, I would say that the facilities we have, you will commonly find that every gymnasium is full, the bowling alleys are full. That would probably accommodate about 25–30 percent of our command on weekends.

Mrs. COLLINS. OK, now under your point J in the same listing there, you talk about the chain of command, we talk about another step for it is to educate the chain of command, and more importantly, the individual soldier in drug programs are not punitive. Now this is a point I wanted to bring out. I don't know if you are aware of it or not, but we understood from other groups that many times a soldier is asked to go take a urinalysis test as a punitive measure, whether that soldier has done anything or not. This is something I certainly hope somebody is looking at, because if this is the case, it makes your whole program fall flat on its face. It makes a joke of the whole thing.

Major General TICE. Yes, ma'am, I would not suggest that they are not without human error in the chain of command in any organization in my division, but I would hope that that would surface so you could identify those individuals who are violating the oath or the execution of their office. I don't think that you can legislate as a commander to prevent such action from taking place on a random basis. What I do, I refuse to accept generalities from anybody. When somebody tells me that everybody is doing it, then I say, "Step forward, raise your right hand, give me the name, date, the circumstances, and I will prosecute." But what happens is that mostly a lot of emotion is involved here. I talked to a young soldier just last week in an armored tank battalion, a company with 92 soldiers, and I said, "How many people are abusing drugs?" He said, "Hell, sir, 50 percent." I say, "Good, now who are those 50 percent in your company?" He says, "Well, there is about 8 or 10 soldiers." Mathematically, he has a problem.

Mrs. COLLINS. Well, I certainly agree with that. Now, let me get to one other point that you raised, too, Major General Tice, and that was that the soldiers say that they have nothing to do. Now we certainly

heard a great deal of that. Then everybody that we seemed to talk to said, "Gosh, this is a wonderful place to be, soldiers can take a tour of Spain for $116, or they can go to Copenhagen," all of this kind of stuff. Is that realistic? It seems to me if you have the young E–1 coming in off of the slum street, as one might find in Chicago, he couldn't be less interested in going to Spain then anybody I can think of. It's just not relative to his way of thinking. He has no frame of reference. He couldn't care about Spain. Most of them have come in here for one of two reasons. A major reason, I submit, is because they can't find any jobs out in the streets. They don't have the education, they are hard to employ for a whole lot of other reasons, and talk to this guy about going to Spain, when he sees no interest in it at all, is just unreal, quite frankly. In talking to the same bunch of kids, I asked, "Well, what did you come in here for?" and a number of them said, "We wanted to get an education of some kind. They put us in an educational program, we start going to school and then they ship us off to play some kind of war games," and these are their words, "We come back again and we don't have time to make up, we lose our money that we had to put in for tuition, or whatever the thing is, and it's just not fulfilling the promise that we had." I think—and it's not my job here to give my own view—but I think that if you could concentrate more on something that the young men claim that they want to do and are interested in, then you would get a lot better response than telling them something about taking a tour to Spain, or going skiing when they have never been on a pair of skis in their lives. I think you should try something much more relevant.

Major General TICE. I'm sorry, madam, that you would zero in on that, but that's only two elements, and I know that for black soldiers, skiing doesn't appeal to them, and I perhaps know that going to Spain does not appeal to them, so we have——

Mrs. COLLINS. Are you doing anything to specifically appeal to those soldiers, the young black soldier, besides basketball? We all know about the basketball.

Major General TICE. I understand that, and I fully comprehend that. You must understand that I have 40 percent of my command as minority, and to not be concerned about the desires of each would be a breach of my contract with the U.S. Army, and I work very hard in that area.

Mrs. COLLINS. Thank you, sir.

Mr. ENGLISH. Mr. Jenrette?

Mr. JENRETTE. Thank you. Captain Davis, if you refer to third-country nationals, that is, other than German citizens, and as you know, in Berlin, West Berlin is the sixth largest Turkish city in the world.

Captain DAVIS. But Turkey is a friend.

Mr. JENRETTE. It's a friend, but if there is money to be made on trafficking in drugs, I'm sure that the nationality is no discriminator.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. General Tice, first I would like to commend you on that part of your statement in which you pointed out the effectiveness of the tank units, I believe. I found in talking to a number of troops that while they were performing very well and their machines were performing very well, that they were still griping about being able to

get supplies. So, I don't know what part of this problem that we hear is what the troop perceives and what part of it is what the troop is. Now I wanted to make that clear. I wanted to ask Colonel Vanderploog some questions. First, would it be of any assistance at all, in your opinion, that once you've identified a drug user or pusher that that person can be removed from the unit immediately?

Colonel VANDERPLOOG. Yes, sir; it would, particularly when we get to the advanced stages. I had an experience in the last year where two soldiers that were ultimately separated through medical channels were pending court-martials. The interim was since there was host nation involvement in apprehension and a number of other legal factors, the soldier was no threat to flight, in fact he wanted to stay in the area, he had no desire to leave, was in fact addicted, had a dependency code. When that individual is no longer in the unit, with the exception possibly of periods while he was pending his trial where he did attend a detoxification program at a medical facility, it's a bad impact on my soldiers. When we can move that individual out of the area, it obviously helps improve our environment.

Mr. EVANS. Colonel, if I might, we had quite a conversation earlier, and I might say that I was very impressed with your unit, and I thought they went about their job very well and they seem to be performing very well, but even recognizing that you have your unit doing its job and prepared to do its job, we discussed some figures on drug abuse, which I would like for you to repeat to the committee, if you will, sir, all kinds of drug use.

Colonel VANDERPLOOG. Sir, at that time when you and I did discuss the subject, the figures I quoted, based on my 10 months in command and observation and those reported up through my chain of command to include firstline supervisors, I believe we came to a conclusion that I had approximately 25 percent, high side of 30 percent of my soldiers that were not or had not been involved with drug usage. We then discussed a bracket of soldiers that we in the battalion have come to identify as the experimenters. We said that bracket was about 35 to 40 percent of my soldiers. The way we define that, they tried a hard drug or soft drug at least once in their lifetime, by and large is not a group that represents a significant problem to operational readiness or effectiveness, and at the high side, transitions into a cell that we call the P and P users, or payday and party users, where we find the recreational use in peer pressure. From that group, we defined a group of 30 to 40 percent of the soldiers that are recurring marihuana or hash users. Again, not an exacting definition of usage, but we believe this group would use it at least once a month, up to a frequency of possibly two times a week. We then went into an identificational group of recurring hard drug users. And again, at least once a month to two times per week. In our battalion, this narrows to about 3 to 5 percent of my soldiers. Lastly, we discussed the habitual—in our choice of words—hard or soft drug users. In this group, at least once a week up to including daily or multiple usage in a given day. We believe in the hard drugs, this percentage stands about 1 to 3 percent, and soft drugs approximately 2 to 4 percent. The low side of those numbers do basically cover my battalion, with a couple of percentage points that are not defined. I believe it is accurately reflected in my organization. It does not necessarily reflect other

units, and again, we have a luxury, I have a rather small battalion, 379 soldiers, including myself. Out of that, 28 percent of those soldiers are in the grade of E5 and up to include myself, a lieutenant colonel. For every three soldiers that we have that are E–1 to E–4, we do have an E–5 or better on the ground right now. Our collective assessment does provide the breakup that I have given you.

Mr. EVANS. In one way or another, you stated that 15 percent of your time is involved.

Colonel VANDERPLOOG. At the current time, based on facts that we know and what we are trying to accomplish, yes, sir.

Mr. EVANS. Thank you, sir.

Mr. ENGLISH. I want to thank you gentlemen very much. You have been very helpful and we deeply appreciate your testimony. The committee now will break for an hour recess and we will be back here then at 1:30. Thank you very much.

[The committee recessed at 12:30 p.m., and was called to order again at 1:30 p.m.]

AFTERNOON SESSION

Mr. ENGLISH. The chief of staff will call the next witnesses.

Mr. LAWRENCE. The committee calls Captain Barnes, Staff Sergeant Brooks, Specialist Five Shouse, and Specialist Four Sellers.

Mr. ENGLISH. We have a change. We will go with the law enforcement panel first, since the rest of the witnesses are not here.

Mr. LAWRENCE. The committee calls Brigadier General Kanamine, Major Mason, and Mr. Thomas Cash.

[Brigadier General Kanamine, Major Mason, and Mr. Cash were sworn.]

Mr. ENGLISH. General, if you would proceed with your statement. As we said earlier, if you could summarize it to be brief, it would be most helpful. If you have a prepared written statement, we will be happy to include it in the record.

TESTIMONY OF BRIG. GEN. THEODORE S. KANAMINE, PROVOST MARSHAL, HEADQUARTERS, U.S. ARMY, EUROPE, AND 7TH ARMY; ACCOMPANIED BY MAJOR MASON, AND SPECIAL AGENT THOMAS CASH, DRUG ENFORCEMENT ADMINISTRATION

General KANAMINE. Sir, for the past 8 days, we in the law enforcement family have provided you and members of your committee with information regarding drug availability in the Federal Republic of Germany, and our coordinated methods of suppression and interdiction. We have discussed the general availability of drugs, types of drugs being trafficked, the routes by which drugs reach the FRG and Berlin, the nature and the method of operation of traffic routes and the relative insignificance of military traffic route involvement. We have also discussed our drug suppression activities, past and present, and ongoing initiatives which would enhance our future efforts. The apprehension and seizures statistics presented to your committee vividly illustrate the existing and the potential threat of our service members and the intensity of our enforcement efforts.

Lastly, I cannot over-emphasize the excellent relation and the mutual support we enjoy with host nations, and other U.S. law enforce-

ment officials at all levels of government. Mr. Cash our DEA representative from Bonn would like to make a statement and after he is done, sir, Mr. Cash, Major Mason, and myself would be available for questions.

[General Kanamine's prepared statement appears on p. 177.]

Mr. ENGLISH. Thank you very much. Mr. Cash?

Mr. CASH. Chairman English, ladies and gentlemen of the delegation, I appreciate this opportunity to appear this afternoon before the House Select Committee on Narcotic Abuse and Control. We discussed the role of the Drug Enforcement Administration in respect to the problem of drug abuse in the military. I believe the committee has a copy of my statement for the record. I would like to point out at this time, if I might, that there are a couple of changes that have occurred since the writing of that statement. Particularly on page 5, wherein I report that to date, 140 kilograms of heroin was seized in the Federal Republic of Germany. Actually, that figure is 172.5 kilos as of this date. On page 12 there is a typo which relates to overdose deaths in the city of Berlin. The figure given on page 12 is 62 and actually the figure is 52. I would like to take in a little summation, Mr. Chairman, of what DEA's role is here and establish somewhat our position. DEA agents have, as their responsibility, the following objectives: The cooperation and exchange of drug intelligence with appropriate host country law enforcement officials; to assist in the continual development of a host country drug law enforcement capability; to develop within the U.S. mission appropriate resource requirements for host country drug law enforcement organizations, with these requirements being keyed to the ultimate goal of reducing the availability of illicit drugs on the U.S. market, and to develop within the U.S. missions specific short-term and long-term bilateral drug intelligence programs that will accrue the benefit of both the host country and the United States.

I believe that through your visits to Berlin and other cities of the Federal Republic, it has become very obvious to you that heroin availability is certainly a factor here in the Federal Republic. I think that if we can realize that total heroin seizures in 1968 in the Federal Republic amounted to 1.825 milligrams, and if we realize that from 1969 through 1972, heroin seizures in Germany amounted to a total of 6.7 kilograms, and we see to date 172.5 kilograms have been seized in the Federal Republic, it is painfully obvious——

Mr. ENGLISH. Mr. Cash, can I interrupt you right here? Would that be attributed to better law enforcement or more heroin in your opinion?

Mr. CASH. In my opinion, Mr. Chairman, seizures are more indicative of what is available as opposed to law enforcement successes. Certainly in those individual cases, in those seizures, there were initiative, aggressiveness, and some pretty good investigations on the part of our German police colleagues. At the same time, I think it would be more clearly an indication of availability because of the law enforcement effectiveness. I think in the second quarter of 1977, as you have heard from numerous witnesses who preceded me to this podium, a change was noted by the Federal Republic of Germany as it was becoming clear that heroin from the Near and Middle East was readily available. In fact, in that quarter, police reported that 77 percent of

the heroin seized was coming into Germany from the Middle East, being carried primarily by Turkish nationals. I think that in addition to heroin, the other problem that you have heard about during your hearings, was hashish, the hashish traffic. In 1977, there was a total of 9 tons of hashish seized in the Federal Republic.

There is no primary city involved in this type of traffic. Germany does not seem to have the New York or Chicago or so-called recognized problem areas. Three major seizures occurred in, for instance, Bonn, Bad Godesberg, Mainz, and the northern German port of Emden, when 1.3 tons, 2.3 tons, and 2.8 tons of hashish respectively were seized. So, I think that this gives you some example that heroin and hashish seem to be the two most readily available drugs from your interviews and from your studies, certainly those were the two drugs that have been the most frequently addressed by this committee, and we believe that other drugs, of course, are available—I think you heard earlier about marihuana, but as was said previously, there is a small amount involved. We are talking about maybe 100 kilos on an annual basis, primarily coming from Africa and brought in small quantities by students. The work of DEA with the military, we feel, has been extremely successful. All DEA agencies in Germany have provided regular information to the military on narcotic traffickers, smuggling methods, and intelligence-related trends, and we believe that we have actively assisted in military enforcement efforts, and we enjoy a very close working relationship at all levels throughout the FRG. That's a general overview, and there are a few more details relative to overdoses, and so forth, which appear in the statement and in the interest of time, it probably would be better to continue from this point with questions.

[Mr. Cash's prepared statement appears on p. 182.]

Mr. ENGLISH. General, you indicated in your testimony that you felt that the relations with the German Government here was very good. The information we received is somewhat contrary to that. We found that it varied from state to state, from locality to locality, some areas it is very good, other areas it is very questionable. We found that a number of people have indicated, to us at least, that they believe, in fact, that many of the German political officials in particular, really do not recognize drug abuse as being a major problem to their population, that there are many other priorities which come before drugs, and that as a result, many of the local law enforcement officials are beginning to fear that there seems to be more and more usage by the German people. Do you find that to be the case?

General KANAMINE. Sir, as I testified before on the 12th, we came, a couple of years ago, from a position of almost not even recognizing the fact that there was anything in the local communities, to a point where today my feeling is, and the feeling of provost marshals that operate at community levels, is that the recognition is there from one level on down into city level and that, as I indicated to you, that association seems to be a good one, it needs a lot of nurturing and growing, of course, but they come to the point of recognizing that drugs are a problem in their communities, in the German communities, and also I think you heard me mention that what this committee might be able to do for us is to assist us at the Federal level wherein

perhaps they would give as much attention to drug suppression as they have in the present times to terrorism.

Mr. ENGLISH. We heard one account at one installation of a recent event in which a CID official had contacted the local police, had indicated he had intelligence information relative to a purchase that was going to be made at a local park and had requested the assistance of the local government, and such an individual then was involved in this particular situation expecting a backup from the local police, who evidently were not there, and the individual found himself all alone out there. Is that correct?

General KANAMINE. Sir, I'm not sure what the situation is you refer to. Perhaps somebody down here knows, but occasionally there is a kind of lack of communication that do go on, but I can tell you that in the majority of instances, and I would say 99 percent of the time, that those operations are well planned and they do go well.

Mr. ENGLISH. A second similar incident I heard about, which again this was in the last few months, another CID official again found himself in a similar position and then suddenly found himself in a shoot-out with local drug suppliers, and even eventually ended up being arrested himself because of the involvement. Is that correct?

Major MASON. Mr. Chairman, if I may address that. The apprehension would be a question I would like to get more information on. From time to time we do have, as we plan operations, we do come across situations where a signal is missed, or the German police have not gotten into position in time to witness the transaction. Now I know of no instances where an individual within the second regency CID was apprehended, if it was a real apprehension. Now we have certain covert techniques, and this may have been what you heard about, Mr. Chairman.

Mr. ENGLISH. Well, it came from CID officials. If it was one of those covert operations, somebody forgot to tell the other agents, because they believed it was for real. Mr. Cash, would you care to comment on this problem?

Mr. CASH. Sir, I am unfortunately not familiar with all of the details of the incident to which you are speaking. I am familiar with generalities only, and I don't think I'm very well qualified to comment on it.

Mr. ENGLISH. What about my comment with regard to there being a vast difference between communities between states within Germany as far as the degree of cooperation and support dealing with drug abuse?

Mr. CASH. Well, sir, I think that what we have here in the Federal Republic at the present time is a problem that all indicators show is rapidly rising, and there's not, in my opinion, a correlation of resources to keep up with that problem. The German police officers are outstanding, they are very hard working and diligent as General Kanamine has related. Perhaps it is more of a manpower problem, and the manpower problem, as I see it in the Federal Republic, is prioritized as we in the United States prioritize our information, to the point to where terrorism is their first priority and, as a result, there is emphasis placed on all terrorist programs and quite a bit more support given in the direction of terrorism than there would be in narcotics.

Mr. ENGLISH. General, in 1977–78, how many officers and how many noncommissioned officers have been arrested for either selling hashish or hard drugs?

General KANAMINE. Sir, I would have to get those exact statistics, and I am prepared to do that, but I don't have them right here. Officers and NCO's, I can tell you it is a very small amount.

Mr. ENGLISH. But you have made arrests on officers for selling hashish or hard drugs?

General KANAMINE. I haven't in the MPI side, sir, and the CID experience is—probably Major Mason can answer that.

Major MASON. Mr. Chairman, we do from time to time, and we have in fact apprehended officers, but to look at a special operation which we conducted not long ago, and which we identified a number of military traffickers, I would like to read you——

Mr. ENGLISH. Well, I just wanted to know. My time is very short. I just wanted the number of officers and the number of noncommissioned officers that have been apprehended in 1977 and 1978.

General KANAMINE. Mr. Chairman, we would have to get that information, we don't have it available.

Mr. ENGLISH. Is it that common that you wouldn't remember the number of officers that have been apprehended?

General KANAMINE. It's not a common thing, sir, but I do not have that information.

Mr. ENGLISH. Are there more than 100?

Major MASON. No, there is less than 100.

Mr. ENGLISH. More than 50?

Major MASON. I would say there was less than 50, on officers.

Mr. ENGLISH. I would like to have that number by our next hearing on Wednesday, if we could. We have heard quite a number of allegations, particularly of noncommissioned officers selling hashish to the men in their units and we have heard some indications, of a few, and I should stress very few, officers, people who know, but there have been officers and there have been noncommissioned officers arrested on these offenses. Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman. I would like to address a question to both General Kanamine and Mr. Cash. Are you finding that the level of cooperation with the type of government of Germany that it is a good level, a good working level? Have they been cooperative, have they been focusing enough attention on the drug problem?

General KANAMINE. Sir, again we are talking at whatever level, the street level and the lawn level, I am satisfied that at this particular time that they are doing what they can do. Certainly, there is more that can be done, and it would be helpful if the emphasis came from above. However, I can tell you that unequivocally they are together, working together on what's occurring right now, and the relationship with my people and the CID and the German police is a good one.

Mr. GILMAN. Mr. Cash?

Mr. CASH. Well, I think that we have to make some clarifications here. I also think that our expanse, the DEA agents here in Germany, would very much mirror what General Kanamine has referred to here. But I believe that at the Federal level, and that is our interest at the Embassy in Bonn, we are attempting to elevate the interest of the Federal Republic on the narcotic problem, on its dangers, and on the manpower requirements that I see, looking at Germany as a whole, and I think I'm referring here specifically to the level of interest given the narcotic problem that exists in our own country. As you

know, Mr. Gilman, we have a longstanding experience in this field and we feel that we have progressed quite a bit in the last few years. We have been ahead of the problem, thanks to our intelligence-gathering overseas. I believe Mr. Bensinger, our administrator in February 1978, speaking in Geneva, pointed out at that time that the threat of increased Middle Eastern heroin to Europe, and whereas our country has had this high level interest from the White House and the Congress, that level of interest does not exist at the present time in the Federal Republic. I cannot say that there is a high interest in what would be our equivalent Presidential level, but the increasing awareness of the problem is certainly bringing forth more attention on the part of the German authorities, and we don't feel that there is bad cooperation, let me make that perfectly clear. What I do feel is that we do have to have a little bit more attention at the higher political levels to subsidize, if you will, and support those diligent officers that are spending so much time on the street now. I think that they could and would welcome the additional personnel.

Mr. GILMAN. Besides additional personnel, are there any other areas that require better assistance at the Federal level?

Mr. CASH. Well, we would like to see, of course—and perhaps this is a little selfish—but we would like to see more coordination between the health treatment rehabilitation and the law enforcement sides of the house. As you know, it is an opinion by the DEA and the Justice Department that the most effective way to combat this problem is on a two-prong attack through your enforcement interdiction efforts and your rehabilitation, and we in the United States work very close, as you know, with all of the health agencies, the National Institute on Drug Abuse, the Department of Health, Education, and Welfare, and the Food and Drug Administration, constantly working back and forth to give both sides a feel for what actually may be the next potential problem, and we would like to sell that idea here in the Federal Republic and we are certainly trying to do that through the embassy in Bonn, our Ambassador, and the other Government officials representing the U.S. side.

Mr. GILMAN. General Kanamine, would like to comment further?

General KANAMINE. No, I think not.

Mr. GILMAN. What do both of you estimate to be the extensiveness of the narcotic problem in West Germany? How much trafficking is there in heroin? Do you have any idea? Can you project from what you have seen by way of seizures?

Mr. CASH. You know our indications primarily come from the statistics that are published by the Federal Republic of Germany insofar as their narcotic problem, it would be the equivalent of our uniform crime report that we see in the United States. They had, last year, 39,089 cases which could be anything from simple possession to use, and 13,799 cases of sale and smuggling. Now, that's up 11.3 and 12.4 percent respectively, and taking their figures as published by the Federal Government, that particular problem, that being the narcotic problem, is up this year, or the last year for which statistics are available, 7.5 percent. So I would have to say that we do have an increasing problem.

Mr. GILMAN. Do you have any dollar estimate of what the narcotic trafficking amounts to in West Germany?

Mr. CASH. No, sir, I'm afraid I don't. It would be a figure that would stagger the imagination.

Mr. GILMAN. I note you say there are 40,000 hardcore drug addicts in West Germany.

Mr. CASH. That's the figure generally used by the law enforcement authorities. Now at the end of 1977, there were actually——

Mr. GILMAN. Those figures actually come from convictions; do they not?

Mr. CASH. Those come from people who are registered charged by the police and carded as drug abusers.

Mr. GILMAN. Those who are registered have come into contact with the law at some point or another; isn't that right?

Mr. CASH. They would have to in order to be recorded.

Mr. GILMAN. So that could be actually a very small percentage of the total usage; is that correct?

Mr. CASH. That is quite correct, sir.

Mr. GILMAN. Less than half, would you estimate?

Mr. CASH. I would hate to get into an estimate, sir. I don't have any way of backing it up.

Mr. GILMAN. Just one more question. Why don't we have DEA agents in Berlin?

Mr. CASH. Well, sir, the Drug Enforcement Administration is under the State Department mode system, relative to manpower. We have requested additional agent personnel as well as compliance personnel. I think you mentioned earlier about Mandrax, and our compliance division would deal very heavily in the illicit manufacturing and control of pharmaceuticals, and these requests have been made through the embassy and up through the chain of command, so to speak, sir, and at this point I have not seen a final answer.

Mr. GILMAN. Berlin is a big center for narcotics abuse and trafficking; is it not?

Mr. CASH. It is a significant center, definitely, sir. Berlin is Germany's largest city, and there is a significant trafficking. I think the caseload runs around 178 cases per 100,000 people, and that tops all other cities in Germany.

Mr. GILMAN. You've recommended that we have some DEA people in that area?

Mr. CASH. We recommended that Berlin be given coverage by the Drug Enforcement Administration. The Minister in Berlin, Mr. David Anderson, and the Ambassador, Mr. Stoessel have both requested there be a DEA agent stationed there.

Mr. GILMAN. It is up to the State Department now to approve it; is that where it stands?

Mr. CASH. As I understand it sir, the State Department and OMB decides what the overseas staffing patterns will be, and we fall underneath that jurisdiction for overseas slots.

Mr. GILMAN. Thank you. Thank you, Mr. Chairman.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. Thank you very much. Mr. Cash, I was looking at your total written statement here, and I agree with what you say on page 3, the seizures are not always indicated by the enforcement success. Wouldn't one of those indicators also be the level of purity of the heroin? I'm inclined to think that enforcement could also be measured with a decrease in the level of purity, is that not correct?

Mr. CASH. Absolutely, Mrs. Collins.

Mrs. COLLINS. Have you seen any indication of that? That the decrease in the level of purity is coming in, or is it pretty much the same?

Mr. CASH. I've seen no indication of a decrease in the level of purity. I think you said earlier today 30 to 40 percent, which is pretty much on the money. The analysis done by the German police services at the present time relates to whether the substance is heroin or is not heroin, and the German police, the West German Federal Police, DKA, have taken a very aggressive stand within the last year and are going to begin a program for the examination of that very question. We call it in the United States price purity index, and the DKA has been keeping those statistics for a number of years. But in any event, the Germans are now beginning more and more to be aware of the significance, both in tracking the strength of the heroin, as well as the source. As the heroin percentage increases, the logical assumption is that the person arrested with that high a percentage of heroin was closer to the source and so it wasn't cut as it went along, thus diluting it, and thus providing some very significant narcotic intelligence information.

Mrs. COLLINS. From the responses to some of the questions that have been asked you, I kind of get the feeling that you have a good working relationship with the German Government, that it's a problem with the higher-ups in the political structure of Germany. Is there a significant increase in the amount of heroin being used by German nationals than there was, say, some time ago?

Mr. CASH. Yes ma'am. I think I quoted some figures here to you which come from the Federal statistical reports, which do show that there is an 11.3-percent increase totally.

Mrs. COLLINS. Would I be correct in saying that if these figures were to increase more and more rapidly, that then the political structure would become much more interested in this and would do more about keeping these drugs out of the area?

Mr. CASH. I think that perhaps that has a great deal of validity. I don't believe that it is dereliction, though, on the part of the Federal Government, as much as it is priority and awareness of the problem at those levels. I must repeat again what we here in Germany see, and you must have seen in your travels around the country relative to the security measures taken against terrorism. Terrorism occupies a great deal of the law enforcement effort and as a result of this, that is, in my opinion, probably the reason why there is not at this moment more interest or more acute awareness, if I may use the term, in the narcotic problem.

Mrs. COLLINS. Well I sure hope we will get to the point where the Germans will perceive this problem to be one of almost equal importance. I know it's not going to be of equal importance, but similar importance. On page 6 of your statement you mentioned that Turks usually sell their heroin to German middle-level dealers. Do you know how many arrests have been made to the German middle-level dealers?

Mr. CASH. Total arrests, Ms. Collins, for sale and smuggling of narcotics in 1977——

Mrs. COLLINS. Not broken down by German nationals, right?

Mr. CASH. Yes, ma'am, they are broken down.

Mrs. COLLINS. They are? What page are you on?

Mr. CASH. Well, no; I didn't include that in my statement. In the Uniform Crime Report, they break out the number of foreigners who are arrested for sales and smuggling, and in that regard, there were 2,650 foreigners. Now, taking consideration that there were 13,799 total arrests, you have to say that the foreigners, while playing a role, were overshadowed in the totality of the problem from a sheer statistical point of view, and I think you know that these statistics as we have seen throughout are subject to a number of interpretations. Looking at the record, this is what it appears to be.

Mrs. COLLINS. On page 7, I'm just wondering if these figures that you have for deaths in 1971–78 are for all deaths or just deaths of GI's?

Mr. CASH. Mrs. Collins, these death figures here do not cover GI's.

Mrs. COLLINS. Do you have any figures for GI's during that period?

General TICE. I have them, ma'am.

Mrs. COLLINS. Could you read those please?

General TICE. Yes, ma'am. The last page. In 1977, drug deaths—31. In 1978 through the 10th of September—26.

Mrs. COLLINS. How many OD's have lived during this same period? Do you know?

General TICE. No, ma'am, I don't.

Mrs. COLLINS. Could you get those for us by the next hearing?

General TICE. I'll try.

Mr. CASH. Mrs. Collins, if I might point out, also in the statement, I make the fact that drug abuse deaths—and these are drug abuse deaths—they are not broken out by strictly heroin, but drug abuse deaths are not the result of medical examinations of the deceased. These figures emanate from the police, which differs in our assumptions in the United States, as they come from medical sources.

Mrs. COLLINS. I yield just for a second.

Mr. GILMAN. Could you just comment for us on the number of drug abuse admissions in that period of time?

Mr. CASH. Drug abuse admissions in hospitals?

Mr. GILMAN. For overdose.

Mr. CASH. No, sir, those figures are also not available.

Mrs. COLLINS. General, would you have those figures for GI's? Or could you get them for us by Wednesday?

Mr. CASH. Now, I'm speaking from the civilian side of the house. Are you aware of that?

General TICE. Exactly now, what is it you want?

Mrs. COLLINS. How many admissions for drug overdose by GI's in your instance? Recapturing my time for this one final question, on your trends that you show on page 8, it is a 3-year trend, could you provide us with information trend here today through 1977, or what you have so far in 1978?

Mr. CASH. This is the arrests by drugs trend?

Mrs. COLLINS. Yes.

Mr. CASH. I would have to check the sources, Mrs. Collins. Unfortunately, Mrs. Collins, those statistics weren't available or I would have included them, and I do not believe that they brought them up from 1977 and 1978, but I will check on that and let you know.

Mrs. COLLINS. Thank you very much. Mr. Chairman has been more than generous in extending my time. Thank you, Mr. Chairman.

Mr. ENGLISH. Mr. Jenrette?

Mr. JENRETTE. I will be very brief. Mr. Cash, did I understand you to say that there were some 64 percent increase in trafficking in 1978?

Mr. CASH. No, sir.

Mr. JENRETTE. In Berlin itself?

Mr. CASH. No, sir, I think I said in the beginning that there was a typographical error in the number of deaths in Berlin. They were from 1962.

Mr. JENRETTE. Has it increased from 1977 to 1978?

Mr. CASH. Actually, it has decreased from 1977 to 1978, sir, the overdose deaths.

Mr. JENRETTE. Trafficking, just generally?

Mr. CASH. My statement was that overall trafficking between 1976 and 1977, in two categories, one category was the possession and use arrests, or apprehensions, That increased 11.3 percent. Then there was the other category of illegal sales and smuggling of narcotics, and that increased from 1976 to 1977, 12.4 percent. They have not got to 1977–78 figures yet because 1978 is not completed yet.

Mr. GILMAN. If the gentlemen will yield, the commander of the Berlin forces told us that trafficking and smuggling was up in the period of January to September 1978 as compared to January to September 1977, by some 46 percent. Does that sound like a reasonable figure to you?

Mr. CASH. Yes, sir, because Major General Benedict in Berlin is quoting from Berlin police statistics which were provided to him for that specific period for your visit.

Mr. GILMAN. Up to close to 50 percent in 1 year.

Mr. CASH. Yes, sir, that also stems from an increased activity on the part of the Berlin police in their pursuing the higher level traffickers. As you know, one of our primary responsibilities over here is to focus host country law enforcement effort at the highest level of traffic as opposed to arrests for, say, sales and possessions and I think this increases the statistic by showing their increased emphasis on that particular problem.

Mr. GILMAN. I yield back to the gentleman.

Mr. JENRETTE. I yield the balance of my time, Mr. Chairman.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. Mr. Cash, given the open government we have and open access between the countries, is their any way that DEA or CID or German police, or anybody else is going to be able to significantly control the drug traffic as long as we have got the supply that we do here?

Mr. CASH. Well the problem on any international borders, Mr. Evans, as you know, is very difficult, even the United States and Mexican border, and I would have to say that our objective must continue to be developing actionable and live intelligence, something in a viable, real time mode with which we can act. That's where our best effectiveness comes. The policing of the borders also in Western Europe, as you know, is complicated somewhat by the common market in that identity checks are practically nonexistent in certain countries for instance between France and Belgium, and Belgium and Holland.

Mr. EVANS. I understand that's true, Mr. Cash, but my question is this: Well, like for instance, in the United States, at least the effort has been able to reduce the street purity to something like 4

percent as opposed to 40 or 50 percent in this country and in the European nations, and Amsterdam. As a practical matter, aren't we going to have to face the fact that we cannot stop the problem, but that we are just finding a holding pattern? I don't mean to imply in any way that you shouldn't maintain and increase the efforts that you are making, but aren't we dealing with a problem that is much larger than we have in other areas where the borders are controlled?

Mr. CASH. Yes, sir, I would think that that does present a rather unique problem, as you say. I think we have also had tremendous success at source countries, which have impinged or interdicted the flow, the purity, the production.

Mr. EVANS. Well, I know we have, and I, of course, have been to a number of these source countries, such as Thailand and the Golden Triangle Area, but a great amount of the drugs coming into this area are coming out of Pakistan and Afghanistan, and these people are working here and they are bringing it in freely across the border. Is that not the case?

Mr. CASH. It certainly seems to be.

Mr. EVANS. Unless you have intelligence to stop them, I mean some intelligence information to stop them they just about bring it across at will. Is that not the case?

Mr. CASH. There is a high instance of it, sir. I can't refute that with any specific figures. We certainly do see a great many entrepreneurs bringing one to three or four kilograms of heroin by road, by air, by train and by car, which would certainly tend to support your conclusion.

Mr. EVANS. So in the meantime you just have to continue what you're doing to the best of your ability until we can get some kind of a diplomatic agreement to crack down on drug traffic at the borders.

Mr. CASH. I think that's quite true, sir.

Mr. EVANS. Thank you.

Mr. ENGLISH. Mr. Gilman?

Mr. GILMAN. I have one last question. In the past year or two, have we apprehended any major trafficker in West Germany?

Mr. CASH. Yes, sir, we certainly have. We have apprehended what we consider one of the top 10 Asian violators in Hamburg, Germany, largely through a cooperative enforcement effort of the West German Federal police and intelligence and information furnished by the DEA. One of the most significant traffickers in Southeast Asian heroin in Europe.

Mr. GILMAN. What was that traffickers name?

Mr. CASH. Andrew Lim, alias Yal Tae.

Mr. GILMAN. A Chinese national?

Mr. CASH. He was Malaysian, Singapore, Chinese, yes.

Mr. GILMAN. What was the estimate of the amount of trafficking that that organization was engaged in?

Mr. CASH. Well, sir, the Drug Enforcement Administration did a number of studies and, based on our intelligence, he was probably the second or third most important trafficker operating here in Western Europe. Between March and May of 1978, just to give you an example, this particular trafficker was responsible, and we can document, through seizures, 78 kilograms of heroin that he had brought in and

was controlling. The heroin was coming from Malaysia, via Singapore, Frankfurt, and Hamburg.

Mr. GILMAN. What was the estimated street value of 78 kilograms?

Mr. CASH. I don't have that. It runs around say 120,000 deutsche marks per kilo, worked out times 78 kilos, and of course, even this would be the low figure because that is the heroin that was seized, so what we perhaps missed or probably missed, as I said earlier, staggers the imagination insofar as value.

Mr. GILMAN. Was there any other convictions in his distribution network?

Mr. CASH. Yes, sir. There were warrants of arrest and arrests that were executed in the Netherlands and in Germany, and I believe there were some 13 conspirators in addition to Andrew Lim who were convicted behind this particular investigation.

Mr. GILMAN. Was that part of a task force? Was it the product of any task force work?

Mr. CASH. It was the product really of preselection by the identification of the traffickers, preselection of these traffickers, and a task force between the West German Federal police and the Drug Enforcement Administration as well as the Dutch police and the Malaysian police, and that was only one of the successes. There were several others.

Mr. GILMAN. I noted that you had brought together a 90-day Berlin task force, was that a successful operation?

Mr. CASH. We thought it was very successful, Mr. Gilman. This task force operated in Berlin from May until July. The purpose of the task force, we worked with all elements in Berlin, the Army CID was very active in the task force, the Air Force, the German customs and police, the U.S. Mission, and the Drug Enforcement Administration, and the purpose of that task force was to evaluate Berlin to identify, if possible, major traffickers, if any, who were operating in Berlin, and as a result of the intelligence gathered in that particular operation, we were able to much more realistically assess price, availability, and the level of violators trafficking in Berlin, so we consider it quite a success. I think the CID does as well.

Mr. Gilman. If it was successful, why did you discontinue its operation?

Mr. CASH. Well the task force was specifically funded as part of Operation Leo, to evaluate the role of the Middle Eastern heroin trafficker in Western Europe and we had a 90-day funding to make a determination of what was existent in the city. The task force was really followed up by Major General Benedict, who has created the commandant's task force as a regular standing unit and that commandant's task force does consist of the same membership of the DEA task force plus U.S. mission and embassy representation.

Mr. GILMAN. We did a study to find out who the criminals were, now can't we do that same combined effort to bring the criminal into custody?

Mr. CASH. Well, sir, we have, as a result of that task force, targeted a couple of very major traffickers and there are active investigations in Berlin at this time against those traffickers, and we did identify Middle Eastern traffickers in heroin as well as traffickers in cocaine

and we have opened up investigations targeting these people much the same as the Chinese were targeted.

Mr. GILMAN. It seems to me that there is enough work around for the continuation of such a task force, and I would hope you might explore that.

Mr. CASH. Yes, sir. There is enough work, and as a result of the task force, or perhaps as a contributory effect of the task force, the CID has significantly increased their efforts in Berlin and I think they are one of our major partners.

Mr. ENGLISH. Mrs. Collins has additional questions.

Mrs. COLLINS. Thank you. General Kanamine, I think you might have been in the room, and if you weren't let me repeat a statement I made earlier, that in talking to some of these young soldiers, they said that not only were some of their NCO's and others selling hash and some other drugs, but a lot of times they could get it from the MP's themselves. Have you done anything about sort of checking out the MP situation?

General KANAMINE. Yes, Mrs. Collins, we are, of course, continuously attempting to locate those kinds of military police and get them out of the system, and I can give you statistics for 1977 and tell you that we are not quite done compiling it for 1978, but they are kind of the same. In 1977, there were 40 military police that were apprehended for drug involvement, 34 of them were for cannabis, 5 for dangerous drugs and 1 for narcotics. Now of those cases, of those individuals, that represented 32 cases so a couple of them were multiple offenders. But for those cases, 31——

Mrs. COLLINS. What did you do about the multiple offenders? Did you kick them off the MP's, are they still in the service, or where are they?

General KANAMINE. Well no ma'am, let me just finish. They are, of course, identified as offenders of drugs and, of course, they don't perform duty any more. The program is to reclassify them and, of course, deny their reenlistment. We can't have policemen like that. Thirty-one of those thirty-two cases were for use and possession, and one was for sale and transfer, so yes, there are MP's that are involved in that. It is a very small percentage. We find that we can't really exactly be sure of how many MP's are in fact abusing drugs. I think generally speaking, they associate with each other off duty. We find that most of our MP's do have high standards and do abide by the code of ethics, and I do receive communications often from various peoples about MP's that might be dabbling in this, and we look at each one of those very very carefully.

Mrs. COLLINS. I yield to Mr. Evans.

Mr. EVANS. I was wondering that in civilian life, a policeman who is charged with violating the law himself, is usually given a more severe sentence than a civilian, than a person who is not charged with that. Are you saying that these MP's that are caught and convicted of breaking the law are still in the service, in a different capacity?

General KANAMINE. Sir, they are, of course, soldiers, like others, so there is that occasion where it is difficult to move that process along quickly. I can tell you with confidence, though, that those military policemen are not pulling police duties any more. They may have been

reclassified to other duties, but generally we try to see that they are eliminated from the Army.

Mr. EVANS. Would you agree or disagree that they should be removed from the service?

General KANAMINE. Sir, my personal feeling is that they ought to be removed from the service. They have violated that trust that we think that policemen should have.

Mr. EVANS. Well one person, or one MP charged with law enforcement, when that person is convicted of violating the law, doesn't that create a kind of morale problem and give the excuse to others to use it, because the law enforcement people use it? Doesn't it make it 10 times worse that what it is?

General KANAMINE. I agree with you 100 percent. We are just careful, sir, we try to find all these guys that we possibly can and just remove them from the system.

Mr. ENGLISH. General, you said that you had 40 that you discovered, MP's?

General KANAMINE. Yes, sir. In 1977.

Mr. ENGLISH. And that was in 1977?

General KANAMINE. Yes, sir.

Mr. ENGLISH. How many of those were users and how many were sellers?

General KANAMINE. Sir, we had, of those cases, 31 of them were for use and possession, and one case was for sale and transfer. I think that one case involved one person, so we are talking of the 40 MP's that comprised the 32 cases, one of those cases had to do with a trafficker.

Mr. ENGLISH. You're basically saying you had 31 people who were caught using or in possession, correct?

General KANAMINE. No, I'm saying it was 39.

Mr. ENGLISH. Thirty-nine?

General KANAMINE. Yes, sir. There are 40 total military police, but it comprises 32 cases.

Mr. ENGLISH. The thing I want to ask you, I assume then that once those people were found then they were sent to CDAAC?

General KANAMINE. Yes sir, the same process as——

Mr. ENGLISH. Do they remain in the MP's while they are going through the program?

General KANAMINE. No, sir, at the same time they are referred to that then this other process takes place.

Mr. ENGLISH. Why didn't they continue in the MP's?

General KANAMINE. Sir, we cannot tolerate that. We will not keep them in the MP's.

Mr. ENGLISH. How can you not tolerate it and the rest of the Army can?

General KANAMINE. No, we are talking about those remaining in the Military Police Corps, military police duties.

Mr. ENGLISH. I realize that. What's the difference? I mean you've got your duty. I recognize what you're talking about, you're talking about it as police. But isn't it equally true of a guy out here using a missile? Doesn't he fall in the same category? What about the guy that is using radar? Doesn't he fall in the same category? You know there are thousands of vital jobs within the Army, extremely impor-

tant jobs, just as important as the MP's but all of a sudden here we find there is a break. There is a difference between catching an MP, and we find that he can be removed from the MP's, but we got one of these other guys over here who has used a missile and he can't be, isn't that correct?

General KANAMINE. We may be talking simply of a time element, sir. I'm sure that that commander of that other individual has the same problems of removing people from the job as I do.

Mr. ENGLISH. We understand that the entire success of CDAAC is tied to one thing, and that is, bringing that person back to his duty with the unit he was with. But the only place that is different is in the MP's.

General KANAMINE. Sir, I'm going to have to get you some more definitive information.

Mr. ENGLISH. Do you understand what I'm getting at here?

General KANAMINE. Yes, I do.

Mr. ENGLISH. Why can't we remove him from the rest of the service if we can remove him from the MP's? That sounds to me like it is strictly policy and nothing else. It's obviously not law. The law would apply to the MP's the same as it does the rest of the units. It is obviously not a court decision because a court decision would apply to the MP's the same as it would to the rest of the units. So this has to be a policy from the Department of Defense, and the MP's are an exception.

General KANAMINE. I'm not prepared to say that either.

Mr. EVANS. Would you have any objections to the other units receiving the same treatment that the MP's receive, namely, you yank them out of there and get them out of those units?

General KANAMINE. No; I wouldn't.

Mr. EVANS. Doesn't that seem to you to be a perfectly logical and progressive step toward ridding the unit of an influence there that could spread?

General KANAMINE. Yes, sir, I guess so.

Mr. EVANS. What is the law that requires the soldier who is caught with drugs being retained with his unit, and how are the MP's an exception to that?

General KANAMINE. Sir, the MP, after he is caught, he is still a member of that unit until these processes are completed, wherein he is either out or reassigned, I'm simply saying that he no longer pulls military police duties.

Mr. EVANS. I see. You're saying that the MP's are given a special assignment. Now is there a sacred MP unit, and that's their primary duty being military police? I mean isn't that one of the divisions that you can go into when you go into the service?

General KANAMINE. The MP Corps, yes, sir.

Mr. EVANS. But if I went into the infantry, and I could stay with my unit right on and keep doing the same thing while I was going through the CDAAC program, couldn't I?

General KANAMINE, Yes, sir.

Mr. EVANS. But if I were an MP I couldn't do that; is that correct?

General KANAMINE. That is correct.

Mr. EVANS. Do you know the law which makes that differentiation? I mean is that the court of military justice saying that you've got to put him back with unit? Who says you have to?

General KANAMINE. No; he is still assigned to that military police unit, but he is simply no longer pulling those duties. He may by that company commander be in the motor pool helping with that or other places, but he is no longer out there interfacing with people.

Mr. ENGLISH. An MP who is caught under these circumstances and who finally receives a discharge, does he go ahead and receive an honorable discharge with full veterans' benefits?

General KANAMINE. Yes, sir, it is the same as the others in the Army, when it comes to that point.

Mr. JENRETTE. If we did leave him in there, we would have A Company, 263d Addict Division, Addiction Division.

Mr. ENGLISH. Getting back to the point, that may be preferable to what we end up with now, when you got them all throughout and you don't know what they're doing. All they are doing is carrying that kind of influence and spreading it throughout the services.

Mrs. COLLINS. If they have a channel for distribution with drugs they are going to do that, too.

Mr. ENGLISH. General Fitts would like to make a statement.

General FITTS. You talked of missiliers. The fact is that we have other individuals other than the MP's that are in that kind of a situation, including the missiliers, and in the Army, we have what is called by Headquarters, Department of the Army, "personnel liability program." Under that program, for some individuals that are assigned to extremely sensitive positions that would be like nuclear or the MP's, or some others in that same variety, the normal procedure would be, upon discovery of something of this nature, to actually remove them from those organizations, and you would probably want to know that here in the Army in Europe, we are removing probably 150 a month from units of that type for all purposes, including drugs.

Mr. ENGLISH. Would you have any objection then in removing them from all the units, regardless?

General FITTS. I think we would have to look at the numbers and what that would mean, sir.

Mr. ENGLISH. By that do you mean what it would mean as far as the impact on the number of people you would have left? So basically, we are right back to the same numbers game, is that we don't have anybody to fill their slots, and that's the reason that they are staying there is because we don't have anybody to fill their slots, and that means that more additional load is going to go on the recruiter back home, which means that he is going to have to reach for even more questionable people, which means we are going to have an even worse problem, which to me, spells out that you've got a failure in the Volunteer Army, it's that simple.

General FITTS. Mr. English, I think what we would say is, from the point of identification of an individual like that, we are under a process whereby if he is going to a court-martial the presumption of innocence—we have to go through that kind of a process. If it's a matter of a user, under our current situation, it is dictated to us, and by Members of the Congress as well, we have some efforts that we have to make to move toward rehabilitation of that individual.

Mr. ENGLISH. But there is nothing that says that that individual must remain in the same barracks associating with the same people, contaminating the rest of the unit, is there?

General FITTS. Well, in the context, our people tell us, the people that we work with, that the best possible hopes of rehabilitating an individual is to keep him in a responsible job and a familiar environment and move on in that direction. A lot of what we do is based on that context.

Mr. ENGLISH. Obviously, if that individual has failed, then he is already beyond that good environment you are talking about. Evidently, he hasn't found it or he wouldn't be using it in the first place.

General FITTS. Mr. English, failure is a very interesting word. If there is a presumption in this, if we are going to attempt to rehabilitate him, that we don't think he is beyond failure because he fell once. He may have fallen in his unit, but we still have some hopes that we are going to return him to being a productive soldier, and that's where we get this from.

Mr. ENGLISH. I think we are going to find, at least in the CDAAC's we have talked to, that it still comes down to the question and the issue of whether he wants to be rehabilitated, or whether he views it as being punitive, and from the information we are getting, you are talking about less than 10 percent, possibly even less than 5 percent, of those who are sent to those kinds of units, so you may be talking about 90 to 95 percent of those people who simply don't want to be rehabilitated, but they are still being left in those units, and it still appears to me it comes down to this issue and this question of slots. You flat don't have the manpower to fill the vacancies, so you've got to keep those men in those slots even though you know it's not likely they are going to be rehabilitated, and that seems to me to be a failure of the Volunteer Army. That's it, it's that simple.

General FITTS. Mr. English, this confirms what we are able to demand and that's our concern, The Department of the Army has committed itself to people, The Army in Europe has an excess of 100 percent of its authorized strength, and for more than a year and a half they have done that. We aren't in the business of worrying about the issue of whether it's the Volunteer Army or not. What we have found is, that we put our demands on the main system and they have satisfied us repeatedly and constantly over that period of time. I have never has a conversation of this type with any of the people who are providing the individuals to us. So it may be some theoretical basis that it appears that way, but it's not within the constraints of what we are doing over here, and I just tell you that as honestly as I can.

Mr. ENGLISH. Yes, sir, but aren't you well aware of the fact that the recruiters are having a difficult time meeting their quotas? Aren't you aware of that? Isn't it also true, or didn't we receive testimony this morning that over 50 percent of the people who come into the services have already had a previous history of using drugs? Isn't that true? Isn't it also true that we've come down to the point to where we are getting testimony in Washington and elsewhere that is springing up all over the country about recruiters who are telling recruits how to get around the drug question, the drug issue? Isn't it true that in many cases the police departments won't even let the recruiters have the records to determine whether or not this individual has been arrested previously for drug use?

General FITTS. I'm not an authority on the recruiting service, but from what I've read up to this point, the Army has been relatively free of those kinds of allegations.

Mr. ENGLISH. Well, we've talked to recruiters all over, not only the Army, but the Navy and the Air Force and elsewhere, and they tell us they are having a tough time meeting those goals and those quotas. You've had a scandal within the Marine Corps, it's been well documented, it has been in the press. Are you trying to say that you don't think that the Army recruiters are having as difficult a time obtaining people as are the Marine Corps?

General FITTS. No, but what I would say is that I've not seen evidence up to this point that they have been involved in these scandalous type things that have hit the press.

Mr. ENGLISH. I'm not saying it's scandalous, I'm saying what it is is a burden upon which recruiters are being demanded to live and they simply can't find the numbers out there to go. So you get more and more of questionable people. You have indications of where the recruiter simply can't find out if that person was using drugs or not. Local police wouldn't let him have the records, and you end up with a situation where all you got is a urinalysis test. All the young man has to do, or woman, is to clean up their act 72 hours and they are home free. They don't have a bit of a problem, but you are finding out once you get them in here, once you get them over here, that an excess of 50 percent have been using hard drugs. That seems to be a very potent type of situation when you place them into an environment where you've got drug availability as high as we've heard testimony about today with a cheap price, and you've got some people, evidently, that already have problems before they came into the service and all they got is more problem. But the question is is why those people haven't been pulled out of that environment. Why haven't they been pulled out of that unit? Why are they allowed to stay there and contaminate the other people? That is the question I've come up with, and it seems to me there can only be one answer. Obviously we can do it for the MP's. You tell us that we can do it with missile units, obviously there are some other cases in which this can be done and is being done, but why don't we do it with the whole thing? That's the question.

General FITTS. I think it comes down to two things. Number one, is we have recognized the sensitivity there is in certain units, the kind of things they are engaged in, justify that type of action. The position of the Department of the Army is, and has been, that for those individuals who we have not determined that they are an absolute failure and should be removed from the system, that the most supportive thing that we can do is to leave them in a responsible position in their current environment. The 50 percent figures you use that we quoted, said that some time in their lives they were exposed to drugs, and that's true. The thing that bothers me about that is that if we get into the debate on this volunteer Army versus the draft, it would be my general belief that the draftees would come from that same general population and I'm not certain they would be greatly different.

Mr. ENGLISH. General, the point that you made this morning in our discussions, and I raised it, you are talking about somewhere in the neighborhood of a 50-percent success rate on your CDAAC's, the people that you refer to. That's what you all testified to this morning. We got into the definition, and that's what I kept going down to, is this definition of what we are talking about when we talk about drug abuse? Is that the reason we are getting these differences between what this committee comes up with and what you all come up

with? When we are talking about definition of success, we simply mean a person who has gone back to his unit and has not been detected again. That is all. It does not mean that that person is not using drugs. And we find a second thing. Of the people in the Berlin Brigade that we ran into, an discussions up there, of the people that went through the CDAAC program, that they continued testing them with urinalysis, 50 percent came up dirty—50 percent. To me that indicates that unless that person wants to be helped, there is nothing CDAAC's or anybody else can do for him. But he still is left in that unit, which means that you've got a potential there of 90 percent, and perhaps more, of those who have been referred to those CDAAC units and staying in their units, may and are likely to continue using and continue contaminating the rest of the group, and I would say to you, sir, that the entire Army is vital, not just the MP's, not just the missiles, we depend on the entire Army for our national defense, and it seems to me that a serious question has to be raised as to why those people are left in those units. Thank you, General.

General FITTS. You are welcome.

Mr. ENGLISH. I would like to thank the panel once again. Thank you very much.

Mr. LAWRENCE. Maj. Anthony DeValentin, please.

[Major DeValentin was sworn.]

Mr. ENGLISH. Major, if you have a prepared statement, I hope that you will summarize it for us and if not, why we will please continue.

TESTIMONY OF MAJ. ANTHONY DeVALENTIN III, ALCOHOL AND DRUG POLICY BRANCH, OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL, HEADQUARTERS, DEPARTMENT OF THE ARMY

Major DEVALENTIN. Mr. Chairman, I am presently assigned to the Drug and Alcohol Policy Branch, Office of the Deputy Chief of Staff for Personnel, Headquarters, Department of the Army. I arrived here in Germany on November 2 to conduct a series of special urinalysis tests. The purpose of this trip was to gain independent data on which to evaluate the USAREUR selected unit urinalysis test of company-sized units, the SUUTCO. To insure the validity and impartiality of these special tests, the purpose of my visit was quite closely held. At Headquarters, Department of the Army, the only individuals that I know who had knowledge, were Major General Ulmer, the Director of the Human Resources Development Director, Colonel Ordway, Chief of Leadership and Motivation Division, Mrs. Helen Gouin, the Chief of Drug and Alcohol Policy Branch, and Lieutenant Colonel Dolloff, of OCLL. There were others in the DA staff who knew I was coming to Germany, but, to my knowledge, did not know the reasons for my trip. Officials in USAREUR were also aware of my trip. This information was passed to Brigadier General Fitts, the Deputy Chief of Staff of Personnel. To my knowledge, five other officers in the USAREUR DCSPER office were also knowledgeable.

On Sunday, November 5, I held a meeting with six NCO's and enlisted personnel from the Heidelberg area who would assist me in

conducting the special urinalysis tests. These individuals were selected late on a Friday afternoon, again, to insure the impartiality of this project. At this point, I would like to indicate that I had the total and complete cooperation of USAREUR to include a letter from General Fitts which provided me authorization to contact any unit in USAREUR and direct urinalysis tests. At approximately 1600 hours on Sunday evening, I advised USAREUR of three units which had been previously tested under the SUUTCO, that would be retested on Monday morning. USAREUR then sent an immediate message to the respective corp's directing these SUUTCO's. On this basis, the most advanced warning a selected unit could have had was 12 to 14 hours. On Monday morning, I met with these special teams and we drove to Mannheim. Upon arrival, we selected the unit that we would test. This was approximately at 0700 hours. I should note, however, that originally I had intended to test another unit other than the one we actually did. The reason I changed my mind and tested the unit we did, was because I learned that this unit had just returned from training in Berlin. The basis for selecting these four units was primarily their location, Stuttgart, Nuremberg, Mannheim, and Baumholder, all of which have at one time or another been identified as a troublesome area with regard to drug abuse. The results of these four tests indicate that 440 individuals were tested, and there were 17 nonauthorized use positives at a 3.8 positive rate. The unit that I personally witnessed had a 2.1-percent positive rate for 139 specimens. The 17 positives broke out to be 12 opiates, which would include heroin, morphine, and codeine, two amphetamines, and three methaqualone, mandrax or quaalude. The positive rate for these four units on their previous SUUTCO's was 4.8-percent positive, 17 opiates, three phenobarbates, and one methaqualone.

On Tuesday, November 3, we tested three additional units, but these had not been previously tested under the USAREUR SUUTCO program. At approximately 1700 hours on Monday, November 6, I provided USAREUR the identification of the units they would test using their normal SUUTCO procedure. Once again, these units had no more than 12 to 14 hours advanced warning. The special team and I then traveled to Wiesbaden at approximately 0630 hours, advised a unit at that kaserne that we were conducting a special SUUTCO. The primary basis for selecting these three units was again location, Augsburg, Hanau, which is just outside of Frankfurt, and Wiesbaden. These tests included 340 individuals, and identified 6 nonauthorized use positives for an overall 1.7 positive rate.

The unit tested by the special team included 90 specimens, with two positives, one for opiates and one for Phenobarb, for a 2.2 percent positive rate. The overall rate for these seven units, which represented approximately 10 percent of the number of SUUTCO's already conducted by USAREUR, was 780 specimens with 23 nonauthorized use positives, for an overall 2.9 percent positive rate. This rate compares quite favorably with the 3 percent positive rate recorded by USAREUR for its 72 SUUTCO's of 10,688 specimens. I might mention that the Army-wide rate for fiscal year 1978 was 2.2 percent of 581,000 tests, or 12,900 positives. My trip was not only designed to independently evaluate the SUUTCO program in Europe, but also to review the procedures used in the laboratory process. In this regard,

after initiating the test in Wiesbaden, I took the specimens from the previous day to the U.S. Army laboratory at Wiesbaden and witnessed their processing. Because of the incubation period for portions of the lab test, and other processing procedures, it was not possible to witness the entire process. However, I did view the initial screening stage, which produces the presumptive positives. When I left the laboratory, I felt very comfortable with their procedures and controls. Mr. Chairman, my overall assessment of the special project, is that it did, in fact, validate the SUUTCO procedures used in USAREUR as well as the laboratory procedures used to identify drug abuse. Thank you very much.

[Major DeValentin's prepared statement appears on p. 186.]

Mr. ENGLISH. Thank you very much, Major DeValentin. There is one other point that probably should be made known to the public, and that is while the major didn't state it, there was one other person who knew about this test, and that was, namely, myself. General Ulmer and I got together in September, there had been a number of allegations made with regard to urinalysis tests here in Germany, and it was basically that the figures were being manipulated, that the test results were being juggled, and it was for that reason that we agreed that there would be a high degree of security around this particular test and that those who would be conducting the tests would be brought from Washington under extreme security, and from what the major has told me both privately and from what he has testified here today, I believe that that was accomplished. I think it should also be pointed out, however, that as we will hear later, there are a number of ways in which people can beat a urinalysis test, but I do think that as far as the question and the issue of whether or not people within the chain of command were in any way manipulating the figures, that that should be laid to rest with this test, and major, I think that you have done an outstanding job. I would like to ask you one question, and that is, how many no-shows did you have on the test?

Major DEVALENTIN. Sir, on the first day unit, there were 14 personnel assigned that were not present. These people were either on TDY or on leave or otherwise at a location too distant from their parent unit for the test. These people were already gone when I got there at about 7 o'clock in the morning. So they wouldn't have known that I was coming in to run a test, and then the people left. In the second, I believe, unit there were five people, I believe, that were either on leave or TDY at the time of the test.

Mr. ENGLISH. Mr. Gilman?

Mr. GILMAN. Major, you weren't present actually when the tests were being taken, were you?

Major DEVALENTIN. Yes, sir.

Mr. GILMAN. Throughout all of the testing?

Major DEVALENTIN. Yes, sir, I watched the entire procedure.

Mr. GILMAN. Each man that was tested?

Major DEVALENTIN. Sir, there would be times when I was at the various stations as the man was being brought up to check his ID card and verify the social security number against the company roster, but I would say that I saw a significant number of people actually provide the specimen. Well over half, at least.

Mr. GILMAN. The other half you weren't present?

Major DEVALENTIN. No sir, but the team that I had was. The only people that were running the actual test itself, was either myself or the six NCO's I brought with me, the impartial people, so we were the ones who were viewing the specimens being made and had complete control over that.

Mr. GILMAN. How many men do you take at one time in performing the testing?

Major DEVALENTIN. We kept it to two people at any one time, and there were two people in the latrine observing the test.

Mr. GILMAN. Where were the balance of the men while all of this is going on?

Major DEVALENTIN. They are standing outside, sir.

Mr. GILMAN. Thank you.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. I don't have any questions, Mr. Chairman.

Mr. ENGLISH. Mr. Jenrette?

Mr. JENRETTE. No questions.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. No questions.

Mr. ENGLISH. Major, thank you very much.

Major DEVALENTIN. Thank you, sir.

Mr. ENGLISH. Chief of staff will call the next witness.

Mr. LAWRENCE. I would like to check to see whether Command Sergeant Major Brown has arrived yet, he was enroute the last time we checked, Mr. Chairman. Is Command Sergeant Major Brown in the room? [No response]. That being the case, the committee now calls Captain Barnes, Specialist 5 Shouse, Specialist 4 Sellers, Carol Bruce, who is clinical supervisor of a CDAAC and mayor of the military community.

[CAPT Barnes, SP5 Shouse, SP4 Sellers, and Ms. Bruce were sworn.]

Mr. ENGLISH. If you have statements and comments, I hope that you will keep them brief, summarized, and if you do have written statements that you would like to present to the record, please feel free to do so. If you don't have any statements, that's fine too, but if you care to make any comments, we will be happy to have them. Captain Barnes?

TESTIMONY OF CAPT. SAMUEL BARNES, ALCOHOL AND DRUG CONTROL OFFICER, BAD KREUZNACH COMMUNITY; ACCOMPANIED BY SPECIALIST 5 SHOUSE, SPECIALIST 4 SELLERS, AND MS. BRUCE

Captain BARNES. Yes, sir. Mr. Chairman, as the alcohol and drug officer for the Bad Kreuznach community, I have direct responsibility for the Dexheim and Bad Kreuznach Community Drug and Alcohol Assistance Centers, or CDAAC, which services 32 companies in separate detachments in Bad Kreuznach, Dexheim, Wackernheim, and Dichtelbach. In this position, I am the installation alcohol and drug abuse prevention and control program manager, and am responsible for coordinating the command staff in the medical aspects of the alcohol and drug abuse prevention and control program. We perform the following functions: We receive all personnel referred by the

commander for evaluation, and conduct an initial interview to determine if and to what degree the individual is abusing alcohol or drugs. Appropriate assistance may be provided to other personnel who have alcohol or drug related problems, but no one will be entered into a rehabilitation program unless clinically confirmed by a physician as an alcohol or drug abuser.

In close coordination with unit commanders, we must design and participate in rehabilitation programs for clinically confirmed alcohol and drug abusers, and conduct social evaluation for those personnel whose clinical evaluations were inconclusive. The CDAAC, in consultation with the unit commander, develops a case designed for an individual based on all available information. Each program is designed to meet the needs of the individual abuser instead of employing a standard model. We provide appropriate counseling in CDAAC staff capabilities. We refer clients who require more help than CDAAC and the unit can provide to other agencies; that is, the chaplain, hospital, extended care facilities, Alcoholics Anonymous, Narcotics Anonymous, mental health clinic, as appropriate, to assist in the rehabilitation efforts. We provide continuous monitoring of individual cases through the followup phase of rehabilitation or until the individual has been eliminated from the service. We also maintain appropriate records in accordance to applicable regulations. When an individual in the followup phase is transferred to another U.S. Army, Europe, unit, serviced by a different CDAAC, his records will be transferred in order that his rehabilitation may continue at his new unit.

At periodic intervals throughout the rehabilitation phases, we provide administrative and clinical recommendations to the commander in order that he might make a decision as to the service member's rehabilitation progress. We assist the community commander and unit commanders by monitoring a urinalysis program to insure that all individuals who are involved in the rehabilitation program are tested at the designated time. This gives the commander additional information on the service member's progress and assists him in indentifying other abusers. The alcohol and drug abuse prevention and control program, while assigned within each community, is subordinate to the V Corps alcohol and drug control office. Since Bad Kreuznach is an 8th Infantry Division community, I coordinate all alcohol and drug abuse prevention and control program activities with the 8th Infantry Division, alcohol and drug control officer, who is assigned to the tactical headquarters.

In the alcohol and drug abuse prevention and control program, I feel it is imperative that all facets coordinate with the unit's chain of command. This program, by regulation, is an additional tool to be used by the commander in order that he may perform his mission more effectively. The rehabilitation program cannot be effective without this close liaison between the alcohol and drug prevention and control staff, and the commander. The entire rehabilitation effort for the client depends on a well-structured program including medical, clinical, and unit involvement. At the unit level, the firstline supervisor and company commander are directly involved in the service member's rehabilitation. During clinical counseling, my counselors, the firstline supervisor, and company commander work closely to

evaluate the progress of the service member. Our clinical recomendations to the company commander and the firstline supervisor's daily observation of the service member is critical in determining the final decision as to whether or not the service member will be a rehabilitation success or failure.

In my opinion, the drug situation in the Bad Kreuznach community is recognized by the commanders, and they are doing all they can do to attack the problem. Our chemical tests show a 3-percent to 6-percent use of opiums, amphetamines, barbiturates, and methaqualone in Bad Kreuznach. This is based on five SUUTCO's which indicate a 5.7-percent usage. A scientific method to identify cannabis is not in use; therefore, the degree of usage is open to debate. The percentage that use cannabis is reported to be as high as 80 percent by those we treat in the ADAPAC program. This amount of use if offered up as a defense mechanism or rationalization for his or her use, and when pressed, they usually admit that their perception is wrong. Other developers, a percent of use based upon their knowledge of a very small group. Drug abuse varies from unit to unit, depending on the unit's training program, his mission, the type of MOS, and the quality of leadership it has. Therefore, it is possible for an individual to be in a platoon where 80 to 90 percent use drugs. This, then, is the world that the individual knows, and when asked about his company or battalion, he will provide the percentage developed from that limited sample to the remainder of the unit. In these situations, the individual is usually very sincere in his beliefs, even if the view is mistaken. One must realize that the individual soldiers have limited perceptions. The arrangements of the barracks into separate rooms combined with the normal work organization of the company into small work elements, precludes the individual soldier from having an in-depth knowledge about the use of drugs in the company. After considering these factors, I believe the use of cannabis is in the 30- to 40-percent range. By use, I mean the soldier uses the drug twice a week.

I believe the key to solving the problem, the alcohol and drug abuse problem, is prevention. We know drugs are readily available in Europe. To prevent a soldier from use or abuse of narcotics, he must be satisfied with what he does. This job satisfaction ties in directly with good realistic training, which helps relieve boredom and frustration. Many of the commanders that I have worked with have expressed their frustration concerning their inability to spend time in the field for training due to lack of funds. Almost every soldier wants to perform the full range of duties or duties required in his or her MOS. Too often this is not possible due to limitations imposed on the time available in the various training areas, the lack of adequate firing ranges, or the lack of funds for ammunition. The more we can conduct meaningful training, the more satisfied the soldier would be, and this would significantly relieve the drug problem. Of course, we must also recognize the need to improve the quality of life for every soldier, with special attention being given to those soldiers who live in the barracks. When the soldier is not at work, he needs to be able to relax in an atmosphere that is conducive to the development of his abilities and other areas, such as photography, crafts, music, and so

forth. Both of these, the training and good recreational facilities, are excellent means of preventing the young soldier from becoming involved in drug usage.

To prevent the newly assigned soldier from becoming involved in drug usage, we have developed a community alcohol and drug abuse prevention and control program orientations. This program stresses the medical, social, economical, and legal hazards of drug abuse.

We present information on the differences of the strength of drugs as compared to the United States, and also the strength of alcoholic beverages here in Germany as compared to the United States. We also give them the chance to observe a mock interview, and based on the information allowed them, to determine whether or not an individual would be placed into a rehabilitation program. Other classes that are currently being conducted, are the prevention of alcohol abuse, the prevention of drug abuse, drug and alcohol education specialist training, whereby the unit's alcohol and drug abuse prevention and control program specialist learns of all new changes and gets a chance to interreact with other drug and alcohol education specialists in insuring that they each have a viable program. We have a commander's call which stresses the indicators of alcohol and drug abuse and efforts for the commander to be able to effectively detect drug abuse within his unit and train his firstline supervisors on detection.

In addition, there has been intensified efforts to disrupt the drug supply. To summarize, I believe the things that can be done to prevent or lower the drug abuse situation in the Bad Kreuznach could be improved training opportunities for the service members and better recreational facilities. Thank you, sir.

[Captain Barnes' prepared statement appears on p. 187.]

Mr. ENGLISH. Specialist Sellers, do you have a statement or anything you would care to say?

Specialist SELLERS. No thank you, Mr. Chairman. At a further time, perhaps if I feel frustrated I will be happy to hand in a written statement.

Mr. ENGLISH. Ms. Bruce?

Ms. BRUCE. I would just like to give you some background information on what a clinical supervisor does in CDAAC. To tell you what else I do as mayor of one of the military communities, not what else, but how I came to be mayor. As the clinical supervisor, I am responsible in Bad Kreuznach for the training for the counselors, 91 Golfs and one civilian temporary counselor. We do not have a clinical director at our CDAAC, so I kind of wear the hat of community liaison with the civilian program and with the school and other community resources, such as ACS, in developing programs and public relations in regards to preventive measures for drug abuse. As the mayor, I was elected last year by my township to be mayor and we have a town council. This job keeps me closely involved with about 252 families in 14 buildings. We do all kinds of things in working with the military in trying to improve the community life. Having been in Germany before, having been in France in the time that the American forces left France, it is very obvious to me that our problem goes much deeper than just drug and alcohol. It is where we are as far as the German community is concerned. The attitude of the Germans has changed towards Americans. Myself, having been here twice, we really

see a different attitude and it is very difficult for me, having traveled and gone around, to get back out into that mainstream when they tell me my dollar is no good and we really don't need the Americans. This is very frustrating for a lot of young service members coming over here, and I think that that is the thing that in CDAAC, or in my programs, that I do in primary prevention, is to try to get individuals to feel good about themselves and let them know that eventually, we are going home in some point in time. This happens with the communities and family people where you have alcohol as a major problem in the family. Years ago we did not have the emphasis, the commanders were not involved with things like child abuse, womens advocacy, rape prevention, and all these things we now have to deal with in addition to the primary mission.

I believe that the command support has been very good at the 8th Infantry Division, and as I go to training sessions throughout V Corps, we get the commanders' support, but the mission is the primary focus, and rehabilitation, I feel, is something the military or you as representatives of the Government have to decide who is going to be in that business. Is it going to be the Army, or is it going to be some other private agency that's not a part of the military structure? I think that at CDAAC one of the things we feel is very important is that we cannot make an individual change. He has to want to make some sort of behavioral change. We do monitor for commanders. A commander sometimes does not want that ultimate decision to decide whether a person is abusing drugs or has a problem that is beyond repair, or whatever. So if a commander refers someone on the basis of suspicion or an isolated incident, we can monitor for him, and then we can talk to the individual and say, "Okay, this is where you are, you make the decision if you want to be in the military, you volunteered for this." So this is monitoring, this is not rehab. Many times we never see the individual. We monitor him in the unit. So everyone who comes to CDAAC is not dipped in a magic potion and sent back in the unit as a productive individual. There is a dual function in CDAAC.

I have worked with people programs for 10 years. I worked with public welfare in the States, and I don't think that there is a magic answer. I do feel that there is a lack of the essential things—manpower, money, and resources—for U.S. Army, Europe, and when these things are available to enhance the creature comforts, then I think a lot of the drug problems will be eliminated.

Mr. ENGLISH. Specialist?

Specialist SHOUSE. No, sir, I don't have anything to say.

Mr. ENGLISH. Captain Barnes, exactly what is your function?

Captain Barnes. I am the alcohol and drug abuse control officer for the community, Bad Kreuznach.

Mr. ENGLISH. What training have you had in drug abuse?

Captain Barnes. Well, sir, my training has come from being on the job. I guess you are aware of the fact that in the military, officers have to be able to function in almost a variety of jobs based on their primary specialty, and mine is in the personnel administrative area, and the position I am holding now is in that area.

Mr. ENGLISH. I don't mean to be disrespectful, but did you write your statement yourself?

Captain BARNES. Well, I did get a little help, sir.

Mr. ENGLISH. Who prepared the statement for you?

Captain BARNES. I did the basic portion of it.

Mr. ENGLISH. Who assisted in the preparation of it?

Captain BARNES. The 8th Division Alcohol and Drug Control Officer.

Mr. ENGLISH. Do you really believe the figures you gave us in regard to hard drug use and hashish use.

Captain BARNES. Well, sir, I'm basing those figures on the people who are in the program. We deal with them only from the standpoint of once they have been identified. In talking to commanders, and in talking to troops, and talking to the people involved in the program, yes, sir, I do believe those figures.

Mr. ENGLISH. Well isn't it somewhat strange that they are almost identical to the figures that, No. 1, you get out with regard to urinalysis testing and, No. 2, what was testified to by generals this morning?

Captain BARNES. Yes, sir, that is kind of strange, but truth is truth, sir.

Mr. ENGLISH. For instance, you have been around drug abuse some. How long have you been on this job?

Captain BARNES. I've been on the job since March.

Mr. ENGLISH. You've been around drug abuse and you've seen a little about what's going on, right? OK, you know then that there are many drugs that were not tested for on the urinalysis, correct?

Captain BARNES. Yes, sir.

Mr. ENGLISH. You also recognize the fact that urinalysis test is good for only 72 hours. Correct?

Captain BARNES. The drugs stay in the system for only 72 hours, yes, sir.

Mr. ENGLISH. In other words, the urinalysis test is only tested for 72 hours. If they have taken it within 72 hours, it might catch it. If they have not taken it within 72 hours, it is not going to catch it, right?

Captain BARNES. Yes, sir.

Mr. ENGLISH. OK, you also recognize the fact that for the most part, soldiers who are using drugs, even those drugs that are being detected, are not addicted to those drugs, isn't that correct?

Captain BARNES. I'm sorry, I didn't quite follow that, sir.

Mr. ENGLISH. Are the majority of the soldiers using drugs that are being detected, addicts? Are they addicted to drugs, drug dependent?

Captain BARNES. No, sir, not the majority.

Mr. ENGLISH. So you've got a very small percentage of them that fall into that category, right? Which means that you've got recreational users. Correct?

Captain BARNES. OK, sir.

Mr. ENGLISH. That means that you've got people who do not use every day.

Captain BARNES. Yes, sir.

Mr. ENGLISH. And that means that in any one given time, there is a large percentage of those who are using recreationally are not using it. Correct?

Captain BARNES. I would agree.

Mr. ENGLISH. So that means in any 1 day out of the week, or month, or year, that you decide to run a urinalysis test, you are only

going to catch a small percentage of those who are actually using drugs at one time or another. Is that correct?

Captain BARNES. Only those who use within that 72-hour period.

Mr. ENGLISH. That is exactly right. Which means that how many times would you say that the average soldier here in Germany is run through a urinalysis test?

Captain BARNES. Every soldier?

Mr. ENGLISH. Once every 3 years, maybe? If he is lucky, or unlucky, depending on how you look at it.

Captain BARNES. I would say it would be a more frequent time.

Mr. ENGLISH. We've got somewhere in excess of 200,000 people here in Germany, right? How many urinalysis tests do you run each year?

Captain BARNES. Remember, sir, I'm just dealing with the Bad Kreuznach community.

Mr. ENGLISH. OK, how many people do you have in your community? How many soldiers in your community?

Captain BARNES. There are 4,400 soldiers that are serviced by our 2 CDAAC's.

Mr. ENGLISH. 4,400 that are serviced by the CDAAC's. How many people are or should I say, how many soldiers have you got under these commands?

Captain BARNES. 4,400.

Mr. ENGLISH. 4,400. How many tests have been run since you have been there? How many individual people, not those who have been run through two and three and four and five times, but those who have been run through once.

Captain BARNES. I don't have those figures with me.

Mr. ENGLISH. What would you guess?

Captain BARNES. 300, maybe 400.

Mr. ENGLISH. 300 or 400 in 6 months?

Captain BARNES. In about a 6-month period.

Mr. ENGLISH. That's about 10 percent, so that means you get 1 out of every 10, the average soldier. Right?

Captain BARNES. OK, sir.

Mr. ENGLISH. OK, and you are only catching those who used within the last 72 hours. Now don't you imagine that that 4 percent that you come up with on the tests just might be just a little bit short of those who are actually using I thought you would see it that way. With regard to those who are using hash, according to the National Institute on Drug Abuse, we've got something like 95 percent of all the high school graduates have at least experimented with marihuana. We've heard testimony here that you have had 50 percent that come into the Army have at least experimented with some kind of drug, probably hard drugs. Given those facts, given the fact that the soldiers themselves see absolutely nothing wrong—in fact we've had soldiers tell us they could perform better after they had had a little hash, than they could without it—and you are trying to tell me that those soldiers are shy about telling the truth to each other about using hash and about using it openly? In fact, we've had them testify to us they're using it on duty, using it in the barracks, using it everywhere they go. No sweat. And your're trying to tell me that they don't know who is using and how much they're using and what is going on in that barracks?

Captain BARNES. I think their perception is based on the people they know.

Mr. ENGLISH. It's the guy who's sitting next to him when they are working and he's using, and the guy that is sleeping next to him in the bunk, and he's using, and the guy that they sit next to in the mess hall, because when they're walking back to work, he's using. Those are the types of things, testimony, that we have received. Now I'm getting at—and I understand what you are saying—you're saying, well they exaggerate and we don't have any tests to show and all this kind of stuff, but given the facts we are just a tad short on urinalysis don't you think we might be just a tad short on that hash as well?

Captain BARNES. That is possible.

Mr. ENGLISH. I believe my time is up. Mr. Gilman?

Mr. GILMAN. Captain Barnes, we've heard testimony today that when an addict is found in the military, that he ought to be dismissed from the military. There has been some question about the effectiveness of the rehabilitation programs that the military have at the present time. How do you feel about once an addict is found and he is referred to your unit, do you find that he may be an occasional user after being referred? Do you think he should be bounced out or should go undergo further treatment?

Captain BARNES. Sir, I think—when I look at addiction, narcotic addiction—I think of a medical disorder, and with that in mind, I think that everyone should be given the opportunity to have that disorder taken care of, and not just strictly from the standpoint of, "You are caught now, you should be kicked out." I think they should be helped.

Mr. GILMAN. Well, in talking to one of the CDAAC's—and I talked to a director of one of the CDAAC's of another post—we found that 80 percent of the opiate users were being discharged. Does that run true to your CDAAC program? In other words, it was being used as a vehicle for discharges. Being referred in, building up a case, and out he goes.

Captain BARNES. Well, sir, we have had some people entered into the program, and either it was the client himself manipulating, or the commander manipulating the system, but it would not account for any particular percentage of whether or not the person was eventually put out of the Army.

Mr. GILMAN. There is some of that manipulation of both sides, is there not?

Captain BARNES. Yes, sir, there is.

Mr. GILMAN. What is the percentage of opiates who are referred to your program who are discharged?

Captain BARNES. Roughly, about 6, maybe 7, percent.

Mr. GILMAN. Only 6 or 7 percent are discharged and the remaining are rehabilitated and sent back in? Now I'm talking about hard drug users.

Captain BARNES. Yes, sir, I understand that, but what I'm basing that figure on is once they have been put into the program, and subsequently had more positive urinalysis, or repeated incidents, and were eventually given a dependency code, did not conform to or come around to the rehabilitation effort, and subsequently received a chapter 9 from the program, and that's what I'm using the 6 to 7 percent.

Mr. GILMAN. You are all CDAAC people, are you not? I have found that there is a certain reluctance by the troops to take advantage of CDAAC because they are afraid of being stigmatized unless they intend to become discharged through this group, and they are concerned that once they get in the program they may be heading for a discharge. Do you find that to be the situation in your various posts? Are you all in the same CDAAC unit? Specialist Sellers?

Specialist SELLERS. Sir, as soon as you asked the question, I started focusing on something else that I feel is more related.

Mr. GILMAN. Please feel free to respond.

Specialist SELLERS. Thank you. I find that one of the problems I grapple with often is the great preponderance of young men I see, I feel are just too young to be here, and the Army perceives in some instances that this man, to me, meaning the Army, has a drug problem. But the man has not lived long enough to look back into his own history and feel enough pain, or enough sense of loss, whether it's from jobs or whatever, to say, "Yes, I'm willing to look at myself and perhaps I do have a problem and perhaps I should do something about it." I don't find too many men who are—talking, for example, about about E1 through E4—simply chronologically old enough to be rendered that openminded. I do once in a while get someone in the office who just wants help.

Mr. GILMAN. Am I correct that it is rare that you get the volunteer coming walking in that door?

Specialist SELLERS. In our office it is, sir.

Mr. GILMAN. Is that true for the whole panel?

Ms. BRUCE. We are getting more volunteers in reference to your initial question. I think it has a lot to do with the attitude of the community about the drug and alcohol program, and when I started working in CDAAC about a year ago, or in January, this was the basic problem, that there was a stigma that was carried over from the old Synanon houses, and the drug programs that had been in the Army prior when they were kind of left to do their own thing, and then the stigma came about, and then the Army said well now we are going to do something about this. We are going to monitor the people in the staff working there, we are going to do a lot of things and, as a result of that, people started getting a very negative attitude. Individually, how—if I go to my first-line supervisor and say I have a problem, how he takes that is really going to be a reflection of what happens when he goes to CDAAC.

Mr. GILMAN. That initial contact with his first-line supervisor is extremely important, is it not?

Ms. BRUCE. Very true, and this is why Captain Barnes mentioned the commander's call, and I have been going to the unit, talking to the firstline supervisors. I have been utilizing NCO's who have come through our treatment facilities at Bad Constatt, which is a very good facility. We have had officers that have gone to that program that have come to our AA sessions to talk to people, and it is a change in attitude that is necessary, and it is not going to come overnight, and I see all of the training that we are getting—we were at a convention in Kassel on primary prevention, and all community resources were there. I think that we are moving in that direction, but it was a step from Synanon to CDAAC, and now it is going to be a step probably from CDAAC to a human resource concept, and a lot of

communities are moving toward that, and I think there is a stigma attached to CDAAC, and the only people who are going to remove it is the chain of command and those people who work there.

Mr. GILMAN. Well, we certainly hope that human resource concept begins to permeate down to the barracks, but I haven't found it happening yet, and I do find resistance to walk in there to that CDAAC program where they can get help. I find resistence, or a lack of awareness at the NCO level in the barracks, of how he should cope with that initial indicator of a problem, and I find resistance, too, of once in the CDAAC program, how he is being handled, whether he is heading out the door of the military or getting some real help.

Ms. BRUCE. Well, I think from the first-line supervisor, if I might make that comment, there is a lot of value conflict because NCO's have to react to the statement of, "Well, it's no worse than booze," and I get this question many times from young service people who come in and they will say, "I don't see any thing wrong with smoking, it's no worse than booze, it hasn't done as much to society as drinking." So, NCO's, really have to be trained to deal with that kind of confrontation.

Mr. GILMAN. Are they being trained right now?

Ms. BRUCE. This is what we are working on.

Mr. GILMAN. Not what you are working on.

Ms. BRUCE. I can't say for the whole Army.

Mr. GILMAN. Is there training besides the training you are trying to give them?

Ms. BRUCE. I can't say for the whole Army because as far as—my husband is an NCO, and——

Mr. GILMAN. Has he received any training besides what you told him?

Ms. BRUCE. Yes, they have training classes offered in the theater, but it is mostly identification, it is not getting down to some of the things that we talk about because I look at it from a different perspective.

Mr. GILMAN. Captain Barnes, is there some program that you get identified with where you help to train the NCO's in what to look for and how to counsel?

Captain BARNES. Not me getting into it that way, sir.

Mr. GILMAN. Who does it, then, if it's being done?

Captain BARNES. It is primarily being handled by the counseling staff.

Mr. GILMAN. Which counseling staff?

Captain BARNES. I'm sorry, sir?

Mr. GILMAN. Which counseling staff?

Captain BARNES. In my CDAAC?

Mr. GILMAN. No, I'm talking about training of NCO's.

Captain BARNES. I'm sorry, I missed your question then.

Mr. GILMAN. How is the training of the NCO's coming about in handling the initial response, the initial contact, the initial request for help?

Captain BARNES. That's coming from the commanders. We are sitting down and talking with the commanders, giving them input and helping to give them insight into the kinds of things they should be looking for, or how to really get into training their NCO's in the idea of detection. They in turn should be training their NCO's.

Mr. GILMAN. You don't know whether that is being done or not?

Captain BARNES. No sir, I don't.

Mr. GILMAN. In your opinion, how can our CDAAC program be improved? I've heard some requests that there should be more professional help, that there should be a greater awareness of the program amongst the NCO's and better training of them. Are there any other areas that you feel could help improve the CDAAC program?

Captain BARNES. Those were the things I was thinking about, too, sir. More qualified people, because my primary thought is an effective program such as the CDAAC would be very effective if I were, in essence, put out of a job, where we had really gotten out and trained people along all lines of alcohol and drug abuse so they would be aware of them, and hopefully not get involved in them. I'm talking more qualified people. More allocations for qualified people, to be able to do just that.

Mr. GILMAN. If you have a particularly difficult patient, what do you do with him, when you find that he needs some intensive care?

Captain BARNES. From what point of view are you talking about?

Mr. GILMAN. Say you get an opiate in and it looks like he is in pretty bad shape and you feel you can't handle it through counseling. Is there any other source of help you can turn to?

Captain BARNES. Yes, sir. At that point, we should think along the lines of the detoxification wards and initially the detoxification wards.

Mr. GILMAN. A detox ward. Suppose he doesn't need to be detoxed, but needs some professional help?

Captain BARNES. Then we will refer him on to a qualified person to deal with his particular situation, sir.

Mr. GILMAN. Where do you refer him?

Captain BARNES. A psychiatrist, if necessary.

Mr. GILMAN. Do you have a psychiatrist in your unit?

Captain BARNES. Yes, sir, the division psychiatrist who interreacts with the CDAAC by conducting in-service training for all of my counselors.

Mr. GILMAN. How often does he visit your CDAAC?

Captain BARNES. On the average, about once a month, average.

Mr. GILMAN. He would handle your more difficult cases?

Captain BARNES. Yes, sir, he would have to.

Mr. GILMAN. Do you ever refer any cases up to the Frankfurt General Hospital?

Captain BARNES. Just a detoxification.

Mr. GILMAN. Don't they have an additional unit besides detox?

Captain BARNES. Well, they also have the care program, sir, and we use that.

Mr. GILMAN. Have you referred any cases out of your unit to the care program?

Captain BARNES. A few, sir, yes.

Mr. GILMAN. For what purpose? How do you distinguish the cases that go to care and those that go to detox?

Captain BARNES. Well, with the two CDAAC's that I have a responsibility for them the one at Dexheim uses the Frankfurt MEDDAC, which would be primarily all facets of the 97th General Hospital. All the units that are serviced by the Bad Kreuznach CDAAC, would be referred on to Landsthul.

Mr. GILMAN. To where?

Captain BARNES. To the Landsthul MEDDAC.

Mr. GILMAN. They have a care unit there?

Captain BARNES. No, sir, at Landsthul, they have a share. It is a 26-day live-in program.

Mr. GILMAN. What determines whether you refer them for the live-in program?

Captain BARNES. Whether or not the client really needs that extra day-to-day kind of therapy as opposed strictly to what we have in the non resident program.

Mr. GILMAN. Is there sufficient spaces in these care units to meet your needs?

Captain BARNES. We haven't had any problems getting one in, sir.

Mr. GILMAN. No delay?

Captain BARNES. Sometimes, just depending on whether or not they were first referred on to detox.

Mr. GILMAN. I guess my time is up. I may want to ask some additional questions, Mr. Chairman.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. Thank you very much, Mr. Chairman. First of all, let me say that in talking to a number of these young men about the CDAAC program, I asked whether they thought CDAAC was effective, and they said no, so my next question is, how long is a person kept in the CDAAC program?

Captain BARNES. Once he is put in, ma'am, he is in for a year, in two phases, an active phase for 2 months, where we see him once a week, and then into the follow-up phase for the remaining 10 months, where we see him once a month.

Mrs. COLLINS. And what happens during that once a month when he is being seen?

Captain BARNES. Excuse me?

Mrs. COLLINS. What do you do when he comes in once a month? Do you just talk to him or what?

Captain BARNES. We conduct the same kind of counseling but not as intense as the first 2-month period. In addition to that, we have been working with all other facilities within our community to try to help the person get into other areas that would be alternatives to drug or alcohol usage.

Mrs. COLLINS. What are those other areas you suggest?

Captain BARNES. We are talking to the crafts, the recreation center, for crafts, etc.

Mrs. COLLINS. In talking to others, they tell me that some of the enlisted men tell me that CDAAC is often seen as an extension of punishment for themselves. Has anybody discussed that with any of you who are counselors? Ms. Bruce?

Ms. BRUCE. Yes, many times service members will say that their commander has told them that if they have done something, then I will send you to CDAAC. This is an individual thing. It is the exception rather than the rule. Individuals will say, "Well, they are hassling me and they are constantly after me and doing these things to me," and I will say, "Okay, what are you doing?" "Well, yeah, I smoke, but that's my business and that's not his business," and you have to bring him back full circle and say, "Well, that is the commanders'

business and he is concerned with the overall unit and if you are doing something, that is against the regulation, then that is his responsibility to get you, to help you if you want help, if not, then you have to make a decision about what is going to happen." So we do hear that. Ninety percent of them that walk through the door—"I don't like Germany, I don't want to be here, and they are hassling me, and all you are going to do is do whatever the commander wants." This is what they say.

Mrs. COLLINS. Let me just confirm one other thing that was mentioned a minute ago about the stigma placed on going to CDAAC. It's my understanding that the chain runs from dirty urine to article 15, to a fine, to restricted duty to CDAAC, and then the stigma of discharge. Is that pretty much the way the thing goes, Captain?

Captain BARNES. I would say no.

Mrs. COLLINS. Why would you say no?

Captain BARNES. When a service member gets a positive urinalysis, while the stigma might be there from their point of view, the commanders that I deal with, while granted, some of them do manipulate the system in order to get rid of, as you say, dirty laundry, the majority of them are really interested in the person, getting him back into the unit in order that he, as a commander, can perform his mission.

Mrs. COLLINS. Do you agree with that, Specialist Sellers?

Specialist SELLERS. Which part of it, ma'am?

Mrs. COLLINS. Well, the part about the chain that goes with the CDAAC, the dirty urine, which leads to the article 15, which leads to the fine, which leads to restricted duty, which leads to the CDAAC, which leads to the stigma, which leads to the discharge. Have you seen that pattern being followed in any consistency?

Specialist SELLERS. Mrs. Collins, I have seen the soldier perceive subjectively that that's the pattern. I hope I don't trouble you as a witness, because I have a tendency to keep looking at the larger view.

Mrs. COLLINS. Which is what?

Specialist SELLERS. Well, to be frank, I certainly have not seen very much of the committee, but the little I have, the metaphor I would use of the dialog that I sometimes hear is like, for example, if I may, the Congress would be saying 30 percent of your men in USAREUR have broken feet. Do you have——

Mrs. COLLINS. I don't want to talk about broken feet, I want to talk about drugs. Let me ask you a question about drugs, if you can't answer my other question. Do you agree with Captain Barnes on his evaluation of the amount of usage of hash and heroin? Do you think that his figure was a good figure, or do you think his figure is higher or lower than the one you suggested?

Specialist SELLERS. I think it would be higher. May I quickly go back to what I said?

Mrs. COLLINS. No; just answer this one. On what do you base the fact that you think it is higher?

Specialist SELLERS. Not that men who use drugs feel that drug usage is pervasive, but that men who are clean and sober feel that they have very few places to go in the evening hours after work where they can be in a clean and sober environment.

Mrs. COLLINS. Well, would you not base your evaluation of the usage of what you see in—do you work in CDAAC?

Specialist SELLERS. Yes, ma'am, I do.

Mrs. COLLINS. Would that be a reasonable assumption on my part to say that you base your feelings of the magnitude of the problem from what you see there?

Specialist SELLERS. No, ma'am. I wouldn't. I would feel that would be tunnel vision on my part, because in working only in the CDAAC, I would end up thinking that 100 percent of the entire Army would be on drugs.

Mrs. COLLINS. Well, you know that you don't see 100 percent in there, don't you? One hundred percent of the people in the Army don't come through CDAAC, do they? I'm sure you can answer that with a yes or no, can't you?

Specialist SELLERS. Yes; certainly I can.

Mrs. COLLINS. Well, then 100 percent of the people in the Army don't come through CDAAC, right?

Specialist SELLERS. No; certainly they don't. I just find that I will probably have a more realistic view by getting my data from various sources as opposed to only the CDAAC.

Mrs. COLLINS. Is it true that once a client is referred to CDAAC that thereafter he is subjected to continual urinalysis testing, Captain?

Captain BARNES. Yes, ma'am, but it is only about twice a month, as the last digit of his social security number is sent out by USAREUR.

Mrs. COLLINS. Would the man perceive that to be harassment?

Captain BARNES. It is explained to him when he comes in for his intake interview, ma'am, about the continuous twice-a-month urinalysis, and I think for the most part that they perceive it as not being harassment, but just a means for them—if they are saying they are not using drugs, or it wasn't their positive to really show that it wasn't theirs.

Mr. GILMAN. Would the gentlelady yield?

Mrs. COLLINS. Yes.

Mr. GILMAN. We talk about stigma. Doesn't it somewhat stigmatize them once he is in the program that continually he be subjected to urinalysis tests?

Captain BARNES. They might look at it that way, sir, but everyone who is involved in the program is also submitting urine specimens twice a month.

Mrs. COLLINS. Ms. Bruce, you wanted to add something to that?

Ms. BRUCE. Including myself.

Mrs. COLLINS. Including yourself?

Ms. BRUCE. Yes.

Mrs. COLLINS. Specialist Sellers, how many people do you see in the CDAAC in a given month?

Specialist SELLERS. In a given month? I would have to estimate roughly about 40.

Mrs. COLLINS. About 40 people? Of those 40 people, do you feel that the level of the usage of hash as opposed to heroin is greater for which group?

Specialist SELLERS. You mean is there more hashish use than more heroin use?

Mrs. COLLINS. Well, I don't know how I can put it. Now, I'll try to phrase my questions in such a way that clear English would give you

the question that I'm trying to ask. Now, you can't answer my question by asking me a question.

Mr. ENGLISH. Would the gentlelady yield?

Mrs. COLLINS. Yes.

Mr. ENGLISH. Specialist Sellers, I think basically what I'm trying to get at, of course, is trying to get your perception of how much usage we have. Now, Captain Barnes has given us one, which is pretty much in line with what the urinalysis is, pretty much in line with the testimony we have received this morning from General Blanchard. Would you say that 3 to 4 percent hard drug usage is low from what you know to be taking place? In other words, from your discussion or whatever other means you have of determining the extent of drug abuse?

Specialist SELLERS. Yes, sir, I would feel it would be.

Mr. ENGLISH. To what range would you consider to be likely as far as what the amount of drug abuse would fall into? In other words, are we talking about—well, just give me percentagewise a range in there that you feel comfortable with that it would probably fall in. Let's say on hard drug use.

Specialist SELLERS. On hard drug use. Sir, I am not a specialist on this, but I have been told by others that it would fall into a range of 25 or 30 percent and I have checked with other counselors in the corps and they have told me that that figure is realistic to them.

Mr. ENGLISH. So, the other counselors you have discussed this with, and your own feelings, and what you have seen and what you have observed, and what other techniques you have for determining, this feels like a right figure, 25 to 30 percent on hard drug usage?

Specialist SELLERS. Recreationally, yes, sir.

Mr. ENGLISH. Recreationally and everything, that covers the whole span, that's right. What about on, say hashish? What category do you think we are talking about there with other counselors and what you have seen and what you know there?

Specialist SELLERS. Sir, the figure that I have been given by both the lower EM and the company commanders has been between 88 and 92 percent, but I don't know what frequency of use this figure represents.

Mr. ENGLISH. So it is to some degree of use. So you have had company commanders that have indicated that to you as well, that that is generally where they feel like it is.

Specialist SELLERS. Among the lower EM's, yes.

Mr. ENGLISH. Among the lower enlisted personnel. Thank you.

Mrs. COLLINS. One final question, please, Mr. Chairman, I am interested in knowing how many women in the group of 40 that you see on perhaps a weekly basis, how many women are in that group?

Specialist SELLERS. Mrs. Collins, I am in an all-male battalion, so there wouldn't be any.

Mrs. COLLINS. Could you tell me Captain Barnes, the percentage of women who are currently in CDAAC, the two you have jurisdiction over?

Captain BARNES. Yes, ma'am. Just taking a guess, it is very low, but just taking a guess I would say about 3 or 4 percent.

Mrs. COLLINS. Let me ask you this question, is that because, as it was said here earlier today, that women come in with higher standards,

are higher for women to come into the Army? We get higher educational levels, or are their barracks any different? What would be the difference of the cause for the low number of women as opposed to the higher percentage of men under given circumstances?

Captain BARNES. I'm sorry ma'am, I really have no feel for that, I really don't.

Mrs. COLLINS. Is there anybody here who can give that information on this particular panel?

Ms. BRUCE. Most of the women that we see most of the time are single and have problems usually with maybe drinking or taking something for weight reduction. A lot of the female service members are married. They have an outlet, whatever it may be, and they have problems dealing with that as opposed to using drugs.

Mrs. COLLINS. Do you know if a study has been done of the single, unmarried female, who comes here who lives in the billets, who has the same problems in language, uniqueness, and all of this, has there been a comparative in analysis been made between her and the E–1's through E–4's who are coming in who are male? Does anybody know that?

Ms. BRUCE. I don't know of a study having been made.

Mrs. COLLINS. Thank you very much. Thank you, Mr. Chairman.

Mr. ENGLISH. Mr. Jenrette?

Mr. JENRETTE. Thank you. Specialist Sellers, the 25 percent hard users for recreational purposes, do you have any feel or statistics relative to the number of those that might become addicted? Do you have a feel for that?

Specialist SELLERS. Sir, I would feel of my clients, the number who would be addicted would be a very small percent. The number that would maybe have a predisposition toward addiction would be, say, the first figure would be 10 percent, the second would be about 40 percent, and the rest to me is basically not a drug problem but an immaturity problem.

Mr. JENRETTE. Do you have any feel—you or Ms. Bruce—either as to the percentages of hard drug use for between E–1 and E–4 living on-post or those who might be married and living off-post? Do you have any E–4's living off-post?

Specialist SELLERS. Very few, sir, of my clients.

Mr. JENRETTE. But you do have some clients living off-post? What percentage of your clients live off-post?

Specialist SELLERS. I think in the last 18 months it would almost be as low as about 3 percent.

Mr. JENRETTE. How many in the battalion that you represent?

Specialist SELLERS. I believe it is a community of 1,000, sir.

Mr. JENRETTE. What is the total community that you represent in your CDAAC?

Specialish SELLERS. The soldiering community is about 1,000, sir.

Mr. JENRETTE. Specialist Shouse, tell me, please, the number in the community that you represent in CDAAC.

Specialist SHOUSE. I am from Bad Hersfeld, sir. There are approximately 1,200 to 1,300 soldiers in my community.

Mr. JENRETTE. How many individuals in CDAAC do you have working with you?

Specialist SHOUSE. There are—do you mean counselors or clients?

Mr. JENRETTE. Counselors.

Specialist SHOUSE. I am the only military counselor, I have a GS–7 supervisor, sir. We have a total case load now of 42 or 43 people.

Mr. JENRETTE. What is your background, your educational background?

Specialist SHOUSE. Well, sir, I've got approximately 24 credit hours since I have been in the Army—of college. I've gone through the 91–G school in 1973, I've been through the Army's Drug and Alcohol Rehabilitation Training School in 1974. This is my second tour in Germany. I've been working CDAAC's now for 4 years. I've worked for a year in mental hygiene at Fort Huachuca, Ariz., and I've been to five or six drug and alcohol schools in Munich, sir.

Mr. JENRETTE. How old are you, sir?

Specialist SHOUSE. I am 23.

Mr. JENRETTE. 1,300 people you, and one other individual counsel those 1,300 people?

Specialist SHOUSE. Yes, sir.

Mr. JENRETTE. Your percentage coincides with that of Specialist Sellers?

Specialist SHOUSE. No, sir, it does not. I would say that of the people who use hashish, about 75 to 80 percent of the younger enlisted soldiers who do live in the barracks do use hashish. As far as harder drugs go, I would disagree very strongly with Specialist Sellers. In my community, the 3d Squadron, 11th Army Cavalry Regiment, we are on the border. We spend a lot of time either on the border or in the field on a TAPS or other field training exercises. I would say that maybe 5 to 10 percent of the younger enlisted soldiers who live in the barracks do occasionally use some type of drug, that is, Mandrax, or amphetamines, or some sort of barbiturate, and less than 2 percent probably use heroin.

Mr. JENRETTE. No addiction out of your CDAAC?

Specialist SHOUSE. As far as I know I have never seen anyone come through the CDAAC with a dependency code, other than the people for alcohol, sir.

Mr. JENRETTE. Major, did you have opposition in your election?

Ms. BRUCE. Yes; I did have opposition in my election. Two military NCO's, and one other female.

Mr. JENRETTE. Does the heat of the political battle cause you to, in your opinion, cause you to be less effective in your CDAAC work?

Ms. BRUCE. I was elected mayor prior to starting to work.

Mr. JENRETTE. So you won't know until your next election.

Ms. BRUCE. I don't plan to run again, sir, because I did go to work, and this is a full-time job, and that was a full-time job also.

Mr. JENRETTE. Would you, in your community—and I apologize if you answered this before—tend to deal with Specialist Sellers or Specialist Shouse?

Ms. BRUCE. Well, I have a lot of difficulty when it comes to addiction versus use, because addiction, 9 times out of 10, a person who comes to the CDAAC initially is not determined addicted. It is after sequences of several positive urinalyses, and then the doctor will determine, and the person admits continuous use, and by the time you

have sufficient evidence, and their percentage, I would say, is very small, that Captain Barnes gave. Once again when we talk about heroin, I think of a person who is shooting up versus snorting, and a person who smokes once or twice, I don't feel he is really addicted to it, and I think when we catch them at that point, many times they may start drinking more or something else to escape the situation, reality, or wherever they are. So when you talk about that kind of use, I would tend to agree with Specialist Shouse as opposed to the higher rate.

Mr. JENRETTE. Are you saying then that if you snort once or twice, one is not addicted. If you shoot up once or twice one does become addicted?

Ms. BRUCE. No, but I think a person who shoots up once or twice has probably been snorting for some time. This has been my experience. He started off smoking hashish, he started off with a chain of events.

Mrs. COLLINS. Do you see a lot of that chain of events going through CDAAC?

Ms. BRUCE. By the time we get an individual I would say the percentage might be somewhere around 15 to 20 percent of those people who have been through that chain of event, who have gotten into difficulty with drugs.

Mr. JENRETTE. Finally, I'd like to carry it a step further. In brief, do you feel that marihuana or hashish is the predominant first user to harder drug, heroin or some other of the uppers or downers? Captain?

Captain BARNES. Well, sir, I think what we are dealing with, while we do not have physical addiction to marihuana or hashish, it is a psychological part of the high. The enjoyable part of it. Once a person has reached a particular point in time, after using marihuana or hashish, I think the psychological craving for a quicker, faster, higher high pushes them on to a harder drug.

Mr. JENRETTE. So you think the progression is there?

Captain BARNES. Yes, sir, I do.

Mr. JENRETTE. Do you Specialist Sellers?

Specialist SELLERS. Sir, I've almost never seen a heroin user who had not taken hashish first. On the other hand, I've seen many hashish users that do not move on to heroin. I think the fact that the Army does not test for hashish——

Mr. JENRETTE. How do you test for hashish other than commanders being right on top of the situation?

Specialist SELLERS. I'm sorry, perhaps I'm wrong. I thought there was a test that we weren't using.

Mr. JENRETTE. Is there a test for use of hashish?

Mr. ENGLISH. It is my understanding at the present time that such a test has been developed, it is being tested, however, it is not being used in the field and no arrangements have been made for purchases as far as we know.

Mr. JENRETTE. Ms. Mayor, would you believe there would be a progression?

Ms. BRUCE. Yes, I think that most people who become addicted are polydrug users of some form or another.

Specialist SHOUSE. I would agree, also.

Mr. JENRETTE. You are a mayor, and don't want to be a congressman?

Ms. BRUCE. I didn't say that. I'm not old enough yet.

Mr. JENRETTE. You are excused, ma'am.

Mr. ENGLISH. Let me say that if you decide you want to run, I hope that you move to South Carolina, Mr. Jenrette will be happy to welcome a little additional competition. Mr. Evans?

Mr. EVANS. Ms. Bruce, have you had occasion to deal with soldiers stationed in the field for long periods of time, in radar units or similar type units?

Ms. BRUCE. Yes, in Bad Kreuznach, sir, there are two missile sites. We are really three. We have a missile unit at Dexheim, but we have the site at Dechtelbach and Wackernheim. When I first started working in the CDAAC, I was a counselor at Dexheim, which I thought was really the pits. Until I went to one of these missile sites, and one of the missile sites, they had no American TV because they cannot get an antenna, it is in the valley, and they have a lack of a great deal of services because there are only about 100 or so men there. The problem is—I know that these are necessary, but I would hope that something could be done, and I have expressed it through the chain of command—that something be done about the length of tour.

Mr. EVANS. In working with and observing the men in these units, what is your estimate of drug abuse in these areas?

Ms. BRUCE. Strangely enough, the number of people we had in the program from these units is very small, and I think it goes back to the fact that these are people in the PRP program, the personnel reliability program, and there is a certain amount of security, and what have you. So you get back to Mr. English's statement that if you identified these people, they have to be removed from the job, and there is a shortage that is going to occur. Now I don't have anything to substantiate that this is what is being done.

Mr. EVANS. My question, though, is what do you estimate the drug use to be, percentagewise? Not how many people are being treated, I say how many are using drugs, recreationally or otherwise?

Ms. BRUCE. Well, if you say alcohol, it would be 100 percent, and that is to the excess, because if they aren't using illegal drugs, then they are drinking excessively.

Mr. EVANS. What about illegal drugs?

Ms. BRUCE. Somewhere in the neighborhood, I guess, of about 70 percent using some sort of drugs.

Mr. EVANS. And this is in the missile units.

Ms. BRUCE. Yes. Now, I'm not saying addicted, I'm saying use.

Specialist SHOUSE. Could I make a statement to that?

Mr. EVANS. Yes.

Specialist SHOUSE. This is my second tour here in Germany. The first time I was here I worked in the CDAAC in Gelnhausen, which is part of the Hanau military community, and now I'm in Bad Hersfeld. In the 11th Armored Cavalry we spend a lot of time in the field, and I think the more time a unit spends in the field training, the lower the rate of hard drug use is going to be. I see it very much lower now than it was back in 1974 to 1976.

Mr. EVANS. I understand what you are saying. You said where people are training, in active training, that there is less usage. Would

this include hashish, which can be taken with them fairly safely to the field?

Specialist SHOUSE. I really don't know, sir. I'd say probably, yes. I've spoken to a lot of my clients about when they go to the field, do they take drugs with them or do they not. Some say they do and some say they don't. I'd say it's just lower in this unit than it was before.

Mr. EVANS. Excuse me, would this not be different where you are in active training with a tank unit or infantry unit than it would with a missile unit in which they may have long periods of inactivity and remain in a remote area?

Specialist SHOUSE. It definitely would be different, and too, I think that it depends on the type of training a unit is doing when they are in the field. A lot of units will go to, say Grafenwoehe, or to one of the firing ranges and they'll stay 4 to 6 weeks, when they could actually do all of their training in 2 or 3 weeks, and they just pull macht nichts details whereas, where I'm at now, we spend 2 or 3 days in the field and we are back.

Mr. EVANS. So the more active you keep the soldier on some kind of stimulating activity, the less drug usage you will have.

Specialist SHOUSE. The more meaningful the training is, I think, the less the hard drug rate will be.

Mr. EVANS. Thank you.

Ms. BRUCE. In addition, about the sites, too, I would like to add that many of the service members who come to these sites are in what they call, MP MOS related things, and they are under the impression they are coming to work in a different kind of job, and this makes a difference as far as they are concerned out at these sites. In expressing their concerns to me, a lot of them feel that the missiles and things they are working on are really outdated and they are not of value. I don't know how true this is, but in talking to them, this is what I get. And that is, again, job satisfaction. If they could be training on something they know is going to be used in the time of a crisis, or is of value, I think it would be much more meaningful for them. They are very concerned that maybe they should rotate back to a white hat duty, as they call it, kind of patrol and then out to the sites again on a rotating basis, because they pull 24 on and 24 off, and they are not able to go anywhere, get involved in these fantastic trips because they have to be back within 24 hours. I think that they definitely need to be looked at.

Mr. EVANS. I think my time is up, Mr. Chairman.

Mr. ENGLISH. Specialist Sellers, I have one or two other questions. Have you found in your experience that you can really do any good for an individual who has been caught using drugs if that individual really doesn't want help?

Specialist SELLERS. No, sir.

Mr. ENGLISH. So it is pretty much a waste of time and a waste of effort.

Specialist SELLERS. You can lead a horse to water, sir, but you can't make him drink, would be my response.

Mr. ENGLISH. Of the people that come into your program, what percentage do you think are willing to accept the help or want help?

Specialist SELLERS. Sir, I would think not over 10 or 15 percent really want indepth change on the drug or alcohol problem, another 20 or 25 percent are able to, for 5 or 6 months, simply remain clean by the behavior modification system of getting urine tested and knowing the CO is watching him.

Mr. ENGLISH. How many of those in those categories voluntarily turn themselves in to CDAAC? In other words, "I've been using drugs, I want help."

Specialist SELLERS. Somewhere between 3 and 5 percent, sir. It's not high.

Mr. ENGLISH. So what you are basically telling me, those that come out of the urinalysis testing, those who have been identified by their commanders through one form or another, caught using, or through urinalysis, then come into the program, you are saying 5 percent of that are coming voluntarily, 5 percent then of those will accept the help and that means about 95 percent of those people you identify just don't want help, is that correct?

Specialist SELLERS. I'm hoping that once they are in counseling, through the counseling process, they will realize there is a serious problem. The percentage of clients that I have that are willing to change their lives around with 180° turn indepth would not be over 15 percent.

Mr. ENGLISH. So as far as those people then that fall into that category, that are voluntarily making this change, what percentage of those do you think really stick with it?

Specialist SELLERS. So far, almost all of them have, sir.

Mr. ENGLISH. You think most of them have? You, as I understand it, you have formed in your area the Narcotics Anonymous, and I believe that is the first in Germany, is that correct?

Specialist SELLERS. Yes, sir.

Mr. ENGLISH. Have you found that this particular program, working in conjunction with your CDAAC work, has been successful for those who want help?

Specialist SELLERS. Sir, I believe that it is working here the way it is working in the States. It is fully effective for those who want help. As a social worker, I have found it a tool for appraising a client's motivation. There is a classic dialog that sometimes happens, "I want help, I am willing to do anything, my CO is about to throw me out, I don't want him to." Are you willing to go to the Narcotics Anonymous meeting? "No, I go to a disco on Friday." And then I've got more of a feel for who the guy is and whether he means business or not. So it works both ways, I think, as a diagnostic tool, too.

Mr. ENGLISH. Let me ask you this: With regard to those, whatever it is, 90 percent, range that come through you, either identified by the commanding officer or through urinalysis, of that 90 percent, are they really just a burden on the system, I mean, they are absorbing resources or absorbing time, do they just simply make your job more difficult, as far as trying to work and give your time to those who really need it?

Specialist SELLERS. Well, that is what I started to say before about that foot metaphor. I see a lot of men that I shouldn't see to begin with. I see a large, large number of men who had drug problems before

they came in, but it has stopped short of heroin. In the environment of it being so readily available, plus the cultural shock, plus not having a good background in German, they seem to go over to the heroin. I have a good, good number of men who are just chronologically so young that perhaps they would have sowed their wild oats without heroin had they remained in America for 2 or 3 more years to get through that stage. I get a lot of men who are basically immature, and once in a while this comes out as a urine positive. It's that basic problem of immaturity. I would say that about 8 percent of the clients I get, because there is the absence of a good NCO around, and sadly because there aren't enough good NCO's and the system says, well, perhaps the CDAAC can help this young man. In this event, we will attempt to do so.

Mr. ENGLISH. So you are kind of the last resort. If we don't know what else to do with them we will throw them to CDAAC and if they can't do anything with them we're going to give them a chapter 9. Is that correct?

Specialist SELLERS. Often our facility is local where some other facilities are not. For example, our psychiatric resources are downtown. This process can sometimes take an entire day, and I think there is a tendency to say, well, we can send him down to the CDAAC to have someone to talk to. So there is a whole realm where drug abuse gets mixed up with immaturity.

Mr. ENGLISH. Well, you were saying that these people shouldn't be sent to CDAAC, you are seeing a lot of people that you shouldn't be seeing. Where should they go? Where should they be sent?

Specialist SELLERS. I guess I'm saying different things, sir. One thing, I just personally just strongly believe is that there should be an age minimum before they come to USAREUR or tour minimum, maybe first tour CONUS, I don't know. Second thing I see is that there is no screening by recruiters. I have had 10 clients this year say that they came into the Army to get out of a jail sentence. Then they want to immediately get out of the Army because they are full of confidence they won't have to go back and serve the jail sentence. There is another margin, I guess, that is a very, very small margin, that perhaps should have preferably been referred to a psychiatrist. That number would maybe be 2 or 3 percent.

Mr. ENGLISH. In your opinion—you have heard me express my thoughts in regard to leaving individuals, particularly those individuals who have been identified as pushers, but also those individuals who have been identified as users, leaving them in their units in their environment that they were situated when they were discovered and the impact it has upon other soldiers who are transferring in who may also already be in that unit and not using—in your opinion, do you feel that there is anything to that? In other words, are you getting the bad influence type of thing that is spreading or not?

Specialist SELLERS. Sir, I try to take the perspective of the soldier that is clean, because I believe that is the soldier that the Army wants, and the soldier that's clean tells me that he has trouble finding environments in which other people are clean. I see that as a very real threat to that man as he states it to me, yes.

Mr. ENGLISH. So that is his barracks primarily, but also where he goes for social activities as well as where he works, is that correct? That is really his entire environment.

Specialist SELLERS. Well, like my colleague here, to some degree I would include alcohol. After 9 or 10 o'clock at night, his NCO club is open. His EM club is open. It is a place with a lot of alcohol and loud music, which kind of keeps a real conversation down and a lot of wild booze up. His photo shop is closed, his craft shop is closed, there is no coffee house where he can go and be clean and sober. His gym is closed. So it kind of implies that you can stay up and drink but you can't stay up and develop photographs.

Mr. ENGLISH. But you can also stay up, and then if he goes back to the barracks, what? Probably he is going to be using something there. You leave the user in there, he can't go to the NCO club, he doesn't want to drink, but he can't go back to the barracks because he doesn't want to be around people using drugs. Isn't that about what you run into?

Specialist SELLERS. I guess what I was trying to sneak in, I think some of the heroin abuse is a perversion of the alcohol culture, which is a little perverted. It's a great influence.

Mr. ENGLISH. Am I understanding you correctly, if you leave those people leave that environment—in other words, if you leave the users there, if you leave the pushers there, all it does is make it much more difficult for that young person who does not want to use drugs. Alcohol, of course it sounds like would fit in the same area, but with particular regard towards drugs, would that be correct?

Specialist SELLERS. I believe it spreads, sir.

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

Mr. GILMAN. Thank you, Mr. Chairman. I just have one or two more questions for the panel. Something we haven't touched on up to this point, is the extensiveness of use of alcohol and narcotics amongst dependents. I received some of that information, as we were talking with the personnel, that there is an extensive problem of amphetamine use amongst dependents. Do you have much of that come through CDAAC? Captain Barnes, are you familiar with the dependency problem?

Captain BARNES. We have had one dependent, a military wife, who came in for a couple of times for conversation with the counselor, but she stopped. We have had no other dependent come in.

Mr. GILMAN. Was that a narcotic problem?

Captain BARNES. Alcohol. But in order to keep that rate down, we have started to move out into the civilian dependent type agencies, such as PTA, teen involvement, to really put out more education, more information on it so that it will keep it down as much as possible.

Mr. GILMAN. Specialist Sellers, have you found any problem in the dependents? Have they called upon your agency for help?

Specialist SELLERS. Sir, I could only speak from rumor. We have never to my knowledge had a dependent walk into our office. In the normal course of gossip I have heard that there is a problem, for example of heroin among dependent wives, so that if a man is trying to get clean and comes back to a wife at home who is taking drugs, this can become a family disease. I don't know any statistics on what that would be.

Mr. GILMAN. I will be pleased to yield to the gentlelady.

Mrs. COLLINS. Is CDAAC set so that if there is a dependent wife, that CDAAC will see that wife as well as the husband?

Captain BARNES. Yes, ma'am.

Mrs. COLLINS. Thank you for yielding.

Mr. GILMAN. I also heard complaint that there is quite a bit of Valium usage and other amphetamine usage amongst the dependent wives. Have you heard any reports of this nature?

Specialist SELLERS. No, sir, I've only heard heroin.

Mr. GILMAN. Ms. Bruce, in your contact with the community, do you find any problem of that nature?

Ms. BRUCE. I haven't heard of that problem, because Valium has to be prescribed through the pharmacists, and in dealing with the colonel at the hospital, he is very aware and conscious of this. I think the problem I find is one, again, with alcohol. Not only with dependent wives and spouses, but with dependent youth. In Germany, it is just a common practice for teenagers to go to the local grocery store and get a bottle of wine or get some beer. Many American youth coming over, first-time exposure to this, is very difficult, especially around your dependent youth activities organization, or DYA.

Mr. GILMAN. But in your CDAAC program you haven't had any involvement with the wives.

Ms. BRUCE. No, not in a counseling status. I do go to all of the civilian supervisors and I provide information for supervisors because we do have responsibility for handling any civilian employees that are around the area.

Mr. GILMAN. CDAAC is open for counseling for the wives?

Ms. BRUCE. Yes, and for civilians that are not part of the military.

Mrs. COLLINS. Would the gentleman yield.

Mr. GILMAN. Yes, I would be pleased to yield.

Mrs. COLLINS. What percentage of wives do you have now in CDAAC?

Ms. BRUCE. In the program? We have no wives in the program. The wives that we are involved with are spouses of service members who are having a problem to the extent that we are going to be doing couples group counseling.

Mrs. COLLINS. But you are not yet doing that?

Ms. BRUCE. We will start December 1st. We have had them in the groups that we do now, as a part of the group, because the wife has volunteered to come in. We are going to be doing some now where it will be just devoted to just couples and not single service members.

Mr. GILMAN. Specialist Shouse, do you have any information?

Specialist SHOUSE. In our CDAAC we have had two dependent wives come in with their husbands for counseling for alcohol. About 6 weeks ago we had a dependent wife busted with quite a large amount of heroin, but she was a local German national and she was put in jail, so we never had anything to do with her.

Mr. GILMAN. She was a trafficker?

Specialist SHOUSE. Yes, sir. Could I respond to a question that Mr. English raised a few minutes ago? When you were talking about getting a hard drug user out of the unit, to a point, I would agree with you. I think when a person is identified as a hard drug abuser, you should try to help him as much as you could within that unit. If he shows a desire to rehabilitate himself, I think the groundwork for the rehabilitation has to be done within the unit because that is where he is going to come back to.

Mr. ENGLISH. Wouldn't you agree, though, that that would be limited to those individuals——

Specialist SHOUSE. Those individuals who want help.

Mr. ENGLISH. You are talking about a very small minority, aren't you?

Specialist SHOUSE. Yes; a very small minority. I think a person who wants to get out of the Army by using the CDAAC program, which a lot of people do, because you can get an honorable discharge, and I don't like that idea of giving a person an honorable discharge, the same thing I am going to get for staying in 3 or 4 years. I think a person, once he is identified as a failure, or a person who is going to manipulate the program to get out, which is very easy to do, I think he should be segregated into a separate unit, just for these type of people, but there is nothing like that in the Army. I have been told that the Air Force has some type of program like that; whether or not it is true, I don't know.

Mr. GILMAN. Thank you very much.

Ms. BRUCE. I would also like to make a comment in regards to the assistance that you may provide, this committee. As a dependent wife coming to Europe and in the hopes of getting a job, it is very difficult, and I would hope that—I have written my Congressman back in the State of Maryland in regards to this problem, but the correspondence—I'm sure he is getting doubletalk, and that's the same thing I got when I was here—there is a tremendous resource in dependent wives that come over here with their husbands, but we are given the short end of the stick as opposed to people who are hired in CONUS and transferred over here, as far as status is concerned. In going back, that is going to be one of the main issues that I will address, and I would hope that maybe some groundwork could be done, because there are a lot of women over here who could do fantastic jobs in terms of counseling, who hold degrees. We have a girl who is temporary hire now, with no benefits, and she is working on her master's in counseling. She is a GS–5. In the States, she would get a much better job. I will be here for over 2 years, probably working in this job, and when I go back I have no reemployment rights and it is like I just sat at home and did nothing for 2 years. I think something could be done in terms of tapping the resources that are here to counteract some of the negative statements about the caliber of counseling within the CDAAC to supplement the 91G's. I think the 91G's are good and can be used, but I deal mostly with senior NCO's and officers, and I think that is a tremendous help because there isn't that exchange between rank. In the same realm, there are senior NCO's with an age difference, and then in the same realm, there are 91 Golfs who can relate, so I think that is one of the areas that should be looked into in regards to whatever rehab program.

Mr. GILMAN. Will the gentleman yield? I think certainly your comments are valid, and as you were addressing yourself to this issue, the thought struck me about the training that you have for this job. Have you been specially trained for this job? I know Specialist Shouse mentioned that he was trained on the job, apparently, and Captain Barnes is trained on the job. Have you had any human resource training?

Ms. BRUCE. My degree was in business administration and management. However, when I worked in the States, I worked in the Department of Social Services. I attended a weekly seminar for drug and alcohol rehabilitation at one of the colleges, and I was going to Rutgers before my husband got orders, but we all go through training programs in Munich, the drug and alcohol school in Munich. Captain Barnes has been to the ADCO course, which is training for a week or so, and then there are classes that start from individual counseling skills all the way up to group counseling skills. I have been to what they call Superman's course, which is for supervisors, that specifically relate to dealing with the problem within the military. I am not going to say that my credentials are all that great because I don't have a social work degree, just because I wanted a degree in management, which to me is all people related.

Mr. GILMAN. Specialist Sellers, what sort of training do you have for this job?

Specialist SELLERS. Sir, my degree is in social work, with a Federal internship and grant, and we have counseling, and we have 6 to 8 years of paid and nonpaid drug and alcohol halfway-house work.

Mr. GILMAN. Thank you.

Mr. ENGLISH. The committee is going to take a 15-minute break. Shortly after the break, we have three panels of enlisted personnel from the field that we will hear from, so we will recess for 15 minutes.

[Recess.]

Mr. ENGLISH. Earlier today, I requested of the enforcement people the information pertaining to those individuals who had been arrested for trafficking in drugs; namely, noncommissioned officers, E5 or above, as well as officers. We now have that information. I would like to read it into the record. In 1977, there were 15 E5's or above that were apprehended, no officers; in 1978, 28 noncommissioned officers were apprehended and 1 officer. I do not have the rank of the one officer that was apprehended. My understanding is it was a first lieutenant. The chief of staff will call the next witnesses.

Mr. LAWRENCE. I call Private Diaz and Sergeant Darwin.

[Private Diaz and Sergeant Darwin were sworn.]

Mr. ENGLISH. I suppose this goes without saying, but I do want to state it for the record. Certainly if there are any repercussions as far as enlisted personnel that should appear before this committee, any type of harassment, or otherwise, this committee certainly wants to know about it as quickly as possible, and I'm sure that General Blanchard would also like to know. That being said, do either of you gentlemen have a statement that you would like to give? Or would you like to say anything to the committee? Sergeant Darwin, do you have anything you would like to say? If you would, move the microphone a little closer to you, I understand we had a little bit of trouble with the rest of us hearing it. It may be tied down, I am not sure.

TESTIMONY OF SGT. CECIL DARWIN AND PVT. ETVEM DIAZ, B COMPANY, 8TH SIGNAL BATTALION

Sergeant DARWIN. On the drugs over here, now a lot of guys say when they give these urinalysis tests, they are being harassed, but my opinion of it is I think it is good for the men to get the test at

least twice a month or more. If he is found taking it, he should be taking more tests. Out of my 6½ years over here, I have had it quite a few times, and it doesn't even bother me. It is just letting my commander know that I am not messing with drugs at all. That's about it.

Mr. ENGLISH. Private Diaz, do you have any statements that you would like to give?

Private DIAZ. Yes. All of this about trying to help people with drugs and so much of the Government putting so much money up to rehabilitate these people, and nothing seems to be going down. Plenty of guys, when they come from the States, they figure they leave the environment back in the States coming to Europe, they can start their whole new life, and when they get over here, it is just a whole lot worse than it is back in the States. Some people say, "Well, the Government is working on it, the Army is working on it, I still see no change at all." My experiences, people that I've seen, that come over here were using drugs a lot less; then when they come over here, it just builds up and gains on them from the boredom, they have no activities, no kind of recreation. They have recreation, but not something to really enthuse themselves, something for them to enjoy. You go to every caserne, every recreation is the same. You have a gym, a recreation center, and NCO club. You have got to have more than that to keep our soliders busy. That's really all I have to say.

Mr. ENGLISH. Private Diaz, from what you were stating—and correct me if I am wrong—are you stating that you believe that there is much more drug abuse here within Germany that there is back in the United States?

Private DIAZ. Yes; there is.

Mr. ENGLISH. Would you say there is a substantially greater amount of drug abuse here in Germany than there is in the United States among the troops that you know?

Private DIAZ. Yes; there is. Over here the hashish is a lot more stronger than marihuana, and it is a lot easier to get than marihuana over here. It makes the amount more greater, and it just builds up and builds up, that's why I figured it's more over here than what it is in the States.

Mr. ENGLISH. What about heroin or hard drugs? Do you feel there are more hard drugs being used here than there are in the United States?

Private DIAZ. Yes; because the soldiers over here are being pressured, tension, you know. They go to the field, they come back, mostly some get mad when they get a letter from home saying that something went wrong. They go ahead and start off with hashish and then they want to go on to something stronger, so they just keep on going on to something stronger so when they do go back to the States, they are already on it.

Mr. ENGLISH. Whenever you came to Germany, was there a great deal of peer pressure? Were you approached by people saying, "Hey, you use drugs," or anything like that?

Private DIAZ. Mainly not right at first, because a lot of people like to try to cover themselves. They don't normally come on and say, "Do you use drugs?" or "If you do it, I got something to sell

you." Normally, they will wait for you to be there about a month to see how you are and then they will approach you and tell you, "If you want some of this, I know where to get it."

Mr. ENGLISH. That's people within your unit?

Private DIAZ. Yes.

Mr. ENGLISH. It took about a month before you were approached with regard to purchasing some drugs to use?

Private DIAZ. More or less about a month.

Mr. ENGLISH. In your particular unit, what would you estimate the hashish use to be? About how many people within your unit that you know about would you say are using hash?

Private DIAZ. I would say, in our whole unit, battalion unit, there are at least 600 of us, male and female. I would say from 300 to 400 would use drugs.

Mr. ENGLISH. So you're talking 50 to 60 percent of them?

Private DIAZ. Yes.

Mr. ENGLISH. What with regard to hard drugs, what percent that you know about do you think are using hard drugs?

Private DIAZ. Well, hashish is more or less what they use more. Hard drugs would be about 35 to 40 percent. Not too much less than hashish.

Mr. ENGLISH. Are people fairly open in using hash, or do they sneak off some place to use hash, or do they use it fairly openly in the barracks and on the job and elsewhere?

Private DIAZ. Well, yes, some use it on the job, some use it off the job, some try to keep themselves away from it and just go in the streets and do it or in the field, or whatever. Some do it in the barracks. Wherever they can do it.

Mr. ENGLISH. But they are fairly open with their fellow soldiers about it, is that correct?

Private DIAZ. Only if they know it is OK with them. If they feel that this person is not all right with them then they will just hold off on it.

Mr. ENGLISH. Does the same hold true for hard drugs?

Private DIAZ. Yes.

Mr. ENGLISH. Sergeant, you were indicating with regard to urinalysis tests, that you feel like it is a good program. Do you believe that the urinalysis test can be beaten?

Sergeant DARWIN. Yes, it can. It can be beaten, because a guy goes in the men's room to take in the bottle, he is not always watched by somebody, so he can have somebody take in another bottle and give it to him, and see, they don't know if it is that individual's or if it is somebody elses.

Mr. ENGLISH. The tests that you have seen conducted, are there quite a few lapses in security, like what you are talking about there where there just isn't anybody much watching them? Is that fairly common?

Sergeant DARWIN. In some of the units I have been in over here in Europe, yes. In ours, they have it set up when a man takes a urine test, it has to be an NCO there watching him. That NCO is signing that piece of paper saying that he watched that man take a urine test.

Mr. ENGLISH. Do you know of any NCOs in your unit who are selling either hash or hard drugs?

Sergeant DARWIN. I don't know about my unit, but I know there are quite a few of them in the battalion that are selling it. There are quite a few that are taking it, too.

Mr. ENGLISH. NCOs?

Sergeant DARWIN. Yes, sir.

Mr. ENGLISH. Does that have quite an influence do you think on the young soldiers that are coming over here from the States, the ones that are just reporting in? Are they most likely to be contacted first by one of these NCOs who might be selling some hash or something?

Sergeant DARWIN. No; they will be contacted by one of the lower ranking EM's first. When I came over here, I was contacted by a lower ranking EM, then an NCO. When I told him no, I don't mess with it, he said, "Well, you don't get high."

Mr. ENGLISH. With regard to the NCOs that do sell, those same NCOs then would be responsible for the security on some of the urinalysis tests; is that correct?

Sergeant DARWIN. Yes, sir, that's correct.

Mr. ENGLISH. Do you know if they protect to a certain extent their buyers?

Sergeant DARWIN. Yes; they do. They will protect them.

Mr. ENGLISH. They make sure the buyer doesn't get caught?

Sergeant DARWIN. If the buyer gets caught, he might get caught.

Mr. ENGLISH. Well, that is a fairly common occurrence among those who are also selling?

Sergeant DARWIN. Yes, sir.

Mr. ENGLISH. I believe my time has expired. Mr. Gilman?

Mr. GILMAN. Gentlemen, do you observe any selling in the barracks, any trafficking in the barracks?

Sergeant DARWIN. Yes, sir, I've seen it done. But see, me, as an NCO, I can't prosecute him unless I've got a witness with me, and it's best to have another NCO to be your witness, because the lower ranking EM's are going to stick together. They are going to sell it to each other, they smoke it. I've busted them quite a few times smoking it, but there ain't anything I can do. There has to be another NCO as a witness to really push it.

Mr. GILMAN. Does the trafficking you've observed in the barracks, does that include the sale of heroin?

Sergeant DARWIN. Yes, sir. They are selling it.

Mr. GILMAN. And the sale of any other narcotic?

Sergeant DARWIN. Well, hashish, that's about it, and maybe Mandrax.

Private DIAZ. Mandrax, hashish, heroin, speed, the type of things you would get walking into a drug store that is legal for Germans but illegal for Americans.

Mr. GILMAN. Is the sale of those narcotics occasional, regular, quite a bit? How would you categorize it?

Private DIAZ. Well, on the Mandrax, and so-called speed they call X112, it is kind of not occasionally, more or less say about twice a month, three times a month, but hashish and heroin more or less you have that every week.

Mr. GILMAN. Is the sale of that going on every week in the barracks?

Private DIAZ. Most likely every week.

Mr. GILMAN. Is it the same individuals who are selling?

Private DIAZ. No; not really. Most of the time it is, but it seems like if one person sees one individual making so much money out of his drugs, he wants to get a piece of the action, so he goes ahead and asks him how did you go about this. Maybe one might not want to tell this, so he can make the money himself.

Mr. GILMAN. Are there ever any disputes of who is the trafficker in what barracks?

Private DIAZ. No, no, I don't think so.

Mr. GILMAN. Do you know how much heroin is selling for now in the barracks?

Private DIAZ. How much it is selling for? The minimum is $20, the maximum, no price.

Mr. GILMAN. So the $20 that they are selling it for, do you know what amount that includes? Is it for one hit?

Private DIAZ. Well, I really can't tell if it is one hit or not.

Mr. GILMAN. Do you know what amount of heroin that is?

Private DIAZ. Well, sometimes it will depend on the dealer, if he wants to be generous or not, he will give you 2 to 3 grams for $20. Dealers try to get over, too, because they are copping quantity and it is still a felony straight out, the way they cop it, pure, they cut it down in order to double and triple their money up.

Mr. GILMAN. Do you know what strength it is that they are selling it at?

Private DIAZ. No, I wouldn't know.

Mr. GILMAN. Do you know how much they paid for it out on the street?

Private DIAZ. Well, like I said, minimum $20, maximum is no price.

Mr. GILMAN. They are selling it at $20 a hit in the barracks. Do you know what they have to pay for that heroin when they purchase it out on the street to bring it in?

Private DIAZ. No, it all depends on how many grams the dealer buys, so sometimes—let's say you take $200, you go out and buy yourself $200 worth of heroin, you come back and make $500 off of it.

Mr. GILMAN. You can make $500 out of a $200 purchase? Have you ever observed a purchase by a trafficker in the barracks when he goes to a dealer?

Private DIAZ. Well, I have seen them in action, but not really seen them. I've seen them, you know, when they talk to each other and then just disappear. More or less you know what they are going to do. They are not going to have a cup of tea or anything like that.

Mr. GILMAN. Is that purchased from a German national, a foreign national?

Private DIAZ. Well it's hard to say, because I really don't go around spying.

Mr. GILMAN. The one you observed, who was that purchased from?

Private DIAZ. From an American.

Mr. GILMAN. From an American?

Private DIAZ. Yes.

Mr. GILMAN. Within the city, I take it, not on the post.

Private DIAZ. Well, I did within the city.

Mr. GILMAN. Is it quite available in town?

Private DIAZ. It depends on the German. Sometimes he has confidence with who he is dealing with; sometimes he don't, and if he feels that this person is right for him, then he will go ahead and it will will be a lot easier. I can call it a 60-40 chance.

Mr. GILMAN. Is any cocaine being sold in the barracks?

Private DIAZ. Well, I haven't seen any of that since I have been here.

Mr. GILMAN. Any PCP being sold in the barracks?

Private DIAZ. No.

Mr. GILMAN. Any amphetamines?

Private DIAZ. No.

Mr. GILMAN. Mostly hash and heroin, is that correct?

Private DIAZ. Hash, heroin, and Mandrax.

Mr. GILMAN. Am I correct that you said that it is about 60 to 65 percent of the troops that you feel are using hash? Or is it higher than that?

Private DIAZ. No, I would say a good 80 to 90.

Mr. GILMAN. 80 to 90 percent. And of those that are using hard drugs, you estimated it to be what percentage?

Private DIAZ. About 70 to 80.

Mr. GILMAN. 70 to 80 percent are using hard drugs?

Private DIAZ. Yes.

Mr. GILMAN. Have you ever seen anyone using hard drugs on duty?

Private DIAZ. Yes, I have.

Mr. GILMAN. Has it affected their ability to perform?

Private DIAZ. Well it depends on the person's system. If he can take it—I've seen some guys that they take it and it makes them work fine. It makes them work like any other human being. Sometimes you can't even notice that they are on it. Sometimes you can. It all comes down to a person's system.

Mr. GILMAN. Have you seen any where it affected their work?

Private DIAZ. Yes, some people, they slow up a little. They get lazy and don't feel like doing anything.

Mr. GILMAN. Have you got any further comments, sergeant?

Sergeant DARWIN. Yes; on the last one. The ones that you can tell are taking it on the job, what they do, the senior NCOs send them down to the company, and then the first sergeant will send them up to the dispensary. If they find out that they have been taking something, they send them to CDAAC, and that's when the individual says he is being harassed, because an NCO like me will turn him in, which I don't care. It is for his good health. I mean, I am a wheel vehicle mechanic. I work on engines, and when I put an engine in another vehicle, I have to road test it, and I go out there and road test it and he is walking out there all scagged up, and I hit him, I am in the wrong. But, you see, if we get him out of that motor pool before something does happen to him, he is all right.

Mr. GILMAN. To your knowledge, has there been any accidents as a result of someone being overdosed from narcotics?

Sergeant DARWIN. As far as the motor pool, no. In the barracks, yes. We have had a guy fall down the steps once, and then we had a guy who got in a fight, thought he could whip the whole world, but he ended up in the hospital. I see no use in it.

Mr. GILMAN. Do you go out to the field training every once in a while?

Sergeant DARWIN. A lot. Once a week on Wednesdays, and we go out for Reforger, tank gunnery, cardinal point one and two.

Mr. GILMAN. Have you observed any narcotic usage out in the field?

Sergeant DARWIN. Yes, I have. Quite a bit.

Mr. GILMAN. What type?

Sergeant DARWIN. Heroin, guys will be smoking hash, popping pills.

Mr. GILMAN. While they are out on field training?

Sergeant DARWIN. Yes, sir.

Mr. GILMAN. I don't have any further questions.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. Thank you, sir. That leaves me to ask you how combat ready do you think these guys are who are out in the field that you see doing these things, in a real live situation.

Sergeant DARWIN. In a real live situation, some of them won't do good, some of them will.

Mrs. COLLINS. How secure do you feel knowing that you have people who are——

Sergeant DARWIN. I don't.

Mrs. COLLINS. You don't feel secure?

Sergeant DARWIN. No, I don't.

Mrs. COLLINS. Do you?

Private DIAZ. No, not too secure.

Mrs. COLLINS. Private Diaz, you mentioned that in your opening statement that a lot of guys come to the service for a change in environment. You don't see any change in the environment—let me see if I can define it. You don't see any positive change, you don't see any change, or you see a negative change?

Private DIAZ. A negative change.

Mrs. COLLINS. You mentioned that about the kinds of recreation. What kinds of recreation would you suggest that the guys would be more interested in?

Private DIAZ. Well, more like on the weekends, like they have trips going to different places, but like they said earlier, a regular E1 coming in is not going to be able to afford that. They can make trips every other week or every week or during the week, just to show them around Germany. Maybe it will keep their minds off of getting high, and drinking so much and everything.

Mrs. COLLINS. Do you guys like to go to discos and dance?

Private DIAZ. Well, that's like the NCO club. They don't have that every night.

Mrs. COLLINS. I see. They would certainly like a little more dancing opportunity.

Private DIAZ. They would like, more like myself, I came here to Europe to explore, to see how Europe is, and I haven't gone nowhere yet.

Mrs. COLLINS. I yield.

Mr. GILMAN. How long have you been in Europe?

Private DIAZ. Four months.

Mr. GILMAN. Have you been off the post at all?

Private DIAZ. Oh yeah, I've been off post.

Mr. GILMAN. Out of the city, out of this region?

Private DIAZ. Yes.

Mr. GILMAN. Have you been able to take any trips?

Private DIAZ. No; because the trips they come up with are too expensive. And when they do come up with it, let's say we get paid at the end of the month, the trip comes up the next week and you have to have so much down payment on it, and they don't realize that so many soldiers have families back home that they have to send money to, and if they can have them at a more reasonable price, I think every soldier would be able to go.

Mr. GILMAN. Thank you, gentlelady for yielding.

Mrs. COLLINS. You mentioned about seeing guys that were overdosed. How much of this hard use of drugs do you see just for recreational purposes, just for no other reason, just that a guy wants to be scagged, as you call it?

Sergeant DARWIN. If we had more recreation, I don't think a guy would be interested in the drugs.

Mrs. COLLINS. What kind of recreation would you be thinking of, the same as he has said?

Sergeant DARWIN. Well, trips, and a lot more martial arts over here, because I am a martial artsman, I like it. It is kind of hard to go from Bad Kreuznach to Frankfurt every day practicing there. If they can get it up around BK, I think a lot of guys would be interested in it.

Mrs. COLLINS. You are an NCO, you said, right? Have you heard of or do you know of any incidents where a guy who is under your responsibility has decided that he comes here, he doesn't like it, he wants to get out, and then he himself has decided to follow this routine that I asked about before, the dirty urine leading to the article 15, leading to the fine and restricted duty to the CDAAC and ultimately to an honorable discharge. Do you know of any instances like that?

Sergeant DARWIN. Yes; there's quite a few of them.

Mrs. COLLINS. Would you say they are common, few, or what? This is as a feeling, not a hard figure.

Sergeant DARWIN. There are a few.

Mrs. COLLINS. But it is common knowledge among all the guys that this is one way of getting out of here?

Sergeant DARWIN. You mean one individual?

Mrs. COLLINS. No; that this is a method by which a soldier can get out of the Army in a shorter period of time than his tour of duty is for, and still get an honorable discharge.

Sergeant DARWIN. Yes, taking the drugs, yes, he can get out a lot quicker.

Mrs. COLLINS. And that's common knowledge among all the men once they get in here.

Sergeant DARWIN. Yes; it is.

Mrs. COLLINS. Thank you, I guess my time is up, but I do have one other question. I have heard from talking to different individual soldiers that aside from all these other kinds of recreation, the biggest problem for the black soldier is that he has trouble when it comes down to finding a girl from this area. Do you know if that is a major problem and if so, is it a problem that is directly related to the use of drugs, in your opinion?

Sergeant DARWIN. Well, in my opinion, I haven't had any problem. If you can't speak the language it is very difficult, because you walk up to a young lady and you say "hi" to her, she is going to tell you, "Verstehen, nicht nicht," just like that.

Mrs. COLLINS. Whatever that is.

Sergeant DARWIN. Well, she doesn't understand. And then you say something to her in German and she will come in the English and right then you know she speaks English, and understands it, but a lot of the guys that come over here with a negative attitude. They want out of here. They don't want nothing to do with these women. And there are lots of them out here.

Mrs. COLLINS. Isn't that a little unusual to have a bunch of guys that don't want to have anything to do with the women?

Sergeant DARWIN. I think something is wrong with the man upstairs.

Mrs. COLLINS. I have no further questions, Mr. Chairman.

Mr. ENGLISH. Mr. Jenrette?

Mr. JENRETTE. Thank you, Mr. Chairman. Private Diaz, what is your MOS, please?

Private DIAZ. Radio operator, multichannel communicator.

Mr. JENRETTE. And you are stationed where?

Private DIAZ. In Bad Kreuznach.

Mr. JENRETTE. How often do you go out in the field training?

Private DIAZ. Since I have been here, I have been in the field, I went to Reforger, that was a 30-day field exercise, after that I went to a 1-day field problem, and a 2-day field problem, not enough, though.

Mr. JENRETTE. Very little.

Private DIAZ. Very little, yes.

Mr. JENRETTE. The sergeant testified that about a month after he came in he was approached by an individual in the barracks for the purchase of drugs.

Private DIAZ. Excuse me, could you repeat that?

Mr. JENRETTE. The sergeant, I believe, testified that it was about a month after he came in he was approached for the purchase of drugs, or was that you that testified?

Private DIAZ. No, that was me.

Mr. JENRETTE. Have you seen that same individual that approached you approach other individuals that came in the service?

Private DIAZ. I believe so, yes.

Mr. JENRETTE. When an individual in the barracks is smoking hashish, is there anyone in your barracks that would tell on him, or would go to the first sergeant, or go to the company commander, or the platoon leader?

Private DIAZ. I don't think they would. They have their reputation and themselves about, "no, not me, I'm not going to turn them in, why should I? There is plenty of other people here." Every individual thinks the same, so it is kind of hard.

Mr. JENRETTE. So in the barracks, though many may not be doing it, they do not disapprove to the extent where they would go tell the platoon leader.

Private DIAZ. Yeah, to themselves, they don't disapprove it, it is not their system. It is not their body, it is not the body they are

hurting. If they try to talk to them one time, and the man disagrees with him, why bother with it, it is his body, not his.

Mr. JENRETTE. Do you believe, Private Diaz, having been here 4 months, that the individual soldier, the E1, E2, and E3 particularly, understand the mission, the purpose of being in Germany, the purpose of being in a far away land with a different language and a different culture, do you think they understand the mission of defense?

Private DIAZ. I don't think they do.

Mr. JENRETTE. You do not think they do?

Private DIAZ. Some of them just think they are over here just for an overseas tour.

Mr. JENRETTE. What do you think, sergeant?

Sergeant DARWIN. Well like he said, a lot of them say they are just over here to do time and get out of here. They don't realize what their job is, what it can do for them and all that. I have been here for a long time, and I plan on staying for a while. I just don't pay no attention to the ones that don't want to be here. I don't mind helping them, like you mentioned to him about the guys telling the senior NCOs. If they do that, then the next thing you know, it is going around the barracks they are a narc, and when your name comes out to be a narc, everybody tries to get you for it.

Mr. JENRETTE. Going back to the mission part, do you feel that the men under your command fully understand their mission?

Sergeant DARWIN. Some of them do and some of them don't.

Mr. JENRETTE. Hypothetically, let me ask you this, as an NCO: you would have a group of how many under your command in a training exercise or an actual military action?

Sergeant DARWIN. Well at my job, I have about 13 men under me, and all our mission is to do is replace parts and stuff like that, or when the truck breaks down and stops running we are to fix it and get it back on the road. That is all we are supposed to do.

Mr. JENRETTE. Well, do you feel that any of those 13 men have a concern about the possibility of their being spaced out, or whatever it might do to them, that they would be letting another buddy down? That something might happen that, not just working, his whole life might depend on that truck being delivered to that point previously assigned to him? Do they understand that mission?

Sergeant DARWIN. No; they don't, because they figure they have others, and they just don't care.

Mr. JENRETTE. Were you here earlier today when the generals testified relative to the orientation program, the speaking the language, the other things; were you here when that was being testified?

Sergeant DARWIN. Yes, sir.

Mr. JENRETTE. Is the mission explained to you at your initial—or maybe the private would know—is the mission explained to you at your initial orientation briefing?

Private DIAZ. I didn't even get an orientation when I got here.

Mr. JENRETTE. What about a narcotics orientation?

Private DIAZ. Neither that.

Sergeant DARWIN. Me either.

Mr. JENRETTE. You never got a narcotic orientation?

Sergeant DARWIN. I never received one in 6½ years.

Mr. JENRETTE. How long have you been in Germany?

Sergeant DARWIN. For 6½ years.

Mr. JENRETTE. Well, you should be giving them now, shouldn't you? This is very interesting, but lastly, Sergeant, have you had any training by a platoon leader or by a company commander, any ranking officer up to a general, that would allow or help you be a counselor for any of those 13 men that you are responsible for?

Sergeant DARWIN. No; because half of the time I am on the job, and we don't get the time. Our equipment stays down so much that we have to work until late at night just to keep it in operating condition.

Mrs. COLLINS. Would the gentleman yield?

Mr. JENRETTE. I would be happy to yield my time.

Mrs. COLLINS. Sergeant, if that is the case, would you say that perhaps you would be combat ready but you wouldn't be equipment ready?

Sergeant DARWIN. That is right, ma'am.

Mrs. COLLINS. Thank you for yielding.

Mr. JENRETTE. Back to you, Mr. Chairman.

Mr. ENGLISH. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. Sergeant Darwin, you have made an estimate of the drug usage in both hashish and other soft drugs, and also an estimate as to the amount of hard drugs. Now, what do you base your estimate on? Is that based upon what you see and what you hear, or what is it based on?

Sergeant DARWIN. Mostly what I see.

Mr. EVANS. OK, you have 13 men under your command. Have you observed all 13 of those, for instance, smoking hashish?

Sergeant DARWIN. No; because there are a few under my command——

Mr. ENGLISH. Sergeant, before you go any further——

Mr. EVANS. That might be making it too specific, but what I am trying to establish is we are given figures by all of the military as to what their estimates are, and what I am trying to determine is when you estimate that 80 or 90 percent of the people are using some type of drug, are you seeing 80 or 90 percent of the people in your company using drugs, or your battalion, or whatever?

Sergeant DARWIN. That is battalionwise.

Mr. EVANS. Yes; I'm trying to get it big enough that you won't be sitting there identifying everybody, I don't want to do that. We are trying to get general information, but I want it to be correct information, and I am trying to find out whether you are basing this on perceptions or other people saying everybody is using drugs; are you talking about what you actually see?

Sergeant DARWIN. Well, what I have seen and what I have heard, but I've seen more than what I've heard using it.

Mr. EVANS. Now, how do you arrive at a percentage? Do you see a number of people that don't use drugs?

Sergeant DARWIN. Yes; I've seen quite a few that don't use it.

Mr. EVANS. That don't use hashish, don't use pills, don't use Mandrax and heroin? Don't use any of that?

Sergeant DARWIN. That's right.

Mr. EVANS. Do you see any that don't drink?

Sergeant DARWIN. Well, I see quite a few drink; I even do it myself.

Mr. EVANS. Yes; I understand. I do, too, but what I am asking is, do you see any that don't drink?

Sergeant DARWIN. No; I don't.

Mr. EVANS. So you think that you would say that close to 100 percent of the people drink?

Sergeant DARWIN. I know it is a big margin, it is a big percent.

Mr. EVANS. Well, I understand, but if you don't see anybody that doesn't drink, surely you come in contact with somebody that doesn't drink. If you don't, then that's where I understand it to be 100 percent.

Sergeant DARWIN. Well, when I drink, I just don't go looking for nobody that doesn't drink.

Mr. EVANS. Do you see a lot of people in there drinking with you?

Sergeant DARWIN. I'll be drinking with them.

Mr. EVANS. OK, whichever. But let me ask you something about people coming over here. Now, do you think that these soldiers when they come over here, do you think they make every effort to help themselves that they can make?

Sergeant DARWIN. Some of them do and some of them don't.

Mr. EVANS. Some of them don't make the effort; is that right? Do you think some of their attitudes are wrong?

Sergeant DARWIN. Yes; it is the attitude.

Mr. EVANS. Do you think there are some things to do here that they don't take advantage of doing? Some of them?

Sergeant DARWIN. Yes.

Mr. EVANS. So this drug usage is not entirely the fault of the Army; would that be your feeling?

Sergeant DARWIN. I couldn't say that.

Mr. EVANS. OK. Well, let me ask Private Diaz a couple of questions. You also used some figures. Do you see all of these people using this stuff?

Private DIAZ. I can't say I see all of them. I see a percentage of them.

Mr. EVANS. Well, how do you establish that percentage?

Private DIAZ. Well, to rate 1 to 10, I would say 9.

Mr. EVANS. You say that 9 people out of 10 use it? What primarily are they using?

Private DIAZ. Most likely, hashish. That is what is mostly around.

Mr. EVANS. OK now, what about heroin? You can chip it or you can sniff it or you can shoot it up. Have you seen many people shooting up heroin?

Private DIAZ. Again, rating 1 to 10, I would say about 7.

Mr. Evans. You've seen 7 people out of 10 shooting heroin?

Private DIAZ. Yes.

Mr. EVANS. Well, they must not worry about whether or not you are going to turn them in. You figure it is their business and you are not going to mess with them one way or the other.

Private DIAZ. Well, once they enter that environment, once they reach that particular high, they don't care about anything.

Mr. EVANS. Is this primarily on the job, or is it off duty and weekends?

Private DIAZ. This is whenever they get it. On the job, off the job, during the week, and whenever.

Mr. EVANS. Aren't they under some type of supervision when they are on the job?

Private DIAZ. Not all the time.

Mr. EVANS. Sergeant Darwin is not going to let them be shooting up on the job, is he?

Private DIAZ. If they do want to shoot up on the job, they will think of some excuse to go to the barracks. Up in the motor pool, they don't have a latrine up there, so eventually you have to go into the barracks to use the latrine, so that would be one way of getting out of the motor pool. Phil, can I go use the latrine? They go to the latrine and come back like brandnew.

Sergeant DARWIN. Excuse me, when you asked him about the motor pool, well, down in the motor pool, all of the NCOs are right there where they are supposed to be, the majority of them are. In my job, I walk up and down the floor, and I haven't seen nobody yet smoking it in the motor pool.

Mr. EVANS. Can you smell it? Does it give off a peculiar odor?

Sergeant DARWIN. It's got a weird smell.

Mr. EVANS. And you don't smell that during working hours?

Sergeant DARWIN. Not in my motor pool; no.

Private DIAZ. Well, the motor pool is out in the area so you eventually got the air blowing around, so it would be very hard to smell that on top of gas and grease and all of that.

Mr. EVANS. So is that where you get away with that? I mean ones who smoke?

Sergeant DARWIN. Yes; you do.

Private DIAZ. I guess so.

Mr. GILMAN. Would the gentleman yield?

Mr. EVANS. I yield.

Mr. GILMAN. It was related to us that on occasion the men would lace the hash with opium, have you observed that at all?

Private DIAZ. No; opium I haven't heard about that over here. Would you repeat that?

Mr. GILMAN. On occasion the men would lace the hash with opium or heroin, have you ever seen that happen?

Private DIAZ. No; I haven't.

Mr. ENGLISH. Thank you very much, gentlemen. Chief of staff will call the next panel.

Mr. LAWRENCE. Sgt. James A. Henderson and Staff Sergeant Brooks, please.

[Sergeants Henderson and Brooks were sworn.]

Mr. ENGLISH. Sergeant Brooks, do you have any statement that you would care to make at this time?

Sergeant BROOKS. No, sir.

Mr. ENGLISH. Sergeant Henderson do you have a statement you would care to make?

Sergeant HENDERSON. No, sir.

Mr. ENGLISH. Both you gentlemen have listened to the questioning that has gone on all day and the discussions. I suppose the first question that I would like to ask you, recognizing the positions that you are both in, do you know of sergeants or noncommissioned officers who are selling hashish or heroin? Sergeant?

Sergeant HENDERSON. Yes; I know of one.

Mr. ENGLISH. You know of one. Sergeant Brooks?

Sergeant BROOKS. I am in a rather unique situation because I am also the NCOIC and the senior counselor for CDAAC, so, yeah, I am privileged to some things that other people aren't. Yeah, there are NCOs that sell drugs.

Mr. ENGLISH. Given the information that you have, would you say that that is a sizable number?

Sergeant BROOKS. I can speak for the Berlin brigade because that is where I am from, and I don't think it is that large a number of NCOs.

Mr. ENGLISH. Percentagewise, of all the NCOs there, can you tell us approximately what we are talking about? 10, 20, 30, 40, 50, percent?

Sergeant BROOKS. No; I don't think it's that high. Anywhere from maybe 2 to 4, at the maximum, 5 percent.

Mr. ENGLISH. Five percent maximum?

Sergeant BROOKS. Yes.

Mr. ENGLISH. Sergeant Henderson, you stated that you only know of one?

Sergeant HENDERSON. Yes, sir. I believe the question you asked that was selling it, now using it I know definitely of a little bit more from observation, in other words, what I feel looking at them in the morning. After a weekend or after a payday or something, I would say confidently that there is more than that.

Mr. ENGLISH. Of those that you know about for certain, can you give us a percentage, say in your brigade?

Sergeant HENDERSON. At NCO level alone?

Mr. ENGLISH. Yes.

Sergeant HENDERSON. Well, I'll speak mainly for the battalion, I would say that about 10 percent in the NCO bracket.

Mr. ENGLISH. Sergeant Brooks, would you care to give us an estimate on using in your area?

Sergeant BROOKS. Probably brigadewise, in NCOs, again, it is not really that high, 2 to 4 percent, maximum 5 percent of NCOs, using the whole spectrum of drugs. Heroin use is probably not even 1 to 2 percent.

Mr. ENGLISH. Are you talking about the same people who are selling are also the ones who are using?

Sergeant BROOKS. Primarily. They are the ones we end up seeing in the program.

Mr. ENGLISH. What percent of those who are using also sell?

Sergeant BROOKS. I wouldn't even want to venture to say specifically that percentage. Again it is not that high. because of the situation in Berlin. You really can't hide there. You are recognizable and it is easier to see people, especially right now because of the focus that has been on Berlin. So the NCOs, the officers, those kind of people, aren't getting involved now. I am talking primarily more than a year ago because of the emphasis, things have changed, shifted tremendously in Berlin.

Mr. ENGLISH. So you've noticed a big in change the last 12 months?

Sergeant BROOKS. Yes.

Mr. ENGLISH. Sergeant Henderson, in your unit I suppose you have a large number of new people who come over here from the States. Do you know of occasions in which those new people are being pressured to use drugs, or being asked if they need drugs, or urged to take drugs in any way?

Sergeant HENDERSON. Well, I am not going to speak definitely about the other men, but I can speak for something that happened to myself. I arrived in my new unit on a Friday evening, fairly late.

Mr. ENGLISH. What rank did you hold at that time?

Sergeant HENDERSON. E–5.

Mr. ENGLISH. E–5. OK.

Sergeant HENDERSON. I was in the unit that night, got to bed late, and the next morning, being Saturday morning, the first day of a 4-day weekend, got up around 10, and before noon I was asked if I wanted to purchase some narcotics.

Mr. ENGLISH. Was that from an NCO or from an enlisted man?

Sergeant HENDERSON. From an enlisted man.

Mr. ENGLISH. Sergeant?

Sergeant BROOKS. No one has ever approached me. As I said, Berlin is a small community, and because of the job that I held, and the feeling that people have toward CDAAC personnel, no one would ever approach me and ask me if I wanted to buy drugs.

Mr. ENGLISH. Well, certainly in your job, you would see a large number of people who would come through and tell about the story with regard to drug abuse and what they got into, are you hearing a lot of stories about this type of activity that they come in the unit and somebody approaches them and tries to sell?

Sergeant BROOKS. We've heard about it through various sources that most of the people say it is less than a month before they are approached to purchase drugs. Probably 75 to 80 percent before they got a month in country.

Mr. ENGLISH. Do you hear of many that had the experience Sergeant Henderson did, namely, being approached in 24 hours after they arrived in the unit?

Sergeant BROOKS. Roughly, 25 to 30 percent, probably the first week. The openness is amazing because the openness is there. The young people aren't hiding it the way we would think they would be. I don't know what that means, but it is their security of their own particular realm of friends. It's not that if I come around they are going to be doing drugs, that's not going to happen, but when they are together in a group, alone, then there is not real hiding. NCOs have said they've walked in the rooms and found people with needles in their arms, and they really didn't know what to do in that situation. So that does happen, true.

Mr. ENGLISH. Would you both please give me your estimates with regard to the use of percentagewise, of those that you know, percentagewise, how many use hash and how many use some form of hard drugs?

Sergeant HENDERSON. I would say approximately 80 percent use hash, and approximately 10 percent use the harder drugs, or speed.

Mr. ENGLISH. On those people that are using hash, are they using it on duty?

Sergeant HENDERSON. Some of them on duty, yes.

Mr. ENGLISH. Sergeant Brooks.

Sergeant BROOKS. If I am talking about the whole brigade, I would say probably 8 to 10 percent are using hard drugs, experimenting with it or using it regularly, not falling into one category or the other. As far as using hashish, 55 to 60 percent, probably to some degree.

Mr. ENGLISH. On duty?

Sergeant BROOKS. On duty? That is really hard to say, because we have two type situations, we have the infantry situation and support troops. For the most part, the support troops don't have the opportunity to use on duty unless they go to the latrine or something of that nature, in other words they are working in offices and there are other people around. As for the infantry battalions, the only thing I can rely on is what my counselors tell me, what they have heard, and they probably say 10, 15, maybe 20 percent, and that is primarily for hash. Heroin, that's not happening that often, I don't think. Maybe 5 or 10 percent.

Mr. ENGLISH. On duty?

Sergeant BROOKS. Right.

Mr. ENGLISH. Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman. Gentlemen, how much of your time do you spend in the barracks with men? I know you're CDAAC and spend most of your time in CDAAC counseling, but do you also have another responsibility being with the men?

Sergeant BROOKS. Yes; I am also floor sergeant in the barracks.

Mr. GILMAN. How much time do you spend with men in the barracks?

Sergeant BROOKS. I would say anywhere from 1½ to 2 hours a day.

Mr. GILMAN. Sergeant?

Sergeant HENDERSON. I'm directly with my people almost constantly. I see them from 5:30 in the morning to sometimes as late as 9 or 10 o'clock at night.

Mr. GILMAN. Do you find that there is a good rapport with your men? Are they able to discuss their problems with you, or is there some reluctance to do that?

Sergeant HENDERSON. Among some of the squads in the other platoons, I've seen a reluctance and some of them even like to come to other platoons and other squads to talk. I feel pretty fortunate that my squad seems to talk pretty openly, and they seem to be pretty free about the problems as well as being very concerned.

Sergeant BROOKS. OK, my situation again is different because most of my people are staff personnel, and I don't really see them other than what's happening in the barracks, you know, taking care of things of that nature. Again, they don't really talk to me because I'm almost a nonperson to them. They have their NCOICs in their own particular sections that they rely more on. I can only speak for the personnel that work for me, of course, the CDAAC counselors. I think that our rapport is great, from being very subjective about it, and being hopeful, too, I guess. I think we get along well. I think that for the most part, the people in my company in my barracks, the people who live in the barracks, get along well. As far as NCO to EM relationship, I don't think too many of those exist, other than on the job kind of situations.

Mr. GILMAN. Aside from your training for CDAAC, did you have any training to counsel a man as a sergeant?

Sergeant BROOKS. OK, I started as a neuropsychiatric technician, and I have been in the Army for 14 years, so I have been around for a while. I have been to the behavioral science, the 91–G course. I've been to a number of drug and alcohol courses and the NCO and

advanced NCO courses. Counseling is taught in all of those schools, so I think that I've been very fortunate in that respect.

Mr. GILMAN. You've had specialized training in that area. What about you, Sergeant Henderson?

Sergeant HENDERSON. Nothing, sir.

Mr. GILMAN. None at all. Are you aware of whether there is such a program?

Sergeant HENDERSON. Yes, sir, I am aware that there is such a program as CDAAC and it covers everything from alcohol to hard drugs. I have my own personal beliefs about this program and its effectiveness.

Mr. GILMAN. What is your opinion about it?

Sergeant HENDERSON. I think it does no good.

Mr. GILMAN. Can you tell us why?

Sergeant HENDERSON. Because it is developed to a point, in my opinion, that the program is no good. Men are using it as a means of getting out of work, a means of trying to get out of the service early, they are tempted by the honorable discharge, they can't take some of the long hours and some of the hard work that is put upon combat arms, or a lot of the support units, I believe, don't have the pressure that we do in front line soldiers, so they try to use it as an escape to get out.

Mr. GILMAN. Sergeant Brooks, is some of that criticism justifiable?

Sergeant BROOKS. Yes; I have to respond to that in that the reason that those kind of things happen, I think, is because we haven't decided what kind of program we want. I don't think we know if we want it to be a medical program, whether we want it to be a rehab, whether we want it to be administrative punitive; I don't think that definition has been made, so it's confusing everyone, to include the command, the CDAAC staff, and the clients. Nobody knows exactly what the program is supposed to be. Until that definition is made, it's not going to be as effective as it could be.

Mr. GILMAN. That's a good criticism, have you voiced that to higher levels?

Sergeant BROOKS. Thousands of times. I have worked in the program since its inception, and I worked under the medical command and under the administrative command, and I have some very definite feelings in that if it is going to be a rehabilitative program, then take it out of the administrative structure. If it is going to be a punitive program, an administrative program, then put it entirely in that realm and let the units take care of the program. In other words, you've got the unit commanders, and they've got some very legitimate gripes in that you're taking people out of their realm, and you put them in CDAAC and CDAAC is doing these things that they are really not sure what's going on about. Then you are sending them back, supposedly cured. Well, when this person isn't cured, company commanders seem to get upset about that because they've been given guarantees by the military that this person would be cured. There is no magic to the program.

Mr. GILMAN. Are you aware of the hospital program, the in-care program?

Sergeant BROOKS. Yes; we have one in Berlin.

Mr. GILMAN. Do you find that to be worthwhile?

Sergeant BROOKS. It depends on how it is used. If it is used as a threat, which unfortunately sometimes it is, then no. If it is strictly voluntary, and there is more than one way to be volunteered of course, if you have a career on the line, that can be used to make you want to volunteer, then it is going to be effective. To coerce a person by saying this is your last chance, or whatever, and you are going in whether you want to or not, you are wasting a lot of money, time, and effort.

Mr. GILMAN. Sergeant Henderson, you wanted to comment?

Sergeant HENDERSON. Yes; another thing, like I was saying, that I would like to say a little more about, is that a lot of the men are very confused about the honorable discharge factor of going in and turning yourself in. They may feel, "I am getting some heat from up above, my officers know I'm going out and smoking some hash or I am doing something like this, well, I know how to get out of it, I'll go in and drop it on the CO's desk and say I got a problem, send me to CDAAC, help me," and right away they are going to get this little thought that comes in that they can't be prosecuted, no legal action can be taken against them. They feel they do this, they go to a few meetings, and then they can still slip around and do it and nobody is going to be watching them anymore after a couple of months. They go through the program, they feel they can pull the wool over the eyes of the counselors and then the heat is off of them, and they can go right back doing the same thing.

Mr. GILMAN. So they use CDAAC as a shield as well as advice to get out of the service.

Sergeant HENDERSON. Yes, sir, I believe that very thoroughly, and I've even had men admit to me doing this.

Sergeant BROOKS. That can only happen if the command lets it, though. The most important people in this program, in my estimation, and I've heard it said that because they were young that they shouldn't be as first-line supervisors. If those persons aren't knowledgeable of the program, if they don't in essence run the program from the company level, you know, overseen by the unit commander, the first sergeant, or whoever, then the program doesn't work.

Mr. GILMAN. In other words, it has to get down into the barracks to be effective.

Sergeant BROOKS. Definitely.

Mr. GILMAN. And that starts at first line supervision. Thank you. My time has expired.

Mrs. COLLINS. Sergeant Brooks, I've heard from some of the young men that it is very easy to invalidate a urinalysis test, that they can put salt in the urine, or vinegar, this would remedy the test non-effective, have you found this to be the case?

Sergeant BROOKS. There are some things that will work. When I was stationed in Japan, I ran the urinalysis, we, actually the CDAAC collected the urines, took them to the lab, et cetera——

Mrs. COLLINS. Hold on just a minute, I've just been cautioned that you shouldn't say what these things are, but this is a perception that some of the soldiers have and it can or cannot be effective, would that be a good supposition that it can or cannot be effective.

Sergeant BROOKS. Unless someone substitutes an entire bottle for something that's not urine, then it is very difficult.

Mrs. COLLINS. OK, that's a sufficient answer, I think. Do you know of any incidents where there has been collusion with the NCO when it comes down to taking the urine test?

Sergeant BROOKS. I've heard it.

Mrs. COLLINS. But you don't know of any, to be precise?

Sergeant BROOKS. I wouldn't swear to it. I can only say that I've had some people who I consider reliable, tell me.

Mrs. COLLINS. OK. You mentioned, Sergeant Henderson, that when you first came into the area, that within 24 hours, an enlisted man approached you about wanting to know whether or not you wanted to purchase some drugs. Would it seem to you that his NCO did not have knowledge of this? How could it be that an enlisted, or is it possible for an enlisted man to be selling narcotics or drugs or whatever it wants to be called, and the NCO not know it?

Sergeant HENDERSON. It's possible that it can happen, but it is not that probable. Could I make a comment on your urinalysis question you had? It is just like when they bring the marihuana dogs through, Rin Tin Tin and his cousins or whatever, it doesn't make any sense to me to bring them through on the 13th when payday is the 15th. How many people are going to have anything, how many people are broke at that time. Why can't they bring them through payday night or the following morning? Why can't they have urinalysis on the 16th if the payday is on the 15th instead of on the 13th or the 14th? Something to this nature. This is something I have observed since they have been doing this testing. I haven't experienced it with this unit, that I am currently with, but with my past unit I have seen this, and I have also seen where it seems to be a general consensus among the higher ranking NCOs and the lower ranking officers that smoking marihuana and smoking hash, it is off duty and away from the barracks, it is sociably acceptable. Why should you hassle the guy over it? It's like me going out and having a beer. As long as the guy does his job and he is halfway good, leave him alone.

Mrs. COLLINS. It is an interesting observation. Thank you very much, my time has expired. Mr. Jenrette?

Mr. JENRETTE. Thank you. Sergeant Henderson, when you came aboard on that Friday afternoon and you were approached on Saturday morning, have you seen this individual approach anyone else since you have been in the unit?

Sergeant HENDERSON. No; I have not seen him approach another person and ask him to buy anything.

Mr. JENRETTE. How long was the orientation that you were given relative to drugs in Germany when you came on board?

Sergeant HENDERSON. When I first arrived and went over for my in-processing, I began a thing called "Headstart" the following week on a Monday. They spent about 30 minutes talking about it and they had, I believe he was a customs agent, I don't remember exactly, that came in and talked about drugs at that time. The biggest thing that he talked about was warning the guys when they buy the stuff to be careful because the stuff gets laced with a lot of things that could really mess you up or get you hooked on harder stuff. They never really came out and talked about the CDAAC program other than to mention it and they never really came out and talked about what the criminal prosecutions could be of it.

Mr. JENRETTE. In your unit, is the utilization of hashish or a harder drug affecting the fulfillment of your mission?

Sergeant HENDERSON. Yes it is, very definitely.

Mr. JENRETTE. It definitely is?

Sergeant HENDERSON. Yes.

Mr. JENRETTE. Would you say that on days after payday or would you say that—of the 20 days you would train within a month, your mission would be affected on how many days?

Sergeant HENDERSON. I would say the biggest effect would be the first week after payday, but there would be a lingering effect thereon from some of them. I don't know if it is a dependence or not, I'm not a physician, but they seem to want to do it every day, and they do stick together, the enlisted personnel that are smoking, they will stick together and it you finger one of them, they are all going to swear and be damned they didn't. You don't have any witnesses and you can't do anything about it, you are stuck in a corner. What is, more or less, in my opinion, boiling down to, you just got to accept it. You've got to live with it and work around it.

Mr. JENRETTE. What is your actual job? Are you a combat trooper?

Sergeant HENDERSON. I am a frontline engineer, I am a combat engineer.

Mr. JENRETTE. The younger men that you work with, do you think they know their mission, the reason they are in Germany, the importance of their being in Germany?

Sergeant HENDERSON. About half of them understand it to a point. I don't think more than one of them might understand it fully.

Mr. JENRETTE. Sergeant Brooks, you used the word earlier I believe, "focus on Berlin." Elaborate on that for me, please.

Sergeant BROOKS. OK, well, I'm sure that most people are aware of the 5th of July test that was given in Berlin, which resulted in a lot of command emphasis on the drug and alcohol program for a lot of reasons. As a result, those of us working in the program got a heck of a lot more support than we have before. I am not saying that the support wasn't there before, I just don't think the emphasis was there. Of course, when command puts an emphasis on something, everybody seems to get the message. The primary mission being combat readiness, the drug and alcohol program, as with some other programs, is pushed to the side. Now we are being focused upon, the drug and alcohol program is, so quite naturally command is responding to that.

Mr. JENRETTE. What sort of cooperation, if you have a knowledge of it, would you receive from the police in Berlin, the Federal Republic Police, CID, DEA, or any of the other American agencies or German agencies?

Sergeant BROOKS. As a result of what's going on, you mean?

Mr. JENRETTE. No, generally, not as a result of July 5.

Sergeant BROOKS. CID and the military agencies, I tend, as the NCOIC, to keep them out of my realm for obvious reasons. Observations of the German authorities, has been their emphasis wasn't on drug abuse, or on drugs per se drug trafficking. That's changed. I won't say that I know why it's changed, but is took 2 years for it to change. I used to get very upset in that drugs were readily and easily seen in the city, and there seemed to be nothing happening because of it.

Mr. JENRETTE. Has that dramatically changed now?

Sergeant BROOKS. I was under the impression that it had. A week before I left, I saw some things that made me question it, that is being on a U-Bahn stop and seeing some people who were quite obviously high in the U-Bahn station, the underground railroad, and supposedly there are undercover policemen there, maybe there were and I wasn't aware of them, but there were quite obviously a lot of people who were high on drugs in that particular U-Bahn station.

Mr. JENRETTE. Would it surprise you if I told you that I went there and talked with 40 drugs addicts who gave me a total rundown on how they purchase the heroin, how long they have been on it, that it costs up to DM400 a day for some of them to utilize it, would that surprise you?

Sergeant BROOKS. OK, to answer that, I used to work as a disc jockey in the clubs on the German economy, so, no, it wouldn't surprise me.

Mr. ENGLISH. One very quick question, Mr. Evans, if you will allow me. Has there been any discussion about how quick this effort is going to be reduced once the heat is off? You were mentioning that this thing has been building here, is there any indication that it has been building in anticipation of our visit or because of the interest of this committee?

Sergeant BROOKS. Quite honestly, I feel that it's unfortunate for me that I'm leaving now because I think the emphasis will stay there so that the situation doesn't occur again. I don't think that it will decrease. I think it will either stay where it is or intensify to insure that there is no recurrence.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman. Sergeant Henderson, you indicated that, I believe, an estimate of something like 80 percent of hash use in the battalion or in the group unit that you are in; is that correct?

Sergeant HENDERSON. Yes, sir.

Mr. EVANS. And some 10 percent of hard drugs?

Sergeant HENDERSON. Yes, sir.

Mr. EVANS. And you indicated that you definitely felt that that affected the ability of the soldiers to do their job.

Sergeant HENDERSON. Yes, sir, I do.

Mr. EVANS. Tell me about Reforger. We are told in Reforger that units came out rated very highly and did a good job. What is your analysis of that in relation to what you are telling me about the use of drugs and the ability of the men to do the job.

Sergeant HENDERSON. Well, sir, first, sir, I would have to say that my unit was not involved in Reforger in a tactical manner. They were on damage control. They mainly took reports of accidents that took place and of property damage to the German people during Reforger. I personally was not in the field during Reforger this year, so I really couldn't say honestly how it affected them there, but I have been on a couple of trips with my platoon elsewhere and seen how they performed, and the platoon as a whole performed pretty well. My squad, I feel, performed real good, although I did see some people in other parts of the company at different times, not only in the field but in garrison, that you can tell they are not functioning

to their full capacity. You find them sleeping on their bunk, you find them down at the snack bar, just anything, just trying to get away from people for awhile. I'd see it during PT in the morning where guys come out and you can tell by looking at them that something is wrong with them and they can't perform.

Mr. EVANS. You think there was a high incident then of people not being able to do their job while you were in actual exercise of your job?

Sergeant HENDERSON. I feel if we were to move out to the field on alert right now and have to stay for an extended length of time, yes, it would affect our performance very much.

Mr. EVANS. Would it effect it because some people would be having withdrawal pains, or because they would actually have stuff with them to use?

Sergeant HENDERSON. I feel first of all they would have stuff with them, and if they don't, someone is going to bring it to them.

Mr. EVANS. I see. In connection with this drug use, you've seen a great deal of it, I understand.

Sergeant HENDERSON. I've seen enough in the short time that I've been with this unit to make me wonder on whether I would want to go into combat with this unit or not.

Mr. EVANS. You've indicated that you didn't have confidence in the combat readiness. You have indicated that when you saw someone doing something, that if you saw him by yourself, that you could do nothing about it. How many times have you gone to the lieutenant and said, "Lieutenant, you know we've got a real drug problem, we've got 80 percent hash use, what can we do about it?"

Sergeant HENDERSON. Well, first off, you can go with that information, and the first question they are going to ask you is what proof do you have? You say, "I got my word," of "if you want, we can go over there and try to search this man," and then you can't do it, you get into a lot of legal things that come about, or there isn't time, or something to this effect. I have tried mentioning on one occasion an incident that took place. It wasn't directly to my platoon leader it was to an officer in my company, and that person said, "It ain't going to affect nothing."

Mr. EVANS. So, is there an attitude on the part of some of the officers and the middle echelon of officers that smoking hash is something you just have to tolerate and work around?

Sergeant HENDERSON. Yes, sir, like I stated, they feel more or less the general consensus is that it is socially acceptable.

Mr. EVANS. And you disagree with the ability to do the job while using it?

Sergeant HENDERSON. Yes, sir, I don't feel that any combat troop I may have to crawl under a foxhole with some day when somebody is shooting at me should be using any kind of narcotics.

Mr. EVANS. Thank you. Sergeant Brooks, do you generally agree with that analysis of the situation?

Sergeant BROOKS. Which particular parts?

Mr. EVANS. OK. I'll start over. What about the combat readiness, the ability to do the job? Do you think that soldiers can do the job when they are regular or social users of hash?

Sergeant BROOKS. Personally, no. Anytime that you've had anything that's changing the way your brain functions, you don't function the same way.

Mr. EVANS. Have you witnessed people not being able to do their job?

Sergeant BROOKS. Yes; sure.

Mr. EVANS. Has this been extensive or just limited?

Sergeant BROOKS. OK, to be fair, because of my job, I saw a lot of things and situations that the people are going through withdrawal, or they are about to go through withdrawal. Of course, they can't function at that time. Will it affect their combat readiness? Sure, but I don't know how fair an estimate that is because working in a psychiatric ward where these people were taken.

Mr. EVANS. You see a greater incidence of it because of where you work; is that correct? Have you observed a combat unit or any other unit in actual training?

Sergeant BROOKS. Yes.

Mr. EVANS. Have you observed during that time any incidence of drug abuse, or the results of drug abuse, the symptoms of drug abuse, on the part of any substantial number of the men?

Sergeant BROOKS. Not substantial numbers, but there have been instances, of course, accidents, of fights, things of that nature.

Mr. EVANS. Do you think these came about as a result of drug abuse?

Sergeant BROOKS. Some of them did.

Mr. EVANS. Sergeant Henderson, can you tell me anything about the medical care that is provided for the personnel, families, and so forth?

Sergeant HENDERSON. Yes, sir. I think the medical care in the Darmstadt community is very poor, and this, I feel, has a great deal of influence on the morale problem. The morale, I believe is one of the biggest contributing factors to the men turning to drugs. I know of one incident that I personally witnessed where I was in the appointment desk, or at the appointment desk, in the medical facility, trying to make an appointment for my wife when a young couple came in with their daughter who the man was holding in his arms, and she had a pot in her lap, she was white as a ghost, and the mother claimed that the child was running a temperature of 104. The child was puking in the pot, and the nurse came in and says, "Well, I'm sorry, you're 17 minutes late for your appointment, we only allow you 15. We can't see you. Get you an appointment in about 4 days." No matter how they argued, they did not see those people, and they ended up leaving the building and going to the IG's office.

Mr. EVANS. IG's office?

Sergeant HENDERSON. Inspector General, sir.

Mr. EVANS. And what was the result of that?

Sergeant HENDERSON. I have no idea what the result of that was, sir, but I do know that I stood there and witnessed this and we have no dependent sick call. If for some reason my wife was to get sick, not really to the point where she needs to go into the emergency room, but where she does need to see a doctor, I would have to be there early in the morning and hope that I can get an appointment to get in to see the doctor.

Mr. EVANS. Is that because you don't have enough doctors? Why is it?

Sergeant HENDERSON. I believe that's part of the problem. I am not totally aware of why they have this appointment system and why they are so rigid with it at the medical facility, but I do believe we could use a better medical staff. Also, I would like to say that currently my wife is pregnant, and it is almost an hour drive to the nearest facility that can deliver a child, and if she was to have a quick delivery or a miscarriage or something of this nature, how would I get her there very quickly? I couldn't take her to my medical unit because they don't have any facilities for this.

Mr. EVANS. I think my time is up. Thank you.

Mr. ENGLISH. I want to thank both of you gentlemen. You have been extremely helpful, and I simply want to state once again that if there are any indications of people who have resented your testimony here and your frankness and candidness with us, I hope that you will let this committee know, or I'm sure General Blanchard would like to know as well. Thank you, very much.

Sergeant HENDERSON. Mr. English, before I go, I would like to say a few things. Like I was saying, morale, I feel, has to hold a big responsibility for the problem we are having with the narcotics here. Like it has been stated earlier, a lot of the young kids come over here, they have never been away from home for an extended period of time before, and they have got to come over here for 3 years. They are separated, they are pushed into a new environment, a lot of times some of them 17 or 18 years old, and you have some people who have been here for 2 years already, they're 20 or 21 years old maybe.

These drugs have been pushed on to them and now they are pushing them on to these people, and some of the younger people want to resist, they want other things to do, but it seems like a lot of things are falling short. A lot of the trips they are planning, as it was stated earlier, are too expensive for the young man coming into the service, especially if he does have a young wife back home and can't bring her over. Some of the programs, some of the training programs that goes on within the unit, are not doing any good. They are harassment-type things. A man goes to the field, he does maybe 6 hours of honest, good work and training, and learns something out of a 2-day period, and the rest of the time he is just doing a little macht nicht detail. He is not really accomplishing nothing. His morale goes down, his living conditions, especially where I'm at, are poor.

Currently, my men are complaining a lot to me, why do we have to get up at 5:30 in the morning and run PT at 6 and don't go to work until 8:15, and then we have to work until 4:30, and then we have to come in the evening and get ready for IG. Then, we have to get back up and run PT the next morning, when they look at the unit across the way from us, and they see them coming in at 8 and working until 4, and then running their PT and then going home. These are things that are bothering these people. I have an incident with a room where a door is busted for 2 years, even before I came here, they were trying to get a new lock on it. We can't get it. Now, we have a door totally busted. I have to put a man there every hour of every day to guard that room because nobody gives me the door and I keep doing the paperwork they keep shoving at me. All of this, especially those four people

in that room, one of them is taken away from their job all the time and it is bothering them, very much. Their morale is going down. It's like, nobody is saying, "Hey, all right, we will get this thing for you," and the next day it's there or something, or the next couple of days. We have been promised a couple of times that something would be done to this, and it is yet to materialize. Nothing has happened. We have a problem with getting parts. I have a couple of truckdrivers that are very proud of being able to drive trucks, it is what they wanted to do. They can't even keep them on the road hardly. Until recently one was, in my opinion, a rolling death trap, but still we had to take that thing to the field because someone is willing to sign and say if anything happens, I will go to the ringer, but that isn't going to save that guy's broken leg or anything. These men think of this. A general consensus among the men that I have talked to in the past few days, is, they feel the officers will do whatever they have to so that they can improve themselves and the men are just pawns on a chess table. They feel pretty bad about it.

Mr. ENGLISH. Thank you very much, Sergeant. I must say, I bet your door is fixed pretty fast after today.

Sergeant HENDERSON. I doubt it.

Mr. ENGLISH. Thank you very much, gentlemen. The staff will call the next witnesses.

Mr. LAWRENCE. Call a panel of four witnesses, please. PFC Rucker, SP4 George, SP4 Jeffreys, Sergeant Winn.

[PFC Rucker, SP4 George, SP4 Jeffreys, and Sergeant Winn were sworn.]

Mr. ENGLISH. Gentlemen, I want to welcome you here today, and thank you for your testimony. Do any of you have an opening statement that you would like to make, or would you like to make any comments before we begin questioning. PFC Rucker?

TESTIMONY OF PFC. CLIFFORD RUCKER, C COMPANY, 317TH ENGINEERING BATTALION

Private RUCKER. Yes, sir. My name is PFC Rucker, I am a recovered addict and alcoholic. Ever since I have been in the Army I was an addict on heroin, I had a $180-a-day habit, I was hooked on acid, I smoked hash daily on duty, in the field, off duty. I drank very excessively on duty and off duty, in the field. I am recovered now. I have my head together, and the Army definitely has a problem with drugs. It definitely does. In the barracks alone I see, myself, 30 percent of the men shooting heroin or snorting, 85 to 90 percent of them smoking hash, on duty and off duty. Heroin was a big problem for a while. It slowed down lately, but it is still there. Mandrax used to be a big problem. My first positive urinalysis test was Mandrax. I was sent to CDAAC, and I got around it for 3 months, and then I started taking heroin, and I was getting three piss tests—excuse the expression—three urinalysis tests a day for a week. I got around them by using salt or water, mixing it with the urine. I did this for about 3 months. No one knew in my company, CDAAC didn't know that I was a heroin addict. Finally, it got too much for me, too much money, I was in debt, I knew I had a problem. I quit on my own, I had no help. I went to my CDAAC counselor and I told her that I had been

they just cannot speak the language, it is hard. It is not an easy language to learn. Headstart, there is nothing to it. The Headstart on Ashborn, there is a woman that stands up there and tells you her whole life story. It wasn't worth nothing to me, and the lack of interest. They only have certain recreation. They don't have all the recreations that they should have. Like myself, I am a musician, and there are no facilities where I can go and plug my guitar into one amplifier and play it. There is no place where a person can go play a game of pool, or sit down in an atmosphere where there is no drugs or alcohol and just drink coffee.

In sports, football, soccer, basketball, or wrestling or boxing, we have no coaches to teach us. A coach would be somebody like me, and EM that would know maybe a little bit about it, and that's the best that we can do. I would like to talk about on-duty drugs. My experience with drugs, on duty in 1 day, payday, I walked into five different rooms, and in those five different rooms, every single person in those rooms were smoking hash. On payday, at night, after duty hours, I could walk in a room and see somebody shooting up, or snorting, or drinking Jack Daniels, Jim Beam, straight by the bottle. Not just an occasional drink, by the bottle, excessively.

If an NCO or anyone walks in the room and smells hash, or sees it sitting on the table, he can't do anything about it because it's in a common area. If it was on a person or in a locker, they could arrest them, but if it was in a desk, on a desk, on a table, on the floor, you can't do anything about it, it's in a common area. Anybody could have put it there.

On education, I heard a lot of people talking about education today. I was a high school dropout and I wanted my GED bad, with a passion I wanted it. They have classes through the education center for the GED. Two people in our platoon had already been through high school were going to these classes, and I hadn't been through high school, I wanted to get in these classes and my squad leader and my platoon sergeant and my first sergeant, all the way up to my CO, told me my GT score was too high, that they couldn't get me in the classes. Yet, these guys have already been through high school and I haven't. I had to go up to take my GED on my own. I had no schooling before I went. I went on my own. I talked to my commander about that, my battalion commander, and he told me, "That's the way the Congress runs it." That was his answer. That's all I have to say, sir.

Mr. ENGLISH. Well, PFC Rucker, I think I speak for the entire committee in saying that I think you are one of the most courageous young people that we've met, and we deeply appreciate your being candid with us and I think each of us has been touched by your problems and your difficulties. Specialist George, do you have a statement you would care to make?

TESTIMONY OF SP. 4C CHARLES W. GEORGE, D COMPANY, 547TH ENGINEERING BATTALION

Specialist GEORGE. I have a few things I would like to bring up as far as troop morale. First of all, there is entirely too much time spent in the field as far as the troops that are involved in field training.

hooked on heroin and I had a problem but I could manage it, and she told me, "Are you sure you can manage it?" I said, "Yes; I thought I could." Then I went home on leave about a month later and I got with my friends back home, and heroin wasn't there, it was LSD, and the LSD got me. I came back to Germany with six hits of acid, or LSD on me. I was caught in customs. I was sent back to the company. I went to CDAAC again, talked to my CDAAC counselor. I admitted to myself that I was powerless over my drug addiction. I had a sick mind, I was a sick person.

Mr. ENGLISH. Excuse me, how old are you?

Private RUCKER. I am 18.

Mr. ENGLSIH. You are 18 now?

Private RUCKER. Yes, sir.

Mr. ENGLSIH. How long have you been in the Army?

Private RUCKER. One year, sir. At the time that I was a heroin addict, an addict on LSD, and smoking hash I failed to see my alcoholic problem. I was drinking very excessively. I was drinking a quart of Jim Beam a night. I was drinking beer all of the time. I had a beer in my hand every minute of the day. I went to the field to Reforger and got in a lot of trouble over alcohol. I went with a bunch of friends to a gasthouse, and we smashed it up. We broke a door. I ended up paying for a door that I didn't break, an Article 15, extra duty, and suspended bust. I then realized I had a problem, and I had to solve it. I solved my problems and the only way I did it was to admit to myself and to God that I was powerless over my addiction. For the man that's in the barracks that's an addict now, he can't be helped unless he wants to be helped. If he don't want to be helped, he ain't going to be helped. He will go back out and shoot up another hit of scag or smoke a bowl of hash. CDAAC, in my thoughts, doesn't work, because I got around it. I got around it very easily. I have been here since 9 this morning, I've heard a lot of generals, colonels, talking, and I wrote down stuff that I thought were plain out bullshit, that's the only way I can describe it. On recreation, on the post that I'm on, there is none. There is some, but it is so bad the people don't even bother with it. We have a broken-down theater that the film projector, all it does is crackle and crink all through the show and you can barely hear the sound. We have a craft shop with no supplies.

You go over there, you have to have your own supplies, and you have to buy it on the German economy, and it gets very expensive. We have a gym which is an air bubble gym, I think that's what you call it; it's a gym, a temporary gym. It is a nice gym, it is about the nicest thing we got. Our club is all broken down, it doesn't have recreation for all people. It only has recreation for people who like country and western music and soul music. You get into rock music and they don't have none. Our club is scarcely populated on the weekends. There is hardly anyone in there at all. I heard a man say, or a soldier, "Sir, there is nothing to do." The reason a soldier would say there is nothing to do it's because if there is a trip, there is lack of money. I don't make enough to go on a ski trip to Berchtesgaden. My roomate and a couple of other people went to a ski trip to Berchtesgaden, I couldn't afford it. I didn't have the money. To go anywhere, to a German gasthouse, you have to know German, you have to be able to speak the German language. For some people,

The time they spend in the field, there is not enough time spent in the actual MOS that they came in the Army to perform. They are either doing janitorial services or odd jobs or something like that.

Mr. ENGLISH. In the field?

Specialist GEORGE. Yes; and back in garrison. The D-Mark devaluation is a morale factor as far as the troops over here. In my battalion there is not enough facilities to accommodate the personnel assigned there. Personnel that wish to participate in educational opportunities, as he said, they can't because they are constantly in the field. I think the length of the tour should be cut because you've got your average 18-year-old guy gets out of AIT, comes over here, spends 3 years of his life not knowing what's going on. Our EM club on our post is too small for the amount of people assigned to our battalion, our PX is not large enough, a lot of the money that is spent on these projects when we are out in the field is to do for other people's facilities, when we could be doing it for our own. That's what we are, engineers, but what they do is hire the German civilians to do our work, which is a morale factor as far as the people, because they put work in other people's projects and can't put any work in theirs. There is not enough space in the billets for the personnel assigned there. On our battalion, they've got one building supplying two companies. They've got the barracks split in two. Also the expenses for noncommand sponsored members over here, they can't afford to get their families over here, and if they do, they can't afford to keep them here. As far as drugs, there is a drug problem in our battalion. NCO's, is definitely a problem with drugs. Officers, there is definitely a problem. I know of a few myself.

Mr. ENGLISH. Officers who are using drugs?

Specialist GEORGE. Yes, sir, and selling them.

Mr. ENGLISH. How many?

Specialist GEORGE. I would say four. That's all I have to say.

Mr. ENGLISH. Specialist Jeffreys?

TESTIMONY OF SP. 4C MIKE JEFFREYS, 317TH ENGINEERING BATTALION

Specialist JEFFREYS. Yes, Mr. Chairman, I would like to speak on behalf of PFC Rucker. I feel our command knows the problems that people have, but they try to hold it inside their command. I heard the generals speak this morning, and they sit here and they don't want to tell the committee what the real problem is. They say they got the problem in their hand, but they really don't know what the problem is. I have experienced something maybe that nobody else would ever experience. I had a friend that OD'd here in Germany, a real tight friend, and the Army is just not what I expected it to be.

Mr. ENGLISH. How many people do you know who have overdosed, who have not died, but had drug overdoses?

Specialist JEFFREYS. Two.

Mr. ENGLISH. You know of two and then you had one friend that died?

Specialist JEFFREYS. Yes.

Mr. ENGLISH. Three that you know of. Sergeant Winn?

TESTIMONY OF SERGEANT WINN, 317TH ENGINEERING BATTALION

Sergeant WINN. Yes, sir, I would like to emphasize on a few basic issues that you have been talking about all day long. You've got more or less your figures on how much drugs there is in Europe, I think you got a pretty well basic idea, which I don't care to go into because you have your own idea. I know you do.

Mr. ENGLISH. Do you think what this committee has been talking about is within range?

Sergeant WINN. One hundred percent. I couldn't disagree with you at all. It might vary in different places, but you got it on the nose.

Mr. ENGLISH. Would you go through those numbers once again for the record for what you think the numbers are in your estimation.

Sergeant WINN. Well, I can only speak for my battalionwise.

Mr. ENGLISH. Those cases you know about.

Sergeant WINN. Right. But basically I would say this, CDAAC can work and it can't work. It could work, but it won't work, because you don't have the right qualified people. They can sit here and they can tell you they can feel sorry for the individual that comes in, but actually as far as going out and helping this person, they can't because they are not around them all of the time. I agree with you 100 percent about the person shouldn't be sent back to the company. He should be sent off to a different environment, maybe have some admin leave, or something, with a special group or something. Getting back to figures on the post, I would say 70 to 80 percent of the people indulge in drugs on our caserne, whether it is frequently or everyday. What I would like to impress upon you right now is something to prevent this, which I think is very strong in Europe. With us being the Army, we are, as far as budgets and spending and everything, kind of the low people on a totem pole. As far as the Air Force, for instance, they are in our command, I respect them a lot, they are our fighting team. It kind of irritates me to go down to Spangdalhem Air Force Base to visit a friend of mine and I walk in and he has wall-to-wall carpeting, maids vacuum the floors and everything, he's got wooden wall lockers, a wooden bed, and he is living like a king, and I have to go back to my caserne, walk in, see friends of mine living in metal bunks, OD blankets, and wall lockers arranged and everything is fit and ready to go. Ready to impress all of you people, that's fine. How can you expect a person to go out and perform his duties and still come home to his room, which is supposed to be his common area and sit here and tell you that he has never indulged in drugs or have any knowledge of seeing this. How can he prevent this? Go outside and go to a disco, pay 5 or 6 marks to get inside the door and then pay 5 marks for beer, or maybe go break his neck on the side of a mountain trying to learn how to ski.

You tell me. What I want to tell you, sir, is of the recreational facilities here we need money for. We need it bad. I think every caserne in Europe should have a tour office. There is no reason in the world why each company and each battalion shouldn't have at least one tour arranged on a weekend basis as far as a 4-day weekend. The companies can work around their rosters for this. There is no reason in the world. They talk about USO trips and get 25 people

and you go on your merry way, but let me tell you something, you try to get 25 people up and you try to do it. You can't do it by yourself. You have got to have somebody with some pull. Being an E5 in the Army, you don't have no pull. You've got to work as a team. That's one of the biggest problems in the Army right now, everybody is out for himself.

Mr. ENGLISH. Thank you very much. Leading off the questioning, Private Rucker, could you tell this committee how soon after you entered your unit here in Germany you were approached with regard to purchasing some drugs?

Private RUCKER. Five minutes, sir.

Mr. ENGLISH. Five minutes before you were approached? Were you approached by an enlisted man or by a noncommissioned officer?

Private RUCKER. A noncommissioned officer, sir.

Mr. ENGLISH. So one of your sergeants approached you with regards to use.

Private RUCKER. Yes, sir.

Mr. ENGLISH. Did you accept or decline at all?

Private RUCKER. I accepted, sir.

Mr. ENGLISH. You accepted? At any point in there were you intimidated or pressured into using other drugs or more drugs?

Private RUCKER. Heroin, yes, sir. I would have to say yes. You have people coming to you all the time, pushing it on you. When I came back home off of leave, after I had been busted, I wasn't in the company 5 minutes and somebody had been up to my room asking me if I wanted to smoke a bow, or do some scag.

Mr. ENGLISH. Were you ever physically intimidated with regard to the use of drugs?

Private RUCKER. No, sir.

Mr. ENGLISH. Do you know of anyone who was physically intimidated as far as—because they turned down drugs or didn't want to use drugs?

Private RUCKER. No, sir.

Mr. ENGLISH. OK. People who did not use drugs in your unit, were there any who simply refused to use any drugs, whether it is hash or heroin or whatever?

Private RUCKER. There were a few.

Mr. ENGLISH. Could you tell us what life was like for those individuals?

Private RUCKER. What life was like?

Mr. ENGLISH. Yes. In other words, were they generally accepted by all the rest of the group and did they get along with everybody and it just really didn't make any difference whether they used drugs or not, or were they treated differently?

Private RUCKER. It really didn't make any difference.

Mr. ENGLISH. It didn't make a lot of difference?

Private RUCKER. No; it didn't.

Mr. ENGLISH. OK, no pressure was brought to bear upon those people?

Private RUCKER. Well, if they were in a room drinking with different people, they would offer it to them, but they would just pass it on.

Mr. ENGLISH. Specialist George, with regard to your situation, how long was it after you entered the Army?

Specialist GEORGE. To tell you the truth, sir, I was approached on the airplane before I landed in Frankfurt.

Mr. ENGLISH. So you were approached before you even got here.

Specialist GEORGE. Yes; and when I got here I was approached by an NCO which was the CQ who signed me into the building.

Mr. ENGLISH. An NCO approached you as well? That was when you were first checking in?

Specialist GEORGE. Yes, sir.

Mr. ENGLISH. So you weren't here 5 minutes, then.

Specialist GEORGE. It was at the time I came into the building checking in for linen and everything.

Mr. ENGLISH. Specialist Jeffreys, could you tell us how long it was before you were approached?

Specialist JEFFREYS. Approximately 15 minutes, sir.

Mr. ENGLISH. Fifteen minutes? Were you approached by an enlisted man?

Specialist JEFFREYS. An enlisted man.

Mr. ENGLISH. An enlisted man approached you? Sergeant, what about you when you first came over here? Were you approached?

Sergeant WINN. Well, sir, it's really kind of different because when I first came to the unit they thought I was CID, so I wasn't approached for a while.

Mr. ENGLISH. You were CID when you first came to the unit?

Sergeant WINN. I was definitely CID. I was the man; they told me to clean out the place.

Mr. ENGLISH. Can you tell me with regard to that unit how long it was before people were approached?

Sergeant WINN. I'll put it this way, if it was payday, probably right outside the door, right there on payday line collecting their dues, you know. That's everywhere. It's not one caserne, there is not one caserne in Europe that you can say is drug free. There is probably not one caserne in the States you can say is drug free. But there is one thing I would like to elaborate on, that's the Headstart program we have over here. We send our troops over from the United States and we send them to Europe. The first week they get over here and they process in and they are sent to a program called Headstart. Headstart is fine if you are in the States and want to learn German or want to learn a little about the German culture or about exams or something, that is fine. But when you are actually over here and you have got to live here, in 1 week you cannot learn German. Believe me, I'm married to a German citizen and I've been married for almost 9 months now and I still can't say "Guten Tag" right. The thing about it is, you get 1 week shot of this, so you take down all the notes you can and you're put out on your own. Well, you forget it all because there is no actual training or anything at all.

What I would like to say is, would it be possible for a man who has orders and knows he is coming to Europe, to train 3 to 6 months on the culture of Germans, the German ways, more or less, on the language barriers so a man could actually come over here and carry a conversation or more or less get his point across. It causes a big problem over here because I know for myself, even with my father- and mother-in-law, when I go to their house and stuff, I can barely just talk about weather. That's about as far as it goes. As far as getting down to

personal feeling or trying to explain something, it is more or less a show of hands, and I've found it hard, but I do try to help myself and everybody else who wants to help themselves tries, but the hours that you work are really bad. We waste a lot of unnecessary time. It's not the commander's fault. Personally, it's the pressure being put on him by higher up. I feel if we would come more to the point, become more realistic about the job that you have and the missions you have to accomplish that day, and work around it, that as far as college-wise, because who in the world that's married, I know myself, I want to go to college more than anybody I think sitting at this table. That's my opinion. I can't work 12, 13, 14 hours a day and then go to college and then come home and say, "Howdy doody" to your wife, you know, and then get back up at 4:30 in the morning and go to work. It's very hard. Think about it, it is very hard, and it just knocks the pie off the cake, it just doesn't make any sense, and that's a big problem over here. You just don't have the education, you don't have the facilities. No matter what you do about it, you can't get it done because it's just not here, and there has got to be more emphasis put on this. If you don't, your drug problem is going to be the same thing 10 years from now, your morale problem and your Volunteer Army will not work this way because CDAAC is a commander's tool, it's a personnel tool. For instance, I see people coming over here, I see in spring break at college.

They know they are getting out on chapter 9. They know that they have got their educational benefits. Why? Because the people in the United States, it's not only the Congress, it is everybody. They don't realize just how many people are actually getting out on chapter 9's. They are just coming in the Army 180 days and going home and spending the taxpayers' money on their educations. They are benefiting themselves. They'll grow up to be fine men. That's really great. It's really fine and dandy, but he didn't stay in Uncle Sam's Army and do his time and put his fair share in, and that's a big morale problem right there.

You see people going in and out of the service like you strike a match and light your cigarettes. There has been more turnover in our battalion on chapter 9's than I'd wager to say in any unit in our brigade. Just check the facts and you will see. This is ridiculous. This is plain ridiculous, and there should be something done about this.

Mr. ENGLISH. Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman. Gentlemen, I, too want to join my colleagues in thanking you for being so frank and candid, and I hope that some of the gentlemen in the back aisles are listening carefully because you certainly are focusing attention on some of the needs that are required here. When all of you came over, did you get any drug orientation? How about you, Private Rucker?

Private RUCKER. No, sir.

Specialist GEORGE. No, sir.

Specialist JEFFREYS. No, sir.

Sergeant WINN. Well, I was shown our general defense plan and our basic missions and it was by our battalion commander and it was very good, but as far as drug orientation, no, you process in, you go to your CDAAC building and they ask you, do you have a problem, and that's about basically it.

Mr. GILMAN. How about communication with your NCOs? Were you able to establish any rapport with him? Was he any help to you when you started running into a drug problem?

Specialist JEFFREYS. I feel the only NCOs that care about the drug problem are the ones who are doing it themselves.

Mr. GILMAN. Do you find much of that?

Specialist JEFFREYS. Yes, I do.

Private RUCKER. I don't sir.

Mr. GILMAN. How about you, Sergeant Winn?

Sergeant WINN. Well, I'd say that the NCOs have drug problems, I would say this. Some a bit more than you would think by just seeing them on an everyday basis, but the majority of the drug problems are doing it at the lower ranks, because these are the ones that are caught in a bind. These are the ones that are married, or they are not married and they got to suffer the consequences.

Mr. GILMAN. Private Rucker, I assume that to satisfy your drug habit of $180 a day, was that about it, you had to do some narcotic trafficking, is that right?

Private RUCKER. That's right, sir.

Mr. GILMAN. Where were you buying your narcotics?

Private RUCKER. Well, there's a place in Frankfurt, it's called "Shit Park."

Mr. GILMAN. And it's all available there?

Private RUCKER. It's as available as you give me $130 and I can have it for you in a half hour.

Mr. GILMAN. Did you have one contact there, or was it many contacts?

Private RUCKER. You don't have to have a contact, you just walk up to anybody.

Mr. GILMAN. How much did you have to pay for the narcotics?

Private RUCKER. I paid $130 a gram.

Mr. GILMAN. That was for heroin?

Private RUCKER. That was for heroin.

Mr. GILMAN. How much were you selling it for?

Private RUCKER. I was selling it for $20 a hit.

Mr. GILMAN. Twenty dollars a hit? How much in a hit?

Private RUCKER. On a weighed gram, you get about 25 hits.

Mr. GILMAN. Twenty five hits. Did you have any problem at all in purchasing it or selling? Did anyone interfere with that at all?

Private RUCKER. No, sir.

Mr. GILMAN. How long did that go on?

Private RUCKER. To supply my habit.

Mr. GILMAN. And your sales were in the open in the barracks?

Private RUCKER. Yes; they were very open. All I had to do was sit in my room and the people would come to me.

Mr. GILMAN. Everyone in the barracks knew you were a seller?

Private RUCKER. That's right, sir.

Mr. GILMAN. Were there other sellers in your barracks?

Private RUCKER. There were quite a few, sir. Most of them had got caught and have been discharged and sent to Mannheim. Some haven't, some are still around, still dealing, still doing drugs. I know of an NCO that doesn't do drugs at all, just sells them. He was a main pusher at the time when a lot of the main pushers got busted.

Mr. GILMAN. Was there any dispute about who was to be the pusher in the barracks?

Private RUCKER. No, all you had to do was have it.

Mr. GILMAN. Did you ever observe any of the men using narcotics while on duty?

Private RUCKER. Oh, yes, sir, I still do now.

Mr. GILMAN. Hard and soft drugs?

Private RUCKER. Yes, sir.

Mr. GILMAN. In your opinion, has this affected their ability to perform their duty?

Private RUCKER. On hashish, not really. On heroin, yes, it does. It makes them nod out, it's a depressant. It makes them, what we call nodding out. When I was on heroin, people could be talking to me and I would fall asleep on them in the middle of a conversation. It got to me so bad that somebody could tell me something, to do something, 5 minutes later I'd have to walk back and ask them what they said because I had forgot.

Mr. GILMAN. Had you used narcotics before you came into the service?

Private RUCKER. I smoked marihuana occasionally.

Mr. GILMAN. No hard drugs?

Private RUCKER. No hard drugs.

Mr. GILMAN. Hard drugs for the first time when you were over here?

Private RUCKER. That's right, sir.

Mr. GILMAN. How about you, Specialist George.

Specialist GEORGE. Sir?

Mr. GILMAN. Did you use any narcotics before you went in the service?

Specialist GEORGE. No, sir, I get enough satisfaction out of beer and women.

Mr. GILMAN. How about over here?

Specialist GEORGE. No, sir.

Mr. GILMAN. Specialist Jeffreys, have you used it at all?

Specialist JEFFREYS. No; I haven't.

Mr. GILMAN. Sergeant Winn?

Sergeant WINN. Yes; I smoked marihuana in the States, I sure did. It was a high school thing, you know.

Mr. GILMAN. Did you all observe sales in the barracks? Specialist George?

Specialist GEORGE. I have; yes.

Mr. GILMAN. Specialist Jeffreys?

Specialist JEFFREYS. Yes, sir.

Mr. GILMAN. Sergeant Winn?

Sergeant WINN. Quite frequently.

Mr. GILMAN. Is it going on at the present time?

Specialist GEORGE. Yes, sir.

Mr. GILMAN. How long were you in CDAAC, Private Rucker?

Private RUCKER. I've been in CDAAC since March.

Mr. GILMAN. You are still in CDAAC?

Private RUCKER. Yes, sir.

Mr. GILMAN. Has the counseling been worthwhile?

Private RUCKER. Well, I'll put it to you this way, sir. If it wasn't for my counselor, I probably would have never quit drugs. I probably

would be home right now with a bad conduct discharge or a chapter 9, either one. I can't say it was all her help, because it was part of my own, too. It was my decision. I needed a better way of life.

Mr. GILMAN. I have no further questions.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. Private Rucker, I am interested in knowing inasmuch as you did not use a harder drug, or had not had any history of using it before you came here, what caused you to use it?

Private RUCKER. Peer pressure.

Mrs. COLLINS. Peer pressure, period. Was that peer pressure, was that coupled with what you found to be a negative quality of life here?

Private RUCKER. Well, ma'am, when you first come to Germany among the soldiers that have been here longer, they call you what you call a "cruit," and you ain't nothing but a piece of shit, and my feelings were if maybe if I do blow with them or smoke a bowl with them or get drunk with this man that maybe he will accept me. That was my feelings.

Mrs. COLLINS. Did it have anything at all to do with—well, that was your basic reason. We've heard a lot of talk about the quality of life and the fact that there is no recreation, but that was not a major contributing factor in your case.

Private RUCKER. It was part of it, ma'am.

Mrs. COLLINS. It was part of it. So it was all of these things taken together. Was it inability to speak the language fluently?

Private RUCKER. All of it together, because you couldn't leave the barracks, and the barracks is the main spot where the drugs are. If you get away from the barracks, you're all right.

Mrs. COLLINS. How long did you stay on drugs?

Private RUCKER. I was on drugs from when I got here, and that would be, I'd say, about 9 to 10 months.

Mrs. COLLINS. Let me ask you one other question. There has been a lot of talk here about people—and you called yourself an addict, I believe—you said you were addicted to heroin, you were addicted to this or that. What do you think about addicts being retained in the system? Do you think they should be kicked out instantly; do you think that they should be given a chance to prove that they can be rehabilitated? What's your general feeling?

Private RUCKER. My general feelings are, if a man don't want to be rehabilitated, get him out.

Mrs. COLLINS. But for those who do, you suggest that they be sent through the program?

Private RUCKER. Yes, ma'am.

Mrs. COLLINS. And that there is a very good possibility of a high success rate for that man?

Private RUCKER. Yes, ma'am.

Mr. ENGLISH. Do you want to yield at that point?

Mrs. COLLINS. Yes; I'll yield.

Mr. ENGLISH. I think it is a very key point and a very important point. I'm curious, PFC Rucker, what would you think for an individual who had your problem, namely addicted? Was it more difficult to withdraw because you were kept within the barracks and other people continued to use and everything, would it have been better if you had been able to get out of that, at least for awhile, until you

were able to whip the thing? Did it make it that much more difficult for you to be in there when other people were still using it?

Private RUCKER. Yes; it was, sir.

Mr. ENGLISH. It would have been easier or better if you had been able to get removed from there and get someplace clean where they weren't using it and kept busy?

Private RUCKER. Yes, sir.

Specialist JEFFREYS. I have to add, I would have to say yes for that because I was on the same road. That's why I volunteered myself for what they call "Detox." Detox, you go there, you are there for 3 days, you can't go nowhere, you have to be escorted by a doctor, he has a key to the door, and when you are having withdrawal pains, they do give you—I forget the name of the medication she gave me, but it did calm me down, and it helped me out a lot. But I was into it for about almost a year, every day.

Mrs. COLLINS. Thank you very much for your insight. Sergeant Winn, you got off on the recreation thing. How much support does a young soldier have for recreational activities? Suppose a young soldier wants to join a softball team or become a boxer or something like that, how much support does he have?

Sergeant WINN. Well, what kind of example shall I start off with first? Company level, it's pretty bad. It's not the commander's fault because he can't get blood from a turnip. Basically, all of our unit funds consist of primarily of maybe $100 at the most. Ours, I think now, is less than $100. We have a company level, as little or nothing as far as the individual physical fitness, as far as going out and having his own recreation, we have none available as far as doing it and having the right facilities to do it. We just don't have it. We do have PT, but quite frankly, I think it is a little ridiculous to go out there in freezing weather and try to run 3 or 4 miles. It just don't make no sense to me, when you can break your companies into the platoons and have one person maybe working out on weights in the gym, and someone shooting basketball, more creative activity, which should happen. You know, you talk about teamwork, well, this is where it all begins. It begins at your company level, and I think if the unit commanders could have more money to utilize in dayrooms and in the company access, because a lot of the young troops are really scared to go out on the economy because they can't afford it. They are not married, they don't have the money to go out and buy nice clothes to be presentable in most of your discos, or most of your shopping areas, or most of your German restaurants, because they feel like an outsider because immediately the average GI walks into a German restaurant immediately anybody can look up and tell this person is a GI, on the average.

Mrs. COLLINS. How can they tell that? Because they don't have on a coat and tie or something?

Sergeant WINN. Well, quite basically because this man is probably wearing volar gear or he is wearing combat boots because he doesn't have the money to spend on clothing, which is a shame.

Mrs. COLLINS. Then it is kind of a dress code then there, isn't there?

Sergeant WINN. There is a dress code in a lot of restaurants, and there are a lot of restaurants, and there is a lot of bars and shopping areas.

Mrs. COLLINS. Do you think some of these entrepreneurs use a dress code to keep the GI out?

Sergeant WINN. Quite frankly, yes. Usually the short hair gives a GI away, there are a lot of bars and facilities that flat won't let the average GI come in. They don't want him, he doesn't have the money no more and they don't want that type of crowd in there. You kind of have to look at it from their standpoint of view, too. They are in there for the money, and the poor soldier, he just don't have it no more. My own opinion, you know, the drug problem can be solved in Europe if the Congress, if you people, and the President wants to stand behind giving us some facilities to do, giving us some opportunities, starting at your company and your battalion levels, work out these tours, have a tour on post, have something to do, you know? Give these people that are single, that must stay in the barracks, that doesn't have the automobile, that can't pay the insurance on automobiles. My lord, the insurance is outrageous, and if you are E–1 to E–4 you are damn lucky to own a car.

Mrs. COLLINS. You mentioned that you have a heck of a time getting 25 people together to even take one of these tours. Why is that?

Sergeant WINN. Well, that's because of the train schedule and the lack of time. Quite frankly, there could be time, there could be something set up where you could use the USO a lot more, because it's there and it can be utilized a lot more than what it is if the battalion commanders will back it up. My personal belief is there should be one man designated. It doesn't have to be an officer, because to line up at least one trip per month, it could be utilized and it could be backed up on the train schedules and your company commanders and first sergeants say, "We will work train schedules in, we will work a duty roster around these trips. Can we have volunteers, say 2 weeks ahead of time, we have a choice to go to Berchtesgaden or to Munich, and this is the rates, and this is how it will be done, volunteer now." If this will be utilized, it could be a worthwhile thing and it would help. I am saying if you would build these recreation centers, if you would train these people at least 3 to 4 months before sending them over to Europe, let them know the background of Europe, let them know how the Europeans react over here toward the Americans and how the Americans must react toward the Europeans to live in this society. If education could be worked with your training schedule, if you could actually go to college, if you would have a decent college on this caserne, rather than these shacks in the corner. They give you this literature that isn't worth a row of beans, you know what I mean? But, you are spending your GI bill, which you come in the service for. If they would utilize this, you could eliminate a lot of your hardcore drugs. I'm not saying you could eliminate it, I'm not saying that you could vanish it from the system, but you could darn sure get rid of a lot of unnecessary drug problems, and by doing this, you could eliminate a lot of hash smoking too.

Mrs. COLLINS. Thank you, very much.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman. Private Rucker, you went in service when you were what, 17?

Private RUCKER. That's right, sir.

Mr. EVANS. How did you get in? Did somebody sign for you to come in?

Private RUCKER. Yes; my parents did.

Mr. EVANS. Do you think it would take a great deal of money to organize competitive sports among the various squads in the companies?

Sergeant WINN. I think at first it would take an exceptional amount of money to get the proper equipment, the right facilities, get some construction projects going to build some decent theaters, gyms, and it would take a lot more civilian workers to do this. It is not all military's obligations. I really do. I believe at first it is going to be a big mountain to knock out, but once you do this, you will see improvement in the long term.

Mr. EVANS. Let me ask you one other thing, then, You mentioned that they hired civilians to do the work on your barracks and everything that you need to do, that you could do because of your training in the Engineer Corps and all of this. What would be the situation if the law would change so that you could be paid for offduty work? Do you think that would build up any pride in the people to be able to improve their own facilities and be paid for that?

Sergeant WINN. Yes; that would be an outstanding idea.

Mr. EVANS. Do you think that would help take away some of the outgo of money into the German economy where they hire locals to do the work on your barracks?

Sergeant WINN. Exactly. We have facility engineers, which is mostly occupied by German workers which are hired by the Government which come in and pull maintenance on most of the billets, which they do a really half job, you see what I am saying? You got the same problem all the time.

Mr. EVANS. OK, but do you think you could do a better job because you would have a personal interest in the facilities that you were working on?

Sergeant WINN. I really do. If you don't do your job, you just don't have your rank.

Mr. EVANS. I yield.

Mrs. COLLINS. Thank you very much. I just wanted to ask Private Rucker just one question. In the several days that we have been here, I've talked with a number of people higher up, and I asked them if since there was such a problem here, was there a problem in basic training of people who admittedly had used marihuana or some other kind of drug or something before coming into the Army, and I was told that everybody, for all practical purposes, was drug-free in basic training; was this your experience?

Private RUCKER. No, ma'am.

Mrs. COLLINS. Any of your experience?

Sergeant WINN. Not entirely drug-free; no.

Mrs. COLLINS. By and large, it was not a major problem?

Sergeant WINN. It was a whole lot less than what it is when you are actually in active duty.

Mrs. COLLINS. I yield.

Mr. ENGLISH. You mentioned about the language training back in the States. Is there any language training at all over here?

Sergeant WINN. OK, there are college courses, they are available, but there is no credit hours, which really doesn't matter, but the point about it is, the excessive amount of unnecessary hours that you

must report in and the lack of time of getting out. You never can say, "Well, honey, I'll be home at 5," because if you tell her this then she will start cooking and you come home at 8. It happens all the time.

Mr. EVANS. Will the gentleman yield? Is that part of the problem with taking the tours, or organizing the tours yourself, that you never know which people are going to be on duty at any particular time in advance so that you can set up the tour for those people who want to go?

Sergeant WINN. Well, basically, you have a training schedule, which amounts to your CQ, and you have one sergeant on duty with two CQ runners. The schedule is made every week. That's what I'm saying. If you could get in to organize this, then you could work around the training schedule which is no problem. But the point I'm saying is, that you can never say exactly what time you will get off during any given duty day because there is always something that comes up that you could have done that day, they waited around until the last minute to give it to you. That's why your college classes are so hard to stay in because 1 minute you are in the field, 1 minute you're there, and you can't plan.

Mr. GILMAN. Sergeant Winn, am I correct then that the only language classes that are being offered to you are the college classes?

Sergeant WINN. Yes, sir, the college classes, which is the Central College of Texas, I believe.

Mr. GILMAN. There is no orientation plan which they try to teach you some basic language?

Sergeant WINN. None whatsoever, and I can repeat there is none on your caserne.

Mr. GILMAN. Is that right for all of you?

Specialist JEFFREYS. I've heard that they've got it offered, but it's on your own time, after duty hours.

Private RUCKER. And if you're not in the field.

Mr. GILMAN. No further questions.

Mr. ENGLISH. I want to thank you gentlemen, again, and I deeply appreciate your candidness. As I have stated before, and I don't think it needs to be stated, but I will state it again anyway, if there are any indications of any repercussions, I hope that you will notify this committee, and I'm certain that General Blanchard would also like to be notified. Thank you, very much.

Mr. LAWRENCE. The committee calls Command Sergeant Major Brown.

[Sergeant Major Brown was sworn.]

Mr. ENGLISH. Thank you very much for coming. Sergeant Major, do you have a statement that you would care to give this committee?

TESTIMONY OF SERGEANT MAJOR BROWN

Sergeant Major BROWN. Sir, I would like to make a brief opening statement based on some of the comments made by the group of young soldiers that were here just a few minutes ago. I think that the young soldier coming into Europe today experiences a tremendous cultural shock. We have been here in Germany for more than 33 years. We have been living in some of these old buildings for 33 years, and

Mr. GILMAN. Sergeant, one of the things that I've noticed in wandering around the barracks and talking to the men is the lack of having an opportunity to consult with their first-line supervisor, the NCO, when they run into a problem, and the lack of consultation and guidance by the NCO. What seems to be the problem there?

Sergeant Major BROWN. Command emphasis in a commander assuring that his noncommissioned officers take care of his soldiers entrusted in his care, where you have a commander that insists on check to make sure, make sure that his senior noncommissioned officers check to insure that that first-line supervisor is doing the things that the U.S. Government is paying him to do, and that is, to train, to teach, and to look out for the welfare of his troops. Where you find that, you will not find a statement that they do not have someone to talk to, and that is the problem.

Mr. GILMAN. We've got to do more than just issue a directive, we have got to do some following up.

Sergeant Major BROWN. Definitely so, sir. In this army today, you have to check and you have to establish standards, you must check to see that those standards are maintained and you must hold your noncommissioned officers, and officers, accountable if they are not maintaining these standards, and when we start doing that, I think we will have one heck of a fine army in Europe, not only in Europe, but throughout the world.

Mr. GILMAN. Sergeant Major Brown, is there a need, too, to do some better training of the NCO's in how to deal with the men, how to counsel them on the narcotic problems?

Sergeant Major BROWN. Definitely so, sir. We have noncommissioned officers who's afraid to even talk to an individual concerning drugs, so we need training in that line, a tremendous amount of training. Then we need followup to insure that that individual, or those individuals, are doing it.

Mr. GILMAN. How long have you been in the German theater?

Sergeant Major BROWN. I will complete my 3-year tour in about 2 weeks from today, and I will be on my way back to the States.

Mr. GILMAN. Have you seen in that period of time any progress being made with regard to the narcotics problem, or is it in your mind getting worse than it was?

Sergeant Major BROWN. When I arrived in Germany, we had the mandatory urinalysis testing. I think drugs were down tremendously, for the hard drugs. There is no test that can actually pinpoint hashish or marihuana at this time, so I'm sure that the drug use in those fields were pretty rampant, but the hard drugs were down, because an individual did not know when he would be called on to give a urinalysis sample. When the urinalysis testing went out, the hard drug scale started rising until, as pointed out here today, I think it has reached a very maximum proportion to a degree. I think the urinalysis sampling and urinalysis testing that we had, that was mandatory, was a good thing, and we need it.

Mr. GILMAN. Sergeant Major Brown, how do you account for the difference in perception by the high command of the amount of drug usage in their forces, as compared to what the enlisted men see? I think certainly the command is well meaning and well intentioned and wants to rid their troops of the problem, or at least try to accommodate the problem and meet the problem head-on. How do you

account for the vast differences in statistical analysis? On one hand the command says, "Well, we've got about 7 to 9 to 10 percent of hard drugs," the troops say, "It's up around the 30 percent level." They say, "Hash is 30 percent," the troops say, "It's 80 to 90 percent."

Sergeant Major BROWN. I think I can answer your question this way, sir. A commander's perception of what is going on in a unit is on a broad base. He sees many things that he takes into account, and that is good, but he must know what that soldier's perception is to really make his perception meaningful. I think we have so many commanders that only have his perception, and he has never heard the perception that you've heard here today by talking to his soldiers, or having somebody to talk to his soldiers, and finding out what their perceptions are. I think a lot of people's eyes were opened here today just listening to these individuals you called up here.

Mr. GILMAN. I certainly hope it's going to be beneficial to not only the command, but to the troops and to all of us in trying to work out this problem. I thank you for being so candid, Sergeant Major Brown.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. I pass at this time, Mr. Chairman.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. Sergeant Major Brown, you heard the testimony of the troops that were here previous to you, I guess?

Sergeant Major BROWN. Yes, sir, I did.

Mr. EVANS. Do you think that they have a pretty accurate perception of what's going on around them, since they are not exposed to the social life of the officers and the others of higher rank? Do you think that they have a pretty good grasp on what's happening among the E–4's down to the E–1's?

Sergeant Major BROWN. I would say that's a very valid perception.

Mr. EVANS. Do you think that the things that we've talked about, such as recreational facilities, education, reduction of useless work, would be beneficial to giving these troops more morale and reducing the incident of drug abuse?

Sergeant Major BROWN. I'm sure it would, sir. However, may I clarify this a bit?

Mr. EVANS. Yes, sir.

Sergeant Major BROWN. In Germany, you have many little casernes, all right? Where in the States you have a big military post and everything is on that military installation that a soldier can think of. That same soldier leaves that environment and comes to Germany and he is on a small installation—I don't know how old some of these things are, I guess they were here when the Kaiser was here—and the U.S. Army tries to put on each one of these installations the same thing that is on a large installation in the States. We don't have the money, we don't have the people to run them, but we've got the building there, we can't maintain it properly, but we can say, "Yes, we've got a gym, yes, we've got a craft shop, yes, we've got a photography shop." Now it might be the raggediest photography shop you've ever seen, it might be the worst gym you've ever seen, it might be the worst craft shop you've ever seen, and probably we don't even have qualified people to run these things, but we've got them. That aggravates the soldier. When he goes to participate in these things that soldier likes to do, he finds the craft shop is either closed, or somebody is not there who knows what's going on, and goes

we have been patching them up for 33 years, and these are some of the problems that these young soldiers are talking about. We are overcrowded. We don't have the facilities, as was pointed out by these young soldiers. That's one of the statements I would like to make. The other statement that I would like to make is that we waste too much of the soldier's time. A soldier needs to be busy and doing things that are constructive. It takes a lot of planning on the commander's part and the staff's part to keep that soldier busy. Planning and also supervision to insure that the noncommissioned officer is keeping that soldier gainfully occupied, not make work, not sitting in the back of a truck like this young man was talking about, or walking out in the bushes, but teaching him those things that a soldier needs to know to keep him alive on the battlefield, because we wear this uniform for one reason and that is to fight our country's battle, should that ever become necessary. I think we waste too much time on some of the other things other than teaching that soldier those things that he needs to know. That is my opening statement.

Mr. ENGLISH. Thank you very much, Sergeant Major. How long have you been in the Army?

Sergeant Major BROWN. I've served in the United States for 33 years. I am going into my 34th year. I was one of the command sergeant majors, approximately 3 years or a little more ago, that was selected for retention of 35 years.

Mr. ENGLISH. You related to me an experience that you had had in going into combat, particularly during the Korean war, would you care to relate that to the committee in regard to drug use?

Sergeant Major BROWN. Right, sir. As I pointed out to you last week, drugs, to me, was not a new experience that it came to be to the U.S. Army and the rest of the world in the very early sixties. As a noncommissioned officer in the all black unit, more than 32 years ago, I had my first experience with drugs. I went into combat as an infantry platoon sergeant with approximately 5 percent of my platoon who were hardcore drug addicts.

Mr. ENGLISH. Addicts, not users, but addicts.

Sergeant Major BROWN. These were addicts, mainliners. That was a problem for me as platoon sergeant, and there is no way that I know of that an addict can function in combat.

Mr. ENGLISH. Could you tell us of what your experience was as far as these people fighting people once they got into the combat itself.

Sergeant Major BROWN. I d like to start when we first landed in Pusan. It was on June 27, 1950. We had removed this 5 percent of my battery from their source, so the whole 5 percent, after about a day in Korea, getting ready to march with the equipment and move into the line up around the Tague perimeter, the whole 5 percent were on with withdrawal symptoms, clutching, frothing at the mouth and the whole bit. I took these individuals to the dispensary who said, "We have no treatment for them. You are going into the line, that will be the treatment for them." The doctors did not know or did not treat drug addicts. It wasn't something you talked about at that time. I went into the line and I would put these individuals into their position, I would go check that position about 10 o'clock, they would be there. Again, about 12 o'clock, they would be gone, and I would not see them until such time that they found the drugs they needed and they would come

back. It is an impossibility to keep a drug addict gainfully employed when he does not have his drugs. He will do anything to get it, and it is an impossibility to keep him there, and I could not even keep them in combat. My solution to the problem, I thought, I would put these individuals, whenever we moved into position, on the point, right up front. Maybe if I could not keep them in positions where they should be, by virtue of being exposed, probably I could get rid of them that way. I reached a conclusion that God protects fools, drunks, and dope addicts. I never got a one of them killed.

Mr. ENGLISH. Sergeant Major, given the amount of drug usage that is taking place here within Germany and recognizing the fact as we've all stated, I think, that the troops here can do the job, but the question is, you have a good idea of where troops are performing at their maximum level. Given the amount of drug usage here, what would you say that the condition is of our fighting men to go into battle here in Germany as a result of drug usage?

Sergeant Major BROWN. I think we would have to quantify the type of drugs we are talking about. We talk about today, two different types of drugs. Society condones one type, and kind of frowns on the other. We talk about hard drugs, the addict, and we talk about the user who goes out and blows a bowl or smokes a joint. I, myself, feel that we would have a very sorry army if it's made up of hardcore addicts, because there would be nobody in the U.S. Army who would do any fighting. Soft drugs, as far as the staying power of the individual, I really don't know, but I don't think any man who has got his mind mixed up with anything is in any condition to really fight and to stay in battle, because battle is a heck of a place. That in itself is the worst experience an individual will ever have, and to have your mind messed up with something, whether soft drugs, and I know it's bad if he's got hard drugs because he's not going to be there, it's a problem.

Mr. ENGLISH. Given the amount of drug usage that we've heard testimony of and that you know of throughout the Army here in Germany, do you feel comfortable going into battle with these people?

Sergeant Major BROWN. Sir, I would not feel comfortable, from what I've heard today, going into battle with anybody in the 7th Army today.

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

Mr. GILMAN. Thank you, Mr. Chairman. Sergeant Major Brown, you certainly pinpointed a lot of the problems in talking about some of the utilization of time. Why is it that there can't be better planning and better supervision of the soldier's time over here?

Sergeant Major BROWN. Sir, that takes a lot of work, and sometimes it takes a commander saying, "I know this is what the soldier needs, and this is what I'm going to do." That commander, himself, has got a lot of pressure from high up about doing these things and doing this.

Mr. GILMAN. I notice that you were probably present this morning when General Haig's assistant mentioned that that was one of the items that they recommended right from the brainstorm session that they had. Apparently that hasn't filtered down yet.

Sergeant Major BROWN. I don't think it has, sir, in some units. I think the case in point is some of the testimony you've just heard, and I see this constantly.

Mr. EVANS. You stated that you had used some marihuana when you came in the service.

Private RUCKER. That's right, sir.

Mr. EVANS. Were you satisfied with the representation given you by the recruiter?

Private RUCKER. Not really, sir.

Mr. EVANS. You don't have any particular complaints about it?

Private RUCKER. Well, he told me that I could get into drafting, and I don't do any of that. All I do is build bridges.

Mr. EVANS. What is your MOS?

Private RUCKER. I'm a 12 Bravo, I'm a combat engineer.

Mr. EVANS. Combat engineer?

Private RUCKER. That's right, sir.

Mr. EVANS. That's not what you feel comfortable doing?

Private RUCKER. Pardon?

Mr. EVANS. Is that not what you wanted to do?

Private RUCKER. Not really, sir.

Mr. EVANS. But you wanted to remain in the service, apparently.

Private RUCKER. Yes, sir.

Mr. EVANS. You worked hard to get rid of this addiction so that you could remain in the service?

Private RUCKER. That's right, sir.

Mr. EVANS. How would you differentiate between the heroin addict, once he is identified, as to whether or not that person wants to remain in the service so that you could get rid of those that didn't want to help themselves. You follow me?

Private RUCKER. I'm sorry, sir.

Mr. EVANS. OK; say you wanted to stay in the service, and you should have the opportunity to do that if you want to work out your problem, right? But if somebody gets in the boat you were in and doesn't want to help himself, you stated that you felt that they ought to go ahead and get them out of the service; is that correct?

Private RUCKER. That's right, sir.

Mr. EVANS. How do you tell the difference between the two?

Private RUCKER. If the man wants help, he is going to ask for help, he is going to admit that he has a problem, he is going to say that "I want to change my life, I can't live the way I'm living," and you can tell the difference after a person has quit drugs.

Mr. EVANS. Unless a man wants to beat the drug habit, he is not going to do it, is he?

Private RUCKER. That's right, sir.

Mr. EVANS. Then there is no reason to keep that person in the service, would you say?

Private RUCKER. That's right, sir.

Mr. EVANS. I would like to just summarize, then, some of the things that you have been telling us. You think that there should be more training time in helping people become adjusted to the German society, either in the States or here, when you originally get here, is that correct?

Private RUCKER. Yes, sir.

Mr. EVANS. You feel that—I believe that some of the others have testified, I believe Sergeant Winn—that there is too much useless work; in other words, too much make work, whereas if you could go ahead

and do your job and then get off and be involved in an organized recreational program, or an educational program, that you think this would decrease the drug abuse in the military?

Sergeant WINN. Exactly.

Mr. EVANS. You feel that there could be more company organization in sports; in other words, more people at the company commander level, or the captain level, or the squad level, taking part in organizing the squads into competitive sports?

Sergeant WINN. Exactly. You could start right there at company level. It wouldn't have to go no further, if they would have sufficient amount of funds to do this, and if they could have the time, which they sure in the world do have.

Mr. EVANS. So if they would quit some of this useless work and put it into organizing offtime activity, then you think that would be more constructive as far as keeping the soldier in physical fitness and morale; is that correct?

Sergeant WINN. Yes, sir, give them something to build his life on, give him a point in life to climb, give him a future, you know what I mean? Give him something so he can come in his room and say, "Hey, this is my room and I want to sit here and read a book, or I want to sit here and listen to my stereo." Make his facilities nice. If he wants to take a hot shower, he can take a hot shower. Give him something where he can honestly say he can live in. Just don't give him a room with four walls and a wall locker and a bunk. Come out and give him some carpet on his floor, do something nice. Just don't keep the idea in mind that you are a combat engineer, or you are in the Army now, fit to fight, gung ho. That's good, but there are other ways of working around this.

Mr. EVANS. Say sometimes that you are not a soldier, when you are off duty, is that right?

Sergeant WINN. That's right; married people have a life, too.

Private RUCKER. Sir, can I say something?

Mr. EVANS. Yes.

Private RUCKER. He was talking about useless work. The last two field problems that we have had, Reforger and ARTEP, I did nothing but sit in the back of a 5-ton on both field problems. Either that or pulling guard out in the woods.

Mr. EVANS. It's not hard to learn how to do that, is it?

Private RUCKER. No; it ain't.

Mr. EVANS. How long does it take you to learn how to sit in the back of a 4-ton?

Private RUCKER. It takes about 2 seconds.

Mr. ENGLISH. Would the gentleman yield?

Mr. EVANS. Yes.

Mr. ENGLISH. How long were you out in the field on Reforger?

Private RUCKER. Reforger was 2 weeks long.

Mr. EVANS. All right, what do you all think about the morale and the combat readiness of the troops over here?

Specialist JEFFREYS. It's way down.

Private RUCKER. It's all simulated, what we call simulated. We don't do nothing real.

Sergeant WINN. We got a paper Army.

to the gym, and half of the stuff in the gym doesn't work, so this is the problem that confronts us here.

Mr. EVANS. Do you believe that the enforcement of the laws respecting drug abuse vary from unit to unit over here?

Sergeant Major BROWN. Most definitely.

Mr. EVANS. Do you think that if the soldiers knew that they would be removed from the armed services if they were caught using drugs and these people wanted to stay in the service, do you think that that would help in any way if we had a uniform policy regarding drug abuse so that a person would know that no matter if he was Bravo unit or another unit that if he were caught using any kind of illegal drugs he would be out of the Army? Would that make any difference in the incidence of drug abuse or not?

Sergeant Major BROWN. I'm sure it would make a tremendous difference, but, I must ask one question: Would that soldier going out of the Army still have the benefit of an honorable discharge?

Mr. EVANS. Well, that's a question that we need to address ourselves to, but if he did or if he didn't, what difference do you perceive that that would make?

Sergeant Major BROWN. I think it would make a tremendous amount of difference, because if a guy wants to get out and knows he is going to have all these benefits, he would use drugs.

Mr. EVANS. Suppose then that he knew that he would not have an honorable discharge, that he would not have VA benefits where he did not fulfill his contract with the U.S. Army, do you think that if he wanted to either remain in the service or to get an honorable discharge that this would affect his use of drugs?

Sergeant Major BROWN. I think you would have the best deterrent that you could ever devise right there, sir.

Mr. EVANS. Even with the lack of facilities and the lack of other things that we already have here? Do you think that would improve the situation so far as drug abusers are concerned?

Sergeant Major BROWN. Even with the lack of facilities, sir.

Mr. EVANS. Thank you.

Mrs. COLLINS. No questions, Mr. Chairman.

Mr. ENGLISH. Thank you very much, Sergeant Major. You've been extremely helpful, very candid, and we deeply appreciate it. Thank you. Call the next witness, please.

Mr. LAWRENCE. The committee calls Dr. Erwin Backers, chief of the drug and alcohol rehabilitation program, 97th General Hospital.

[Dr. Backers was sworn in.]

Mr. ENGLISH. Thank you very much for coming, doctor, and thank you very much for being so patient, it is very kind of you. Do you have a statement you would like to make to the committee?

TESTIMONY OF DR. ERWIN BACKERS, CHIEF OF THE DRUG AND ALCOHOL REHABILITATION PROGRAM, 97TH GENERAL HOSPITAL

Dr. BACKERS. Only to say that I am at the rehabilitation end of this problem. I, therefore, cannot help you sorting out the various figures that you have gotten on drug use. This is not one area of my expertise. Those people that I deal with all have a problem of substance abuse, and I do not have any other valid figures that I can give you.

Mr. ENGLISH. Is there anything further you would care to say?

Dr. BACKERS. No; not at this time.

Mr. ENGLISH. We've heard a great deal this afternoon with regard to attitude on whether or not an individual really wants help, or whether he views the program that he is being referred to as a punitive type program, a punitive measure being taken against him. Are we correct in assuming that an individual who does not want help is really not going to find much help through these programs? In other words, does he have to want help for the thing to work?

Dr. BACKERS. If he really doesn't want help, then, of course, we all would be wasting our time. However, I don't think we should take the no as a definite answer. In other words, it is our duty and we try within our limitations to motivate someone to get help even if he seems unmotivated. This in itself, of course, is a difficult and time consuming job.

Mr. ENGLISH. Doctor with regard to the professional care, obviously you've got an awful lot of people that are being referred to the CDAAC units, for instance, and the indications we've had is that while there is some professional care there, it's really left wanting it, and it seems to me that the drug problem is one that is so complicated, so difficult to solve, there are so many problems that are behind it, as the cause of it, that I really wonder whether these people are receiving the degree of care that they really should have if they are going to get help, particularly those that are wanting help. Would you care to comment on that?

Dr. BACKERS. There's no doubt in my mind that the CDAAC program could be improved. What is, I think, an important factor now in some of the deficiencies of this program, is the fact that there is really not sufficient communication between the command on the one side, and the command has administrative responsibility for this program, and the clinical people, the physicians. This is something that we have noticed for some time, and we are, I know that the chief of our department and I, we are currently working on proposals to remedy this situation. It will not be easy because the best way to improve it would probably be not to leave the CDAAC counselor entirely faced with these difficult problems all by himself, to give him more supervision, to, let's say, have a rehab board meet that would discuss and make a viable disposition of each and every case that is referred. On such a rehab board, should be the company commander, the man's NCOIC, the CDAAC counselor, and, of course, the physician, but at present, the dispensary physicians in the various areas are so overloaded with work that it would be difficult to put something like this into practice. However, somehow, we have to give thought to improve this situation.

Mr. ENGLISH. Would it be a situation, doctor, if we simply—you know we've heard a lot of discussion again about the amount of drugs that are being used in the barracks and both hard and soft drugs have not only been sold, they are being used there, we find cases in which NCO's have been trafficking drugs and a lot of attention evidently, taking place within that barracks unit and within the unit itself—would it be better both for the unit and for the individual who really wants help to remove him from that environment, from the environment he is in and place him into an area which is drug free, and then

provide him with the type of professional care that you're talking about where he'd be scrutinized much more closely and in which the CDAAC people, who basically are laymen, so to speak, are able to receive the oversight from a professional?

Dr. BACKERS. For the users of hard drugs, this certainly is a possibility that might be quite useful; yes. I would say even more important in the case of heroin use, is an early determination when a man is discovered as a user. An early determination, how extensive the use of drugs is in his case, and to make a professional assessment as to what his rehabilitative potential is. Can he be rehabilitated here in Europe, or would it not be better to send him promptly to the United States to plug him into a rehab facility through the VA, for example? This, I think, is very important also from another viewpoint. Heroin dependence, as we have heard today repeatedly, because of the mere economic aspects of it, becomes a communicable disease, because no serviceman can finance a habit of $50 and more a day out of his salary, out of his pay. He, therefore, has to resort to trafficking in the heroin himself. Heroin dependent users can't sell to each other, they all have the same problem, they, therefore, need to create new users, and so the problem spreads. This is something that is important, but I don't think that we should expect a CDAAC counselor with limited training and experience to make such a far-reaching decision in each individual case. This probably will not work. I also believe that many of the physicians that come to serve in our dispensaries, they are excellent men in their own field, but they have not received sufficient instruction before coming to Europe as to the drug problem that they would be facing here, and I feel this is an important matter also, that these physicians do receive adequate training and adequate instruction as to what the problem here is before they start their service here.

Mr. ENGLISH. Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman. Doctor, could you tell us what your full title is?

Dr. BACKERS. I am the chief of the drug and alcohol rehabilitation program at the 97th General Hospital in Frankfurt.

Mr. GILMAN. How long have you served in that capacity?

Dr. BACKERS. For a little over 2 years now.

Mr. GILMAN. Could you give us some of your background in drug rehabilitation work?

Dr. BACKERS. Well, I am a psychiatrist, I have been psychiatry for close to 25 years now. I have had responsibilities for major psychiatric hospitals. In that capacity, I also have been responsible for drug and alcohol rehabilitation programs. Before coming here to Germany, I was for 5½ years in the Panama Canal Zone where our hospital also served Army personnel and those who had psychiatric problems and, of course, this included also drug and alcohol abuse.

Mr. GILMAN. Dr. Backers, at the Frankfurt hospital you have two units, a detox unit and an in-care unit; is that correct?

Dr. BACKERS. That is correct. These units are not separate. They work together.

Mr. GILMAN. I had the opportunity of visiting your unit the other night, and found the patients there were lauding the work of your unit, and found it to be highly beneficial to their problems.

Could you describe briefly the type of treatment that you give an in-patient?

Dr. BACKERS. Of course. It is a rather limited program as to its size, and to the time that an individual can spend there. We have with our present staff, the capacity of about 15 patients, and most of the time we run at rather full capacity.

Mr. GILMAN. How long a period of time do they spend there?

Dr. BACKERS. They spend 4 weeks there. That is about 2 days shy of 4 weeks.

Mr. GILMAN. It is my understanding that there is only one other such unit in the whole German theater; is that correct?

Dr. BACKERS. No; there are more.

Mr. GILMAN. How many?

Dr. BACKERS. There is one in Landstuhl, there is one big alcohol rehabilitation facility here in Stuttgart, in Bad Constatt.

Mr. GILMAN. Is it also for narcotics in Stuttgart?

Dr. BACKERS. No; this is exclusively for alcohol.

Mr. GILMAN. How about just for narcotics?

Dr. BACKERS. For narcotics we don't have an exclusive unit, we treat both there. There is one in Frankfurt, Landstuhl, Heidelburg, Nuernburg, and there is a small unit in Berlin. That's about it.

Mr. GILMAN. Roughly, then, how many beds would all of these accommodate that you're talking about, just an approximation?

Dr. BACKERS. About 130 or 150 beds I would estimate.

Mr. GILMAN. In your opinion, is that sufficient to take care of the problem here in this theater?

Dr. BACKERS. No; if we had more counselors, we could treat more patients. However, this is a rather curious type of a thing. Many of our staff are civilians, like I am, and for some inexplicable reason, to me at least inexplicable, there is a rule that demands that people who have served here a certain number of years, sometimes 3 sometimes 5, whether they want to leave or not, have to pack up and go, and then they go to the States and recruit somebody new at great expense and ship him and his household goods here.

Mr. GILMAN. That's professionals?

Dr. BACKERS. That's professionals and paraprofessionals; yes. In this fashion, we have, for example, only recently lost one of our key men in our rehab unit, and we are standing to lose a senior counselor for that same reason. They both would have loved to stay with us, we haven't got a replacement yet, but they have to go, or will have to go.

Mr. GILMAN. That's an Army rule?

Dr. BACKERS. I don't think it's the Army. It is somehow the civilian personnel office that is in the last analysis probably working under the Department of the Army.

Mr. GILMAN. Are you short of personnel in your unit?

Dr. BACKERS. Yes; we are.

Mr. GILMAN. Do you have any other needs that you would recommend to improve and expand the work of your unit?

Dr. BACKERS. Yes; there are many things. We need to—as I have indicated already, this is probably our primary task. It should be, at least in my opinion, to improve our relationship with the CDAAC's. This in itself cannot be done without the necessary financial support,

but money alone is not the answer. Certainly the problem does not get smaller by just throwing money at it.

Mr. GILMAN. When you say improve the relationship, you're talking about giving them professional support?

Dr. BACKERS. Yes.

Mr. GILMAN. What other needs do you see?

Dr. BACKERS. It would also be important, I think, that the CDAAC offices, their physical location, not be separate and apart from the other offices that deal in the helping services, such as, dispensary, mental hygiene services, possibly even the chaplain's office, that they all be in the same location. This would in itself already vastly improve communication and professional supervision. Help would be there when it is needed.

Mr. GILMAN. You all should be located in the same general area.

Dr. BACKERS. Yes; hopefully in the same building.

Mr. GILMAN. Do you see any other needs or have any other recommendations?

Dr. BACKERS. I think if we could accomplish this, this would already go very far, because that should include, I would again say, more prompt and more competent evaluation of the hard drug user when he is first referred, that a professionally adequate evaluation could take place and a plan be made based on this. Then, if the number of beds were increased, with the necessary supporting staff, if certain silly rules that would bust up our staff would be removed, I would feel a lot more comfortable that we could get a handle on this problem.

Mr. GILMAN. Have you been consulted with regard to the need for training the first-line supervisor, the NCO's, or in training the CDAAC personnel?

Dr. BACKERS. Yes; we do provide this service, but I'm afraid it is not sufficient. The professional staff, for example, from our MED DAC, the 97th General Hospital, the department of psychiatry, services 23 CDAAC's that are within our area, and that is the whole state of Hessen, from Bad Hersfeld and north to Darmstadt in the south, and all together I would say my road includes more than 150 miles of travel, and so we cannot be on the road all the time and give this support. But we do offer training for these 91G's at our hospital however, the time they can spend there is very limited because they have other work to do.

Mr. GILMAN. How many psychiatrists are there in your unit?

Dr. BACKERS. In our rehab unit, I am the only physician, and I happen to be a psychiatrist, too.

Mr. GILMAN. You are the only physician, only psychiatrist for that unit and for the whole 33 CDAAC's?

Dr. BACKERS. No; all the psychiatrists in the department have a certain number of CDAAC's assigned to them.

Mr. GILMAN. How many CDAAC's for each psychiatrist?

Dr. BACKERS. For example, I have to cover five CDAAC's in the environment of Frankfurt.

Mr. GILMAN. I would assume that you could use another psychiatrist or two.

Dr. BACKERS. Very easily, yes.

Mr. GILMAN. Doctor, once again I want to commend you. From the attitude and the comments made by your patients, they felt that this was one program that was highly effective in the Army, and they felt that they were getting some direct benefit. I hope that maybe you can encourage the Army to do more in that direction. I yield the balance of my time to the distinguished gentleman on my left.

Mr. EVANS. Doctor, I'm not going to ask you any questions at this time. Mr. Gilman has covered everything that I was interested in. I would also like to express my appreciation to you for the job you are doing and for waiting so long to testify. Thank you very much.

Dr. BACKERS. You're welcome.

Mr. ENGLISH. Do the members of the committee have any closing statements they would care to make? Mr. Gilman?

Mr. GILMAN. Will we be concluding our hearings on Wednesday? Will we continue on Wednesday?

Mr. ENGLISH. Yes; we will continue our hearings on Wednesday, and if you would rather wait until the conclusion of those hearings before making a statement, that's all right.

Mr. GILMAN. I think I would like to. I would just like to make a comment, Mr. Chairman. I would like to compliment our staff, I would like to compliment the military personnel for helping us to bring to this hearing a broad cross section of opinion, which I hope is going to be helpful in resolving some of the complex problems that we are confronted with.

Mr. ENGLISH. Mr. Evans, do you have any statements you would like to make?

Mr. EVANS. I would just like to say, Mr. Chairman, that I think that the hearings thus far have reflected a good cross section of the military in Europe. I believe that the witnesses have testified to the best of their ability, and they've brought out a lot of different points of view. We certainly think that everyone who has testified has been sincere, and we feel that it would be beneficial to us, not in trying to condemn or point a finger, but trying to get at some of the problems which exist and maybe help in some ways to alleviate these problems.

Mr. ENGLISH. Thank you very much, Mr. Evans, As I've stated earlier, what we were attempting to do today, and we will attempt to continue on Wednesday, is to provide a balanced view. Obviously we have a wide difference of opinion with regard to the extent of drug abuse, the causes of drug abuse, and what we can do to best deal with drug abuse. I think that we've seen a good cross section. We've had people testify all the way from a private to a four-star general, and I think that all the ranks have been represented in all the positions of the chain of command. Hopefully, the hearings on Wednesday will continue in this same vein, will be balanced, and we'll be provided with additional information. This hearing is recessed until 9 a.m. on Wednesday morning.

[Whereupon, at 7:50 p.m., the hearing was adjourned.]

PREPARED STATEMENT OF BRIG. GEN. GRAIL L. BROOKSHIRE, HEADQUARTERS, EUROPEAN COMMAND, U.S. ARMY

Mr. Chairman: I am pleased to be the HQ European command spokesman in addressing the issue of drug abuse within the command.

Today, I would like to outline for you the drug abuse problems and programs as we see them from a joint command viewpoint. The Washington based military service departments are charged with the overall responsibility of worldwide drug abuse programs within their services. These programs are directed through their respective service components, USAREUR, USAFE, and USNAVEUR, stationed in Europe. However, we at the joint command level, are concerned with all problems that affect the morale and readiness of our forces, and certainly drug abuse comes under that umbrella.

Our past interest in drug abuse within the command was one of providing maximum assistance to the service components in the execution of their programs. However, early in 1976 we became aware of the need to exchange ideas, concepts, problems and programs among the service components in the area of drug abuse. Therefore, we established a semi-annual tri-service drug/alcohol symposium that would provide us with a feel for the overall problem within the command and provide an open forum for drug/alcohol representatives to exchange information of mutual interest, we have since extended participants in the symposium to include dependents schools, American Embassy, the Drug Enforcement Agency, and Office of the Secretary of Defense Representatives, and expanded the scope of the seminar to include the entire spectrum of human resources management (race relations, equal employment opportunity, etc.). Because of these changes, we renamed the symposium the "Tri-Services Human Resources Symposium".

We have conducted four symposiums, and all concerned consider them to be very successful. However, one of the things we had hoped to accomplish—gain a feel for the magnitude of the drug abuse problem within the entire command—was not in fact accomplished. This was because of a lack of standardization, in reporting and definition.

Following service regulations, each component was compiling and reporting drug statistics, but the procedures and categories did not permit a consolidation that would, in meaningful terms, identify the command-wide problem.

This aspect gained added significance when indicators of increased drug abuse within the command surfaced in late 1977. Simply, we needed to know the magnitude of the drug abuse problem. In response, General Haig asked that action be taken to 1) determine the magnitude of the problem, and 2) take necessary corrective action. With this mandate, the component commands, in concert with this HQ, considerably intensified efforts in the drug abuse prevention area.

First: To develop methods to identify the magnitude of the problem, we conducted a European command drug abuse seminar at HQ USEUCOM in April 1978 to develop common procedures and techniques, and print a directive that would codify our efforts.

We did accomplish this and printed a European command directive that:

1. Standardizes definitions for common drug abuse terms.

2. Standardized methods for drug abuse reporting, and requires that component commands, using the new standardized procedures, provide this HQ with a quarterly report. This report will permit us to measure the command-wide magnitude of the problem and, over time, direct our priorities and measure the effectiveness of the corrective drug abuse programs. The first two quarterly reports (Apr–Jun and Jul–Sep) have been compiled. Copies of those reports were provided the committee.

In summary, the reports tell us that the European command has a drug abuse problem. We consider it a serious problem, as anything that adversely impacts upon the ability of this command to fight and win is serious. And, we are equally concerned about the exploitation of young Americans, and the destructive effect of drugs on their lives. Most important are the facts that we have identified the problem, have considerable actions under way to address the problem, and have, through our new reporting procedures, established a "Baseline" which will allow us to measure the results of our programs.

As mentioned, our task was to (1) identify magnitude, and (2) develop necessary solutions. In an effort to get a feel for the nature of the drug problem so that we could work toward solutions, during August 1978, we conducted a brainstorming session here at the HQ in which general and other senior officers, primarily from command positions, participated. Some of the most interesting points developed during this session are:

Our commanders must intensify their efforts to keep our people productively occupied, especially during off-duty time.

Command presence must always be felt in the barracks.

We must work to eliminate negative peer pressure.

As far as use of drugs is concerned, off-duty activities are more important than on-duty. The depressed value of the dollar is making virtual prisoners of many of our young people on military kasernes. We must have morale, welfare, and off-duty recreational programs to offer them alternatives to drugs.

We must work to remove legal and regulatory constraints that currently inhibit our corrective efforts in the drug abuse area.

We must attack the total drug system from the source to the user. However, our primary emphasis must be on the source. To illustrate, it is easier to burn a bale of marijuana than to police up 5,000 marijuana cigarettes once they are distributed. Intelligence indications show that West Germany is targeted for a significant increase in narcotics during the next year. This further emphasizes our priority effort on the source.

Following the general officers seminar, we all went to work to translate the concepts and problem areas developed into action programs.

USAREUR has outlined their plans and programs in this area. However, since USAFE and USNAVEUR are not scheduled to appear at the hearings, I will outline some of their and, of course, HQ USEUCOM plans and programs concerning drug abuse problems.

USAFE has launched a comprehensive drug abuse suppression program named "Counterpush." This program is designed to thwart the transportation, sale, and use of drugs. In this effort, they have requested an additional 28 air policemen and 25 special agents and investigators who will be dedicated to drug abuse programs. The program includes a considerable increase in the use of drug detection dogs. In their rehabilitative effort, USAFE is increasing their clinical and medical, social actions, and program control strength by 86 personnel. Overall, a comprehensive and, we feel, potentially successful program.

As you know, the Navy strength in Central Europe is almost nil. In addition, two-thirds of their assigned personnel are stationed aboard fleet units where shipboard control factors reduce exposure. Nevertheless, in those countries in the European Command in which there is a significant USN population (Italy, Spain, and the U.K.) NAVEUR has active programs. They have recently taken action to increase their special agents and investigators by 20 percent (7 people) and their clinical and social action strength by an additional 6 personnel. In relative terms, these are significant increases.

Both USAFE and NAVEUR have active liaison programs with the constabularies and local police and drug intelligence personnel of host nations.

In HQ USEUCOM, we have taken and will continue to take extensive measures in our effort to get at the real problem—the source of drugs.

First, we maintain an on-going effort to solicit administration, congressional, Department of Defense, and Department of State support in having Government programs at the highest level directed to eliminating the source and interdicting the international movement of drugs.

General Haig has recently written to FRG Minister of Defense Apel soliciting his support in the development of a more intense program of cooperation within the Federal Republic designed to suppress drug sources and availability.

We are in the process of establishing a four-man drug enforcement cell working directly for CINCEUR. The cell will act as an interface between U.S. military law enforcement activities in Europe and drug investigator and law enforcement personnel of host nations and other U.S. activities in country, such as drug enforcement agency, Embassy narcotics coordinators, and U.S. Customs.

To underscore the degree of cooperation existing between all U.S. agencies in country to get at the drug abuse problem, on June 9, 1978, Ambassador Stoessel and FRG Foreign Ministry State Secretary Van Well signed a U.S.–FRG narcotics control agreement that will support our mutual efforts to check drug and narcotics abuse. The bilateral program calls for semi-annual meetings and on a daily basis will address the entire spectrum of common drug abuse problems, and will enhance interoperability within the drug abuse area. There will be a subcommittee for police and customs enforcement on which CINCEUR will have a military representative. In addition, there will be a military subcommittee that will concentrate on problems common to our military forces. The first meeting of the narcotics control central committee is scheduled for December 15, in Bonn.

I hasten to add that all aspects of the programs mentioned are in agreement with the principles of and in most cases directly enhance the 12 point Department of Defense drug abuse program espoused earlier this year to Congress by Deputy Secretary of Defense Duncan.

We feel that the programs discussed, along with the very comprehensive USAREUR program you have heard represent a formidable challenge to drug abuse within the European Command.

Having outlived our plans, Mr. Chairman, there is of course an "—Oh, by the way" attached. It involves a need for some increased resources and some congressional assistance.

We need to upgrade our morale, welfare and recreational (MWR) facilities in Europe. Over the past few years, we have seen a trend toward reducing appropriated fund support for our essential morale, welfare and recreational activities and facilities. The contention that funds can be generated from non-appropriated fund sources to support these essential facilities requires charging the troops a fee to use gymnasiums, athletic courts, facilities and equipment. These are precisely the facilities most useful in providing alternatives to drug abuse.

We need to reduce tour length of our young, first-term, unaccompanied Army soldiers in Germany to 18 months. Studies and commanders' experiences tell us that current tour lengths of up to 40 months for these young people are just too long, and are a contributor to drug abuse.

Next, personnel are needed to man our new programs. We have mentioned some requirements and the USAREUR presentation mentioned more. In sum, the European Command is requesting 439 additional personnel in the law enforcement, clinical and medical, customs and command and control areas. These requests have been forwarded through service and, in the case of this HQ, the Joint Chiefs of Staff channels. Also, we have made our consolidated needs known to the Secretary of Defense.

Finally, we need legislative understanding and assistance in areas where U.S. law, and the U.S. Court of Military Appeals interpretation of U.S. law in those cases where decisions are founded upon evidentiary as opposed to constitutional principles, are major impediments to vigorous prosecution of drug abuse cases. Of specific concern are:

Removal of the effects of *U.S.* vs. *Jordan*, which renders inadmissible in courts martial such evidence collected by foreign authorities which does not conform to U.S. rules of evidence, even though they do meet host nation rules of evidence, and

Removal of the effects of *U.S.* vs. *Ruiz* which requires the military departments to separate an individual with an honorable discharge when the reason for separation is based on evidence developed as a direct or indirect result of a urinalysis test or by a servicemember volunteering for treatment for a drug problem.

This latter provision, allowing an individual to procure a drug-related discharge, and thereby shirking an enlistment and overseas tour commitment while receiving an honorable discharge and subsequently the full range of veteran benefits, makes a joke of the concept of military justice and creates a severe creditability problem between the system and the people in the system.

We understand, Mr. Chairman, that you have expressed a willingness to support our additional resource needs in the Congress. Such support will be appreciated.

Mr. Chairman, that completes my statement. Again, I would like to express my thanks for the opportunity to address the committee.

PREPARED STATEMENT OF GEN. GEORGE S. BLANCHARD, COMMANDER IN CHIEF, U.S. ARMY, EUROPE AND 7TH ARMY

Mr. Chairman: On behalf of USAREUR's almost 400,000 soldiers and dependents, welcome to Germany. Your presence here demonstrates the concern we all share for Americans serving their country in a foreign land.

It is our hope that during your time with us, you will have the opportunity to come to know USAREUR; for it is made up of about as diverse and talented group of men and women as you will find anywhere. Further, it is a command that all Americans can be proud to call their own.

Like any large organization, we do have our share of challenges. But let me assure you, we are aware of them.

As we have for nearly thirty years now, we are meeting the challenges.

And if needed, we stand ready to do our job as part of the NATO team.

During my more than five years in Europe, first as VII Corps Commander, and since 1975 as Commander in Chief, US Army, Europe, and Seventh Army and Commander, Central Army Group, I have noted a tremendous resurgence in our capability to do our job. The progress has been gratifying.

We have recovered from the austere days of Viet Nam.

Discipline problems are down. In fact, we have the lowest AWOL rate, when compared with the rest of the Army.

Our equipment and material is in better shape than it has been in my memory.

The leadership is solid.

And our units are training for their missions.

In an operational sense, we are doing things today that I wouldn't have thought possible two or even three years ago. And that is solid testimony to the motivation and skill of our soldiers.

In spite of all the progress, there is still much work to be done. One area that concerns all of us, and is the primary reason for your visit, is the matter of drug use.

With your indulgence, I would like to give you my assessment of where we stand in our effort to overcome this very persistent and insidious enemy.

At about the time of my arrival in Europe in 1973, we began to experience a decline in the incidence of drug use from the almost epidemic proportions that existed at that time.

The downward trend continued through 1974–76.

However, we seemed to level off in 1977 and are now experiencing a mild upturn. We are nowhere near the situation that existed in the early 70's, nor do I think we will ever see a return to those days. But let me say, categorically, I am concerned, and we are aware of the problem we face.

One soldier on drugs is one too many, in my opinion.

And I am totally committed to reducing drug use to the lowest level possible, commensurate with available resources.

In my estimation, the upturn in drug use is due in large part to five factors:

The ready availability of high grade, relatively inexpensive heroin and other dangerous drugs here in Europe.

A reduction in resources allocated to the drug fight brought on by a number of budgetary factors, to include the teeth to tail ratio.

Boredom and lack of alternatives for soldiers who perceive that the quality of life afforded them in Europe isn't nearly up to standards in CONUS.

Tour lengths in excess of 18 months for our junior enlisted soldiers.

The value of the dollar as it affects the ability of the soldier to get out of the barracks coupled with an increased effort to exploit our soldiers by pushers whose total motivation is profit notwithstanding the wasteland they create on the human level.

At all levels, gentlemen, I think we relied too much on the success we achieved in 1975 and 1976, and misread the trend line for a time in 1977. We began then to recognize that drug abuse represents an incipient threat to U.S. Forces. This threat affects not only the working and living conditions but the individual soldier, his family, their careers and future well-being. We have been moving out for more than a year to do something about drug use in USAREUR and continue to intensify our efforts.

First, we are making maximum use of available assessment tools to quantify the extent of the problem. Special surveys and the USAREUR Personnel Opinion Survey have been valuable tools in assessing drug abuse levels and trends here in Europe.

Preliminary drug estimates have been drawn from the early returns of our most recent survey, which was sent to the field for administration in mid-October.

These preliminary data indicate that the total number of people involved in monthly or more frequent drug abuse has not increased significantly during 1978. However, an increase in the popularity of narcotics is evident in the trend analysis of the survey data.

We have also compared our survey results with the results of our unit urinalysis testing program. Given the difficulty of measuring exact drug abuse prevalence we find that these two independent sources of information are in very close agreement; and this has reinforced our confidence that we have a fairly accurate assessment of the extent of the problem.

This assessment, however, indicated that drug abuse levels are not uniform throughout the command. They vary from unit to unit, and within the various

age and rank groups. For example, we would expect drug abuse among the young, junior enlisted soldiers of certain units to be much higher than the estimates applied to the entire command. We think we are beginning to see a clustering effect where our unit urinalysis program reveals in some cases excessive drug use among a given racial or ethnic group in a few units and just the reverse in other units.

In talking to soldiers, and specifically abusers, one may hear judgmental estimates that 40 percent or more of the personnel in a given unit are abusing narcotics or dangerous drugs. Our statistical data do not support such estimates, which may be made by honest, but unskilled observers based on their sphere of association.

Second, we are moving out aggressively to do something about drug use in the command, and the effort is extensive.

Our most active and aggressive effort is to deal with drugs at the source. We have taken strong action to increase our drug suppression capability by shifting MPI assets, emphasizing drug suppression as our first law enforcement priority and requesting assistance from DA as needed. We see it as essential that we reduce the availability of drugs to our soldiers.

We have requested the necessary resources to upgrade our 80 outpatient treatment centers and 5 inpatient facilities for drug patients.

We have intensified our urinalysis program with Selected Unit Urine Testing for Company Size Units (SUUTCO). When we get the portable urinalysis devices this program will be further enhanced.

Across the board, there has been renewed emphasis on:

Drug awareness.
Drug suppression.
Treatment and rehabilitation.
Enhanced cooperation with host nation law enforcement agencies.

In short, the measures are sophisticated, and there is good cooperation throughout the command. Also, much that we do beyond this point is dependent upon additional resources to be provided by Department of Army and Department of Defense. I have strong assurances from Department of Defense and the Army leadership that these will be forthcoming soon. You should know that we are seeking an overall increase in resources for this program of about 25 percent.

You will be hearing a lot more about our drug program from other members of my staff, so I won't dwell in detail on this subject now. Let me conclude by saying that it would distress me, and I think be a disservice to our soldiers if a picture were painted that we've got a command of druggies and losers over here.

I'm very proud of the soldiers we have serving in Europe, and I think' Americans, in general, should feel the same.

They're a dedicated group of men and women, and they're making numerous sacrifices in behalf of their country.

And I'd stack the effectiveness of US Army, Europe, today against that of any previous force or that of any of our NATO Allies.

Should the need ever arise, I am confident, they will do the job that needs to be done. At the same time we are moving in the most aggressive way possible to stamp out the exploiters of our soldiers and we intent to succeed.

Addendum to General Blanchard's Prepared Statement

Mr. Chairman: On November 12, 1978, several members of my staff and I presented testimony regarding the drug abuse situation in U.S. Army, Europe (USAREUR). Since then, you have been traveling throughout USAREUR visiting and talking with a cross-section of our leaders and soldiers. I hope this has been a worthwhile and rewarding experience for you. I am certain that your close contact with many of our fine young men and women has given you a better perspective, not only on the capability of our units to accomplish their mission, but also on the quality of life shortfalls that may contribute to drug abuse. We, in USAREUR, are proud of our command and hope that you, too, share that pride. Today, we are here to follow up on our earlier presentations and answer your questions. As a lead-in to our discussion, I will summarize some of the main points we covered on November 12, 1978.

We recognize that we have a drug problem here in USAREUR, and I assure you that the availability of high grade, inexpensive heroin is a matter of special concern. Further, we believe we are aware of the magnitude of the problem and action is being taken at all levels to reduce the availability and abuse of drugs.

Never in my five years in Europe have I witnessed the degree of awareness of the problem and the intense desire to do something about it which prevails today. Of course, you recognize that there are limits to the ability of the Army in Europe to solve this problem. Given the ready availability of hard drugs, and the ease with which this young group can be targeted, to solve this problem, we need and solicit considerable additional help from the countries where our soldiers serve, and especially from the countries which are interdiction routes into the FRG.

At this point, I would like to emphasize my commitment to solving the problem in Europe. With your permission, I would like to read into the record two letters that I have dispatched to commanders down to and including company commanders in USAREUR. The first letter was disseminated on August 24, 1978, and reads as follows:

"I am deeply concerned about the increasing availability and abuse of drugs in the U.S. Army, Europe. Drug abuse represents a threat to the readiness of U.S. Forces and affects the living and working conditions of every USAREUR soldier.

"Recently we began selected unit urine testing for company size units (SUUTCO) to determine the extent of drug abuse in USAREUR. This program will help to provide a drug-free environment. It is not harassment. In this regard, I expect commanders to supervise personally the implementation of SUUTCO to ensure all testing is conducted in a dignified manner and individuals rights of rights of privacy are not unduly infringed.

"Challenging training, educational opportunities, and a variety of recreational activities are available as meaningful alternatives to drug abuse. Commanders and supervisors should emphasize these alternatives and provide effective counseling. We must also make every soldier aware of the dangers drug abuse poses to the individual and to USAREUR. Together, we must minimize the effects of drug abuse in USAREUR by prevention, whenever possible, and provision of help for those who need it. I urge each member of this command to support the alcohol and drug abuse prevention and control program."

The second letter specifically addresses the issue of recognition for the commander or supervisor who has been particularly effective at dealing with the drug problem. On October 19, 1978, I dispatched the following communication, also down to company level:

"A vigorous program for identifying alcohol and drug abusers and reducing this abuse in USAREUR units is essential if we are to maintain our personnel readiness.

"Commanders at all levels must be involved and committed to reducing the impact of alcohol and drug abuse in their units. USAREUR commanders have my wholehearted support in their efforts to reduce such abuse by pursuing a lawful and vigorous alcohol and drug identification and prevention program. I expect the chain of command to support these endeavors by all appropriate means, to include recognition of achievements in connection with this program."

Additionally, on August 5, 1978, I dispatched a message to all commanders, to include community and sub-community commanders. This message stated in part:

"I want you and your NCO's to get thoroughly involved personally. Initially, our drug education programs need to be upgraded to insure that the young soldier understands the implications of the use, even though experimental, of hard drugs and the need to curb it. Secondly, our attempts to ferret out drug abusers must be intensified. We have numerous resources to do this, including provost marshal activities, searches and seizures, health and welfare inspections, our various urinalysis programs, etc. I want you to become personally involved in using all the capabilities that we have. Thirdly, I want you to insure that the CDAAC's are performing well. You need to make frequent visits to check on the quality of their people and the effectiveness of their counseling of your soldiers. Fourthly, you need to crack down on the drug abusers themselves.

"Our efforts to identify drug abusers must be intensified. Every legal and authorized means for accomplishing this effort should be utilized.

"By cracking down on the drug abusers themselves, I mean for you to take whatever affirmative action is proper and appropriate to deal with each individual case. Where rehabilitation is deemed appropriate, it should be attempted. Where administrative disposition is deemed appropriate, the various administrative mechanisms at your disposal should be employed. If appropriate and warranted, Article 15 or judicial action may be initiated against drug law violators. In each instance, you as commanders, have freedom to select the appropriate disposition."

In the area of law enforcement, we already have taken a number of actions to strengthen our drug suppression effort.

First, we have emphasized that drug suppression is our number one priority.

Second, we recently opened a Drug Suppression Operations Center (DSOC) which centralizes our efforts in acquiring, analyzing, and disseminating all available drug data. The DSOC should provide for improved coordination of everyone who is working on this problem, a more rapid response to perishable drug intelligence, and better utilization of law enforcement assets.

Third, the cooperation and working relationship between the Federal Republic of Germany (FRG) and all U.S. law enforcement agencies continues to improve. We have representatives participating in a number of host nation drug-oriented law enforcement working groups on a regular basis.

Finally, the addition of CID and Military Police Investigators (MPI) to an already formidable force enhances our capability to take more drugs off the street and out of our military communities.

Despite our intensified law enforcement efforts, we anticipate that the easy availability of drugs will continue to pose our most serious problem. Regardless of the level of effort the Army devotes to reducing the availability of drugs to our soldiers, the extent of success will be strongly influenced by the host nation's and other governmental agencies' ability to suppress drugs.

Our identification, treatment and rehabilitation program needs improvement. In the area of identification, we have initiated several measures that will increase our ability to detect at the individual level and improve our capability to assess the overall magnitude of the problem. Our recently implemented selected unit urine testing for company sized units (SUUTCO) and special surveys—in conjunction with the continuation of the USAREUR personnel opinion survey and our regular commander directed urinalysis program—have proved to be excellent assessment tools which provide us with useful estimates of drug abuse levels. Also, we are moving ahead in our bid to obtain additional resources to improve rehabilitation services. We recognize the shortfalls in our Community Drug and Alcohol Assistance Centers (CDAAC) and plan to upgrade the quality of this program by providing a trained, experienced psychologist or social worker to the staff in each of our 80 CDAAC's and by hiring additional civilian counselors who possess the qualifications, skills, and maturity to deal with the complexities of the drug situation in Europe. More professional CDAAC staffs and higher quality rehabilitation effort will increase the confidence in our program at all levels. We also intend to tie in the CDAAC to the chain of command in a greater degree than heretofore.

In short, we believe we are taking the kinds of action within our capability to combat the drug problem. We have used DOD's twelve points as a basis for developing a comprehensive plan for improving all of our drug-related programs and activities. It is my desire and my intent to take every appropriate action to reduce to the absolute minimum the availability of drugs to our soldiers, to minimize their abuse in our units and to either rehabilitate or eliminate the abusers in our ranks.

I would like to clarify one issue that was raised on November 12, when I submitted my statement to the committee.

That issue concerned the effect of drug abuse on the readiness posture of this command. I recognize the danger of drug abuse and the threat it poses to our readiness. In assessing the present effect of drug abuse as opposed to its potential ultimate effect, I weigh several factors.

First, I consider the views of my Chief Surgeon. He has told me that most drug abuse in this command is not the result of hard core addiction. This view is reinforced by the drug abuse prevalence estimates drawn from our biochemical testing programs and our opinion survey data.

Second, I consider the substances abused, the frequency of their abuse, and the population engaging in that abuse. All prevalence estimates must be well defined in these three parameters in order to have real meaning. As I review these numbers I am, of course, very concerned about the soldiers who abuse drugs. We've worked very hard to understand the relationship between what our surveys show, what our urinalysis testing reveals, and what our soldiers tell us. The objective estimates that we receive from different sources seem to agree very well. However, in dealing with subjective estimates from soldiers, we keep in mind that it is extremely difficult for one person to estimate the drug abuse habits of another. Further, soldiers seem to base their estimates of the whole on their perception of what their immediate associates are doing.

Third, I consider a number of indicators of effective unit performance; the results of training tests and exercises, the level of equipment maintenance, the level of physical fitness and appearance, and the results of inspections throughout the command. Our most recent Reforger exercise provided a graphic demonstration of the combat readiness of USAREUR and CONUS reinforcing units.

Fourth, I consider indicators of personal conduct and discipline such as military police reports, AWOL rates and accidents.

Fifth, I consider the views of my experienced subordinate commanders right down to company level. Readiness is the number one concern of all these leaders. They are continuously aware of a broad range of factors which can and do affect the readiness of their units. They tell me that drug abuse has less effect on readiness than a number of other factors, such as limited access to training areas, limited training funds and the long tour for first term soldiers. In this context the effects of drug abuse on combat readiness—serious though they may be—do not loom as large compared to a significant number of non-drug-related issues.

Finally, I merge all of these considerations, indicators and views with my own judgment and observations. Having done so, I conclude that my command today is ready to fight and is better equipped and trained to carry out its combat mission than at any time in my experience—and that goes back to 1973. Having said that about the effectiveness of our units, let me emphasize to you that I know drug abuse degrades the personal readiness of the abuser, and that I am aware of the fact that we have many abusers in our units. We are working hard to determine some means to measure and assess the impact of individual abusers on our total combat readiness. We have not yet succeeded in that endeavor, even though everyone who looks at our units in training and in exercises comes to one view—that our force is ready to fight. Yet, we all know intuitively that fewer abusers in the command would make ours a better force, and consequently, a more combat ready force. Moreover, we believe that given the current availability of relatively pure heroin in USAREUR, our force will be in great jeopardy if our current intensified efforts are not successful.

We have attempted to develop precise, quantified measurements of our readiness—Both individual and unit—and we will continue to do so. In the interim, we are open to any recommendations and we are prepared to support research into this difficult problem.

You have asked on several occasions what the Congress can do to assist us. You can help USAREUR by supporting our proposed program enhancements and requests for additional resources. If we are to succeed, our current and planned efforts to combat drugs must be complemented by attendant improvements in the general environment in which our soldiers live and work. The quality of life in USAREUR must become more nearly like that enjoyed by service members in the United States. Improved environment and quality of life, together with a shorter tour for the first-term, unmarried, unaccompanied soldier, will help to provide acceptable and attractive alternatives to drug abuse. I would also like to emphasize as I indicated previously, that we need all the assistance that this committee and the Congress can render to deal with the international traffic of drugs in areas in areas where our soldiers are the targets.

PREPARED STATEMENT OF BRIG. GEN. WILLIAM H. FITTS, DEPUTY CHIEF OF STAFF, PERSONNEL, HEADQUARTERS, U.S. ARMY, EUROPE AND 7TH ARMY

Mr. Chairman: Since my testimony before the House Select Committee on Narcotics Abuse and Control in May 1978, USAREUR has taken a number of positive actions to enhance its capability to deal effectively with the drug abuse problem. In our efforts to reduce drug abuse among our soldiers, we have initiated a program that will intensify our identification procedures, improve our methods of assessment, increase our drug suppression activities, and revitalize our rehabilitation and treatment efforts. The purpose of my statement today is to provide you with an update of the current drug situation in USAREUR as we perceive it and to discuss our initiatives for improving identification, assessment, suppression and rehabilitation.

AVAILABILITY

A wide variety of drugs—including narcotics, dangerous drugs and cannabis—continue to be readily available to our soldiers. Hashish is the drug most widely abused, with approximately 34 percent of our E–1 to E–4 population using a

cannabis product on a monthly or more frequent basis. Although we are concerned about the widespread abuse of hashish, the easy availability of high grade, inexpensive heroin presents a potentially more serious problem to our personnel readiness. The amount of heroin seized by both US and indigenous law enforcement agencies has increased steadily since 1977, and our drug intelligence indicators reflect an even greater increase in the availability of opiates during the next 12–18 months. BG Kanamine, the USAREUR Provost Marshal, will elaborate on drug availability and drug suppression activities in a separate statement.

PROBLEM ASSESSMENT

Although we continually seek new methods to improve our capability to assess drug abuse rates, we believe that our USAREUR Personnel Opinion Survey (UPOS) provides a valid estimate of the drug problem magnitude. The results of our surveys over the past 4 years are shown on these two graphs (figures 1–2). These figures are based on monthly or more frequent abuse and expressed as a percentage of the total USAREUR population. Since the survey has been in effect, we have noticed that drug abuse has decreased from its highest level in 1974 to a temporary low in 1976 and began to show signs of upward trend in 1977. In October 1978, we administered our latest UPOS and the results are being tabulated now. Although our final estimates of the abuse rate are not available today, preliminary data based on a 25 percent return of the survey indicates that drug abuse has not increased substantially in 1978.

In addition to the UPOS, we monitor several other indicators that assist in determining the extent of drug abuse. For example, we track the number of soldiers arrested for both use/possession and sale/trafficking of drugs; the number of personnel identified as drug abusers who are entered into rehabilitation; the number of new hepatitis cases; and the number of alcohol/drug related disciplinary actions and administrative separations. With minor exceptions, these indicators reflected a slight but steady upward trend from mid-1977 through the 2d quarter 1978. However, our most recent 3d quarter 1978 data show a decline in most of these areas. (Figures 3–10 furnished for the record.) This is an encouraging sign, but it is too early to ascertain whether this is a trend or only an aberration.

While a number of our indicators suggest an increase in drug abuse over the past 12 months, they should be viewed in light of two factors. First, the statistics we track are influenced significantly by the amount of effort dedicated to combating the problem and the degree of command emphasis placed on identifying drug abusers. Second, the abuse of drugs by type may vary considerably over time based primarily on factors such as ease of availability, cost, and preferences within peer groups. A thorough analysis of all available indicators has led us to the conclusion that the abuse of heroin is definitely increasing, based primarily on ease of availability and low cost, but the total population of narcotics and dangerous drug abusers has remained about the same during the past year. The preliminary results of our October UPOS tends to support this analysis.

The apparent increase in the abuse of heroin is of serious concern to this command and has resulted in the intensification of our total effort to reduce drug abuse throughout USAREUR. Drug suppression is the number one law enforcement priority and drug problem awareness is receiving more emphasis now than at anytime in recent years. Already these increased efforts have produced results as reflected in the increased number of identifications, apprehensions for drug related offenses and the seizure of illegal drugs.

Selected Unit Urine Testing for Company Sized Units (SUUTCO) was initiated in May 1978 to provide USAREUR with an additional assessment capability of drug abuse trends. SUUTCO is an amplification of existing urinalysis and provides for the testing of an entire unit when a demonstrated need exists. The SUUTCO may be USAREUR-directed or Commander-requested and requires testing of all members of the unit regardless of age, grade, or sex. To date, we have tested over 70 units using this procedure. The results are shown on this chart (figure 11). We believe that we have created an assessment tool that will greatly assist us in monitoring the drug situation.

IDENTIFICATION AND REHABILITATION

Our Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) is a balanced effort designed to assist the commander in the vital areas of prevention, identification, and rehabilitation or separation. Commanders utilizing the procedures and facilities provided by the ADAPCP have been moderately

successful at identifying drug abusers, entering them into rehabilitation and returning them to duty. During 1977, 2157 soldiers successfully completed the rehabilitation program. This represents a success rate of more than 50 percent and a savings to the Army in personnel replacement costs approximately 23 million dollars. Thus far in 1978 our success rate is running about 57 percent. Despite these successes, we realize there is a need to upgrade the quality of service provided by our Community Drug and Alcohol Assistance Centers (CDAAC). Our goal is to improve program credibility, thereby, increasing the number of abusers referred for treatment and our success rate. A request for the addition of experienced professional counselors, psychologists, and clinicians is pending approval.

IMPACT ON READINESS

We recognize that any degree of drug abuse has some adverse affect on personnel readiness and impacts on the health, welfare and morale of our soldiers. Given this known factor, we have attempted to gauge the impact of drug abuse on our total force readiness. In assessing the problem magnitude we are monitoring several areas: first, our May 1978 survey of over 300 commanders helped us determine their perception of the affect of drug abuse on readiness; second, our SUUTCO data representing a snapshot in time has been a good indicator of the abuse rate at a particular point in time; and finally the high states of personnel, material, and training readiness provide useful but imprecise tools for assessing the impact of drug abuse on combat readiness. Analysis of these indicators tell us that drug abuse does have some adverse affect on individual readiness, but it is not yet of sufficient magnitude to seriously impair the capability of our units to accomplish the mission. We are fully committed to our fight against drug abuse and realize it could result in a situation where our fighting ability could be degraded. Moreover, we are incensed at the level of exploitation of our soldiers that this represents and are committed to driving out the pushers by any legal means at our disposal.

USAREUR INITIATIVES

In July 1978, the Honorable Charles W. Duncan, Jr., Deputy Secretary of Defense, outlined DOD's 12 point plan to reduce drug abuse in the military. We have adapted each of these 12 points to our level of operation. The remainder of my statement will outline the rapid and decisive action we have taken to comply with these points.

Point No. 1. Design and administer a comprehensive personnel opinion survey.

USAREUR INITIATIVE

As I mentioned earlier, we feel strongly that our USAREUR Personnel Opinion Survey (UPOS) is a reliable assessment tool for determining the magnitude of the drug abuse problem. Since 1974, over 40,000 soldiers of all rank, age, race and varying social background have been surveyed on an anonymous basis. Our latest survey was conducted in October 1978 and the completed results will be available within a few days. When the final results are compiled they will be provided to you for the record. In addition to continuing our UPOS on a semiannual basis, we plan to conduct special surveys on an as needed basis. Last May we surveyed a group of commanders to assist us in determining the impact of drug abuse on combat readiness. This was a highly successful effort and we plan to continue administering surveys of this type.

Point No. 2. Augment existing devices for assessing the extent of drug abuse and locating drug problem areas.

USAREUR INITIATIVE

Our recently implemented Selected Unit Urine Testing for Company Size Units (SUUTCO) is proving to be an excellent assessment tool for determining the extent of the problem and identifying areas where drug availability and abuse may be particularly acute. SUUTCO is probably our best device for measuring the impact of drug abuse on combat readiness since it gives us a good indication of the number of personnel abusing a substance at a point in time. The 3.0 percent of abuse in the 70 plus units that have undergone SUUTCO tends to nail down the scope of this problem on a unit basis. Additionally, we have improved our capability to analyze the data produced from our regular command-directed urinalysis testing program. Through this effort we expect to identify high risk

drug abuse areas and improve our trend analysis. These data will be used with our other indicators to reinforce our overall estimate of the problem. One final action in this area, once implemented, is the establishment of a USAREUR Drug Assessment/Assistance Team. A major function of this team will be to identify units/areas with a high incidence of drug abuse so that appropriate preventive action could be taken.

Point 3. Redesigning of the drug reporting system to allow for a more uniformed and ready access to trend data.

USAREUR INITIATIVE

In August all service components provided their first quarterly report to USEUCOM as required by EUCOM Directive 30–17. One purpose of the directive is to establish standardized reporting of key drug abuse indicators. This should result in readily available data on drug abuse trends and indicators that present a uniform picture of the drug situation throughout Europe.

Point 4. Accelerated testing of portable urinalysis equipment.

USAREUR INITIATIVE

Action is underway now for USAREUR to procure two Enzyme Multiplied Immunoassay Technique (EMIT) portable urinalysis machines. The operators for these EMIT machines have been selected and are undergoing training in CONUS now. A pilot program is being developed in conjunction with the 7th Medical Command to determine the advantages and disadvantages of portable urininalysis testing machines at various levels below the central laboratory level to include cost, reliability, maintenance, operator qualification, morale, and regulatory considerations. It is anticipated that the pilot program will commence on or about 8 January 1979 and terminate six months later.

Point 5. Reemphasize to command and medical personnel the significance of curtailing drug abuse.

USAREUR INITIATIVE

We have taken a number of actions to reemphasize the importance of reducing drug abuse to the absolute minimum. The CINCUSAREUR has demonstrated a strong personal commitment to the fight against drug abuse and he has taken action to insure that subordinate commanders share his concern. In the last 3 months General Blanchard has written two letters that received command-wide distribution emphasizing the importance of our drug related programs. Recently, a complete review of the entire Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) was undertaken by several key members of the USAREUR staff. A number of issues needing improvement were identified and a program designed to accomplish our objectives is in various stages of implementation. Additionally, the USAREUR Surgeon, MG Reid, communicated with his medical command a need for increased support of the ADAPCP by physicians and other medical support personnel.

Point No. 6. Accurately assess the magnitude of drug abuse by dependents and determine how well existing programs are responding to dependent needs.

USAREUR INITIATIVE

We recently contracted for the development of a survey instrument to measure drug abuse rates in the dependent sector. Through this means we hope to learn more about dependent drug abuse and its relationship to the military problem. We should have the results of our first survey by mid-1979. The availability of treatment for dependents under USAREUR's existing programs has not posed any unique problems. We have a requirement to provide an out-patient rehabilitation service for drug abusers in all of our 35 major communities and most of our sub-communities; therefore, the service is reasonably available to all dependents.

Point No. 7. Review our law enforcement capabilities to determine whether we need more and different types of law enforcement personnel.

USAREUR INITIATIVE

In recent months USAREUR law enforcement agencies (Provost Marshal, 2d Region USACIDC, and 42d Military Police Group) have re-examined their drug suppression capabilities and the number of personnel devoted to this effort. A

number of initiatives were generated to improve supression operations and additional resources were identified and requested to support enhanced levels of efficiency.

To designate suppression as our number one effort we have in advance of authorization applied significant additional resources to suppression activities in the past year. Additionally, the Second Region USACIDC and the USAREUR Provost Marshal's office have requested an increase of 20 CID Special Agents and 45 Military Police Investigators (MPI) who will devote full time to drug suppression. We have already assigned the 45 MPIs to these duties in advance of new authorizations. These resources will increase our capability for gathering intelligence, investigating drug activities, and interdicting drug traffic by roughly 100 percent.

Additionally, a review of the 42d Military Police Group's (Customs) role in drug suppression disclosed several areas where drug interdiction efforts could be improved. We have requested 50 Military Customs Inspectors/Investigators and 20 dog handlers, who will devote the majority of their effort to drug suppression activities. Primarily, these resource increases will enhance existing border, vehicle processing, mail handling operations and military customs inspection program for household goods and hold baggage shipments.

As a major new initiative, the CINCUSAREUR directed the formation of a Drug Suppression Operations Center (DSOC) to coordinate all USAREUR law enforcement drug related activities. The purpose of the DSOC is to optimize our capability to reduce the availability of drugs in USAREUR. The DSOC will centralize and improve our efforts to acquire, collate, and analyze all available drug data. Operational elements will include representatives from the USAREUR Provost Marshal and Deputy, Chief of Staff, Personnel, 2d Region USACIDC, 42d Military Police (Customs), and major subordinate command Provost Marshal offices. It will operate under the supervision of a Brigadier General who has directive authority in executing all drug suppression activities. We anticipate that the centralization of our drug suppression operations will result in better coordination among participating agencies, a more rapid response to perishable drug intelligence, and better utilization of available law enforcement resources. In conjunction with this action, the CINCUSAREUR has stressed to his commanders that drug suppression is the top priority in our overall law enforcement effort.

Point No. 8. Examination of the investigative and prosecutive follow-through in the United States of arrests made on military installations.

USAREUR RESPONSE

This is not a constraint upon our prosecution or enforcement efforts in USAR EUR. Nevertheless, in the United States the lack of jurisdiction over drug offenses which are not committed within a military installation is a serious problem.

Point No. 9. Establish a Berlin Task Force designed to focus on the singular problem of that free port.

USAREUR INITIATIVE

On 30 June 1978, the US Commander Berlin (USCOB) convened a meeting of all agencies involved in combating the flow of drugs into and through the western sectors of Berlin. The objective of the initial meeting was to determine the extent of the problem; the impact on the American and German Communities; American involvement in drug trafficking; and actions that could be taken from the US military command structure, US State Department, Drug Enforcement Agency, US military law enforcement agencies, and West German Police and Customs officials. The working group established in June 2 was institutionalized and conducted its first official meeting in September. The following task force goals were established.

Determine measures that can be taken to interdict the drug flow into and through the western sectors of Berlin.

Determine measures that can be taken to isolate the American Community from the drug flow.

Determine programs or actions that can be taken to assist German law enforcement agencies in improving their capability to combat drugs.

Provide an overview and direction to assessment, prevention and rehabilitation efforts in Berlin.

The task force will furnish the CINCUSAREUR with periodic progress reports at least quarterly on its achievements and activities. We anticipate that dedicated

pursuit of the above goals will enhance our capability to reduce drug availability in Berlin.

Point No. 10. Contribute to the drug related research effort.

USAREUR INITIATIVE

Drug overdose deaths are matters of serious concern; however, little is known about the people at highest risk for overdose, the environments that encourage them, or what might be done to prevent such casualties. The US Army Medical Research Unit (Europe) is conducting a research project to explore three fundamental areas:

Are there personalities or social environments that make death by overdose a higher risk for some people than for others?

Can death by overdose be prevented?

What is the significance of an overdose casualty for either assessing current drug use within the Army or predicting future use?

The research project began in July 1978 and is expected to last through July 1980. Anticipated results include:

Psychological profiles of overdose casualties.

Descriptions of high risk environments.

Suggestions for prevention.

Point No. 11. Evaluation of our drug-related programs.

USAREUR INITIATIVES

We have reexamined the drug situation in USAREUR and the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) and identified specific actions to reduce the availability and abuse of drugs and upgrade the quality of our programs. The following objectives have been identified as essential to accomplishing this task:

Reduce the availability of drugs to USAREUR soldiers through increased drug suppression efforts. It should be no surprise that we list this objective as first in our efforts.

Reduce alcohol and drug abuse to the absolute minimum (i.e. 1976 levels or below).

Improve USAREUR's drug education program through compliance with Department of Defense directives.

Improve the quality of the Community Drug and Alcohol Assistance Centers, thereby restoring commander confidence in the ADAPCP and subsequently increasing abuser referral rates by 10 percent.

Increase alcohol/drug abuser rehabilitation rates by 10 percent.

Using the foregoing objectives as guidance, a study group consisting of representatives from the Office of Deputy Chief of Staff (Personnel), Provost Marshal, 2d Region USACIDC, Judge Advocate, Public Affairs, Office of Deputy Chief of Staff (Resource Management), and 7th Medical Command developed a comprehensive drug abuse reduction plan. Where possible our initiatives were aligned with DOD's 12 point plan and have been addressed in previous portions of this testimony. Naturally, any significant improvement in our ADAPCP or overall capability to combat the drug problem will be somewhat dependent on the acquisition of additional resources. Resources required to fully implement our Drug Abuse Reduction Plan are addressed in our response to point No. 12.

Point No. 12. Increase the number and quality of personnel assigned drug prevention and control related duties.

USAREUR INITIATIVE

In addition to the increased number of CID special agents, Military Police, and Customs investigators mentioned earlier, we have requested a substantial increase in manpower and fiscal resources to enhance our capability to identify and rehabilitate drug abusers. Essentially we are seeking a 25% increase in manpower and dollars over current levels. The following resources have been identified as necessary to achieving our objectives.

Manpower Resources:

6 officers and 17 enlisted personnel to support USAREUR's Drug Education and Assessment/Assistance Teams.

50 (GS 11/12) Clinical Directors.

40 (GS 7/9) Counselors.

4 (GS 13) Physicians.
4 (GS 11/12) Social Workers/Psychologists.
8 (GS 7) Social Service Assistants.
2 (GS 4/5) Secretary/Admin Asst.

Associated funds:
Civilian salaries—$2,085,000.
Civilian Benefits—$222,000.
TDY Funds—$130,000.
Education Support Funds—$30,000.
Covert Quarters (CID Support)—$45,000.
Maintenance—$10,000.
One-Time Support Costs—$177,800.
Total First Year Cost—$2,689,800.
Recurring Annual Cost—$2,522,000.

Adding these resources to any already effective program should increase commander confidence in the ADAPCP and result in increased numbers of soldiers referred for treatment and improved rehabilitation rates. This mix of law enforcement personnel, professional counselors and ADAPCP staffers will give our total program the credibility and balance necessary to attack the drug abuse problem on all fronts and win.

FIGURE 1.—Percentage of the population abusing cannabis.

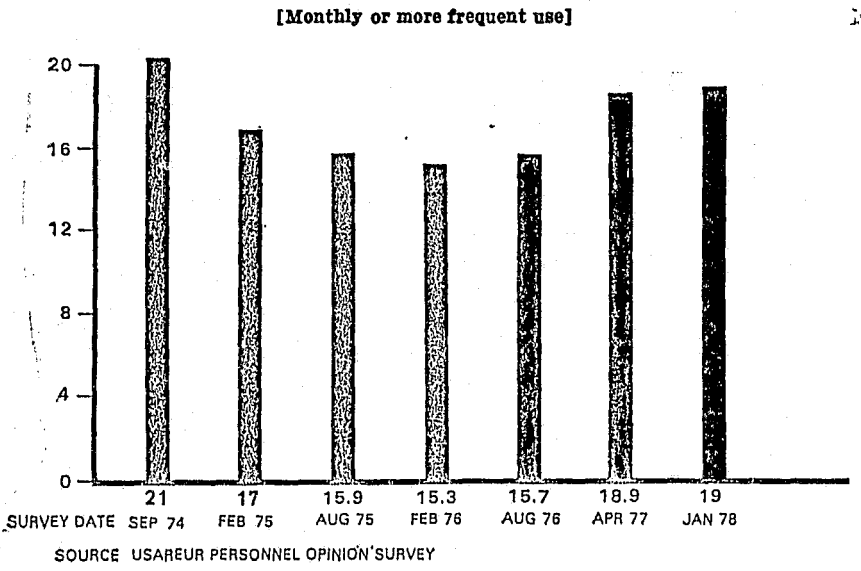
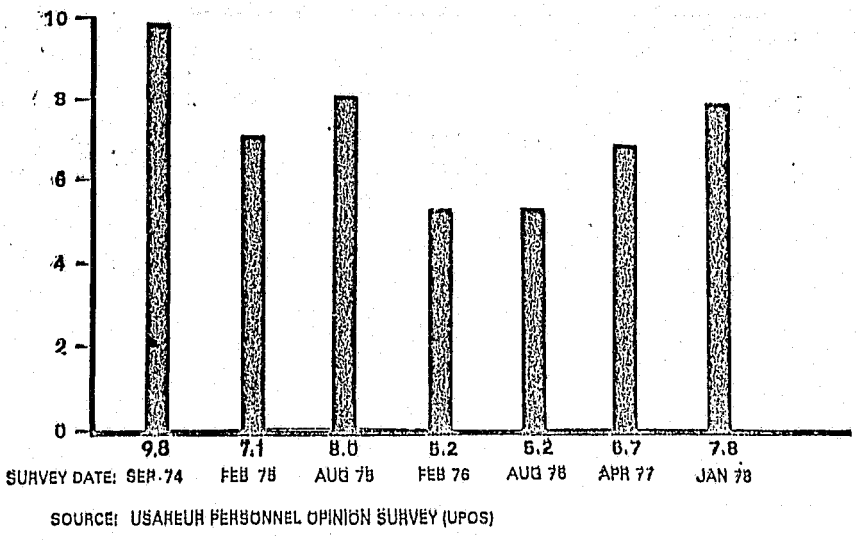


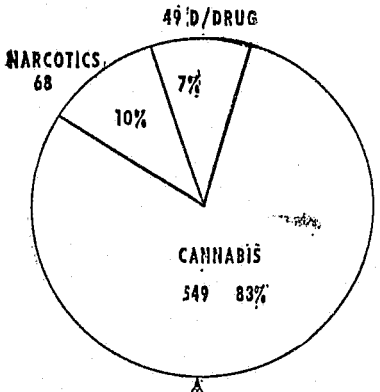
FIGURE 2.—Percentage of the population abusing narcotics and dangerous drugs.

[Monthly or more frequent use]



SOURCE: USAREUR PERSONNEL OPINION SURVEY (UPOS)

FIGURE 3.—Identified offenders use/possession.



Quarters

CATEGORY	3/77	4/77	1/78	2/78	3/78
Cannabis	451	515	550	699	549
Dangerous Drug	54	62	54	59	49
Narcotics	24	46	57	64	68
TOTAL	529	623	661	822	666

(Monthly Average Per Quarter)
Source: DA Form 2819

FIGURE 4.—CID sale and trafficking cases.

[Monthly average per quarter]

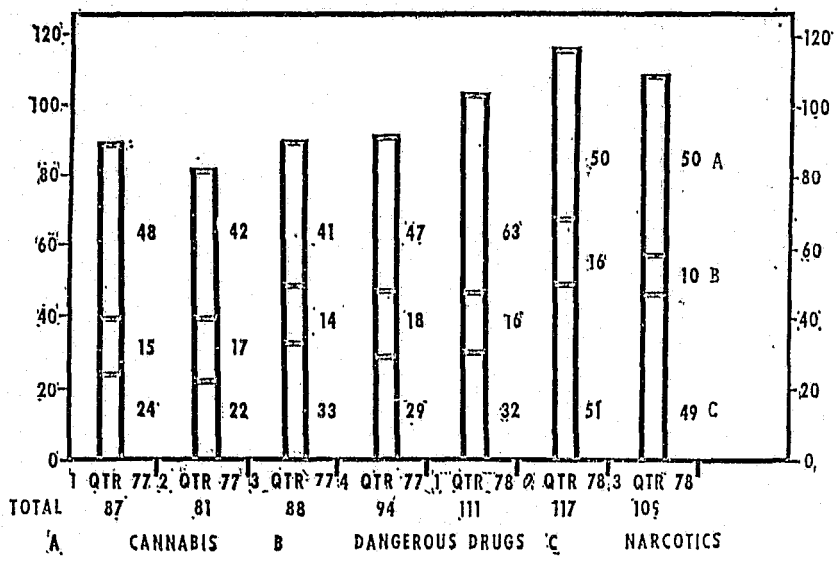
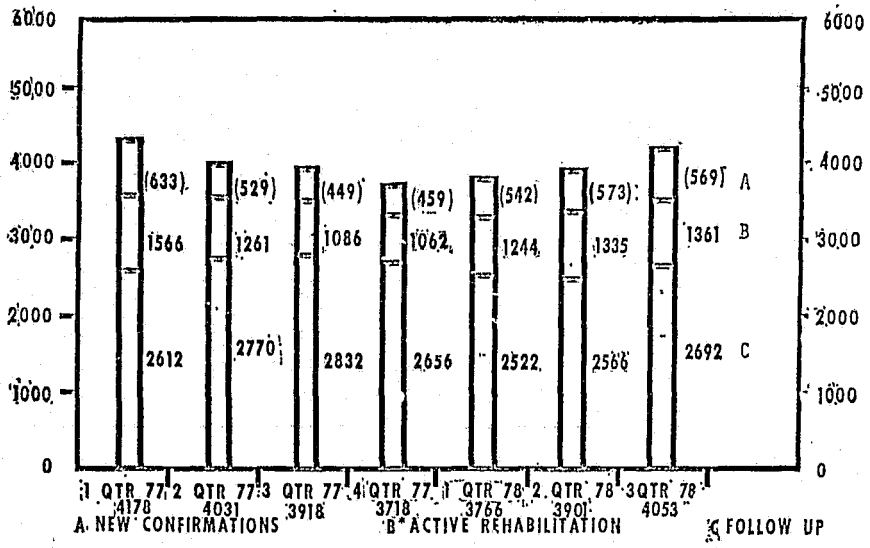


FIGURE 5.—Personnel in drug rehabilitation.

[Monthly average per quarter]



*INCLUDES CONTROLLED ENVIRONMENT, EXTENDED CARE, AND CDAAC

FIGURE 6.—New drug confirmations by drug type.

[Monthly average per quarter]

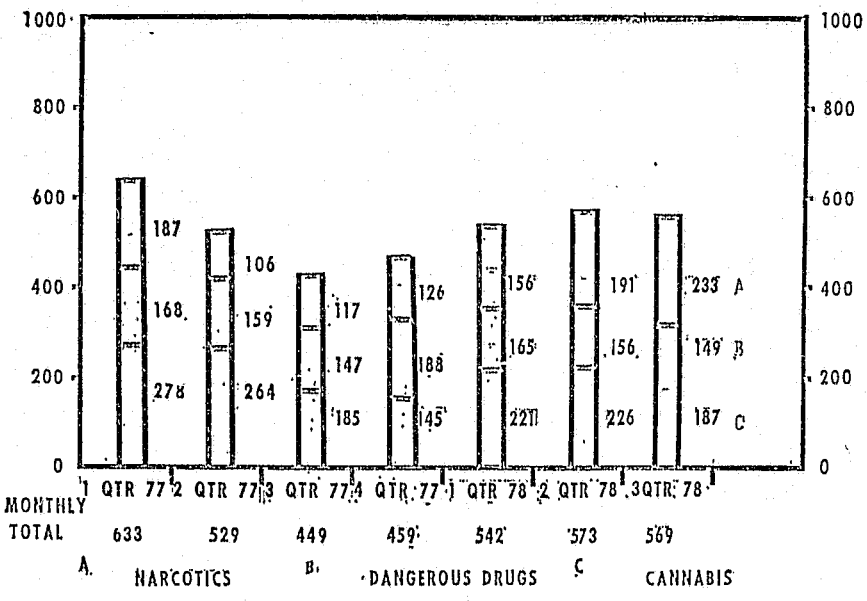


FIGURE 7.—New cases of hepatitis.

[Monthly average per quarter]

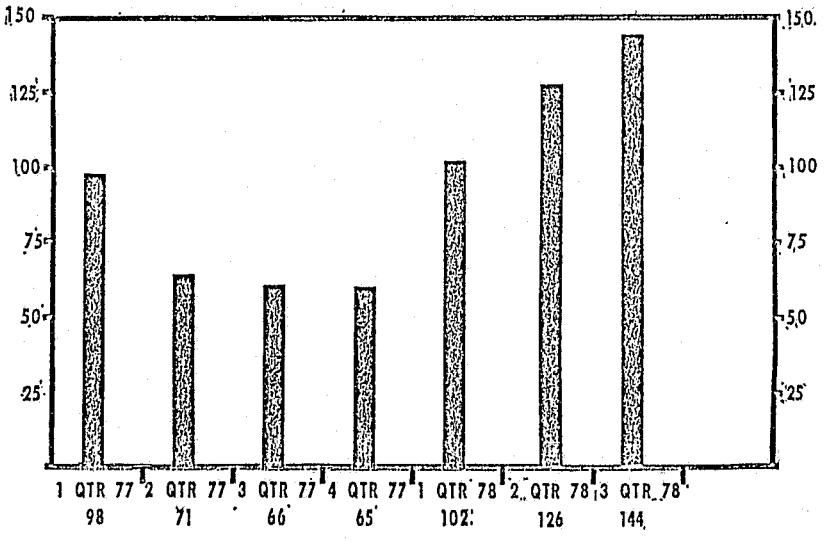


FIGURE 8.—Alcohol and drug abuse disciplinary actions article 15.

[Monthly average per quarter]

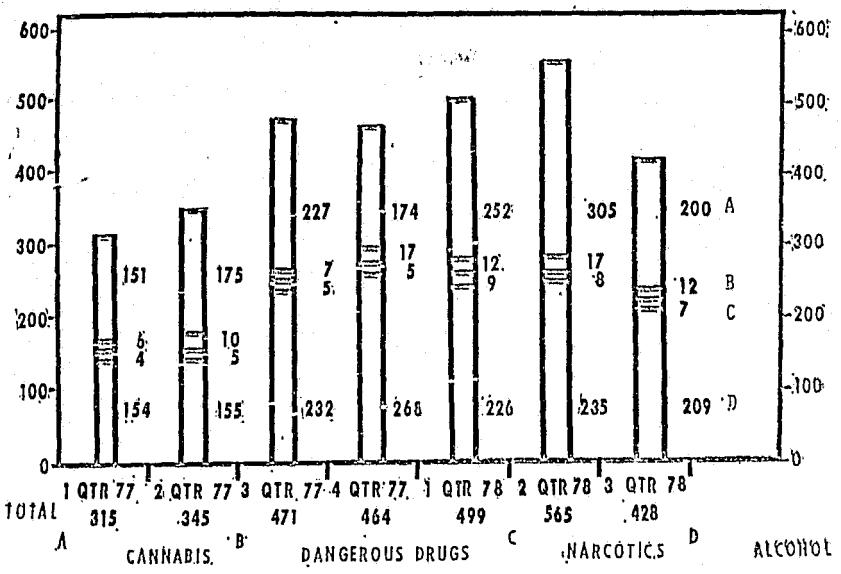


FIGURE 9.—Alcohol and drug disciplinary actions court martial.

[Monthly average per quarter]

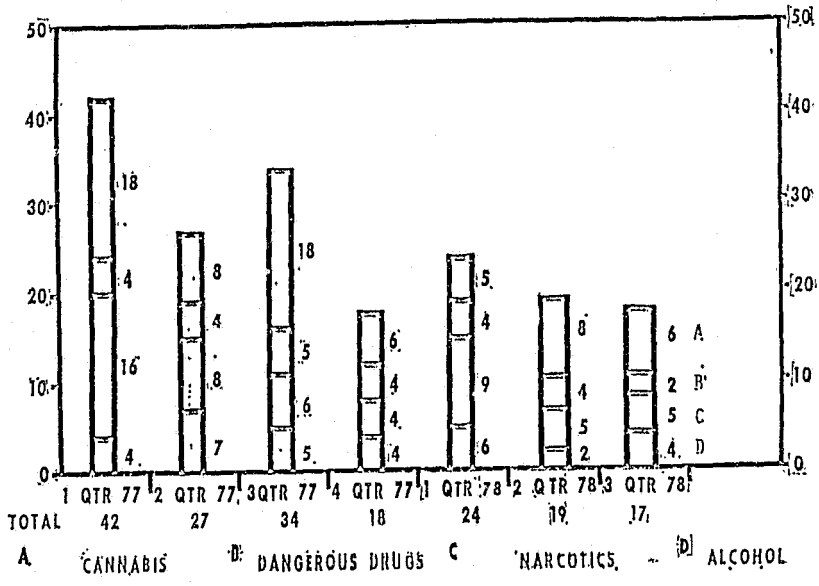


FIGURE 10.—Administrative separations.

[Monthly average per quarter]

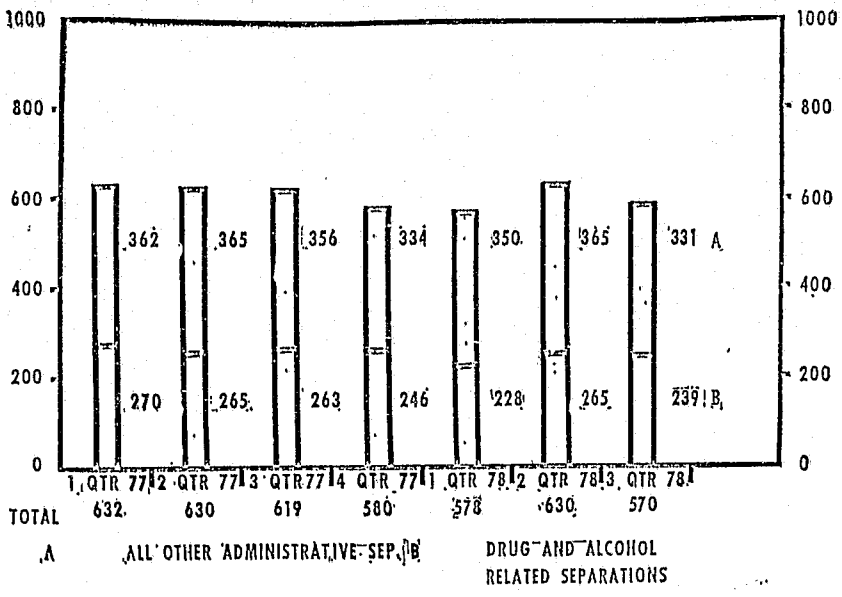


FIGURE 11

SUUTCO RESULTS

NO. OF UNITS 72 TOTAL SAMPLES 10,688 AS OF 10 NOV 78

	CONFIRMED POSITIVE	PERCENT
OPIATES	185	1.7
METHAQUALONE	56	.5
AMPHETAMINES	58	.5
BARBITURATES	22	.2
TOTAL	321	3.0

PREPARED STATEMENT OF MAJ. GEN. SPENCER B. REID, M.D., CHIEF SURGEON, HEADQUARTERS, U.S. ARMY, EUROPE, AND SEVENTH ARMY

Mr. Chairman, as Chief Surgeon, I exercise responsibility in seven major areas of the Alcohol and Drug Abuse Prevention and Control Program. These areas are:

1. *Technical Supervision of Community Drug and Alcohol Assistance Centers (CDAAC).*—There are 80 CDAAC's plus a number of satellite centers in USAREUR. I provide technical and clinical supervision of all rehabilitation as well as assessment of clinical effectiveness. This supervision is exercised by myself through 12 regional clinical consultants to the 80 CDAAC's in the field. When present, the primary supervisor is the CDAAC Clinical Director. My staff has recently completed an initial analysis of the clinical effectiveness of 79 of 80 CDAAC's treating 3,913 substance abusers during the 1st and 2nd quarters of fiscal year 78.

a. Using the quantitative success criteria of retention on active duty the ADAPCP successfully rehabilitated 60 percent of the 3,913 substance abusers. When the total sample is broken down the ADAPCP successfully rehabilitated 65 percent of the 1,565 alcohol abusers and 57 percent of the 2,348 drug abusers.

b. Using the qualitative success criteria of retention with a Commander's rating as an "effective" soldier, 47 percent of those 1,817 soldiers terminating the program during the period of study were successfully rehabilitated to "effective" status.

c. Based on retention criteria 77 percent of CDAAC's had a moderate success rate and 15 percent had high success rates.

d. Based on the retention as "effective" criteria 81 percent of CDAAC's had moderate success rates and 14 percent had high success rates.

2. *Detoxification.*—Every USAREUR MEDDAC provides detoxification services to substance abusers suffering withdrawal symptoms or adverse reaction to drugs or alcohol. We have detoxified 1,121 patients for drugs and 921 for alcohol in fiscal year 78.

3. *Inpatient Rehabilitation.*—There are five Extended Care Facilities for the young drug and alcohol abuser in USAREUR; they are: Berlin, Frankfurt, Heidelberg, Landstuhl and Nuernberg.

In addition we have the specialized Alcohol Treatment Facility at Bad Cannstatt designed for the older, senior alcoholic. Approximately 190 medical personnel are involved in some aspect of rehabilitation.

These rehabilitation centers deliver a variety of therapeutic modalities generally stressing development of individual responsibility for behavior, improvement of social skills, and a chemical free existence within an external framework of a four week, residential, group setting in which military standards are maintained.

We have had 336 drug and 596 alcohol rehabilitation patients in our Extended Care Facilities in fiscal year 1978. The Alcohol Treatment Facility opened in January of this year. Thus far we have had 327 graduates, 200 alcoholics and 127 co-alcoholics. Twenty alcoholic graduates have been officers, ten have been NCO's from our two highest grades. Eighteen alcoholics have been women.

We are just as concerned with the effectiveness of our inpatient programs as we are with community programs. There have been three locally done follow-up studies on three different Extended Care Facilities during the past two years. There is an overall success rate of about 50 percent.

4. *Medical Complications.*—Our medical treatment facilities handle a wide variety of medical, surgical, and psychiatric sequelae of alcohol and drug abuse. Medical literature indicates that a large portion of patients requesting emergency room treatment may be substance abusers. "Bad Trips", hallucinogen precipitated psychoses, amphetamine psychoses are treated in our psychiatric services. Trauma cases are in our intensive care and surgical wards. Hepatitis is a prevalent medical illness associated with intravenous drug use and "passing the pipe". Our Hepatitis rates have returned to 1976 levels during the past few months.

5. *Medical Statistics.*—Overdose is, of course, the most serious adverse consequence of drug use. Our Patient Administration Division has recently developed a computerized recording system for collating overdose incidents. In 1977 we recorded 26 active duty deaths. This figure is as close to absolutely accurate as possible. It is based on a retrospective chart review. The 1978 figures are from our new computerized recording system. There is an average 90 day lag in reporting while toxicology studies are completed and records processed. As of 10 September we had recorded 25 active duty deaths. This indicates a substantial increase in deaths resulting from overdoses of abuseable substances.

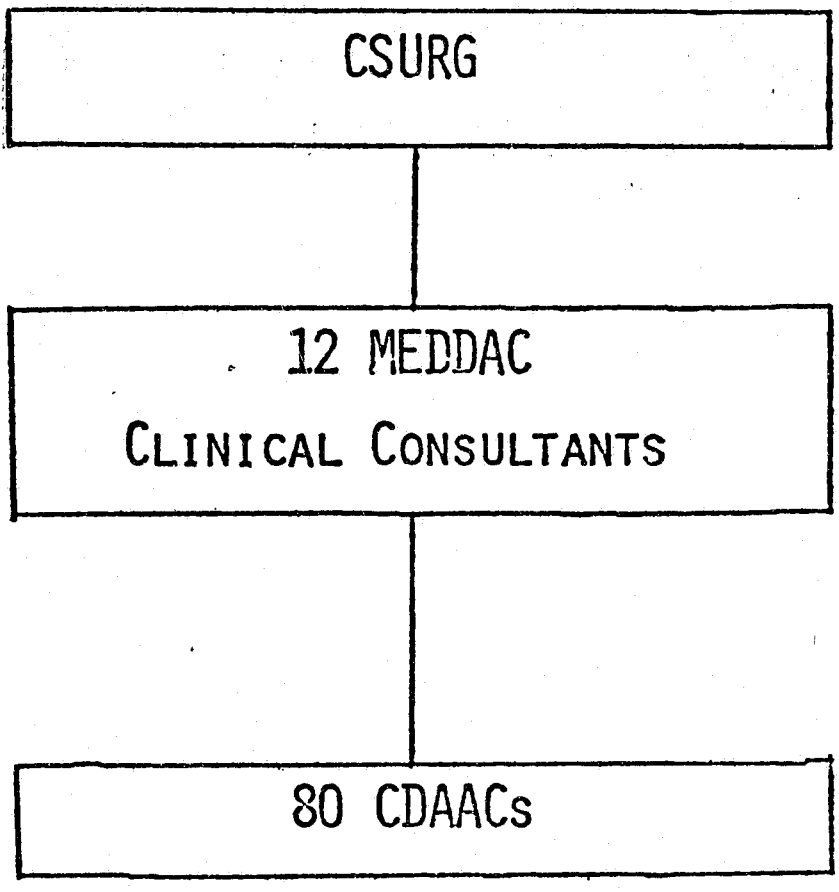
6. *Research.*—Also working in the overdose area is a Europe based team from the Walter Reed Army Institute of Research who are conducting a psychological investigation into this phenomenon. Using the technique of the psychological autopsy we hope to delineate a psychological profile of the potential overdose victim and investigate aspects of early identification and prevention as well as attempting to assess the relationship between overdoses and drug use patterns.

7. *Urine Testing.*—Last but not least we operate what is believed to be the largest urine testing laboratory in the world, averaging nearly 25,000 specimens per month during fiscal year 1978. The laboratory has maintained a remarkable 0 percent false positive rate on Armed Forces Institute of Pathology double blind controls for seven consecutive years. Complete results for fiscal year 1978 have must just been compiled. (This graph takes total positives, breaks them down by drug for four major drugs and plots them on a monthly basis.) There have been striking shifts in composition of total positives with opiates and barbiturates increasing and amphetamines and methaqualone decreasing. This would seem to indicate shifts in patterns of usage.

CHIEF SURGEON RESPONSIBILITIES

1. Technical supervision of community drug/alcohol assistance centers;
2. Detoxification;
3. In-patient rehabilitation;
4. Medical complications of drug/alcohol abuse;
5. Medical statistics gathering, review, analysis;
6. Research;
7. Urinalysis testing.

TECHNICAL SUPERVISON OF CDAAC



FOLLOWUP SUCCESS RATES ON 79 CDAAC'S TREATING 3,931 SUBSTANCE ABUSERS

A. Using quantitive success criteria (retention on active duty), the ADAPCP successfully rehabilitated:

1. 60 percent of 3,913 substance abusers;
2. 65 percent of 1,565 alcohol abusers (improper users of alcohol and alcoholics);
3. 57 percent of 2,348 drug abusers (improper users of drugs and drug dependent).

B. Using qualitative success criteria (retention of active duty and were "effective soldiers"):

47 percent (847) of 1,817 program terminators were "effective" soldiers (in second quarter fiscal year 78).

CATEGORIZATION OF 79 CDAAC'S IN TERMS OF THEIR EFFECTIVENESS

A. Based on quantitative criteria of success:

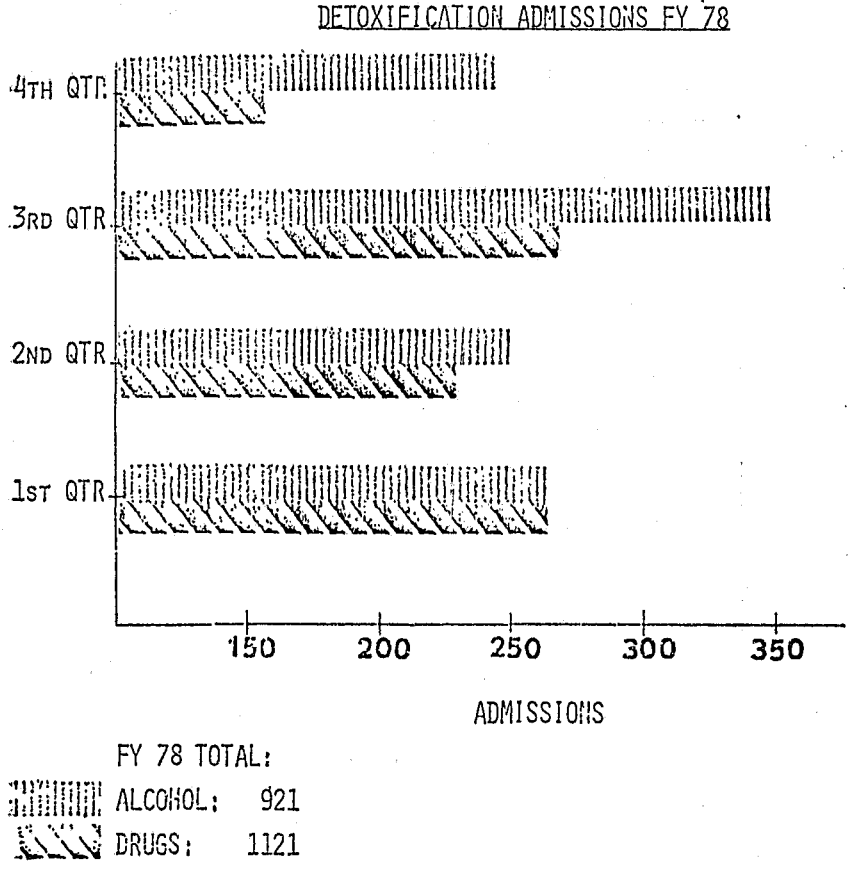
77 percent of all CDAAC's had moderate success rates in the range of 40 percent to 80 percent retention on active duty;

15 percent of all CDAAC's had high success rates in the range of 83 percent to 86 percent retention on active duty.

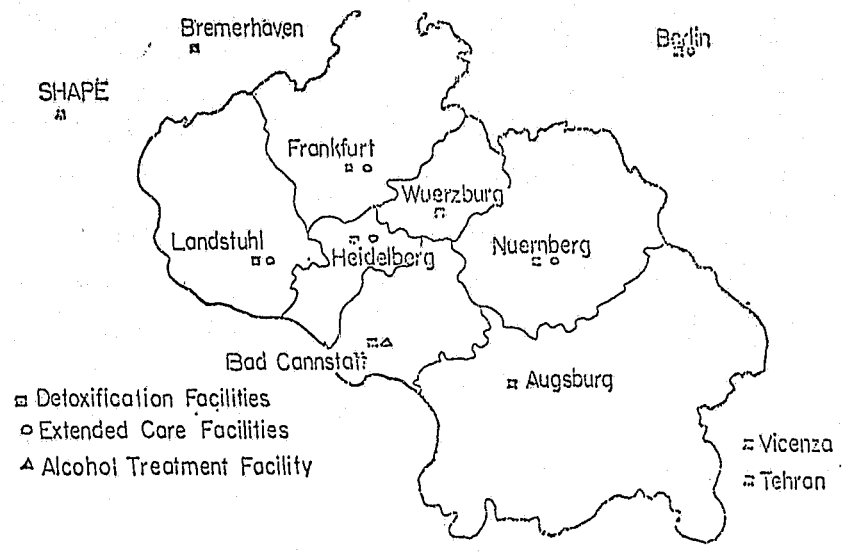
B. Based on qualitative criteria of success:

81 percent of all CDAAC's had moderate success rates in the range of 28 percent to 68 percent effective soldiers on duty;

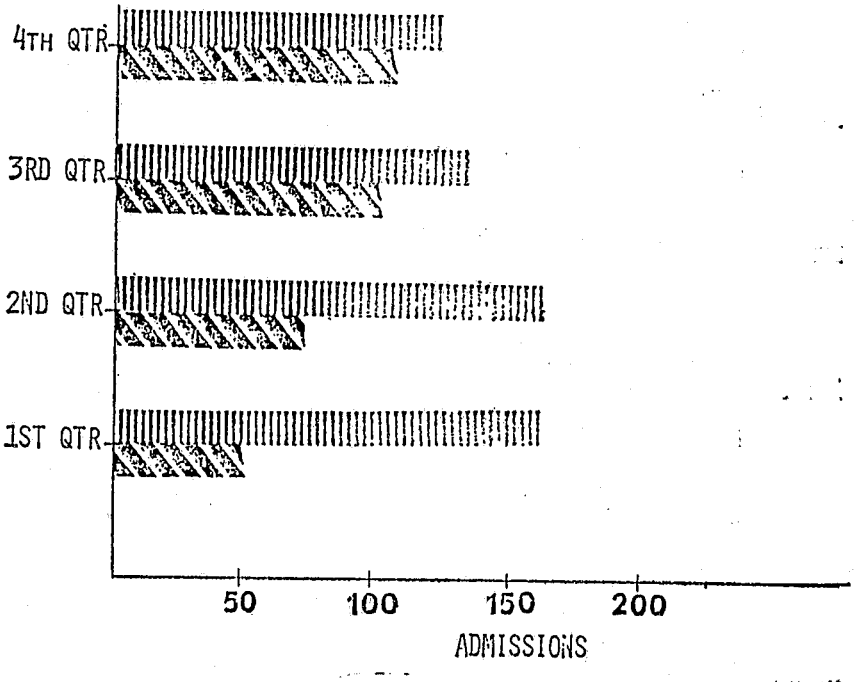
14 percent of all CDAAC's had high success rates in the range of 78 percent to 80 percent effective soldiers on duty.



7TH MED COM MEDICAL DEPARTMENT ACTIVITIES



EXTENDED CARE FACILITIES ADMISSIONS FY 78



FY 78 TOTAL:

ALCOHOL: 595

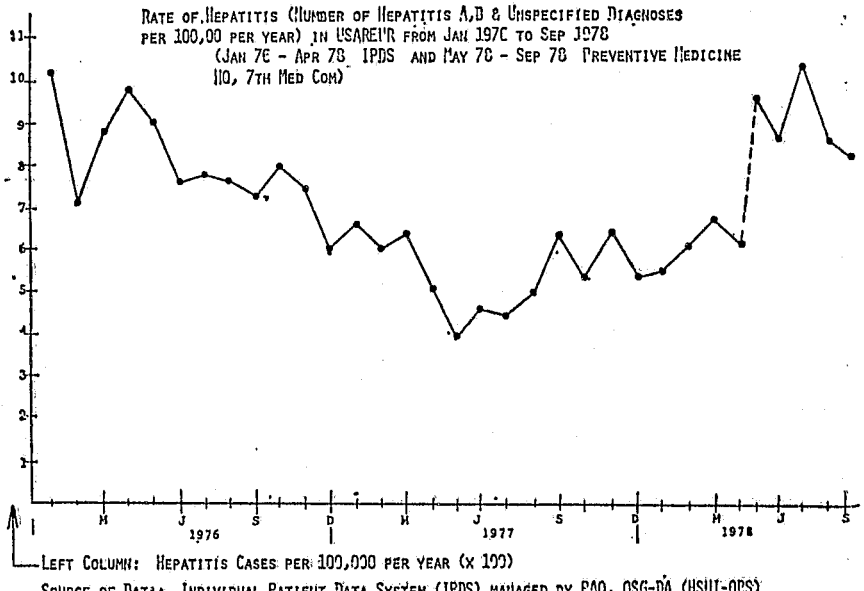
DRUGS: 336

Alcoholism treatment facility discharges—Jan. 1, 1978–Oct. 18, 1978

Alcoholics	200
Coalcoholics	127
Total discharges	327
Officers:	
O5	3
O4	5
O3	5
O1+O2	4
W2+W3	3
Total	20
Senior NCO's:	
E–9	4
E–8	6
Total	10
Females	18

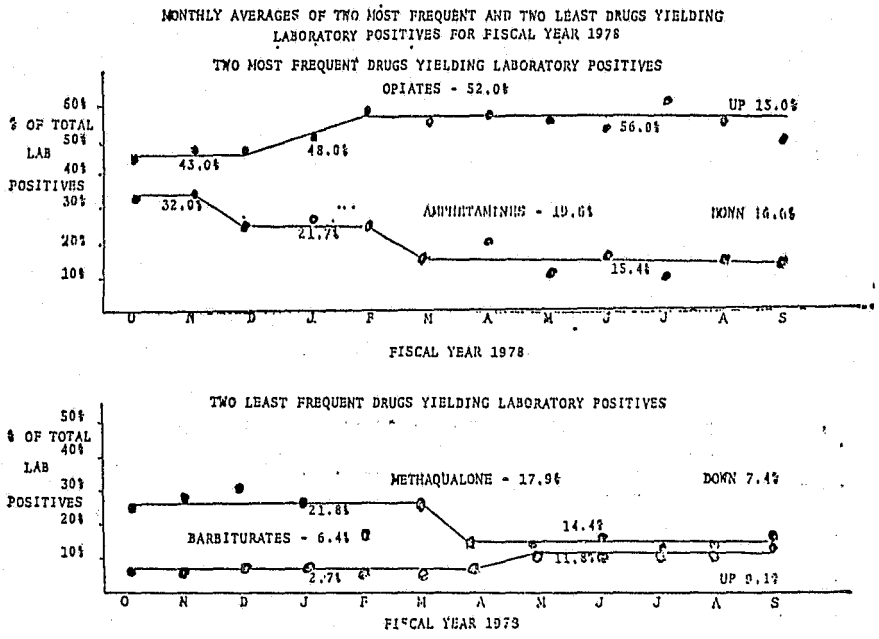
FOLLOW-UP SUCCESS RATES FOR BOTH DRUG AND ALCOHOL ABUSERS FOLLOWING TREATMENT AT 3 EXTENDED CARE PROGRAMS (ECF'S)

1. Frankfurt "CARE" extended care facility, 6 criteria of success: 42 percent—1 year followup;
2. Heidelberg "DARE" extended care facility, 4 criteria of success: 50 percent—1 year followup;
3. Landstuhl "SHARE" extended care facility, 2 criteria of success: 59 percent—3 to 4 months followup.



Drug deaths

1977:	
U.S. Army active duty	26
Other	5
Total	31
1978:	
U.S. Army active duty (Sept. 10, 1978)	25
Other	1
Total	26



PREPARED STATEMENT OF MAJ. GEN. R. DEAN TICE, COMMANDER, 3D INFANTRY DIVISION, 7TH ARMY, U.S. ARMY

Mr. Chairman, I appreciate the opportunity to discuss drug abuse. My remarks and those of the other panel members will be based on our experience as commanders and leaders of troop units in Europe, I ask that you bear in mind our program is two pronged, concerning itself with both alcohol and drugs. As a result, some of our discussion and answers may include information concerning alcohol.

The first point I will address is the magnitude of the drug problem. While this is a very difficult area to provide data on, I do know how many soldiers in my Division are identified drug users. The percentage of identified drug users for Fiscal Year 78 ranged from a low of 1.99 percent in 3d quarter to a high of 2.58 percent in 4th quarter. In May 78, the Selected Unit Urine Testing for Company Size Units (SUUTCO) was initiated. During the last six months eight of my 121 company size units were tested under this program. Thirty soldiers were positively identified as hard drug users, 3.39 percent of those tested. I realize this is a small sample, but the program has only been in effect a short time. However, survey information from my commanders shows their estimate that 4–5 percent of their soldiers use hard drugs. We can find no single reason as to why a soldier uses drugs. They are numerous and varied. Some of the most common reasons are:

a. *Experimentation*—many of our younger soldiers have experimented with drugs before entering the Army. Only last week a young soldier in my Division explained to his Company Commander that he had smoked marijuana and hashish since he was twelve years old. This response was made when he was apprehended by his Platoon Sergeant for smoking hashish. The young soldier went on to say that he wanted to stay in the Army but he also wanted to continue smoking "pot". He saw absolutely nothing wrong with what he was doing. Besides, he said, both his mother and father smoked "pot" as well as most of his teachers in high school. Once in the Army, many develop an "I'll try anything once" attitude. This attitude, coupled with the feeling the individual attains during his or her first "high", can lead the soldier to further experimentation with other type drugs and to possible dependency.

b. *Boredom*—the Kasernes in Germany do not have all the facilities the soldiers are accustomed to having in the States. The facilities are old, sometimes in a poor state of repair due to limited funds, and in many cases battalions are isolated. Additionally there is hesitance to use German facilities because of language barrier and high costs (based on dollar devaluation). These facts seem to promote depression of both the soldier and his dependent especially when they reflect upon the recreational services provided in the States. Thus, we must admit that the Quality of Life in Germany cannot compare with the Quality of Life on a military post in the United States.

c. *Peer Pressure*—the youth and immaturity of our soldiers cause him to submit to the persuasion of using or at least trying drugs or alcohol. This probably results because the individual wants to feel that he "belongs" with the crowd.

d. Other reasons for drug use are to relieve tension and to provide pleasure. In these areas you will usually find the more experienced users. They are familiar with different type drugs and their effects. As a result, these users are the most difficult to identify.

e. *Drug Dependency*—it does exist and will continue to exist as long as drugs are available. For some of the soldiers, drug dependency sets in without their realization.

My second major point is the effect drugs have on readiness. My immediate subordinate commanders have mixed feelings on this point. Some feel that the effect is marginal. Considering all the data available to me and the current state of readiness, I believe that drug abuse does adversely affect some individual performances, but it is not yet of sufficient magnitude to impair the capability of my Division to accomplish its mission. The time that my commanders dedicate to the administration of the drug program (prevention, detection, and counseling) does take time away from their supervisory efforts in training and maintenance. Perhaps this time loss hurts combat readiness more than the use of drugs by individual soldiers.

My third point covers action we are taking to prevent drug abuse:

a. First and foremost is a dynamic and challenging training program to insure that our Division can fight during time of war. This challenge has been passed down to the lowest levels of command within the Division. I am convinced that such training will do more to limit drug abuse than some of the clinical approaches. For sure, a dynamic training program does much to offset boredom which we all know tends to enhance drug abuse.

b. The urinalysis testing program is controlled by USAREUR. The selection procedure for personnel in the drug program is based on the use of the last digit of the SSAN. Each day's numbers are randomly selected by HQ USAREUR. Additionally, the commanders of company size unit can direct three of their people each day to provide urine samples. These selections are based on suspicion and are not used for random testing.

c. Under the selected unit urine testing program for company size units (SUUTCO), our commanders can obtain approval to direct urine testing for the entire unit if they believe they have a drug problem in the unit. Since the commencement of the program in May 1978, the 3d Infantry Division has tested eight of its 121 company size units and received 30 positives. Out of eight units, 884 soldiers were tested, resulting in a 3.39 percent positive rate. However, it is interesting to note that some units had no positives while one unit had 19. This tends to distort the average, but these small samples are all we have available at this time. The 3d Infantry Division percentage of positives on SUUTCO is in line with the USAREUR average.

d. The division has an active Health and Welfare inspection program within its units. When conducted properly, these inspections turn up drugs and paraphernalia associated with drug use.

e. *Clinical evaluation*—once an individual is suspected of being involved with drugs, he is interviewed by the unit commander. If after the interview, the commander still suspects that the soldier uses drugs, he is sent to the Community Drug and Alcohol Center (CDAAC) for an interview. If the CDAAC feels that the soldier is a user of drugs an appointment is then made with the Medical Treatment Facility and a Psychiatrist determines if the soldier should or should not be in the Drug Program. The Commanders are supporting the program as reflected in our 97–100 percent record of having soldiers clinically evaluated when necessary.

f. *Recreational and sports program*—the Division and Communities have active sports programs for soldiers in basketball, volleyball, softball, flag football, soccer, and numerous individual type sports. In addition each community has a recreation center, bowling lanes and gymnasium. These activities provide a healthy option for the soldier's leisure time.

g. Club renovation is another continuing effort to improve the quality of life on each caserne. We also vary the entertainment to fit the many preferences of soldiers as well as improving club facilities and appearance. In the past year, for example, we completed major renovation to 3 of the 10 NCO/EM Clubs in the Wuerzburg area and 4 more are due renovation by next summer. Present renovation has included new carpeting, furniture, kitchen, and "disco" equipment. Additionally, I closed one club which had too much drug potential in its downtown location.

h. The Division also has an International Tours and Travel Office that makes many tours available at reasonable prices. The units in the Division encourage their soldiers to use these tours and get out of the barracks as often as possible. The tours have been widely accepted and provide our soldiers another alternative to drug and alcohol use.

i. A few months ago the Division's Provost Marshal established the Covert Joint Drug Suppression Team operation, in cooperation with USACIDC within my military communities. This operation is now being expanded in coordination with the USAREUR effort. The purpose of this effort is to conduct coordinated operations to further suppress the trafficking, use, and possession of drugs. We anticipate the covert stage of this operation to be fully implemented by 22 November.

j. Another step forward is educating the Chain of Command and more importantly the individual soldier that the drug programs are rehabilitative in nature rather than punitive. Approximately 20% of the soldiers presently in the CDAAC program have been identified by Military Police and other Law Enforcement Agencies. Unfortunately, this type of referral causes those soldiers to feel that they are in the program for punishment rather than for rehabilitation. Consequently, additional emphasis has been placed on "Early" identification by the Chain of Command.

k. Drug and Alcohol Abuse training and counselling have been incorporated into the Non-Commissioned Officers Professionalism Program. Our units are using CDAAC personnel and chaplains to assist in conducting these classes, and are receiving a favorable response from both the NCO's and guest instructors.

What can Congress do to help with the drug problem?

a. I would encourage the committee to support funding levels to insure that adequate training be maintained within USAREUR to meet the threat.

b. I would also encourage the committee to support increases in manpower and fiscal resources so that we can enhance our capability to identify and rehabilitate drug abusers.

c. Recognize that the declining dollar prevents soldiers in Europe from becoming interested and involved in local German activities. This financial inability to participate may contribute to increased boredom and drug involvement.

Mr. Chairman, in closing, I would like to say that I am very proud of our soldiers. They are making numerous sacrifices and are being required to live in a completely different environment. They are a dedicated group and I believe prepared to do the job that needs to be done. We are ready for your questions and comments.

PREPARED STATEMENT OF BRIG. GEN. THEODORE S. KANAMINE, PROVOST MARSHAL, HEADQUARTERS, U.S. ARMY, EUROPE, AND 7TH ARMY

Mr. Chairman, I would like to present an overview of the coordinated law enforcement effort to combat drug abuse among U.S. Army personnel in Western Europe with particular emphasis on the Federal Republic of Germany.

In mid 1977 it became apparent to the law enforcement community in Europe that heroin availability was increasing and that the shortage that existed for the previous six months had ceased. At that time we began to strengthen our law enforcement effort to combat this increased availability. I shall detail our actions, past and present, but first I would like to discuss present trends concerning drug offenders among our troop population and methods by which drugs are trafficked here in Germany.

Drugs of all types continue to be readily available in the Federal Republic of Germany. Cannabis is clearly the drug of choice among U.S. Forces personnel as reflected in our law enforcement apprehension statistics. The dangerous drug abuse trend ranges from stable to downward. Heroin is an entirely different matter with relatively low cost, high purity heroin being readily available throughout the Federal Republic of Germany.

There are basically five echelons of the drug supply system in Europe. *The European Main Source Level* and *The Major Middleman Supplier* are predominantly Germans or third country nationals; *The Middleman Supplier* who can be any of the above. If a U.S. soldier is operating at this level, he has received additional financial backing; *The Middleman Streetpusher* who can be either a German national or a U.S. soldier; and *The Military Drug Abuser/Street Pusher* who is usually a soldier who purchases drugs and sells them to other soldiers. There are also instances of German nationals providing drugs to U.S. soldiers at this level.

Drugs are introduced into the FRG through varying routes. Hashish is transported into Germany from a number of countries, primarily the mideast and North African countries. Principal routes include: Northern seaports of Germany and other Atlantic coast countries and land routes through Italy and Austria. Most heroin being seized in Germany is now of Mideast origin. It is transhipped through Turkey, Bulgaria, Yugoslavia and Austria into Germany. Additional suspected routes are through Italy, France, Belgium and Luxembourg. Narcotics are entering Berlin via normal transit routes by automobile and truck from or through the FRG, by air via Tegel Airport and by train from Frankfurt. A certain percentage of heroin comes from the East but the exact amount is not known. Estimates from various sources range from 20–30%; however, it is generally agreed that the majority of heroin comes from locations other than the German democratic republic and East Berlin. These facts were revealed during an "Operation Leo" program which was recently conducted by DEA to determine sources and flow patterns of near and middle east heroin through Europe to the United States.

Before I discuss the details of our drug suppression program, I wish to illustrate a few trends in use and possession of drugs and sale and trafficking cases. The first chart shows the monthly average of use and possession founded offenses for all drug categories. As I stated earlier, cannabis offenses represent the overwhelming majority of cases investigated. The popularity of this drug continues to grow and its availability compounds the problem. Dangerous drug abuse remains at relatively low levels due in part to the recent popularity and availability of heroin. Our chief concern is the increase in narcotics cases. While a portion of the increase can be directly attributed to our intensified law enforcement program, the statistics reflect the degree of heroin availability and the potential threat that it poses to our servicemembers. We are viewing third quarter statistics with cautious optimism and watching this closely to determine if the problem has stabilized or if the current quarter is merely an aberration of the previous upward trend. In the second chart we have identified the offenders associated with the offenses in the previous chart. Here we continue to experience an increase in narcotics offenders, but the current increase is relatively modest compared to the previous 3 quarters. The third chart shows the average monthly sale and trafficking cases involving military personnel. Military trafficking cases are rarely significant and they normally represent small amounts of drugs. In addition to these military cases, approximately 560 cases were developed involving

German and third country nationals. Approximately ⅓ of our trafficking cases are for narcotics which reflects our level of emphasis in our heroin suppression efforts. The fourth chart identifies the offenders associated with the cases in the previous chart. The percentage of offenders in each category generally corresponds with the percentage of offenses in the previous chart. It should be noted that these offender statistics only include military traffickers. In addition, Level I and Level II operations have resulted in the apprehension of 255 German nationals and 141 third country nationals in the 1st nine months of this year. During the same period in 1977, 181 Germans and 99 third country nationals were apprehended.

We have a comprehensive law enforcement drug suppression program in the U.S. Army Europe theater of operation. I shall briefly review our CID and military police involvement in the drug suppression program and develop this further into other areas that are required to make our program a success. Drug suppression requires a total dedication and a great deal of energy to be successful. We have approximately 5,500 "Street" military police in Europe, all of whom become involved, to some extent, in the drug enforcement effort. Approximately 15 percent of all of our offenses deal with drugs and the "white hat" military police in our military communities often receive the initial information that a drug offense has occurred. Depending on the severity of the offense, the case is then referred to our accredited military police investigators (MPI) or CID agents for investigation. HQ, 2d Region CID has a total of 44 special agents dedicated to drug suppression activities. Five of these agents and two interpreter investigators are assigned to the Level I drug suppression effort. These agents operate covertly in targeted communities posing as drug buyers, using large amounts of "flash money", luring wholesale traffickers into situations that allow host nation police to apprehend them. These agents have already seized approximately 16 kilos of heroin in the first nine months of 1978. Five additional special agents are being sought for inclusion into the program. Level II drug suppression operations consist of CID special agents, MPI and military police operating covertly or overtly on or within close proximity to military installations. The objective of Level II is to identify and apprehend personnel engaged in drug trafficking to U.S. Forces personnel.

There are currently 28 special joint drug suppression teams consisting of CID/MPI and MP's operating in Germany. There were eight such teams operating in mid 1977 when the increase in availability of heroin began to appear. The joint team concept was pioneered in USAREUR in early 1976 with the formation of two joint drug suppression teams and has progressivley grown to its present level based on the perceived threat. I might add that the joint team concept has been so successful that the CID command in Washington has encouraged an expansion of its implementation worldwide. 39 CID agents and 75 MPI/MP are currently assigned to these teams and another 20 CID special agents have been requested for assignment in the program. The last echelon of drug suppression is Level III which involves CID agents and MPI operating overtly to investigate reported or detected instances of use, possession or trafficking of drugs by U.S. Forces personnel. At this point I would like to discuss a few seizure statistics which will further illustrate the intensity of our program and the availability of heroin in Germany. In 1976, 15.722 kilos of heroin were seized by our law enforcement agents. In 1977, when there was a heroin shortage in the first half of the year, 11.991 kilos were seized. In the first nine months of 1978, 21.761 kilos had already been confiscated. The fifth chart shows the street value of drugs seized by each category. The price of drugs varies with availability and fluctuation of the value of U.S. currency in Europe.

The drug suppression program cost $196,900 in .015 contingency funds and another $93,000 in travel funds during fiscal year 1978. Our drug seizures have amply rewarded our return on investment.

Another very important element of the drug suppression and enforcement effort is the 42d MP Group (Customs). This is a highly specialized unit which has operations in approximately 45 field locations throughout USAREUR. One important aspect of their effort is joint involvement with German Customs and Border Police at the FRG international border crossing sites. Eleven personnel involved in Border Operations on a daily basis are linguists and have proven invaluable to the German officials in assisting when U.S. Forces personnel are involved. There are 30 personnel involved in this effort and 19 additional have been requested to supplement their efforts. This unit also has proponency for the Narcotic Detector Dog Program in USAREUR in support of their broad mission as well as responding to requests for assistance from Commanders for health and

welfare inspections in troop billets and other facilities on our installations. There are currently 23 Drug Detector Dogs strategically located throughout Europe and another 20 have been requested to augment the current effort. Another important aspect of the 42d MP Gp (Customs) Drug Suppression Program is the operation at Rhein-Main Air Base. All in- and out-bound flights are inspected for drug contraband with special emphasis on outbound flights where a 100% inspection of baggage is accomplished to prevent drugs from being returned to the United States. Approximately 10% of all inbound personnel are inspected upon arrival in Germany. The objectives on inbound traffic is to prevent the introduction of drugs into the FRG by newly assigned soldiers. Most of the drugs being carried by inbound personnel are small amounts and the majority of drugs are dropped in the Amnesty Box prior to proceeding to the baggage inspection area. The 42d MP Gp (Customs) also assists APOs in inspecting 2d, 3d and 4th Class mail for drugs.

The Narcotic Detector Dogs facilitate this inspection process. An additional 15 inspectors have been requested to augment this program with special emphasis being placed on the mail handling facility at Rhein-Main where approximately 4.5 million pounds of mail is processed monthly. These additional assets will permit the inspection of approximately 50% of the mail, a substantial increase over the current 8% level. Finally, the 42d MP Gp (Customs) is responsible for the Military Customs Inspection (MCI) Program. This program consists of inspections of household goods, hold baggage and the vehicle processing point at Bremerhaven. Five (5) additional MCI have been requested for the vehicle processing point. The 42d MP Gp (Customs) has executive agency responsibility for the European Command (EUCOM) MCI Program, to include policy development, training, information and intelligence for MCI programs at all EUCOM bases involving the inspection of personal property, DOD cargo, passengers and accompanied baggage, POV's and mail destined for customs territory of the United States. 15 additional supervisory MCI have been requested as an extension of the Executive Agency for support of U.S. Air Force and Navy installations in European countries outside USAREUR's area of operation. The unit conducts a 24 hour training course to senior MCI prior to their involvement in the MCI Program. Two U.S. Customs Service Advisors are colocated with the 42d MP Gp (Customs) in Mannheim. These officials inspect and accredit MCI programs once they have met the standards established by the U.S. Customs Service.

I would like now to discuss another part of our Drug Enforcement Program which is vital to continued success—Our relations with host nation and other U.S. Law Enforcement Officials. We enjoy excellent relations with our host nation counterparts in Europe. The German authorities recognize the drug problem as their own and consider U.S. Forces involvement as a small portion of the overall problem in both use and possession and sale and trafficking cases. They recognize our expertise in drug enforcement matters and actively solicit all information and training that they can receive from us. The result of this has been an aggressive enforcement effort on their part which has contributed immensely to suppressing the flow of illicit drugs to U.S. Forces personnel, because we all recognize the potential for an even greater drug problem among our troop population, in consideration of current availability. This high level of rapport is maintained through constant coordination and liaison between our elements at all levels of Government. I, myself, visit the interior Minister President, the President of the Federal Criminal Police (Bundeskriminalamt) and Police Presidents of the FRG states. Additionally, the Commander, 42d MP Gp (Customs) maintains liaison with the Federal Customs Criminal Institute (Zollkriminalinstitut) in Cologne, the FRG Minister of Finance and the Border Police Directorate in Drug Investigation/Suppression matters. Each Major Command Provost Marshal, CID District Headquarters and Resident Agency, and local MP Law Enforcement Operator meets and works with FRG counterparts on a continuous basis.

The 42d MP Gp (Customs) field elements maintain daily liaison with FRG Customs Border Police officials and participate in combined customs/drug suppression operations. Another dimension of this program is our active membership and participation with host nation officials in Drug Working Groups at various levels and regions within the FRG. These groups include: The Permanent Drug Working Group which is chaired by the FRG Bundeskriminalamt, meets monthly, and includes representatives from the Federal and State Police officials of the FRG, Holland, Belgium, Switzerland, Luxembourg, France, Austria, DEA, U.S. Customs Service and Interpol. We also have representatives on the Southeast Drug Working Group which meets monthly with Bavarian and Austrian Police officials and a representative from DEA; the Dutch-German Drug Working Group (monthly); and the French-German Drug Working Group which has met annually for the past two years. In addition to this active interplay at the

international, federal, state and local levels, the German Government has recently proposed another working group which will be devoted strictly to German-American drug problems. This working group, which will include a central committee and subcommittees involved in each functional area of the Drug Abuse Program, will further enhance our already successful joint efforts. The central committee is scheduled to meet for the first time in mid-December. Planning guidance and implementation of the sub-committees is still in diplomatic channels in the Ambassador's office in Bonn. Of course, we maintain an active liaison with the DEA, U.S. Customs Service and our counterparts in the Air Force and Navy in Europe in our joint efforts to interdict the flow of drugs to U.S. Forces.

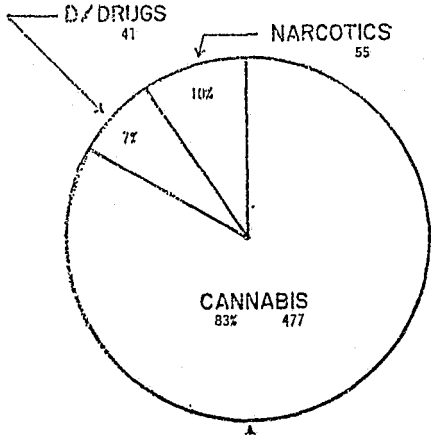
I wish to expand the discussion of some recent initiatives we have taken in USAREUR to enhance our Drug Suppression Program. In addition to the augmentation of assets dedicated to Drug Suppression which I discussed earlier, we have established a USAREUR Drug Operations Center which is located in Mannheim. This center serves as the focal point for all Drug Suppression operations in USAREUR. The center collects, analyzes and disseminates all Drug Law Enforcement information to agencies involved in the Drug Enforcement Program. The center facilitates the establishment of trends in areas, units and communities and provides the wherewithal to immediately act on drug enforcement intelligence which is often perishable. Ultimately, the center will have an automatic data processing capability which will provide an extensive storage and rapid retrieval capability of the type information we need to enhance our program even further. Another noteworthy initiative has been the establishment of a joint mobile CID-MPI Task Force which is inserted for a short period into an established drug "hot spot" to saturate the area and withdrawn when the traffickers and drugs have been seized. The initial employment of the Task Force resulted in a seizure in excess of $800,000 street value of illicit drugs and the apprehension of approximately 35 military and 12 German and third country nationals.

In summary, I wish to reiterate our total commitment to the Drug Suppression Program in USAREUR which has been identified as our number one Law Enforcement priority. We will continue to take every measure necessary to curb drug abuse among U.S. Forces in Europe by interdicting illicit drugs at their source and identifying abusers and traffickers through apprehension.

I can assure you that the U.S. Military and Civilian and host nation Law Enforcement authorities are united in a common effort to achieve this end.

CHART 1

LAW ENFORCEMENT
FOUNDED OFFENSES-
USE/POSSESSION OF DRUGS

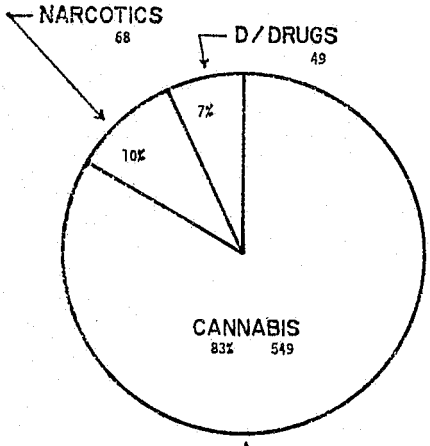


CATEGORY	QUARTERS 4/77	1/78	2/78	3/78
Cannabis	413	468	543	477
Dangerous Drugs	50	45	53	41
Narcotics	37	51	56	55
TOTAL	500	564	652	573

(MONTHLY AVERAGE PER QUARTER)
SOURCE: DA Form 2819

CHART 2

IDENTIFIED OFFENDERS
USE/POSSESSION

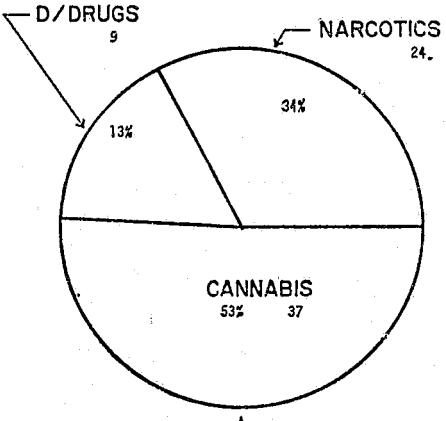


TYPE DRUG	QUARTERS 4/77	1/78	2/78	3/78
Cannabis	515	550	699	549
Dangerous Drugs	62	54	59	49
Narcotics	46	57	64	68
TOTAL	623	661	822	666

(MONTHLY AVERAGE PER QUARTER)
SOURCE: DA Form 2819

CHART 3

LAW ENFORCEMENT
FOUNDED OFFENSES-
SALE/TRAFFICKING OF DRUGS



CATEGORY	QUARTERS 4/77	1/78	2/78	3/78
Cannabis	26	52	40	37
Dangerous Drugs	13	14	10	9
Narcotics	16	19	17	24
TOTAL	55	85	67	70

(MONTHLY AVERAGE PER QUARTER)
SOURCE: DA Form 2819

CHART 4

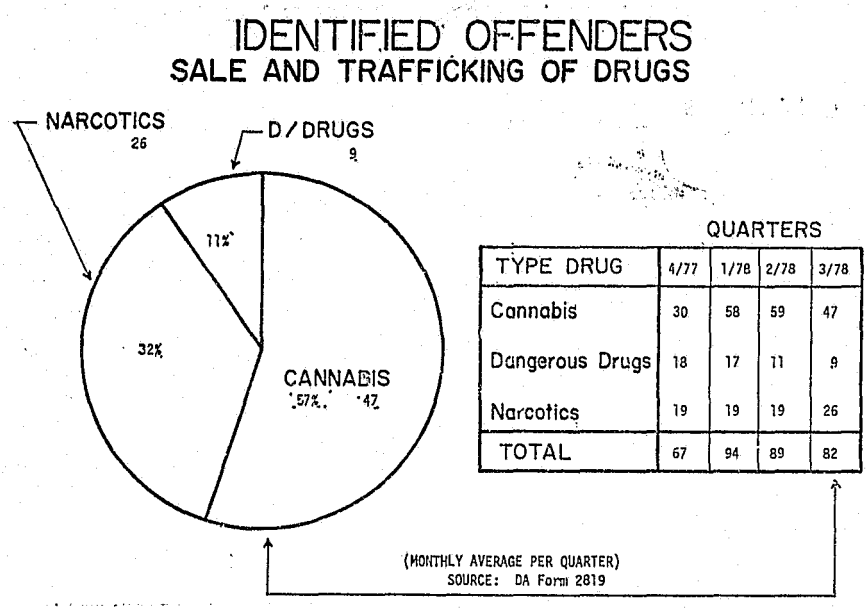


CHART 5

DRUG SEIZURES, STREET VALUE

Period	Cannabis	Dangerous drugs	Heroin	Other opiates	Total
1976	$1,378,681	$796,169	$5,180,084	$58,825	$7,413,760
1977	1,584,670	2,850,251	6,819,813	3,116,416	14,368,150
1978[1]	1,762,949	2,696,965	17,417,733	423,037	22,300,684

[1] Jan. 1 to Sept. 30, 1978.

PREPARED STATEMENT OF THOMAS CASH, SPECIAL AGENT, DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE

Chairman English, Gentlemen of the Delegation: I appreciate this opportunity to appear this morning before the House Select Committee on Narcotics Abuse and Control to discuss the role of the Drug Enforcement Administration (DEA) with respect to the problem of drug abuse in the military.

The Drug Enforcement Administration has six special agents stationed in the Federal Republic of Germany. These agents are stationed in Hamburg, Bonn, Frankfurt, and Munich and are under the direction of the Country Attache in Bonn. DEA special agents stationed in Germany operate within specific DEA foreign activities guidelines which are published and set forth our parameters for being in Germany. (I have included a copy of these guidelines.)

DEA agents have as their responsibility the following objectives:

(A) Cooperate and exchange drug intelligence with appropriate host country law enforcement officials;

(B) Assist in the continual development of a host country drug law enforcement capability;

(C) Develop, within the U.S. Mission, appropriate resource requirements for host country drug law enforcement organizations, with these requirements being keyed to the ultimate goal of reducing the availability of illicit drugs on the United States market; and

(D) Develop, within the U.S. Mission, specific short-term and long-term bilateral drug intelligence programs that will accrue to the benefit of both the host country and the United States.

The Federal Republic of Germany and the United States have worked closely together in the narcotics control field over the last ten years. On June 9 of this year, Ambassador Stoessel, on behalf of the United States, and State Secretary of Foreign Affairs, Guenther Van Well, on behalf of the Federal Republic, signed a bilateral agreement known as the United States/Federal Republic of Germany Narcotic Agreement. This agreement recognizes the cooperation of the past, provides an efficient organization for exchange of narcotic information for the present, and offers us further ways to coordinate our intelligence, enforcement, and rehabilitation exchange efforts in the future.

Our relationships with our German police colleagues are outstanding. Perhaps the depth of this relationship is best demonstrated by the fact that our DEA special agent who works with the West German Federal Police in Wiesbaden has been provided an office within this Federal Police Headquarters and is considered by the Germans themselves to be a vital part of the West German Federal Police enforcement effort. We in Germany are proud of our DEA-German police relationship and feel that this contributes significantly to the accomplishment of the DEA mission here in the Federal Republic.

Seizures are not always indicators of enforcement success, but these statistics do show availability of narcotics within the country. When we couple seizure data with our investigative enforcement efforts aimed at disrupting heroin traffic, we get a very clear picture of increased heroin availability. Prior to 1968, Germany was not confronted by any significant narcotic problem. Total heroin seizures in Germany in that year, as reported by the West German Federal Police, amounted to 1.825 milligrams of heroin. For the years 1969 through 1972, heroin seizures in Germany amounted to a total of 6.7 kilograms. In 1973, heroin seizures began to rise, as a total of 15.4 kilograms were seized that year. Since then, the amount of seizures has increased dramatically:

	Kilograms
1974	33
1975	31
1976	167

In 1976, DEA and German police efforts determined through investigations that approximately 75 per cent of the heroin seized in that year originated in the Far East and 25 per cent was from Near and Middle East sources. A large part of the heroin seized in Germany in 1976 was in transit to the Netherlands and specifically Amsterdam.

In the second quarter of 1977, a change was noted; it was becoming clear that heroin from the Near and Middle East was becoming more significant as police reported that 77 per cent of the heroin seized was coming into Germany from the Middle East, being carried primarily by Turkish nationals. Total seizures of heroin in Germany in 1977 amounted to 60.1 kilograms, a decrease in amount seized, but a distinct reversal of past trends in that the majority of the heroin seemed intended for the German drug market and not marked for other destinations. Second half-year figures for 1977 showed that of the 39.6 kilos seized during this time, 80.1 per cent of the heroin came from the Near and Middle East, 16.4 per cent from the Southeast Asia area, and, in 3.5 per cent of the cases, the origin could not be determined.

Turkish defendants were involved in 73.5 per cent of the cases where heroin was seized in the second half of 1977. The so-called Middle East heroin began to appear as if it was the predominantly available heroin.

This year, however, we see that heroin seizure statistics have not declined, but are almost the equal of the 1976 record year. To date, over 140 kilograms of heroin have been seized. Data analysis by the West German Federal Police indicate that in the first quarter of 1978, 30.9 kilograms of heroin were seized. Fifty-six and a half percent of this heroin is from the Near East and 40.2 percent of the heroin is from Southeast Asia. It should be noted that the Southeast Asian heroin, for the most part, was found to be destined for the Netherlands. German authorities consider that their main heroin problem comes from the Near and Middle East as little Southeast Asian heroin has been seized at the street-level.

At present, we find that Turkish nationals are involved in bringing from one to five kilograms of heroin to Germany at a time from various countries in the Near East. The heroin arrives by land, by train and by air as traffickers resort

to age old methods used by smugglers all over the world. There have been instances where we have found heroin in small amounts being smuggled from Germany to the United States. The intelligence we have gathered indicates that the heroin in Germany is cheaper and purer than that found on the market in the United States. There is a potential threat to the United States in that heroin now available in Europe can find its way to the American market. This is a potential that we are constantly monitoring.

By tracking and charting heroin price and availability we see that the cities of Berlin, Frankfurt, and the area of the Ruhr around the Dusseldorf/Duisburg area appear to have readily available supplies of heroin. The Munich area has also been seen as an active supply area. Coincidently, these are areas where the largest numbers of Turkish nationals reside and it is in these communities where enforcement has been the most active. As I noted earlier, the Turkish smugglers usually sell the heroin to German middle-level dealers as well as to other nationalities. These persons then distribute the heroin down to street-level users. Most police and Government estimates place the addict population in the Federal Republic at around 40,000; however, these individuals are engaged in multiple types of narcotic abuse and there is no accurate assessment of the number of addicts purely dependent on heroin.

Statistics of deaths resulting from drug abuse are recorded by the police and are not the result of medical examinations of the deceased. The number of deaths is increasing and is indicative of the narcotic availability and its attendant social cost. In 1970, there were 29 deaths as a result of misuse of drugs, two of which were connected with hard drugs. In Germany, opium, morphine base, heroin and cocaine are considered hard drugs. These figures have risen dramatically in every year since 1970.

	Deaths
1971	67
1972	104
1973	106
1974	139
1975	194
1976	337
1977	[1] 387
1978	[2] 240

[1] 300 FRG ; 87 West Berlin.
[2] As of August.

In 1977, the problem of heroin availability and its effects was seen clearly in Berlin where 83 civilians and four GI's died of drug abuse. Of these fatalities, over 90 per cent of the deaths were directly related to heroin use. Generally, of these deaths, 73.9 per cent of the victims were between 18 and 25 years of age.

I have emphasized heroin abuse and availability up to this point as I believe that this drug deserves our all-out effort and is indeed DEA's number one priority. In Germany, the two prime drugs of abuse are heroin and hashish. Other drugs seem to play a minor role at this point. Hashish is the chief drug available and there appears to be a never ending supply. I would like to enter into the record some arrest statistics from 1974 to 1976, which indicate a three-year trend that, in my opinion, is still continuing whereby heroin arrests are increasing as cannabis arrests decline:

ARRESTS BY DRUG

[In percent]

	1974	1975	1976
Cannabis	64.4	60.6	52.4
Heroin	19.7	26.6	38.0
Other drugs	15.9	12.8	9.6
Total	100.0	100.0	100.0
Total arrests	6,739	7,328	8,946

Cannabis remains so readily available in Germany that some high police officials believe that Germany has become a transit point for dealers in hashish who come to Germany and take hashish out of this country to other areas. In-

deed, there has been an increasingly large number of major seizures of hashish on an almost continual basis. In 1977, over nine tons of hashish were seized in Germany and there appears to be no central city or location involved. Of these nine tons, for example, three major seizures occurred in Bonn-Bad Godesberg, Mainz and Emden when 1.3 tons, 2.3 tons and 2.8 tons respectively were seized. The hashish comes to Germany from Turkey, Lebanon, Pakistan, Afghanistan and India. The amounts seized clearly demonstrate the size of the hashish market in Germany. One has to remember that Germany is a country the size of the State of Idaho, although densely populated with 62.5 million people including over two million foreigners.

From DEA's point of view the American soldier is a victim of high drug availability in Germany and is not a major part of the drug problem in the country. Additionally, it should be noted that the German Police themselves do not feel that the American military is a significant factor in the narcotic traffic in Germany.

The Drug Enforcement Administration has excellent relations with both the U.S. Army Criminal Investigation Division, and the U.S. Air Force Office of Special Investigations. As Country Attache, I have insured that the Ambassador in Bonn receives quarterly reports from the Military Services. The Ambassador has been personally briefed by the responsible military services at the quarterly task force meetings.

All DEA agents in Germany have provided regular information to the military on narcotics traffickers, smuggling methods and intelligence related trends. DEA has actively assisted military enforcement efforts, for example, by funding a DEA informant who has been operating in Berlin since August with instructions to focus on sources of narcotics who are supplying military personnel at street level. This confidential source has worked exclusively for the U.S. Army and has been very successful. His work with the CID and German Police Organizations has led to significant arrests and seizures involving heroin, LSD and cocaine. Dealers immobilized through this informant's work were dealing drugs primarily to military personnel.

The U.S. Army has been kept informed of those locations within the country that have a high drug-availability. One of the cities with the highest narcotic supplies was thought to be Berlin. In early 1977, DEA began to notice that prices for heroin in Berlin were low; availability was high; and overdose deaths were steadily rising.

As I stated earlier, one of DEA's overseas roles is to develop within the U.S. Mission specific short-term and long-term bilateral drug intelligence programs that will accrue to the benefit of the host country and to the United States. Berlin presented such an objective. DEA was conducting an operation to determine sources and flow patterns of Near and Middle East heroin through Europe to the United States. This heroin appeared readily available in Berlin, so for intelligence purposes, Berlin became a major subject for inclusion in this operation. The Embassy in Bonn, the U.S. Mission in Berlin, the U.S. Army CID, U.S. Air Force OSI, German Police and German Customs were all brought together and a 90-day Berlin Task Force was created under DEA leadership with all participants fully sharing information and intelligence that developed. DEA brought in undercover operatives and the end product clearly showed that availability was higher in Berlin than in other cities in Germany. The situation pinpointed by DEA led to increased enforcement efforts at every level and an awareness of the problem at all levels of the allied forces, as well as with the Berlin Government.

The Berlin Commandant for American Forces, Major General Benedict, has created a Commandant's Task Force consisting of many of the participants from this operation plus State Department participation headed by the Berlin Public Safety Advisor. This group, which includes DEA, continues to monitor the situation and develop new approaches to combat narcotic abuse in the military, as well as in the civilian sector of that city. In Berlin, the 1978 overdose death figures are down significantly (62 deaths have been recorded thus far), although deaths are up in other parts of Germany. This small indication of success in Berlin is being closely watched.

The problem of narcotic abuse is worldwide and its full impact on Europe, and Germany in particular, is now being felt. Through exchanges of experiences, intelligence information and enforcement expertise it is hoped that some control over the international narcotic traffic in this country can be realized.

PREPARED STATEMENT OF MAJ. ANTHONY DEVALENTIN III, ALCOHOL AND DRUG POLICY BRANCH, OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL, HEADQUARTERS, DEPARTMENT OF THE ARMY

Mr. Chairman, I am presently assigned to the Drug and Alcohol Policy Branch of the Office of the Deputy Chief of Staff for Personnel, Headquarters, Department of the Army.

I arrived in Germany on 3 November to conduct a series of special urinalysis tests. The purpose of this trip was to obtain independent data to evaluate the USAREUR selected unit urinalysis test of company size units (SUUTCO).

To assure the validity and impartiality of these special tests, the purpose of my visit was kept close hold. At Headquarters, Department of the Army, the only individuals that I know had knowledge were Major General Ulmer, director of Human Resources Development Directorate; Colonel Ordway, Chief of the Leadership and Motivation Division; Mrs. Gouin, Chief of the Alcohol and Drug Policy Branch; and LtC. Doloff, OCLL. There were others on the Department of the Army staff who knew I was coming, but I do not know who they were nor the extent of their knowledge.

There were officials in USAREUR who were also aware of the purpose of my trip. Brigadier General Fitts, Deputy Chief of Staff for Personnel was my initial point of contact. To my knowledge, there were five other officers in USAREUR who had knowledge of the reason for my visit.

On Sunday, 5 November, I conducted a meeting with six noncommissioned officers and enlisted personnel from the Heidelberg area who would assist me in conducting the special urinalysis test. These individuals were selected late Friday afternoon (3 November) again to assure the impartiality of this project.

At this point I would like to indicate that I had the total and complete cooperation of USAREUR, to include a letter from General Fitts which gave me the authority to contact any unit in USAREUR and direct a special urinalysis test.

At approximately 1600 hours on Sunday evening, I identified three units which had been previously tested under the SUUTCO and requested that USAREUR initiate a re-test of these units on 6 November. USAREUR then sent the immediate messages to the respective corps directing these SUUTCOs. On this basis, the most advance warning a selected unit could have had was 12 to 14 hours.

On Monday morning, 6 November I met with the special team and we drove to Mannheim. Upon arrival, we selected the unit to be tested. This was approximately 0700 hours. I should note, however, that originally I had intended to test a unit other than the one we actually tested. The reason for this change was because we learned that this unit had just returned from training in Berlin.

The basis for selecting these four units was primarily their location—Stuttgart, Neurnberg, Mannheim and Baumholder, all of which have at one time or another been identified as troublesome areas with regard to drug abuse.

The results of these four tests indicate that 400 individuals were tested and there were 17 non-authorized use positives for a 3.8% positive rate. The unit that I personally supervised had a 2.1% positive rate for 139 specimens. The 17 positives included 12 opiates (heroin/morphine/codeine), two amphetamines and three methaqualone. The positive rate for these four units on their previous SUUTCOs was 4.8% positive—17 opiates, three phenobarbs and one methaqualone.

On Tuesday, 7 November, we would test three additional units, but units which had not been previously tested under SUUTCO.

At approximately 1700 hours on Monday 6 November I provided USAREUR the identification of additional units they would test using their normal SUUTCO. Once again, these units had no more than 12 to 14 hours advance warning.

The special team and I traveled to Wiesbaden and at approximately 0630 hours advised the selected unit that a special SUUTCO would be conducted. The primary basis for selecting these three units was again location—Augsburg, Hanau which is just outside Frankfurt, and Wiesbaden.

These tests included 340 individuals and identified six non-authorized use positives for a 1.7% positive rate. The unit tested by the special team included 90 specimens with two positives (one opiates and one phenobarb) for a 2.2% positive rate.

The overall rate for these seven units, which represented approximately 10% of the number of SUUTCOs conducted by USAREUR, was 780 specimens with 23 non-authorized use positives for an overall 2.9% positive rate. This compares quite favorably with the 3% positive rate reported by USAREUR for its 72 SUUTCOs of 10,688 specimens. The Army-wide rate for fiscal year 1978 was 2.2% of 580,845 specimens or 12,901 positives.

My trip was not only designed to independently evaluate the SUUTCO program but also to review the procedures used in the laboratory process. In this regard, after initiating the test in Wiesbaden, I took the specimens from the previous day to the U.S. Army Laboratory at Weisbaden to witness their processing. Because of the incubation period for portions of the laboratory tests and other processing procedures, it was not possible to view the entire process. However, I did witness the initial screening stage—radioimmuno assay which produces the presumptive positives. When I left the laboratory. I felt very comfortable with their controls and procedures.

Mr. Chairman, my overall assessment of this special project is that it did in fact validate the SUUTCO procedures used in USAREUR as well as the laboratory procedures used to identify drug abuse.

Thank you very much.

PREPARED STATEMENT OF CAPT. SAMUEL A. BARNES, ALCOHOL AND DRUG CONTROL OFFICER, BAD KREUZNACH COMMUNITY

Mr. Chairman, as the Alcohol and Drug Control Officer for the Bad Kreuznach Community, I have direct responsibility for the Dexheim and Bad Kreuznach Community Drug and Alcohol Assistant Centers (CDAAC) which services 32 companies and separate detachments in Bad Kreuznach, Dexheim, Weuschheim, and Dichtelbach. In this position, I am the Installation Alcohol and Drug Abuse Prevention and Control Program Manager and responsible for coordinating the command, staff and medical aspects of the Alcohol and Drug Abuse Prevention and Control Program. Secondly, for exercising supervision or operational control of the Alcohol and Drug Abuse Prevention and Control program personnel, facilities and funds. Also, I am responsible for developing, coordinating, and recommending Alcohol and Drug Abuse Prevention and Control Program policies for implementation. I establish communication, referral, and processing channels with and between the military and civilian activities that can contribute to the Alcohol and Drug Abuse Prevention and Control Program, serve on the Alcohol and Drug Dependency Intervention Council, provide periodic program evaluation to the commander, and I am responsible for the administrative maintenance of records and reports in accordance with applicable regulations. I authenticate all the Alcohol and Drug Abuse Prevention and Control Program reports furnished to higher headquarters, and lastly, I provide data for budget and manpower planning and maintain appropriate records for resource transactions.

The Bad Kreuznach Drug and Alcohol Assistance Center is the central facility to which 32 separate unit commanders refer all military alcohol and drug abuses. The CDAAC operation is the responsibility of the Bad Kreuznach Community Commander. We provide service to all eligible civilian personnel, active and retired military employees, and the dependents of active and retired military and eligible civilian employees. The CDAAC in cooperation with unit commanders, the medical treatment facilities and other appropriate community agencies assist commanders in the rehabilitation effort and perform the following functions:

We receive all personnel referred by commanders for evaluation and conduct an initial interview to determine if and to what degree the individual is abusing alcohol or drugs. Appropriate assistance may be provided to other personnel who have alcohol or drug related problems but no one would be entered into a rehabilitation program unless clinically confirmed by a physician as an alcohol or drug drug abuser.

In close coordination with unit commander, we must design and participate in rehabilitation programs for clinically confirmed alcohol and drug abusers and conduct social evaluations for those personnel whose clinical evaluations were inconclusive. The CDAAC, in consultation with the unit commander, develops a case designed for an individual based on all available information. Each program is designed to meet the needs of the individual abuser instead of employing a standard model.

We provide appropriate counseling in CDAAC staff capabilities. We refer clients who require more help than CDAAC and the unit can provide to other agencies (i.e., Chaplain, hospital, extended care facilities, Alcoholics Anonymous, Narcotics Anonymous, mental health clinic) as appropriate to assist in the rehabilitation effort.

We provide continuous monitoring of individual cases through the follow-up phase of rehabilitation or until the individual has been eliminated from the service.

We also maintain appropriate records in accordance with applicable regulations. When an individual in the follow-up phase is transferred to another United States Army Europe unit serviced by a different CDAAC, his records will be transferred in order that his rehabilitation may be continued at his new unit. At periodic intervals throughout the rehabilitation phases, we provide administrative and clinical recommendation to the commander, in order that he might make a decision as to the Service Member's rehabilitation progress. We assist the community commander and unit commanders by monitoring their urinalysis program to insure that all individuals who are involved in the rehabilitation program are tested at the designated time. This gives the commander additional information on the Service Member's progress and assists him in identifying other abusers. We continuously assess the drug and alcohol situation in the Bad Kreuznach Community and provide the Community Commander with this information periodically.

The Alcohol and Drug Abuse Prevention and Control Program while assigned within each community is subordinate to V Corps Alcohol and Drug Control Office. Since Bad Kreuznach is an 8th Infantry Division Community I coordinate all Alcohol and Drug Abuse Prevention and Control Program activities with the 8th Infantry Division Alcohol and Drug Control Officer who is assigned to the tactical headquarters. My responsibilities and functions in this capacity are manage the Alcohol and Drug Abuse Prevention and Control Program's administrative functions. I must coordinate operational functions among designated alcohol and drug abuse prevention and control staff personnel. I prepare data for budget and manpower resource transactions. I supervise the administrative staff and provide consolidated staff input to the Alcohol and Drug Control Office for ongoing program evaluation.

In the Alcohol and Drug Abuse Prevention and Control Program, I feel it is imperative that all facets coordinate with the unit's chain of command. This program, by regulation, is an additional tool to be used by the commander in order that he may perform his mission more effectively. The rehabilitation program can not be effective without this close liaison between the Alcohol and Drug Abuse Prevention and Control staff and the commander. The entire rehabilitation effort for the client depends on a well structured program, including medical, clinical, and unit involvement. At the unit level, the first line supervisor and company commander are directly involved in the service member's rehabilitation. During clinical counseling my counselors, the first line supervisor, and company commander work closely to evaluate the progress of the Service Member. Our clinical recommendation to the company commander, and the first line supervisor's daily observation of the service member, is critical in determining the final decision as to whether or not the service member will be a rehabilitation success or failure. My staff, with cooperation from the commander, and the doctor effectively accomplish this process. I also provide periodic program evaluation to the commander. This evaluation is not only in the area of rehabilitation but, in his unit's overall Alcohol and Drug Abuse Prevention and Control Program. Another service I provide is an educational program based on the commander and his needs. We provide technical information about other Army resident treatment programs to the commander and we make recommendations or referrals of the clients to these other agencies. By doing all these things for the commander, I am, in essence, an extension of his command; and I assist him in insuring that his unit can perform its mission with every available manpower asset.

In my opinion the drug situation in the Bad Kreuznach Community is recognized by the commanders, and they are doing all they can to attack the problem. Biochemical test results show a 3% to 6% use of opiate, amphetamine, barbiturates and methaqualone in Bad Kreuznach. This is based on five SUUTCO's which indicate 5.7% usage. A scientific method to identify Cannabis is not in use; therefore, the degree of use is open to debate. The percentage that use Cannabis is reported to be as high as 80% by those we treat in the ADAPCP program. This amount of use is offered up as a defense mechanism or rationalization for his or her use and when pressed, they usually must admit that their perception is wrong. Others develop a percent of use based upon their knowledge of a very small group. Drug abuse varies from unit to unit, depending upon the unit's training program, its mission, the type of MOS, and the quality of leadership it has. Therefore, it is possible for an individual to be in a platoon where 80 to 90 percent use drugs. This then, is the world that the individual knows, and when asked about his company or battalion, he will apply the percentage developed from that limited sample to the remainder of the unit. In these situations, the individual is usually

very sincere in his beliefs, even if the view is mistaken. One must realize that the individual soldiers have limited perceptions. The arrangement of the barracks with the separate rooms, combined with the normal work organization of the company into small work element, precludes the individual soldier from having an in depth knowledge about the use of drugs in a company. After considering these factors, I believe the use of Cannabis is in the 30 to 40 percent range. By use, I mean a soldier uses the drug twice a week.

I believe the key to solving the alcohol and drug abuse problem is prevention. We know drugs are readily available in Europe. To prevent a soldier from use or abuse of narcotics, he must be satisfied with what he does. This job satisfaction ties in directly with good, realistic training, which helps relieve boredom and frustration. Many of the commanders that I work with have expressed their frustration concerning their inability to spend time in the field for training due to lack of funds. Almost every soldier wants to perform the full range or duties required in his or her MOS. Too often this is not possible due to limitations imposed on the time available in the various training areas; the lack of adequate firing ranges, or the lack of funds for ammunitions. The more we can conduct meaningful training the more satisfied the soldier will be and this will significantly relieve the drug abuse problem. Of course we must also recognize the need to improve the quality of life for every soldier with special attention being given to those soldiers who live in the barracks. When the soldier is not at work he needs to be able to relax in an atmosphere that is conducive to the development of his abilities in other areas such as photography, crafts, music, etc. Both of these, the training and good recreational facilities, are excellent means of preventing the young soldier from becoming involved in drug usage.

The commanders in the Bad Kreuznach Community feel as I do that it is the responsibility of the first line supervisor to detect any drug abuse. The first line supervisor, therefore, becomes an important factor in the area of prevention and early detection of drug abuse, and educating the troops on the hazards of drug abuse. To assist the commanders in training their first line supervisors, I have initiated an education program which stresses the indicators of drug and alcohol abuse, and we are presently presenting these classes to company commanders so they can teach their NCO's. These classes will be extended to teach the NCO's the same indicators.

To prevent the newly assigned soldier from becoming involved in drug usage, we have developed a community Alcohol and Drug Abuse Prevention and Control Program orientation. This program stresses the medical, social, economical, and legal hazards of drug abuse. We present information on the differences of the strength of drugs in Europe as compared to the United States, and, also, the strength of alcoholic beverages here in Germany, as compared to that of the United States. We also give them a chance to observe a mock interview, and based on the information, allow them to determine whether or not an individual will be placed into the rehabilitation program.

Other classes that are currently being conducted are:

(1) The prevention of alcohol abuse.

(2) The prevention of drug abuse.

(3) Drug and Alcohol Education Specialist training, whereby the unit's Alcohol and Drug Abuse Prevention and Control Program Specialist learns of all new changes and gets a chance to interact with other drug and alcohol education specialists in insuring that they each have a viable program. We have a Commander's Call which stresses the indicators of drug and alcohol abuse in an effort for the commander to be able to effectively detect drug abuse within his unit and train his first line supervisors on detection. In addition there has been intensified effort to disrupt the drug supply. To summarize, I believe the things that can be done to prevent or lower the drug abuse situation in the Bad Kreuznach Community would be:

(1) Improve Training opportunities for the service members.

(2) Better recreational facilities.

As my final point, I want to address the need to rehabilitate those that do fall into the drug habit. Hopefully, the actions as I have proposed will reduce drug abuse, however, there is a need to provide intensive training and education for the Alcohol Education Specialist at the unit. There also needs to be an increased allocation personnel strength within the Alcohol and Drug Abuse Prevention and Control Program, in order to increase the services that are currently being provided to the commanders.

DRUG ABUSE AMONG U.S. ARMED FORCES IN THE FEDERAL REPUBLIC OF GERMANY AND WEST BERLIN

WEDNESDAY, NOVEMBER 22, 1978

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Stuttgart, Germany.

The Select Committee met, pursuant to notice, at 9 a.m., in the NCO Club, Patch Barracks, West Germany, Hon. Glenn English (acting chairman of the Select Committee) presiding.

Present: Representatives Billy L. Evans, Benjamin A. Gilman, Cardiss Collins, and John W. Jenrette, Jr.

Staff present: William G. Lawrence, chief of staff; David Pickens, project officer; Elliott A. Brown, professional staff member; and Daniel A. Stein, researcher.

Mr. ENGLISH. The hearing will come to order. Today we're going to focus on a different aspect of drug abuse in the military. Obviously, the extent of drug abuse within the military is extremely important, and particularly those actions and those methods being used by the military to deal with it. However, there is another extremely important aspect with regard to the extent of drug abuse taking place within Germany, and of course, that has to do with the availability of drugs. I think there is one point that we can all agree on, and that is that availability and price are two of the most important ingredients in determining the extent of drug abuse. We have a somewhat different situation in foreign countries where our troops are stationed. Namely, we must depend upon the host government to assist us in keeping the level of drug abuse and drug availability at acceptable rates. I think that it's clear to all, from what has been stated in earlier testimony, that certainly hard drugs are plentiful, and they are readily available to all of our service people as well as the German civilian population. It is for this reason that the committee yesterday traveled to Bonn to visit with German Government officials to emphasize our interest in this problem and to extend to them our offer of cooperation and assistance. Certainly drug abuse is no respecter of international boundaries, and certainly drug abuse is not a respecter of State borders. Therefore, it is not only the American serviceman that we concern ourselves with, but also the German population in total. So today we want to focus upon what we can do, what assistance we can offer to the German Government through our Ambassador here and State Department in bringing a curb to the plentiful availability of hard drugs in particular. But I think we must once again emphasize that hashish, which so many young people seem to equate with the use of marihuana in the United States, that it brings on a whole new dimension, mainly due to the fact that the hashish that is being used by

young people here in Germany is roughly 10 times stronger than the marihuana that is being used in the United States. With this, I would like to say that we are looking forward in the future to working with both the military and the State Department in resolving this very difficult problem. Mr. Gilman, do you have any comments you would like to make?

Mr. GILMAN. Thank you, Mr. Chairman. During the past few days, and during our first hearing, it became quite evident that there are some serious problems confronting our military people in West Germany. The extensiveness of the amount of drug abuse and drug trafficking has exceeded our initial estimates. It is a problem that is quite critical, but the military administration cannot be blamed for the drug culture in which they find themselves, and unless some serious efforts are made to reduce the availability of narcotics in this part of the world, in West Germany, then we can't continually point the finger at a lack of administrative attention by the military. That effort in West Germany is going to take a great deal of cooperation between our Government and the West German Government. I was very much impressed with our meetings yesterday in Bonn with some of the West German leaders. I am impressed, too, by the fact that we are about to embark on a working group, an informal working group, that will be meeting regularly that is comprised of representatives of both Governments. I think that that working group can be of a great deal of benefit in making an overall plan and implementing such a plan. However, I did find that, as with the military, there are some people in the West German Government who have couched themselves and cushioned themselves in some relatively complacent statistical data, data that we find has really a lack of substance when it is placed under the microscope. Some of the bureaucrats have stated that they have reached a plateau in narcotic abuse in West Germany, and of course, we find that that is not the situation, that narcotic registrants have been climbing, that the overdose deaths have been climbing, that overdose admissions to hospitals have been rising, that arrests have been rising. There are many indicators out there that disclose that the narcotic situation has not reached a plateau in West Germany, but has been accelerating.

Of course, if we are going to rectify this problem and apply a remedy, we first have to recognize the illness and admit that we do have some problems, and I'm hoping that those bureaucrats that are in charge, those ministers who are in charge of this problem, will give that a candid and frank appraisal so that as we work together we can help to resolve this very critical situation that is confronting our military people in West Germany. Thank you, Mr. Chairman.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. I have nothing, Mr. Chairman.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman. I don't have a long comment, I would like to state that I'm appreciative of the fact that we do have some people over here who have been working on the drug problem for a long time. Ambassador Stoessel, who is reputed, according to the information we have, to be very interested and informed about the drug problem; David Anderson, the minister to the U.S. Mission in Berlin, who has a reputation for having been for a long time

involved in the drug problems and trying to alleviate some of these problems. Mr. Chairman, I see that part of our problem is that the individual branches of our Government, or the individual agencies, cannot deal with this problem alone, and I feel that it is necessary for this committee and the Congress of the United States to lend its support completely to the various agencies and departments that have been having to deal with this problem, and I think that only by all of us working together can we address the problem, and I hope that by these meetings we will do that. That you, Mr. Chairman.

Mr. ENGLISH. Thank you very much. Would the Chief of Staff call the next witnesses, and I might say before he issues that call, that we have made the decision that the representatives of the State Department should come forward as a panel. Most of the questions that will will be asked will be questions that we will want to ask each of the representatives present.

Mr. LAWRENCE. The committee calls the Honorable Walter J. Stoessel, the Honorable David Anderson, and the Honorable Mathea Falco.

Mr. ENGLISH. First of all, I would like to welcome you here and thank you for taking your time out of a very busy schedule—each of you I know is extremely busy—to assist us in this matter. I also would like to state that if you will summarize your statements, that would be most helpful. Your complete statements will be made a part of the record. Mr. Ambassador?

TESTIMONY OF HON. WALTER J. STOESSEL, JR., AMBASSADOR OF THE UNITED STATES OF AMERICA TO THE FEDERAL REPUBLIC OF GERMANY

Ambassador STOESSEL. Thank you very much, Mr. Chairman. I'm grateful for the opportunity to be with you today. At the beginning I had thought to give a brief overview of our relations with the Federal Republic of Germany and put this into the context of our joint efforts with the Federal Republic to combat the problem of illicit drug trafficking and abuse. I think it's clear we have many common interests with the Federal Republic. We work together very closely on a wide variety of foreign affairs problems, we cooperate closely in troubled areas of the world, we work together in connection with efforts to promote economic stabilization throughout the world.

Clearly in the field of security, in the field of arms control and disarmament, we have the closest of relations. This includes our efforts in NATO, and overall in East-West relations. We do have problems, of course, but I think we can solve these in a spirit of cooperation as friends and partners. We know we can rely on each other and we do have a good mutual understanding. I think these characteristics of our relationship carry over into the field of illicit narcotics. We have had a growing cooperation with Germany to combat trafficking and abuse in recent years. Prior to the late 1960's, West Germany's problem was relatively small and stable, and German-American efforts in the field of narcotics were carried on in this country through liaison between our military law enforcement personnel and German Federal Land Police, and internationally through our normal customs Interpol health and technical exchanges. Shortly before the onset of

the 1970's, the indicators of increased trafficking and abuse rose in the Federal Republic and this has continued to the present day, and with this upsurge, began an intensification of our bilateral cooperation in this field. We have had Drug Enforcement Administration agents in Germany since 1970, and we have cooperated very closely through the DEA with the German authorities. The DEA has offered its own experience in combating illicit drugs, cooperating and exchanging intelligence, developing intelligence programs, and the embassy role in these efforts has been and is to provide support and to integrate these enforcement efforts within the foreign policy aspects of the international narcotics problem.

In the embassy, we have had a task force established since 1972 to focus particularly on narcotics and bring together officers of the embassy and representatives of our military services in order to coordinate our antidrug efforts. This task force continues to this day, and the responsibilities of this task force will soon be assumed by the central working group to which you referred in your statement. In the decade since the onset of the Federal Republic's narcotics problem, our cooperation has greatly expanded. Land and Federal police have developed very close working relationships with our DEA and military enforcement agents. We have DEA agents located in Hamburg, Frankfurt, Munich, Wiesbaden; we have a narcotic attache in Bonn, and they're closely involved in drug suppression effort. West German police have received training in the United States sponsored by the DEA, and this training has ranged from basic enforcement to special training for instructors to executive observation programs for officers at the highest level.

In 1973 the DEA and the German Federal police recognized the need for a centralized narcotics enforcement effort, and founded the permanent working group on narcotics. This group is composed of officers from Federal and Land police and the customs and border protection services along with embassy, narcotics, and custom attachés, and representatives of the U.S. military. Austria, Switzerland, France, Luxemburg, Belgium, and the Netherlands have joined this group and meet on a regular basis in this working group. This is a clearinghouse for collection and evaluation of relevant information on drug trafficking. In 1973, also, the United States and the Federal Republic concluded an agreement providing for mutual assistance between our customs services, and this agreement provides for mutual help in investigating and preventing narcotic smuggling. We recognize, of course, that cooperation in enforcement can only be a part of our response. Our joint efforts must be, and they have been, broadly based. We have had exchanges in many areas, such as health, rehabilitation, education. In September, eight leading U.S. specialists spent 3 weeks in Germany consulting with German counterparts and studying the problems of drug abuse. There have been a number of other visits which are mentioned in my statement. West Germany, until recently, supplied a police training unit to Afghanistan. This unit had direct contact with DEA agents in Kabul in assisting the Afghans to enforce narcotics laws. The Federal Republic's contributions to the United Nations Fund for Drug Abuse Control have been small. The Germans, however, are currently considering increasing their contributions, and we are very hopeful that they will do so.

I have outlined for you some of the ways in which we cooperate between our two Governments. I believe that this cooperation will intensify in the months ahead. This drug problem will continue to receive my personal attention, as well as that of the other senior embassy officers. I have personally been very interested in the drug problem, have tried to keep myself up to date on it, have worked with our task force in the embassy. In February, 1977, I first addressed the need for increased German-American cooperation in this field when I called on Minister of State Wischnewski in the chancellor's office. Other embassy officers and myself have continued to make high level approaches about narcotics to the West Germans. We were instrumental in convincing President Carter to speak to Chancellor Schmidt about the narcotics problem during the Summit Meeting in Bonn in July. Our Deputy to Chief of Mission again raised the issue in a call on State Secretary Schueler in September. I believe these efforts are bearing fruit. In June, I had the privilege of joining with State Secretary Van Well of the Foreign Office in signing a narcotics control agreement. This agreement made formal some aspects of our past cooperation, while contemplating broader mutual bilateral and multilateral efforts to suppress the production and distribution of illegal drugs and abuse of all drugs. The agreement establishes a central working group composed of representatives from relevant German ministries and from the embassy and the military. Minister of Health Huber and I have agreed to convene the first session of this working group in mid-December. Thereafter, the group will meet at least twice a year to discharge its responsibilities, to develop joint policy, and establish priorities, and assign tasks related to its decisions to the subcommittees also established under the agreement.

The Permanent Working Group on Narcotics formed in 1973, will operate as one of the subcommittees. There will be three other subcommittees; Legal; Prevention in Medicine; and Military. However, the working group may establish other committees as it deems desirable. I am confident that the opportunities provided under this agreement will lead to rewarding innovations in our common battle against drug abuse. Certainly the modern world with telecommunications and transportation have shrunk the world beyond anything we have known before. In most respects these technical advances have helped the community of nations to understand each other better and to realize how interlocking our lives really are. However, rapid transportation has also meant rapid movement of illicit drugs, and it is no longer possible for any one nation alone to combat narcotics abuse effectively. As the dealers become more sophisticated in seeking and protecting and expanding their markets, so must the governments of nations, both consumer and producer, increase their efforts in both the supply and demand fields. I think that West German-American cooperation in many respects has been a model in this fight, and I am confident that such mutual efforts will continue to be a hallmark of our countries' relations in the coming years. I thank you.

[Ambassador Stoessel's prepared statement appears on p. 218.]

Mr. ENGLISH. Ms. Falco?

TESTIMONY OF HON. MATHEA FALCO, SENIOR ADVISER TO THE SECRETARY OF STATE, AND DIRECTOR FOR INTERNATIONAL NARCOTICS MATTERS

Ms. FALCO. Thank you, Mr. Chairman. Since Ambassador Stoessel and Minister Anderson will be addressing the situation here in Germany, I will address my remarks to the sources of the illicit traffic coming into Western Europe, and I will address them very briefly, since I understand that you have already dealt very thoroughly with many of these issues.

Let me just say briefly at the outset, that I think that this kind of interest on the part of the committee in coming directly to a very difficult problem area is tremendously helpful, both in our bilateral efforts and in our multilateral efforts to develop regional and international cooperation in drug control. As you have noted, yesterday in your meetings with German officials, the drug problem in Western Europe is rising at a truly alarming rate. The figures I have laid out already in my prepared testimony, I would simply note that the number of overdose deaths exceeds the number in our own country, and the indicators for this coming year do not show that there is going to be any kind of leveling off or decreasing in the size of the problem. I think it is often very hard for industrialized nations in particular, including ours, to recognize the scope and the potential danger of this kind of drug problem. As you know, 10 years ago in our country we were facing a similar kind of epidemic of heroin addiction, an epidemic which it took us quite a while really to respond in any kind of effective way. I see the same kind of pattern emerging now in Western Europe.

One of the reasons, I think, for this epidemic is the very ready availability of high purity heroin in this part of the world. The primary source of this heroin, it remains South-East Asia. All of the Middle-Eastern heroin is quickly moving forward to supplement the already very easily available supplies. Two of the primary producing areas of the world, which in the last year and a half have become really the largest producers of opium—Afghanistan and Pakistan—are of particular great concern in our international effort. Their production figures, even at the most conservative end of the spectrum, will probably be about 800 tons of opium this year. The DEA estimates go as high as 1,000 tons, and I don't think that would be surprising. This opium is refined, as you know, in illicit laboratories in that region of the world, Afghanistan, Pakistan, some in Iran, some in Turkey, and then brought by various means into Western Europe, where there are very ready markets. This presents a very great threat, not only to the countries of Western Europe, but obviously also to our own troops who are stationed over here. It also has an increasing impact on the domestic drug abuse situation in the United States. As the Mexican sources of heroin are being reduced because of the eradication and enforcement efforts of the Mexican Government, they supply increasingly less of the illicit heroin coming into the United States. The latest Drug Enforcement Administration figures put the estimate around two-thirds, two-thirds of our heroin still comes from Mexico.

The other third is comprised of Middle Eastern heroin and Southeast Asian heroin. I am personally extremely concerned about the prospects in the next 2 years, given the really large increase in production in the South Asian part of the world, Afghanistan and Pakis-

tan. One of the themes, I think, that you have already touched on, is the role of the United Nations in moving us together with our European colleagues to do something about the situation worldwide. The question of voluntary contributions to the U.N. Fund has been a long and troublesome one. You and other members of this committee have worked valiantly to try to increase the levels of contribution. I would be extremely pleased if we did see some dramatic donations from some of the Western European countries, in particular, which are most severely affected by the heroin problem. The U.N. Fund has projects in Afghanistan and Pakistan, as well as in Southeast Asia, and indeed in Afghanistan is the only vehicle right now for our drug control efforts. As you know, the difficulty which those governments face in controlling illicit opium production is compounded by the fact that they do not entirely control, and in some cases, really not at all, the areas in which this opium is grown. The United Nations has provided a vehicle, whereby these governments have been able to begin to develop alternatives for the tribes people in some of these very remote regions of their countries to find other crops, other means of subsistence other than the opium on which they've relied for so many generations. Another very important area, I think, which we are finally bringing to bear in dealing with this problem, and one in which again our European colleagues could be very helpful, is the International Financial Institution role. We have been working very hard this last year, and with some success, to insure that assistance from the World Bank, from the Asian Development Bank, from other regional lending institutions, is not misdirected toward cultivation of larger, stronger poppies, but indeed goes to developing alternative means of livelihood for these farmers.

One of the specific concrete ways of trying to do this is to have anti-poppy-growing language in the terms of the agreement or in exchange of side letters with the recipient government. Another focus we are trying to encourage for the international institutions is to direct development assistance money into some of these primary areas. We're doing that obviously also with our own Agency for International Development. Many of these areas are indeed inhabited by the poorest of the poor people, the natural recipients for this kind of assistance. Unfortunately, in the past, narcotics has not been a major factor in making determinations as to directing development assistance. The Norwegian Government this last year made a very large contribution to the United Nations Fund, specifically for use in Burma, in rural sections of Burma, where opium is illicitly produced. They, in order to make that contribution of $5.4 million, dipped into their development assistance funds. That was the first time that a government had made such a substantial recognition of the concept. The development assistance moneys are appropriate vehicles for dealing with the narcotics problem worldwide.

That is a concept that we are trying very hard, together with the Norwegians and the Scandinavian countries, to communicate to other potential donor countries. As you know, the United States also has various bilateral narcotic control efforts with major source countries, and I could describe those in detail as the committee wishes. I think at this point, perhaps. I will just pause and take questions as the chairman wishes.

[Ms. Falco's prepared statement appears on p. 220.]

Mr. ENGLISH. Thank you. Mr. Anderson?

TESTIMONY OF HON. DAVID ANDERSON, MINISTER, U.S. MISSION, BERLIN

Mr. ANDERSON. Thank you, Mr. Chairman, for asking me to appear here today. You and your colleagues have been to Berlin; you've seen the city. It is, in the final analysis, a big part of the larger Germany-European drug problem, with certain special characteristics of its own, of course, involved with the large number of checkpoints and roads in and out of the city, and the complex character of the traffic in and through the city. I will be brief here today in summarizing my statement. I would like to refer to your opening remarks. Today we are addressing ourselves to the availability problem. Berlin is the largest German city, and it has a major heroin problem. Heroin in Berlin is extremely cheap, and it is potent, and it is easy to buy. While this is a relatively recent problem in its present severity, there has already developed in Berlin a civilian addict community of at least several thousand teenagers and young adults. I think that you and some of your colleagues saw some of the victims in the subway station on Berlin's main shopping street last week. It is not a pleasant sight. Quite honestly, I don't believe that either the American authorities or the Berlin authorities know the full dimension of the Berlin heroin problem. There have been increased seizures and arrests this year, as my statement indicates. These suggest not only improved and more vigorous police and customs work, but sad to say, possibly also that the trafficking has also been on the increase. We do take some comfort from the drop in overdose deaths this year, but again that, too, may be due to other circumstances and improved techniques in the hospitals. We believe that the Berlin police and customs are trying hard to cope with the problem that has developed in the last 1½ years. They are eager to stem the flow of the drug into the city. The police themselves have tripled their drug force within 1 year, and all of them are now gaining experience. In particular, police and customs are working together, I think, in the most cooperative way that has been experienced in Berlin in many years, and they are targeting their efforts where it really counts—less against the smalltime dealer and more against the major trafficker.

I would like to say a word, if I might, about the DEA role in Berlin. DEA has played a most important one, and its representative has really been at the source of much of the success of the effort in the city. I would like to feel that there has been in the past year a major change in the attitude and the effort of the Berlin authorities. I include in that, among these, the Berlin political and health authorities. Berlin is one place where the top city officials recognize that they have a major problem on their hands and they are willing to devote the necessary resources to solving it. They also welcome our assistance. There is obviously much more that we and the Germans have to do together to contribute to the solution of the problem, and speaking for the Berlin aspect, to contributing to Berlin's ability to assess the exact dimensions and nature of the problem. I think you found in Berlin last week that there was a certain lack of data on which to base even the most simple solutions. Some of these we are going to try and come up with in the coming months. For example, I think we need to develop a system to uncover data or develop a regular data base for overdose hospital admissions.

I also think we have to approach yet again the subject of stationing on a full-time basis, a DEA agent in the city. Sir, I think I have described the essence of my statement sufficiently, and I would like to take questions.

[Mr. Anderson's prepared statement appears on p. 225.]

Mr. ENGLISH. Thank you very much. The first question I have is, how many DEA agents do we now have in Germany, both in West Berlin as well as the rest of Germany?

Ambassador STOESSEL. Mr. Chairman, I think we have six DEA agents in the Federal Republic: One is in Hamburg; one in Bonn, the Narcotics Attaché; one in Munich; one in Wiesbaden; and two in Frankfort. We do not have a permanently stationed DEA agent in Berlin, as Mr. Anderson has suggested. We have recommended to Washington that such an agent be stationed there in Berlin. I know this is under consideration now. I hope that that would be acted on very soon.

Mr. ENGLISH. When was that recommendation made, Mr. Ambassador?

Ambassador STOESSEL. I recall that was made last spring. I don't have a precise date; I could get that for you.

Mr. ENGLISH. It's been 6 to 9 months, then, somewhere in there?

Ambassador STOESSEL. Something like that; yes.

Mr. ENGLISH. There has still been no action on that by the State Department? Has a decision been made by the State Department?

Ms. FALCO. Not to my knowledge, Mr. Chairman. As I understand it, there were a number of requests worldwide for increases in DEA positions, or shifts in DEA positions, personnel positions. Although, again, DEA could address this probably more accurately. They have, as you know, a certain number of slots worldwide, which is set by their own parent agency, the Justice Department, and which is then reviewed by a part of the State Department known as MODE.

Mr. ENGLISH. What I am trying to get at, though, has State requested one additional DEA agent for Berlin?

Ms. FALCO. The request has gone to this MODE group in the State Department. As I understand it, when I looked into it right before I left, the decision was pending a discussion with DEA with regard to their worldwide allocation of agents. I think when Mr. Anderson is going back to the States, and we plan on going Monday morning and deal directly, specifically with the Berlin question, take it out from the whole worldwide question.

Mr. ENGLISH. Is six the largest number of DEA agents that we have ever had in West Germany and West Berlin?

Ambassador STOESSEL. No; I understand, Mr. Chairman, the number was larger several years ago. I think we had 13 at one point. This was before I came here.

Mr. ENGLISH. Thirteen? So it's been reduced more than half?

Ambassador STOESSEL. Yes, sir.

Mr. ENGLISH. When was that reduction made?

Ambassador STOESSEL. Again, I can't be precise. I think this was 3 or 4 years ago. I think it was also in connection with a worldwide review of DEA responsibilities and agent assignments.

Ms. FALCO. Just as a footnote, DEA is, as you know, constantly reviewing its own allocation of agents overseas. For example, last

month there was a very substantial increase in the number of agents stationed in Colombia. That means that they will probably take those agents out of somewhere else.

Mr. ENGLISH. Well, the thing I am wondering about is, I want to know generally—it was 3 or 4 years ago when it was made. Do you know who made that decision? Was that a DEA decision to move those agents out of here and move them to——

Ms. FALCO. It's something we should probably get for the record. I don't know who specifically made that decision. That preceded Peter Bensinger's administration as well as mine.

Ambassador STOESSEL. Yes; we'll be able to get that for you.

Mr. ENGLISH. So there has been no increase in the number of agents over the past 3 or 4 years?

Ambassador STOESSEL. That's my understanding.

Mr. ENGLISH. You requested additional agents for West Germany, as well as the one additional agent for West Berlin?

Ambassador STOESSEL. No; my only request has been for an additional agent to be stationed in West Berlin.

Mr. ENGLISH. Are these State Department slots that DEA agents are assigned, are, or in any way does it come with regard to the State Department?

Ms. FALCO. No, sir. They sit on their own slots. The State Department role, as I understand it, with regard to any agency overseas, is to approve the numbers of Americans stationed overseas. That's the whole MODE process, which, indeed, I think they also operate on an interagency basis. Again, I would like to put something in the record more specifically on that.

Mr. ENGLISH. It seems strange to me, given the increases that have been described here that have been taking place in Germany for the past number of years, I guess ever since 1970 or 1971, seeing a steady rise in the availability and use of particularly hard drugs, heroin in particular, in this area. Then we had a situation 3 or 4 years ago where there was a reduction in the number of DEA agents. Here we have a situation where more than 6 months ago there was a request for an additional DEA agent, just one, and still can't get a decision out of the State Department with regard to that and nothing has happened, evidently, so it still has to go through OMB and still has to be cleared all the way through the process. They haven't even arrived at a decision there. Doesn't it seem to you people to be a bit on the urgent side that more action be done, given the problems that we've got here in West Germany, particularly as far as our U.S. military forces are concerned, given the increase in availability? You are talking about a pretty good indicator of both the price and the potency of heroin, and particularly in this area, very cheap, cheaper than it is in the United States. You're talking roughly 10 times the strength of heroin than you've got in the United States. All these indicators seem to me to point to a crisis situation as far as this country is concerned. Quite frankly, I can't understand why recommendations haven't been made to at least bring the level back up to the 13 that were here 3 or 4 years ago. Certainly, I cannot understand State Department, Washington, not being able to make a decision for nearly 9 months just on one person, one slot, and given the situation that Mr. Anderson has outlined here, it seems to me that he has a crisis

situation. He's found that DEA has been extremely helpful. He's found that the successes that have taken place in West Berlin, DEA played a major role. All of these indicators point to the fact that a major move could be made if we had more DEA agents. I would like to hear each of your comments with regard to that, and I also would like to ask you the question: Would you be willing to recommend the increase of DEA agents up to that original 13, including the 1 for West Berlin?

Ms. FALCO. Yes; Mr. Chairman, I agree that the situation here is very critical. I do think that before I endorse a specific number, I should talk to Peter Bensinger with regard to his own perception of how DEA might be most effectively deployed. I personally find bureaucratic delays extremely annoying. I think that the primary reason for this one has been that DEA has been trying to develop its own worldwide plan, and that that process hasn't been completed. But I do think that on Monday, as I said, we'll just take Germany out of the worldwide problem and deal with it directly.

Mr. ENGLISH. Well, would you be willing to at least bring the level back up to what it was 3 or 4 years ago?

Ms. FALCO. Absolutely. We'll go and talk to the MODE people about it on Monday.

Mr. ENGLISH. So you have no problem with it?

Ms. FALCO. None at all, if the Ambassador doesn't.

Ambassador STOESSEL. Well, Mr. Chairman, I certainly want to strongly welcome your interest in this, and if we can move ahead particularly on the agent for West Berlin I think this would be very good, because I personally have been disturbed by the delay in approving that recommendation. As far as the overall level is concerned of agents in West Germany, I think this is something, as Ms. Falco says, that should be considered with DEA to get their appreciation of the appropriate level. As I have mentioned, we have had an increase in coordination efforts with German authorities, German police, training efforts, cooperation, have improved and it may well be that at this time we won't need quite the level we had at one point in the early days before we began this.

Mr. ENGLISH. That's what I would like you to address yourself to, Mr. Ambassador. Given the increases that we have had, and it has been a steady increase, given the fact that obviously the market here is flooded, given the price, given the potency of the drugs, particularly of heroin, what basis would we have for not at least coming up with the same effort that we came up with 3 or 4 years ago? I fail to understand how we could come up with less. In fact, it seems to me that we may need far more than the 13. It seems to me that given the importance to our country, I'm talking about to the security of the United States; namely, with the military that's stationed here, and the number of people that are stationed here, and the very important role that they play, that has got to have some impact on the number of people that we have, the amount of effort that is being put forth by Washington in dealing with it. We can't really expect the military commanders, who are laymen, you know they are not trained to go out and deal with the drug problem. They're trained to provide national defense. We've heard people come before us and tell us, military commanders and commanding officers, they spend 10, 20,

and 30 percent of their time trying to deal with this problem, and obviously that's time that is taken away from training, it's resources taken away from facilities, it affects the whole range and quality of life of every soldier that's here in this country. It's having a tremendous impact, not even to mention, the taxpayers, and the impact it has there. Obviously, we can't expect military people to cope with a drug situation, with the flood of drugs that we've got in this country. That's expecting too much. Frankly, I think they have done extremely well just to keep the lid on this thing. It's extremely explosive, you know, to sit here and say, "Well, we've cut it more than half, 3 or 4 years ago the number of DEA agents that we have over here and the amount of effort", and I think that we can roughly equate effort with the number of people that we've got, you can't always do that, but I don't think we're anywhere near that kind of a problem, it seems to me just unbelievable and unforgivable that we allow this type of a situation to develop. Mr. Anderson, do you have any comments that you would like to make? I should say Mr. Ambassador, would you like to explain how that could come about, how we could justify less of an effort than we had 3 or 4 years ago?

Ambassador STOESSEL. Well, Mr. Chairman, I, of course, was not here at the time, and I don't know what considerations went into that. I would repeat that this is something I think we should look to the DEA for and their appreciation of it. I'm certainly not an expert in how to combat most effectively this very urgent and crisis situation, and I agree with you that it is a terribly serious one. As I have mentioned, I think the level of our cooperation with the German authorities has risen. It may well be that we don't need quite as many as we had at one point, it may be that efforts to stop the flow at the source in supplier countries along the supply routes that maybe more agents are needed there, so I don't think I can make a very informed judgment on the adequate level here. I think it certainly should be looked at very urgently.

Mr. ENGLISH. Would you agree that the situation as it exists here in Germany, given the interest of the United States, and particularly with regard to our national defense, would you agree that the stituation calls for a major effort, for an all-out effort to try to dry up the amount at least of heroin that's available in this country?

Ambassador STOESSEL. I certainly would agree.

Mr. ENGLISH. Mr. Anderson?

Mr. ANDERSON. Mr. Chairman, obviously, I share your concern about the heroin flood in Germany and in Berlin. I also appreciate the support you've expressed, at least on the Berlin aspect, for stationing a full-time man, a DEA man, in the city. As Ms. Falco has said, I do plan to return on the weekend to the States. I will push hard not only on the Berlin aspect but also, with Ambassador Stoessel's permission, for an urgent review of the entire look at the German scene, as far as DEA staffing is concerned.

Mr. ENGLISH. Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman. I want to thank the panel for being so candid in their analysis of the problem. Am I drawing the correct conclusion then, as I look over your testimony and listen, that we all recognize we have a very critical problem, a growing problem, a problem that needs a great deal more attention by our

own Government as well as the West German Government? Am I correct that that's a proper conclusion that this committee can leave this area with the recognition that you're concerned that we have a critical, growing problem that needs a greater amount of effort by our own Government and by the West German Government? Mr. Ambassador, is that a proper conclusion?

Ambassador STOESSEL. Yes; I think that's a very fair summary of the situation. I think certainly we recognize that it is a growing problem, and I think there is a growing awareness on the part of the German Government that this is a problem that they need to do more and I think they have been very responsive. They want to learn, they want to share our experience, and I think the steps which I have mentioned, the formation of this committee, are very important in this effort, and I think we will see more intensive work being done in the future.

Mr. GILMAN. Mr. Anderson, I would assume that you agree with that, and Ms. Falco?

Mr. ANDERSON. I agree.

Mr. GILMAN. I'm concerned about something. We see a growing problem in the European theater, particularly here in West Germany. I've done some research and exploring. I don't find much of a mechanism, maybe there is one that I'm not aware of, in the entire European continent, of a working group at government level. I'm not talking about the law enforcement people. Is there something in place, Ms. Falco, with regard to a cooperative European effort on narcotics at government level not military, and not law enforcement—top level in government?

Ms. FALCO. There is a group known as the Pompedeau group.

Mr. GILMAN. I hear the Pompedeau group hasn't had a meeting in 4 or 5 years, or whatever.

Ms. FALCO. No, sir, they met recently in Stockholm. I think that they are not perhaps the kind of organization you would like to see formed.

Mr. GILMAN. Can you tell us what that Pompedeau group consists of? Who do they represent?

Ms. FALCO. They represent the major European, the Western European nations. They focus primarily, however, on questions of drug prevention, drug abuse prevention, and treatment, and they do not take into their purview the whole supply reduction question. I agree that it would be extremely useful to develop a very strong regional European mechanism for coordination.

Mr. GILMAN. Have we undertaken any initiatives in that direction?

Ms. FALCO. We have begun, yes, sir. I think I referred to it briefly in my prepared statement, to explore whether the OECD might be such a vehicle.

Mr. GILMAN. Who's doing that exploring?

Ms. FALCO. Well, we have been doing it both through our Paris office and through Washington.

Mr. GILMAN. What's the response to that exploration?

Ms. FALCO. So far I would say it's encouraging. It's not terribly enthusiastic, I must tell you, that this is not a traditional—this is by no means an excuse, it's just simply an explanation——

Mr. GILMAN. Has any request been made of the European counsel or the European parliamentarians to form such a group?

Ms. FALCO. Not to my knowledge. Perhaps Ambassador Stoessel knows.

Mr. GILMAN. You think we could be exploring that situation to see if we could get the European parliament involved?

Ms. FALCO. You mean as the various countries. You mean as sort of an interparliamentary group?

Mr. GILMAN. An interparliamentary group on narcotics.

Ms. FALCO. It's certainly something we could explore.

Mr. GILMAN. I would think that we should be doing a lot more than we are doing in trying to organize a coordinated effort on the European continent. When you talk about a Pompedeau group meeting once—when was the prior meeting?

Ms. FALCO. It was sometime within the previous 12 months, Mr Gilman.

Mr. GILMAN. It does not sound like a very active group to me, and from what you are talking about, it seems like they are not much concerned about the trafficking situation.

Ms. FALCO. They're not. That is not something that they were going to take within their purview.

Mr. GILMAN. I would hope that your department would take a look, or try to establish a regional working task force of European government leaders to try to reduce supply on the European continent. I think that that's extremely important. We can't just isolate the problem in West Germany. We saw all of the open facets here and every time you plug up one hole here, you find 20 others available, and I'm certain that a cooperative effort could be helpful. I would like to see us take some initiative in that direction. I would hope that maybe as you return next week, along with Mr. Anderson, maybe you could make that approach to someone. I'm pleased that you raised the UNFDAC problem in your testimony and as you know, we've been trying to encourage other nations to take part. Have you discussed this problem personally with some of the West German people besides our own meeting that we held yesterday with Mr. Schueler?

Ms. FALCO. Yes, sir. This is an ongoing concern. I think that really the contribution level from a number of major industrialized countries, including Germany, has been very disappointing. As you know, this is an increasing concern to your Senate colleagues who have specifically restricted our contribution to UNFDAC because of the poor performance of the European nations specifically.

Mr. GILMAN. I'm hoping that as a result of our meeting with Mr. Schueler and your continued efforts that you would have West Germany take a more active role in this problem. I think it certainly is something that is important and it would be an indication of Germany's commitment to the international effort in this direction. I would like to ask the Ambassador, I noticed that we have an embassy task force on narcotics and now we are going to have a new working group, which sounds encouraging. Since you've been in your office here in Germany, Mr. Ambassador, has any overall planning or master strategy plan been presented to you for your consideration with regard to how to tackle the narcotics problem in Germany?

Have you seen any master plan, has any plan or overall strategy been developed?

Ambassador STOESSEL. Mr. Gilman, I would have to say no; I have not seen an overall plan.

Mr. GILMAN. Has there been any talk or suggestion about establishing such an overall plan? I too frequently find we have a knee-jerk reaction to crisis problems without some overall planning, and I'm wondering if anyone is sitting down and taking a good, hard look at an overall narcotics strategy for this area.

Ambassador STOESSEL. Well, my understanding would be that the central working group that will be formed will be dealing exactly with that, and I think it was in recognition of the need for an overall coordinated plan, that it was decided to have the formal agreement between the United States and West Germany, which we signed in June, and out of which has grown this central working group. I would hope that we will be able to focus on just that sort of an overall strategy.

Mr. GILMAN. I hope we are not just forming another committee and doing another study. I see groups here and committees and studies and I am concerned that we just are doing a lot of wheel-spinning, and I hope that this is going to be a serious effort to develop an overall strategy. It would seem to me that with the growing crisis, that certainly an overall strategy would be quite important at this stage, and I hope that someone in charge will make certain that we lay out and map out some long-range planning and not just try to do some more of the emergency reaction and knee-jerk reaction to try to plug a hole here and there.

Ambassador STOESSEL. I agree, and that would certainly be my intention to push for that sort of an overall strategy, which you mentioned.

Mr. GILMAN. Mr. Anderson, I know that up there in the Berlin area you've got a problem of trying to deal with all of the traffic that goes in and out of Berlin. I guess the same problem applies to the rest of Germany, and I certainly welcome any recommendations that you may be able to make, either to this committee, to the working groups, or to the overall effort, in some way of interdicting the trafficking that comes in and out of Germany. Apparently, there is very little that is being done in that direction except an occasional task force effort. I know how difficult the problem is with the extensiveness of the trafficking, but if you come up with some sort of an interdiction effort that could help to deter the excessive amount of trafficking, I certainly think it would be beneficial and I would welcome any thoughts you might have.

Mr. ANDERSON. Mr. Gilman, I think I will have a very active representation on the Bonn working group. We will be looking at ways to help in the interdiction phase, we will be increasing, and we are already increasing the cooperation between the police and the customs in Berlin. As you say, it's a tough problem. We've spent over 25 years trying to open up West Berlin and its various access ways through the West. We succeeded now, and I think we have to move carefully backwards. I agree that with the problem that if we are going to interdict and we are going to stop a certain high percentage

of the stuff that is coming in, I'm not optimistic that we are going to stop all of it, but at least increase the percentage that we know are stopping. We are going to have to move toward, I would say, more intensive spot checks, use of profiles, dogs, and the rest.

Mr. GILMAN. As we talked with some of the ministers yesterday in West German Government, I was very much concerned that some of them felt that they had a grip on the drug problem, that they felt it was something that they had in control, that it was not a problem that was accelerating. I know that you gathered together quite a bit of statistical data, and I would hope that that information would be fully circulated to the West German Government. Perhaps this working group with the West German Government may be the vehicle for doing that. I think Mr. Schueler indicated to us that he certainly would welcome having any further information that we might have that they do not have. For example, they rely on the 36,000 drug addiction statistic; they say there are 36,000 addicts and this has not risen in the past few years. Well, under closer examination, we find that that figure is based upon arrests, convictions, people who have volunteered and come forward and placed their names in treatment facilities. This does not include the vast number who may be out there who are addicted and utilizing the narcotics and, of course, it's only the tip of the iceberg. I would hope that maybe you could further explore with them the statistical information that you have that indicates that there is a critical problem, a growing problem, and a problem that we can't just safely sit back and say, "Yes, we have it under control because the number of addicts that we have recorded is not risen in the past few years." There has to be, to my mind, a greater focus of attention on increasing the public consciousness of the problem and the governmental consciousness of the problem. We have the same problem back in the States, and I would hope that maybe you could focus some attention on that problem here.

Ambassador STOESSEL. We will be doing that, Mr. Gilman. I think there is certainly a difference in appreciation of the problem among various ministries in the West German Government, and we have been concerned about this. I think the central working group will help focus on this, and enhance a better understanding of the overall problem, and I certainly think that the visit of the committee yesterday in Bonn and their talks with the various representatives, and particularly with Mr. Schueler, should help greatly in this direction.

Mr. GILMAN. Thank you, Mr. Ambassador, and I thank the panel. Thank you, Mr. Chairman.

Mr. ENGLISH. Mrs. Collins?

Mrs. COLLINS. Mr. Ambassador, it is my understanding that the DEA can operate here only under your direction, so to speak; is that correct?

Ambassador STOESSEL. Yes, in the sense that I am the representative of our Government here in the Federal Republic, and all of the civilian employees of the Government are under my general direction.

Mrs. COLLINS. Would you tell me then what you perceive to be the role of the DEA here in this area.

Ambassador STOESSEL. Well, I think they certainly should be representing the U.S. Government, their own agency, in fulfilling the policies of the United States in attempting to combat the trafficking

and illicit use of drugs. They have as an important part of their mission, working with German authorities, opposite numbers police authorities, authorities in the various states of the Federal Republic in trying to combat in every possible way the drug problem.

Mrs. COLLINS. Would you like to see an expansion or any kind of modification of their efforts here, their role?

Ambassador STOESSEL. Well, as we've said, I would like to see certainly the assignment of a permanent DEA agent in West Berlin. I think that is an urgent question. Whether more are needed in the Federal Republic itself, I would like to reserve a judgment on and look to DEA itself for their own evaluation of what their needs would be.

Mrs. COLLINS. I was impressed with your statement of the number of actions that you have taken to get further cooperation with the German political officials, and so forth. I just can't help but have the feeling that even though everybody I talked to recently, this morning, or some of the testimony that I've heard, seems to feel that the Germans are very much aware of the problem, so forth, and that they are becoming increasingly so. Do you feel that they have become aware of the problem to the extent that you would like to have them so that you can get a greater commitment from them for help in our mutual problem here?

Ambassador STOESSEL. Well, I would like to see more awareness overall in West Germany, politically, and on the part of the authorities directly concerned. I think there has been a growing awareness of the problem, the problem particularly as it regards the hard drugs and the heroin is a relatively recent one in Germany, and I think in the past few years they have become more aware of this great problem, more responsive to suggestions for how to combat it, but I think there is certainly room for improvement.

Mrs. COLLINS. Do you think the level of their commitment to helping to diminish the problem equals their awareness?

Ambassador STOESSEL. I'm sorry, Mrs. Collins.

Mrs. COLLINS. Do you think that they are doing everything that they possibly can at this time, from your point of view, to help diminish the problem?

Ambassador STOESSEL. Well, I'm sure that there is room for improvement there too. I think perhaps more resources could be devoted by the German Government to this effort.

Mrs. COLLINS. Thank you very much, Mr. Chairman.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman. Mr. Gilman mentioned an overall policy that he felt should be established and developed, and I think that's true, but I think that if we have the same kind of problems that have been evidenced by the testimony so far with the State Department, OMB, and others in the decisionmaking position, that an overall policy will not serve any useful purpose. I'm concerned about the fact that it often seems that the policies and the needs of the State Department conflict with the needs for narcotic suppression, and examples are a situation we found in Burma. There was a very late development in the obtaining of a DEA agent in Burma, and part of the information we got in Washington from the State Department, Ms. Falco, was that, you know, we have information in Burma, you

know, we are pretty well advised about what's going on, we are not sure that we need the DEA agent, and now we see that it's been almost a year since Mr. Anderson has made clear the need for a DEA agent in Berlin. There must be some way that we can, and you have already stated, that you intend to pull out the request Monday, I believe, on this situation, but there must be some way that we can speed up through the bureaucratic process these urgent needs. I would like to ask the Ambassador about the supply drugs here with the continued testimony that the West German Government is aware of the problem, and I believe you said there was room for improvement, but that they are doing a great deal. How do you explain when we have maybe 4 or 5 percent purity of heroin in our major cities in the United States and much less purity in hashish and other nonhard drugs, the ready supply, and the cheap price, and the high purity here, if everybody is so aware of what's going on and doing everything they can? Can you offer any suggestions?

Ambassador STOESSEL. Mr. Evans, I think it is probably a reflection of the access availability in the Federal Republic, the borders are pretty open here. Germany, just by geographic location, is a transit point. The drugs come in from countries which are not that far away, and I think that these are factors probably which contribute to the problem you described.

Mr. EVANS. Well, of course, we heard the figure of 800 million people traveling through Germany each year, in and out, and, of course, we certainly understand the need for open access, and we understand what Mr. Anderson said that for years the attempt to open Europe, and the attempts to put the Common Market together, but is there anything that we can really do, or are we going to be continually faced with this kind of supply and this kind of purity? Are we in a situation that we can't do anything about in terms of present day situation, with the emphasis on the economy and on the free trade and free access.

Ambassador STOESSEL. Well, I would say it certainly is a difficult problem, and it's going to be a very difficult one to solve. I don't like to be discouraged about anything, and I think improvement certainly can be made, and I would expect that they will be made. We probably realistically cannot hope to stop the flow entirely, but we certainly can reduce it and I think there are ways we can approach that.

Mr. EVANS. OK, along that line, could you suggest some ways that you feel that the U.S. people here, along in conjunction with the German Government, West German Government, will be able to reduce the flow? And, I might cite in connection with that, the fact that Mexico is right next to the United States, and yet we've been able to reduce the purity of heroin within this 4- to 6-percent range, so apparently, the proximity of the source country is not the problem. If something could be done of this nature, maybe the accessibility is, I don't know. What are some of the ways that you think that we will be moving in to reduce this purity?

Ambassador STOESSEL. Well, I would think that a sharing of our own experience, just for example, with Mexico, what we've been able to accomplish there and how we've been able to do it, if we can share that with the Germans, perhaps there are lessons that can be applied

to the situation here. I would think that a difference in the situation is the accessibility of Germany. We have so many roads coming in, major highways with thousands of trucks a day, the sheer physical problem of checking all of those trucks is obviously a difficult one, but there are probably ways that can be devised, at least on a spot basis, to improve the checks.

Mr. EVANS. Let me ask you in that connection, I don't mean to interrupt you, but I want to find out, how many of these roads are coming from source countries? Now, the Netherlands, France, and the other nations such as this are not growing poppies, as I understand it, so we are talking primarily of one or two places that you would be—I don't mean one or two roads—I mean one or two countries that we would be getting drugs in from. I know that through Southeast Asia they may come in through the Netherlands or France or some other country.

Ambassador STOESSEL. Yes; well, they do come in that way, I think trucks coming up from the Balkans, into the southern part of Germany, trucks going up to Berlin, of course, airplane travel, too, is wide open, so just the sheer amount of travel by persons, by trucks, is very large. As I say, I think there are things which certainly could be done to include the checking process at the border. I would hope that more could be done in terms of checking at the source, or at least the country from which the refined product proceeds. I would hope that more could be done in that area.

Mr. EVANS. At what stage are we in the discussions with the German Government about these things? I know that you have not been here a long time, and I am wondering if this is a priority item.

Ambassador STOESSEL. Well it is. We have had continuing consultations with the Germans about a variety of problems, and there has been a lack of an overall plan, and I would hope that through this working group which we've set up, as a result of our agreement in June, that we'll be able to have a more intensive consultation on just this type of problem.

Mr. EVANS. I believe Mr. Anderson had a comment?

Mr. ANDERSON. Mr. Evans, sitting in Berlin, you sort of have the worm's-eye-view, because we're sort of at the end of the supply train, and while I, like the Ambassador, don't become discouraged easily, it does cause one sometimes to throw up one's hands when you try to think of trying to stem the flow of what is obviously a large amount of drugs into the city. I think all of us who have looked to the problem at all in a hard fashion in the city, have concluded that far and away the best effort has to be made at the source. We've talked a bit about the Afghan-Pakistan-Turkish route, and looked at it from a narrow angle of Berlin, it seemed to us that the best controls, if it can be controlled, let's say, where the stuff is grown, the best controls have to come at the point where it begins actual shipment. This is where I think I would like to see the focus, the American focus, the German focus, and I think picking up on Congressman Gilman's point, I think it has to be almost a European-wide focus, because treating it as simply a German-American problem, or a Berlin angle to it, I'm just not sure that's going to be sufficient.

Mr. EVANS. Mr. Anderson, do you think Europe has really addressed this problem, or addressed the magnitude of the problem? For instance,

in Thailand, of course now we do have some other countries represented, but we understand that the primary emphasis is by the Americans with the host country, or with the supply country, and we wonder what can be done to bring the magnitude of this problem home to the governments so that they will take their share of the responsibility and load and work with the supply countries to stem the flow that you suggest. Is there anything we can do?

Mr. ANDERSON. Mr. Evans, I'm speaking as a true layman in this field, I suspect there is something one can do. I'm convinced Americans are fairly ingenious at coming up with institutions. Ms. Falco has mentioned the OECD. I'm not sure that that's the ideal way to go in this. It may be, I just don't know. Perhaps some form of USEC cooperation, perhaps something through the IPU. I don't know. I'm fairly sure that if one looked at the problem hard enough, that he could come up with some sort of an answer.

Mr. EVANS. Well, let me ask this and then I'll give the opportunity to respond to, Ms. Falco. I think that a sign of a commitment, and, of course, we all know what state the American economy is in relative to Western European nations, Japan, and other countries, and yet we continue to see the majority of the money and the resources put into the drug effort from Americans. Now, that to me says that the other people don't realize the magnitude of the problem, or they haven't begun to be willing to address it with money and resources, and that's the sign of commitment, and that's what it takes to get the job done, Ms. Falco.

Ms. FALCO. I agree completely, Mr. Evans. My point was simply that I think we are at the hardest part of the whole process, and that is trying to increase the recognition and the acceptance of responsibility by European governments. We met in October in Madrid, all of the embassy personnel and DEA agents involved in drug abuse control efforts in Europe. Under Secretary Newsom flew all night to address that meeting to stress his own personal commitment and the commitment of the whole State Department to making this an important priority in Europe. I must tell you that the scene is not encouraging at this point. I think it will be a long hard process. You, yourselves, here in Germany where the problem is really in a very acute stage, really more actively a problem than it is in other parts of Europe, although all of Europe is experiencing heroin. I think that it just takes a lot of consistent pressure to get them to recognize the problem. I think once the problem is recognized, deciding how to work together to deal with it is relatively easier. One of the things, for example, that I would like very much to see develop as a result of these hearings is the increased focus, both within our own mission here and perhaps in our dealings with the Germans, on the kinds of approaches that can be made toward the primary producing countries. You mentioned Thailand, I am told that 6, 8 years ago in Thailand most people thought it was hopeless to get the Government to do anything and it took years and years of just consistent raising of the issue to get them to focus. The Mexican situation, where we have had a good deal of success, that again was the result of a long, hard process of getting them to recognize the problem and then to take responsibility. Fortunately, I think that there is in the last 2 years a real movement toward in-

creased recognition. Unfortunately, because there are a lot of people dying from heroin overdose all over the world.

Mr. EVANS. Well, one thing that differentiates some of the countries that you have mentioned from the European countries, and the fact that we put a lot of resources into these countries, and that was one way of putting pressure, but here we are dealing with countries that are as well off or better off financially than we are, and we no longer can put the kind of resources that we have put in the past into this problem with countries who are more able to do so than we are. So how do we get the point across? How do we convince the countries in Europe that there is a serious problem that must be addressed with resources, substantial resources, manpower, and everything else at our disposal?

Ambassador STOESSEL. Mr. Evans, I would add to what has been said so far that, as I said before, I think there is a growing awareness here in Germany. It is a relatively new problem, and I recall in our own country when it was new, it was difficult to get the program off the ground, and I think we are in somewhat of that situation here, although I'm encouraged by the responsiveness I find in the German officials with whom I talk, and just outside of Germany in the European area, I'm certainly no expert on all this, but I recall in France there was a great problem, the French connection, and I think that great strides were made by our own Government and by the French Government in controlling that situation. I think the Netherlands also has been very seriously concerned about their own acute problem, so I think there have been successes in the past, I think there is a need for a more coordinated effort, and I think it would be a very good project for Europe as a whole to work on, and I hope will go in that direction.

Mr. EVANS. One last comment. With, of course, our military here, and the daily access to drugs that our young soldiers have, and the age of these people, there is a greater urgency in my mind here than maybe there was in the other countries. There we were just trying to stop the flow of drugs, and we are dealing with countries with people who have tremendous ability who have the resources to solve these problems, so I would hope that we can move forward at a faster pace than what we have seen in our own country and what we've seen in some other countries in getting this problem addressed. Thank you, Mr. Chairman.

Mr. ENGLISH. Thank you, Mr. Evans. Ms. Falco, you have quite a bit of experience and expertise in the drug area, and knowledge of the field. Given the situation here, namely, the availability, high availability, cheap price, in your opinion, until that availability is substantially reduced, do you think that we can really expect the military to have much success in reducing the amount of use among servicemen?

Ms. FALCO. Mr. Chairman, based on the experience in the United States, I would say no. As you know, heroin purity in the United States was up as high as 8 to 10 percent about 8 years ago. That I know is only a third of what pertains here, but to us it seemed extremely high. Overdose deaths were over double what they are now. The number of addicts were as high as 800,000 in the United States. It wasn't until the last 2 years that we began to feel the impact of the Mexican opium eradication program, and the enforcement efforts

along the border that the availability came down dramatically, both in absolute amounts and in purity. Also, the numbers of addicts has gone down in our own country. The latest figures show somewhere between 420,000 to 450,000 people are addicted to heroin. Still largely in the major cities. That's not to say that we by any means solved the problem, but it is such a huge improvement over what existed. Now all of those in the United States who were responsible for various aspects of drug abuse control concur that supply is the critical factor, particularly, when it is so difficult to reduce demand in the face of a continuing ready availability of high purity drugs.

Mr. ENGLISH. So you would concur that we've really placed our military in an impossible situation until that supply is reduced.

Ms. FALCO. Well, I think any population is at very high risk when these drugs are available at low prices. I mean, that's true everywhere in the world.

Mr. ENGLISH. So military is not any different than civilians or anyone else.

Ms. FALCO. Not to my knowledge, sir.

Mr. ENGLISH. Would you also agree that given the fact that military commanders are amateurs in dealing with this problem of drug abuse, I mean they are not skilled professionals as far as knowing the treatment of people who are using drugs and all the ramifications that are dealing with this. It seems to me in the observations I've made numerous times that military commanders over here have done an amazingly good job keeping the lid on this thing, considering the amount of availability; would you agree with that?

Ms. FALCO. To the best of my knowledge, Mr. Chairman. I know that the military has tried very hard.

Mr. ENGLISH. Getting back to this resources of various governments that are involved. We got the impression, at least I got the impression I should say, yesterday in our discussions, that there is a very serious question with regard to whether or not the West German Government recognizes the seriousness of the threat that is facing their people, the German people themselves, and so much of the impression that I got seemed very similar to impressions I got 10 years ago, and it seemed to be an almost identical paralleling to response, reaction, to the various pieces of information that came in, that is dependent upon the various figures which I think our own country, I think the military and everyone else, finds it tends to be misleading and gives one a sense of security when it is not called for. Would you agree that probably the two single factors that the Government could do, the West German Government, is perhaps take a much deeper look at the way the availability, the supply, is affecting the West German people? And No. 2, perhaps take a much harder look at the experiences that the United States went through, the types of things that we were looking at 10 years ago, which turned out to be false, the lack of coordination among Government agencies which lead to the splintering effect, as far as effort is concerned, the lack of resources, the lack of recognition, by elected officials, the lack of understanding by the American people of the seriousness of the problem. Were all my impressions correct? You people are the professionals, and certainly in dealing with other governments. Were my perceptions correct as far as what you found? Mr. Ambassador, I'll let you answer.

Ambassador STOESSEL. Yes; I would agree, Mr. Chairman. I think, as I said earlier, there is certainly a difference of appreciation among German ministries about the problem, German officials concerned with it, and I think there is a need for more awareness of the overall problems. It is strictly a question of availability, and they have a lot to learn in this field. I think they recognize that, and we have a lot of experience to share with them.

Mr. ENGLISH. Unfortunately. Ms. Falco, would you care to comment?

Ms. FALCO. Just to say that I think that in your visit yesterday you all made those points very clearly to the German officials, and I'm sure that those thoughts will have a lasting impact on them. I was struck by the wide variation in perception among the officials that we spoke to. Again, a situation reminiscent of our own country's experience 10 years ago when some parts of our Government said "Oh, no, there is no problem," and other parts said, "We are in the middle of a crisis."

Mr. ENGLISH. Mr. Anderson, would you care to comment?

Mr. ANDERSON. No, Mr. Chairman, I was pondering, as you were posing the question whether it really applied 100 percent to Berlin, and I think I would like to say that I don't think it did entirely. I think the West Berlin leadership probably has awakened to the problem a little bit earlier than the Federal authorities in Bonn simply because the problem grew larger, the overdose deaths were higher in West Berlin much faster than they were in the other parts of West Germany. I think we've awakened. I think the U.S. authorities and the Berlin authorities have awakened a bit earlier. I would like to think we're maybe a little bit further along than the Federal German authorities. There is a long way to go, as I said.

Mr. ENGLISH. Would you all agree that given the indicator that we've seen, given our past experiences in this problem, that the West German Government has reached the point where they are in danger of perhaps finding themselves in a position that where they will never really be able to catch up or not for a long period of time? In other words, where the situation is out of control. I know in our country, in looking back, when once the recognition came, it was too late. The problem was too great, and given the vast amount of resources that we put into that problem in trying to deal with it, we find it very difficult to make any strides and to actually reduce the problem. I think this year is probably the first time, as a result of the eradication program, that we've really seen a reduction, and being able to see some advancement on this case. Would you say in your opinion that the West German Government has reached that level, if they don't act quickly, if they don't deal with this thing quickly, they are going to find themselves in the same position that we did? Namely, they are playing catchup. They are trying to contain and with all our resources going to the containment with no resources left to actually be able to reduce? Mr. Ambassador would you agree?

Ambassador STOESSEL. Yes; I would agree with that, and as I understand too, the question of availability in the furure could become even worse than it is now, and it's already at a crisis stage.

Mr. ENGLISH. Ms. Falco?

Ms. FALCO. Oh, yes, sir. The production situation in Afghanistan and Pakistan indicates that the supplies will become even more easily

available in this part of the world. It's going up geometrically. I think it is at a very critical point.

Mr. ENGLISH. Mr. Anderson?

Mr. ANDERSON. I would agree, sir.

Mr. ENGLISH. I believe my time is expired, Mr. Gilman?

Mr. GILMAN. No further questions, Mr. Chairman.

Mr. ENGLISH. Mrs Collins?

Mrs. COLLINS. I have no further questions, Mr. Chairman, but I was very pleased to have the opportunity to listen to the line of questioning that my colleague, Mr. Evans, pursued, and particularly his points I think should be underscored about the fact about our resources and about the shortness of time that we have to deal with the question here. I think that this really summarizes what I was thinking as well. I'm glad those parts were made, and I hope that they were received. Thank you.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. I would just like to make one interesting observation that I found, and maybe we can all wonder why, but the countries, especially Afghanistan and Pakistan, I understand that these people don't use the drugs that they sell, and it makes one wonder what's wrong with our society that a place where they're readily available, the nationals don't use it. So maybe, we failed in a number of ways. Thank you, Mr. Chairman.

Mr. ENGLISH. Thank you, Mr. Evans. In conclusion, I would like to say that we deeply appreciated the hospitality of USAREUR, the cooperation that USAREUR has given us, it's been extremely extraordinary. I think it should be underscored that the military units that we visited in many cases were not the best in Europe, as far as this problem is concerned, and the decision as to which units we visited was left up to the military. I think that they were candid and honest enough with us that they made certain that we got to see some of the units that were facing great problems, as well as those that were having success and were not facing near the trouble. We certainly want to thank the State Department for the hospitality that it has shown us. It has assisted us greatly, and we hope that we have assisted it with the various governments that are involved. Of course, we certainly want to thank the German people. They have shown a tremendous amount of hospitality toward us, and we've, I think, made new friends. This is the first time that I've ever been to Europe, and while I did not have the opportunity to see the sights, so to speak, I do feel that I did begin learning and knowing people from other lands, and that is always a very rewarding experience.

The opening statement I made with regard to the hearings, I attempted to place this problem in perspective, and I would like to go over a couple or three of those points again. The first thing I think that we all must remember is that the military is part of our society. It draws its resources from our society. The values that our society holds, and particularly the values of our young people, will be brought into the military. The fact that we all recognize is that in many parts of our society, drugs to one degree or another have reached some level of acceptance, and certainly this value is one that is contributing greatly to the problems of drug abuse in the military. I think that it also should be pointed out that those who have the responsibility of

command within the military, have been severely handicapped in a number of ways. There is no one or two easy answers to this problem. There is no one or two tools that we can give the military that will eliminate this problem. There are a number of things that we can do, a number of areas that we must address, but one fact is for certain, we cannot expect the military command to continue to keep a lid on this situation unless we provide those additional tools. As far as our host government again, we have great concern for the German people as well as our own soldiers and citizens living in this country. We feel deep concern with regard to the understanding that the German Government has for this serious menace. The continuation of high availability within Germany will raise some very serious questions. Obviously, the American people must ask themselves if they are willing to continue to place their young women and men in places where such high availability is proven.

Overall, one thing is for certain, that is the question of drug abuse and the threat that it holds for society, will not be solved by this committee alone or by this Government alone, nor by the American and German Governments alone, but instead will take the cooperations of all governments and all peoples throughout the world. I think that we can assure the State Department, we can assure the Army, and we can assure all persons who are interested that this committee will make every effort to attempt to address itself to these problems and to come up with proposals and recommendations that we think will provide assistance. I'm hopeful that at some time in the future that there will no longer be a need for Select Committee on Narcotics Abuse and Control, but given the testimony that we've heard, and the people that we visited with over the past few days, I do not believe that we will see the elimination of the need for this committee any time in the near future. Thank you very much. Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman. I want to first express my appreciation, and I know my colleagues join with me, to our military staffs for their cooperation in assisting this committee's investigation into drug abuse among our soldiers stationed here in West Germany and for their frank participation in our hearings. I also would like to thank the Department of State, our good Ambassador and his staffs for their assistance in the work of our committee. The staff of our narcotics select committee is to be highly commended for the extensive work that they engaged in, in preparing for these hearings.

Bearing in mind that some of our witnesses touched upon some very sensitive matters, I would hope, as our chairman has expressed, that there would be no penalties imposed upon such witnesses, and Mr. Chairman, I request that any action of that nature should be fully investigated by our committee and brought to the attention of the command. I have found that these hearings and our investigations in the field have been extremely helpful in assessing and evaluating the narcotics problem among our soldiers who are stationed in West Germany. Our Select Committee's field study, our conferences with the officers, the enlisted personnel, our meetings with drug enforcement agents, officials of the West German Government, and our State De-

partment, have provided us with a broad background for evaluating this complex issue. Certainly not the purpose of this committee, as you stated, Mr. Chairman, on many occasions, to point a finger or place the blame on any department, branch of service, or individual. Rather, it is our objective to try to help resolve this critical problem that has so affected all of our military personnel.

Narcotics abuse here, as in other parts of the world, is an infectious disease. It reaches out and infects the entire community as a narcotic addict seeks to sustain his drug dependency. In order to cure any illness, though, there must first be a recognition and a proper diagnosis of the illness. What has been most disturbing in this study mission is, to my mind, the lack of recognition by some of our military leaders and governmental leaders that this infectious disease has reached epidemic proportions among our soldiers stationed in West Germany. It's distressing to me that there is such a wide gap between the assessment of the drug problem by our military leadership and the perception of the problem by our enlisted personnel. It's distressing, too, that while these drug problems have been known to our military leadership for at least 2 years, most of their recommendations to diminish and correct the drug problem have not been implemented. It's distressing, too, that some of our military leaders and West German governmental officials are couching their complacency in convenienced statistics that are challenged by the soldiers in the barracks, by civilians in the street, and by this committee's interviews with soldiers in the field.

I would hope that the transcript of this hearing will be carefully reviewed by the military command, by USAREUR, by our Secretaries of State and Defense, by the Administrator of the Drug Enforcement Administration, for there is much work to be done by all of these agencies. Although the military administration in this theater cannot and should not be blamed for the abundant availability of narcotics throughout West Germany, certainly our military leaders can take steps to effectively curtail narcotics trafficking in the barracks and on military posts. Military leadership cannot and should not be blamed for the economic situation in West Germany which helps exacerbate the narcotics abuse limiting the soldiers' access and participation in community activities. The military leadership, however, can take steps to help alleviate the burden by undertaking initiatives to improve living quarters, to improve the quality of life in the barracks, to expand and improve recreational activities of our military personnel. Although our military leadership should not and cannot be blamed for those soldiers who elect to become dependent upon hard drugs, that same leadership can and should help provide skilled professional counseling and rehabilitation for those young men and women who have become victims of the environment that is inundated with the illness of drugs. Our military leadership owes them and their families a responsibility to help treat and rehabilitate their illness. With these thoughts in mind, Mr. Chairman, I would like to make the following recommendations: The Secretary of Defense should promptly approve the recommendations of General Haig, commander of the European command; General Blanchard, commander of the United States Army in Europe, concerning the reduction of the unduly long tour of duty of military personnel assigned to West Germany, a recommendation that we've

been informed has been lingering for at least a year or more in the Pentagon. Second, there should be assigned to USAREUR, sufficient officers trained in human resources and social sciences to help plan, implement, and administer a long-range program to combat narcotics trafficking in West Germany and to help treat and rehabilitate those soldiers who become dependent upon illicit drugs.

These specialists are sorely needed to help provide long-range planning and to implement such plans. We found in too many instances that the recommendations of the military command are not trickling down the chain of command to the barracks. Such specialists would help in that implementation. Third, the Government of West Germany can and should provide greater support for it's law enforcement officials by placing a higher priority on drug abuse and trafficking and help to raise the public consciousness regarding this complex problem. Fourth, our drug law enforcement personnel in West Germany should be expanded. Fifth, the morale of our troops can be improved in the following manner: (*a*) Improve the living facilities to alleviate overcrowding in the barracks—structural repairs in the barracks of such basic necessities of heat, hot water, electricity, and plumbing are urgently needed throughout the command; (*b*) expand the recreational activities and provide more recreational equipment and facilities; (*c*) better planning and supervision of the soldier's time; and lastly, in that category, foreign language training prior to the assignment to West Germany would certainly help reduce the cultural shock for our young soldiers and make the community more available to them. Fifth, with regard to treatment and rehabilitation, our CDAAC needs professional support and supervision, needs more professional training of its personnel, needs to expand the inpatient drug care facilities that presently exist in the 5 hospitals and only have available some 150 beds throughout West Germany. Should also provide drug counseling training for first-line supervisors for our NCO's. And where there has been not prior drug involvement in the service, the hard drug addict should be referred to in-care hospital rehabilitation units, and at recruitment level, it certainly is evident that better screening is needed to weed out the narcotics abuser. Mr. Chairman, it is hoped that these hearings and our preliminary recommendations will help not only our Nation, but West Germany resolve the complex drug problem that is not only adverse in affecting the health of the citizens of both of our nations, but is also seriously eroding our military commitment. Thank you, Mr. Chairman.

Mr. ENGLISH. Thank you, very much, Mr. Gilman. Mrs. Collins?

Mrs. COLLINS. Mr. Chairman, I have no closing statement. I feel that both sides of the aisle have spoken. I certainly associate myself with the remarks that have been made, and particularly with the six-point program that Mr. Gilman has pointed out.

Mr. ENGLISH. Mr. Evans?

Mr. EVANS. I think that the points have been adequately considered, Mr. Chairman, and adequately expressed.

Mr. ENGLISH. With no further comments, this hearing is adjourned until subject to call of the chairman.

[The committee adjourned at 11:10 a.m., November 22, 1978.]

PREPARED STATEMENT OF HON. WALTER J. STOESSEL, JR., AMBASSADOR OF THE UNITED STATES OF AMERICA TO THE FEDERAL REPUBLIC OF GERMANY

Mr. Chairman, I am grateful for the opportunity to be with you today.

I thought it would be most useful for the Committee if I were to give you a very general overview of our relations with the Federal Republic of Germany, and to put into this context joint West German-U.S. efforts to combat the problem of illicit drug trafficking and abuse.

The United States and Germany have shared many common interests and common problems for more than three decades. In recent years, our efforts in international affairs and our fate as nations have converged even more. We share a pervasive pattern of cooperation and responsibility that is virtually world-wide. This pattern includes working together in the troubled areas of the world, such as Southern Africa and the Middle East. It includes our joint efforts in development aid and economic stabilization. And it includes our work and our consultations together on strategic matters, and in the field of arms control and disarmament. Obviously, it also includes our efforts in NATO and in the realm of East-West relations. In short, there are few conceptual areas where Washington and Bonn do not depend on each other's efforts and advice.

Of course, we have problems: between two large and powerful sovereign nations it is not surprising that there should arise occasional differences of opinion. The test of relations between nations is not, however, the absence of problems, but the spirit in which we deal with them and the resolve which we display to find solutions in a constructive and positive manner. The United States and Germany deal with problems in just this spirit. We are not only Allies—we are friends and partners. We know we can rely on each other, and we know that the friendship, the common interests and the mutual understanding which characterize our relations ensure that our partnership will endure and prosper.

As it has been in our other relations, so has it been in the field of illicit narcotics. U.S.-West German cooperation in the battle against drug trafficking and abuse has grown apace with the seriousness of the problem in this country. Prior to the late 1960's, West Germany's problem was small and stable, and German-American efforts in the field of narcotics were carried on here through liaison between our military law enforcement personnel and German federal and Land police, and internationally through our normal customs, INTERPOL, health and technical exchanges.

Shortly before the onset of the 1970's, the indicators of abuse and trafficking began an upsurge in the Federal Republic, which has continued to the present day. With this upsurge began the intensification of our bilateral cooperation in this field.

The first Drug Enforcement Administration agents were assigned to Frankfurt in September, 1970, when the growth in the West German narcotics problem had begun to become apparent, and when there appeared evidence that the raw materials for heroin were transiting The Federal Republic to laboratories in France. DEA's mission had several facets, and that mission, with some changes in emphasis, has continued to this day.

This mission included offering the West Germans the benefit of DEA's experience in combating illicit drugs, and cooperating with German authorities in exchanging intelligence, and developing the intelligence programs necessary to combat international trafficking in drugs. The Embassy role in these DEA efforts was, and is, to provide support, and to integrate these enforcement efforts within the foreign policy aspects of international narcotics problems.

In 1972, my predecessor, Ambassador Hillenbrand, established a special Embassy Task Force on Narcotics. This Task Force, made up of officers from DEA, Customs, the Department of State and the military services, has been charged with coordinating the Embassy's anti-drug efforts and our cooperation with the West Germans, as well as keeping the Ambassador informed about the narcotics problem in this country. The responsibilities of the Task Force, which has continued existence to this day, will soon be assumed by a Central Working Group I shall describe later.

In the decade since the onset of the Federal Republic's narcotics problem, cooperation between our countries in virtually all aspects of the struggle against drugs has greatly expanded.

Land and Federal police have developed close day-to-day working relationships with our DEA and military law enforcement agents. Our DEA agents, located in Hamburg, Frankfurt, Munich and Wiesbaden and our Narcotics

Attaché in Bonn are closely involved with virtually every significant drug suppression effort in the Federal Republic of Germany.

West German police have received DEA-sponsored training in the U.S. and in the Federal Republic involving all aspects of narcotics law enforcement. This training has ranged from Basic enforcement to special training for instructors to executive observation programs for officers at the highest level.

In 1973, DEA and the German Federal Police recognized the need for a centralized narcotics enforcement effort in the Federal Republic, and founded the Permanent Working Group (PWG) on narcotics. The Group is composed of officers from Federal and *Land* Police, and the customs and border protection services, along with the Embassy Narcotics and Customs Attachés and representatives of U.S. military agencies here. Austria, Switzerland, France, Luxembourg, Belgium and the Netherlands have since joined the group with permanent representation.

This Group constitutes a clearinghouse for the collection and evaluation of all relevant information on narcotics offenses, particularly illegal trafficking. It establishes enforcement priorities, and allows a continuing exchange of experience among the participating services.

Also in 1973, the U.S. and the Federal Republic concluded an agreement providing for mutual assistance between our Customs Services. The agreement specifically provides that each Service will help the other "for the purpose of prevention, investigation and repression of narcotic smuggling". This assistance may be nothing more than the timely provision of information necessary for an investigation. But it may also include special customs surveillances, verifications, inspections and fact-finding inquiries.

Of course, we recognize that cooperation in the enforcement area, important as it is, can only form part of our response to the drug problem. Our joint efforts must be, and have been, broadly based. We have had exchanges including experts in the health, rehabilitation, and education fields, most recently in September when eight leading U.S. specialists spent three weeks consulting with German counterparts and studying drug abuse control programs throughout this country.

We have had visits from National Institute on Drug Abuse (NIDA) specialists, from White House experts on narcotics control policy, and most recently from a DEA expert on the control of legitimate pharmaceuticals.

In addition to our direct cooperation the United States and the Federal Republic of Germany share an appreciation of the need to participate in international drug control efforts.

West Germany, until recently, supplied a police training unit to Afghanistan. Working under United Nations auspices, this unit had direct contact with DEA agents in Kabul in assisting the Afghans to enforce narcotics laws.

The Federal Republic's contributions to the United Nations Fund for Drug Abuse Control (UNFDAC) have been small.

The Germans are, however, currently considering increasing their contributions, and we are hopeful that they will do so.

We and the West Germans have supported one another in sessions of the Commission on Narcotic Drugs, and the Federal Republic actively and emphatically continues to support the anti-narcotic efforts of the United Nations specialized agencies, Interpol, and the initiatives and programs of the European Community.

I have outlined for you some of the ways the West German and American Governments have cooperated in the past. I believe and expect this cooperation will intensify in the months ahead. The drug problem will continue to receive my personal attention, as well as that of other senior Embassy officers. I received my first briefing on the problem of narcotics abuse among U.S. Army and Air Force units stationed in the Federal Republic at an Embassy Task Force meeting in November 1976 1 month after my arrival in Bonn as Ambassador. I have kept abreast of narcotics issues through periodic meetings with this Task Force, and with individual Embassy officers who deal with the drug problem on a daily basis. In February 1977, I first addressed the need for increased German-American cooperation in this field when I called on Minister of State Wischnewski of the Chancellor's Office. Other Embassy officers and I have continued to make high-level approaches about narcotics to the West Germans. In recent months, we were instrumental in convincing President Carter to speak to Chancellor Schmidt about the narcotics problem during the Summit meeting in Bonn in July. Deputy Chief of Mission Meehan again raised the issue in a call he made on State Secretary Schueler, also of the Chancellor's office, in September.

I believe these efforts are bearing fruit. In June I had the privilege of joining with State Secretary van Well of the Foreign Ministry in signing a Narcotics Control Agreement. This Agreement made formal some aspects of our past cooperation, while contemplating broader, mutual, bilateral and multilateral efforts to suppress the production and distribution of illegal drugs, and abuse of all drugs.

The agreement establishes a Central Working Group composed of representatives from relevant German ministries, and from Embassy-designated officers of DEA, the U.S. military, and the Department of State. Minister of Health Antje Huber and I have agreed to convene the Working Group for the first time in mid-December. Thereafter, the group will meet at least twice a year to discharge its responsibilities to develop joint policy, to establish priorities, and to assign tasks related to its decisions to the subcommittees also established under the agreement. The Permanent Working Group (PWG) on Narcotics that DEA and the German Federal Police formed in 1973 will operate as one of these subcommittees. The agreement specifies three other subcommittees: legal; prevention and medicine; and military. The Central Working Group may, however, establish other committees or ad hoc groups as it deems necessary or desirable.

I am confident that the opportunities provided under this German-American agreement will lead to some rewarding innovations in our common battle against drug abuse.

Improvements in telecommunications and transportation have shrunk the world beyond anything dreamed of even 25 years ago. In most respects these technical advances have helped the community of nations to understand each other better and to realize how interlocking our lives really are. Unfortunately, rapid transportation has also meant rapid movement of illicit drugs. It is no longer possible for any one nation alone to combat narcotics abuse effectively any more than one nation alone could combat smallpox or malaria.

As narcotics dealers become more sophisticated in seeking, protecting and expanding their markets, so must the governments of nations, both consumer and producer, increase their efforts in both the supply and demand fields. In many respects, West German-American cooperation has been a model in this fight. I am fully confident that such mutual efforts will continue to be a hallmark of our countries' relations in the years to come.

PREPARED STATEMENT OF HON. MATHEA FALCO, SENIOR ADVISER TO THE SECRETARY OF STATE, AND DIRECTOR FOR INTERNATIONAL NARCOTICS CONTROL MATTERS

Mr. Chairman, Members of the Committee, I am pleased to be here in Stuttgart today to participate in these important hearings on drug abuse among the U.S. military in Europe. I understand that Ambassador Stoessel and Minister Anderson will address the drug problem as it relates specifically to the Federal Republic of Germany and Berlin. My remarks will focus on the source of illicit heroin for Europe and international narcotics control efforts.

Drug abuse among our Armed Services personnel in Europe is an unfortunate reflection both of our own drug problem and that which the Europeans are increasingly experiencing. Some of our young men and women assigned to Europe bring with them the same frustrations and sense of alienation which they had in the United States. Indeed, some of them were probably drug abusers at home. Here in Europe they find themselves in a society undergoing the same rapid growth in drug availability and use which the U.S. experienced in the late 1960's and early 1970's. Among the drugs abused in Europe, heroin is by far the most destructive, and is, therefore, the primary focus of international narcotics control efforts.

Europe's heroin addict population has grown to an alarming level. Estimates by the U.S. Drug Enforcement Administration (DEA) indicate that Western Europe has approximately 200,000 heroin addicts, plus thousands who abuse other drugs. Last year an estimated 1,000 heroin-related deaths occurred in Western Europe. Indications currently are that the number of both heroin addicts and heroin-related deaths will show a continued increase when 1978 figures are compiled. The expansion of heroin availability in Europe is reflected by the fact that European heroin seizures in both 1976 and 1977 exceeded those in the United States. This figure is particularly significant when one considers that the addict population of the United States is nearly twice that of Europe. Countries such as the Federal Republic of Germany, France, Italy, Switzerland, the Netherlands, and the Scandi-

navian countries all have growing addict populations and are becoming increasingly concerned about their own heroin problems.

Seizure statistics indicate that Southeast Asia continues to be the largest source for heroin entering Europe. In 1976, 535 kilograms of this heroin were seized in Western Europe, and 451 kilograms in 1977. As of last month, 350 kilograms of Southeast Asian heroin have been seized during 1978. Ethnic Chinese syndicates with members in both Asia and in Europe have traditionally smuggled Southeast Asian heroin into Western Europe, primarily through the Netherlands and France from whence it has been distributed throughout the Continent. Greater vigilance by European and East Asia law enforcement officials, particularly those of Thailand, Burma, Malaysia, and Singapore has made the passage of Southeast Asian heroin through their countries more difficult. As this Southeast Asian source has come under increasing pressure, there has been an accompanying rise in the movement of Middle Eastern heroin into Europe.

Since 1975, the quantity of Middle Eastern heroin entering Europe has increased steadily in absolute quantities as well as in percentage of total imports. European seizures of Middle Eastern heroin have gone from only 8 kilograms in 1975, to 15 kilograms in 1976, to 49 kilograms in 1977, and 79 kilograms for the first ten months of this year.

The steady rise in seizures of Middle Eastern heroin reflects in part the tremendous increase in production of illicit opium in Afghanistan and Pakistan. Recent Drug Enforcement Administration (DEA) estimates indicate that opium output in these two countries is rising sharply—perhaps by as much as 30 percent over last year. The total 1978 Afghanistan-Pakistan opium crop is estimated to range between 800 and 1,000 tons. This threatening availability of opium raw materials and the rapid rise in the smuggling of Middle Eastern heroin are matters of grave international concern.

Despite increased production and no significant increase in local consumption, farm prices for opium in Afghanistan and Pakistan have doubled or tripled over the past 2 years. The most logical explanation for this price behavior is that the growing opium surplus is being converted into greater amounts of heroin for export to Europe, East Asia, and North America.

Through intelligence and recent laboratory seizures, we know that this opium surplus is being refined into heroin of more than 80 percent purity not only where it is grown in Afghanistan and Pakistan, but also in Iran and, more recently, Turkey. From these countries, a variety of couriers move the heroin through such diverse places as the Persian Gulf, the Near East, and Egypt into Europe by air, land, and sea.

The most apparent impact of Middle Eastern heroin continues to be in Central Europe where it is displacing its Southeast Asian competitors in the Federal Republic of Germany, Switzerland, and Austria. Effects of this traffic upon our Armed Services in Europe are, naturally, of great concern for the United States as well as its allies. Looking beyond Europe, however, there are increasing indications that Middle Eastern heroin in limited amounts is being smuggled through Europe into Canada and the United States. Moreover, there have been seizures of narcotics bound from Pakistan for Hong Kong and the East Asian market. If not checked, the growing Afghanistan and Pakistan opium surplus is clearly capable of supplying heroin to many markets beyond those in Europe—including the United States, which is being increasingly deprived of its supply from Mexico.

Our cooperative narcotics control program with Mexico is continuing to curtail the amount of heroin entering the United States. That increasingly effective Mexican opium eradication campaign, combined with close law enforcement liaison and cooperation with U.S. counterpart agencies, has enabled the Mexicans to reduce dramatically the flow of heroin from their country. Recent Drug Enforcement Administration (DEA) estimates indicate only two-thirds of the heroin entering the United States is of Mexican origin—down from 90 percent in 1975–76. In terms of quantity this represents a reduction from approximately 4.5 metric tons down to three.

To replace the decreasing supply from Mexico, there has been a notable increase in Southeast Asian heroin, which now represents nearly one-third of the heroin being smuggled to the United States. Despite this increase from Southeast Asia, heroin purity on American streets is less than 5 percent, its lowest level in recent years, and an indication that the American market is far from fully supplied. If viable trafficking connections are established, there is no reason to believe that Middle Eastern heroin will not be able to compete with Southeast Asian to replace part of that lost Mexican supply.

Bringing Afghanistan and Pakistan opium production under control promises to be a more difficult proposition than it was in nearby Turkey. A good measure of the Turkish success in eliminating the opium production which fueled the "French Connection" was firm Government control in poppy growing areas. The 1972 Turkish opium ban and subsequent introduction of poppy straw in 1974 was accompanied by effective law enforcement which removed Turkey as a source of illicit opium. Today, there is evidence that limited refining of Afghanistan or Pakistan opium into heroin takes place in Turkey and that Turkish citizens are frequently involved in smuggling heroin into Europe. Turkish poppy cultivation is, however, not the raw material source for Middle Eastern heroin. Another ingredient in Turkey's success was that Government's commitment to narcotics control. A good example of this continuing commitment has been the recent initiation of discussions between Turkey and the Federal Republic of Germany regarding cooperative measures to cope with heroin smuggling between these two countries.

The Governments of both Afghanistan and Pakistan are clearly committed to eliminate opium cultivation and drug trafficking within their borders. Unlike Turkey, however, they do not always exercise sufficient influence over poppy growing areas to translate that commitment into uniformly effective narcotics control. In areas under government control, narcotics officers have demonstrated their willingness and ability to move aginst drug smugglers. Yet most of the major poppy growing areas in both countries takes place along their disputed northern border, areas controlled by tribal groups protective of their autonomy and likely to oppose any serious attempt by the central government to limit their opium production. Even if the Kabul and Islamabad Governments were to assume full authority in the tribal areas, it is unlikely they would risk trouble by attempting to end opium cultivation without first providing a viable economic alternative to the farmer—a very difficult task for those relatively poor nations without outside assistance.

The United Nations Fund for Drug Abuse Control (UNFDAC) has let the way in attempting to assist Afghanistan and Pakistan in creating economic alternatives to opium poppy cultivation. The Fund's nonpolitical nature has enabled it to work with and assist non-aligned Afghanistan as well as the more Western oriented Pakistan.

In 1974 the U.N. Fund for Drug Abuse Control (UNFDAC) established its Afghanistan program with a project to provide advisory and equipment assistance to that country's anti-smuggling unit. To date, the UN has provided approximately $2.7 million for this narcotics law enforcement project, and is considering an additional $2 million to extend it through 1980. This past August the Fund for Drug Abuse Control and the Afghanistan Government expanded their cooperation through agreement on a two year $350,000 primary health care project, supported primarily by contributions from the Swedish Government, to include treatment and rehabilitation for drug addicts.

A problem of greater concern to Europe, however, is Afghanistan's massive opium production. The UN Fund, in conjunction with the Asian Development Bank (ADB), is in the final stages of developing a five year pilot integrated rural development project for the Upper Helmand Valley—the source of an estimated 40 tons of illicit opium yearly. This UNFDAC project is tied closely to a planned $7.5 million West Kajaki irrigation project, also in the Helmand Valley, being negotiated between Afghanistan and the Asian Development Bank (ADB). If the ADB's West Kajaki project is approved, the UN plans to provide an additional $4.8 million for social and technical services centering on agriculture, health care, and law enforcement. The combined project, which could begin as early as next spring pending agreement between the three parties, promises to have a significant impact on Afghan opium production, while providing a model for similar projects in other producing areas.

The United Nations Fund for Drug Abuse Control (UNFDAC) has also been active in Pakistan under a three year agreement signed in May of 1976. At the center of this agreement is a crop substitution pilot project in the Northwest Frontier Province's Buner district, an area which produces as much as one third of Pakistan's illicit opium crop. In addition to crop substitution, the Buner project includes health care for drug addicts and broad rural development in fields such as education, transportation, and marketing. The UNFDAC is also working with the Pakistan Narcotics Control Board on a modest program of law enforcement assistance. To date, the Fund has expended $3.5 million on its Pakistan projects.

The work of the United Nations Fund for Drug Abuse Control (UNFDAC) is necessarily constrained by the level of voluntary contributions which it receives from participating nations. For many years the White House and the Congress have expressed concern that the U.S. was providing as much as eighty percent of such voluntary contributions while other economically advanced countries appeared to be contributing less than their fair share. Over the past two years this Administration has supported a determined effort on the part of the Fund to solicit increased contributions from countries other than the United States. As a result of this effort, U.S. contributions for 1977 and 1978 make up only approximately fifty percent of total donations. This reduction has reflected a growing interest in the work of the Fund on the part of European countries, particularly the Netherlands and the Scandinavian countries, and a concomittant increase in their voluntary contributions.

To further encourage donations to UNFDAC from other countries, representatives of the Department of State sponsored a meeting of donor countries in New York earlier this month. I would like to note that this meeting was in response to direct efforts on the part of Congressman Gilman and other members of the Select Committee. The tone of the meeting was encouraging, and we are confident of further contributions in support and expansion of the Fund's fine work.

Earlier in my statement, I mentioned the Asian Development Bank (ADB) in terms of its cooperation with UNFDAC in the combined Upper Helmand Valley/West Kajaki project in Afghanistan. This is but an example of the potential rural development role of international financial institutions in opium producing areas. Working through the U.S. Treasury Department, we are attempting to enlist international financial institution support for narcotics control in two ways. The first is through positive support for projects, like the West Kajaki, which will bring development and economic alternatives to opium growing areas. Simultaneously, we are encouraging them to make loan assistance contingent upon recipient government agreement to prohibit all opium growing in the project areas. We are encouraged by ADB and World Bank consideration of both these approaches in their assistance to Afghanistan and Pakistan. If their efforts are successful and followed by others, the impact on narcotics production will be significant throughout Asia as well as Latin America.

The United States is also encouraging international narcotics control support from aid donors among the industrialized nations. The United Nations Economic and Economic and Social Council (ECOSOC) has endorsed the concept that economic development in primary narcotics producing areas is a desirable objective of foreign developmental assistance funds. Many European members of ECOSOC, such as the Dutch and Scandinavians, have demonstrated an increasing willingness to use their foreign assistance funds for that purpose. I understand from recent debates in the Bundestag that the Federal Republic of Germany is now considering the use of developmental assistance funds in Afghanistan's poppy growing areas in return for more stringent control of poppy production.

In October representatives of the State Department held preliminary discussions with the Organization for Economic Cooperation and Development (OECD) to explore means of using developmental assistance as a positive force to provide economic alternatives in opium producing areas. The U.S. has taken a lead in this direction through the use of so-called poppy clauses stipulating that foreign assistance recipients will not permit opium cultivation in aid project areas. Last spring, under the previous regime, the U.S. cancelled a small AID irrigation project in Afghanistan for failure to comply with terms of an opium prohibiting side letter to that agreement. The U.S. Agency for International Development is now jointly negotiating an agricultural developmental bank credit project with the Afghanistan Government and the World Bank. All concerned have agreed to restricting poppy cultivation under the terms of that agreement. In view of the increasing threat to Canada from Middle Eastern heroin, we are also working with that country to encourage inclusion of poppy clauses in its foreign assistance loans to Afghanistan. In the case of Pakistan, the U.S. was encouraged at European expressions of concern over that country's increasing opium production voiced last June at the Pakistan Aid Donor Meeting in Paris. We are confident that continued such expressions of concern by foreign assistance donor countries will enhance recipient government willingness to take meaningful action against narcotics production.

In addition to multilateral international narcotics control work, the U.S. has continued its bilateral support for Pakistan and Afghanistan narcotics control efforts. This support has served to keep the narcotics control issue in the fore-

front of our bilateral relations with those two countries. Whenever possible, our bilateral efforts have been designed to complement and support multilateral work of the United Nations, international financial institutions, and other countries.

Since 1974, the United States has provided the Pakistan Government's Narcotics Control Board with approximately $1 million for cooperative narcotics control programs involving both police and customs units. This assistance has included communications equipment, vehicles, and operational support for narcotics suppression operations to enhance Pakistan's law enforcement capabilities. Recent developments in U.S.-Pakistan law enforcement cooperation have been encouraging, particularly the continued success of Operation Poker. a joint program involving the Drug Enforcement Administration (DEA), U.S. Customs, and Pakistan's Customs. A special drug enforcement unit created within Pakistan Customs seven months ago to interdict narcotics smuggling in the Karachi area has already made 48 drug seizures, including 60 pounds of heroin, 431 pounds of opium and two and one-half tons of hashish. The Pakistani police have also achieved notable success this past summer, having seized three active heroin refineries.

Since 1976, the U.S. has also provided modest assistance to planning studies in support of crop substitution and integrated rural development, particularly in the poppy-growing Swabi Tehsil region. This study is now in draft, and when printed will be a useful guide for future planning of economic alternatives in Pakistan's poppy growing areas. We have made clear our ongoing interest in substitution projects for poppy growing areas and are confident that appropriate pilot programs can be instituted in the future.

The U.S. is also seeking to establish a bilateral cooperative narcotics control program with the Government of Afghanistan. Last year a Joint Commission on Narcotics Matters was established in Kabul composed of representatives of Afghanistan, the United States and the United Nations Fund for Drug Abuse Control (UNFDAC). The Joint Commission was created principally to explore means of mutual cooperation in crop substitution and integrated rural development, such as the Upper Helmand Valley project, but also addressed narcotics law enforcement issues. Last April's coup interrupted the work of the Joint Commission and temporarily created some uncertainty as to which directions in narcotics control the new government would pursue. In recent weeks, however, the Taraki Government has made clear its desire to renew the Joint Commission and to explore bilateral narcotics law cooperation and assistance.

We are confident that the new Government in Afghanistan is committed to the gradual elimination of opium cultivation within its borders. Moreover, they recognize that this can be done only through full cooperation with international organizations and friendly nations. On our part, we have expressed U.S. willingness to pursue bilateral narcotics control cooperation as well as supporting multilateral efforts. We are confident progress in this area will increase.

Mr. Chairman, members of the Committee, today I have directed my remarks primarily towards the relatively recent, but growing, threat to Europe posed by Middle Eastern heroin. We should remember, however, that although the Middle East is the principal source of heroin affecting our military personnel in the Federal Republic of Germany, the large majority of heroin entering Western Europe continues to come from Southeast Asia. Consequently, we cannot afford to address only one of these threats while neglecting the other. Our international narcotics control strategy will, therefore, continue to emphasize cooperative efforts to bring both sources under control.

Currently, progress in controlling Middle Eastern heroin has not been able to keep up with the rapidly growing availability of illicit opium and expansion of heroin laboratories. Unfortunately, much of the illicit opium cultivation cannot be suppressed because of the lack of full central government authority along the Pakistan-Afghanistan border where the majority of that narcotic is grown. Progress however, continues to be made. Early recognition by the United Nations, the U.S. and others of the potential threat of Middle Eastern heroin prompted timely efforts which have created the basis on which to expand narcotics control cooperation with Afghanistan and Pakistan. It is now up to the international community to expand this cooperation and jointly bring the trafficking of heroin from the Middle East under control. If it does not, I fear that we have yet to see the full impact of that heroin either in Europe or on the North American continent.

PREPARED STATEMENT OF HON. DAVID ANDERSON, MINISTER, U.S. MISSION, BERLIN

Mr. Chairman, I appreciate this opportunity to be with you today.

Berlin is a big city with typical big city concerns. The heroin problem in West Berlin, however, is a relatively recent development. I think all of us—United States representatives, Berlin law enforcement authorities, and others who are concerned for the city and the well-being of its residents—were shocked by the 1977 overdose death figure [1] and other indicators of a growing "heroin epidemic." Obviously, none of us wants to see Berlin develop into a city where the usage of drugs is widespread, nor do we wish Berlin to become a major drug transit point to Western Europe and North America. Because of the city's occupied status, the United States Government has a special relationship towards Berliners and major responsibilities for Berlin. We also have to take special account of the presence in West Berlin of a large number of U.S. Forces who perform vital missions in the city.

Over the past year we have worked hard to come to grips with the problem. The United States Mission in Berlin has encouraged intensive Drug Enforcement Administration involvement [2] and directed intensified police and customs efforts. The police narcotics squad had been almost tripled.[3] The Berlin Drug Task Force, formally constituted this summer under the direction of the U.S. Commander Berlin, has concentrated these efforts.[4] We have worked closely with Ambassador Stoessel and his staff in contributing to the Embassy's ongoing assessment of the drug problem in Germany as a whole.

We know much more about the Berlin heroin problem than a year ago and our work against the traffickers is beginning to pay off. Already this year we have seized more than 10 kilograms of heroin in West Berlin. This is over twice the amount seized during all of 1977. Arrests are also up.[5] In human terms we are pleased with the significant drop this year in the drug overdose death rate.[6]

Our studies show that Berlin is not a major heroin supply point for Western Germany or North America. We know from those arrested that heroin in fact reaches the city through the Federal Republic as well as arriving via more direct routes. As confirmed by DEA and German experts, heroin from the Near and Middle East flows into Europe via a variety of routes. Berlin is one end point, with most of the drugs reaching it destined for consumption in the city and not for onward shipment.

While Berlin has not emerged as a new "Amsterdam," the city's heroin problem remains serious and a cause of concern to the U.S., Allied and German authorities. The fact is that many young Berliners now provide an established market.[7] United States Army representatives have already described for you the impact on some of our young soldiers. Like a growing number of cities in the Federal Republic, we face a situation in which heroin is available at low prices to anyone who wishes to experiment with it.

We have given careful attention to the question of how heroin reaches Berlin. We know it comes in numerous ways, much as people and goods in general reach the city. West Berlin's closest legal, economic, and personal ties are with the Federal Republic, 110 miles away. Our studies indicate that of the estimated 18,000,000

[1] Overdose deaths rose as follows: 1971—9; 1972—6; 1973—6; 1974—13; 1975—31; 1976—54; 1977—87 (including 4 U.S. soldiers).

[2] DEA has sent personnel to West Berlin on temporary assignment and has undertaken a major information-gathering operation (LEO) beginning in January 1978 and continuing, as well as engaging in cooperative enforcement efforts with police and customs.

[3] The 20-officer West Berlin police narcotics unit was expanded under our authority in October 1977 to 53 officers, and in November 1978 to 60.

[4] The Berlin Drug Task Force has active participation by representatives of the German and American enforcement communities in West Berlin, as well as the U.S. Drug Enforcement Administration. Representatives from the U.S. Embassies in Bonn and East Berlin are members. The Task Force concentrates on what can be done to interdict the flow of drugs to West Berlin and on areas where police and customs operations can be more effective.

[5] Arrests for drug trafficking and smuggling for the first nine months of 1978 were 734 as compared with 569 for the same period in 1977.

[6] Fifty-three overdose deaths have been recorded as of November 15. Last Year at this time the total was 76 (eventually reaching 83 for the year).

[7] There are 1,900 heroin addicts registered with the police in West Berlin, and estimates of the total number (adding those who have not been arrested or otherwise come officially to the authorities' attention) range from 2,600 to 10,000.

trips annually in and out of West Berlin, most are to and from the FRG. This is not an unusually large number of entries and departures for a city this size. What is unique, of course, is West Berlin's geographic separation from its main economic and recreational hinterland, and the importance therefore to Berliners of maintaining and strengthening these links.

As a result of agreements reached eight years ago between the U.S., United Kingdom, France and USSR and between the FRG and GDR, transit and travel arrangements have been greatly simplified and improved; West Berliners and West Germans can now jump into their cars and drive through the GDR with minimal formalities. During September an average of 8–10,000 cars arrived every day in West Berlin via the two major road transit entry points at Dreilinden and Heerstrasse. In addition, the city has come to rely on a steady stream of trucks using the transit routes. In September we counted some 1,300 trucks a day on the average arriving through these same points. To those who lived through the days of the 1948–49 Blockade, the arrival in the city every month of some quarter of a million vehicles is nothing less than a miracle.

It is illustrative of the success of the East-West negotiations of the late 1960's and early 1970's that today's West Berliners consider the unimpeded flow of people and goods as their right. Any appearance of interference with transit traffic makes immediate headlines. An understanding of this historical background and the massive dimensions of transit traffic makes clear the political and practical obstacles to any major Western effort to stop and search vehicles arriving at Dreilinden and Heerstrasse. It would be somewhat analogous to instituting customs controls on road traffic between Los Angeles and San Francisco. I would note in this connection that airline connections between West Berlin and the Federal Republic are regarded as domestic flights.

The domestic character of most of the travel into West Berlin has been an admittedly complicating factor in our attempts to interdict drug smugglers, We know that an infinitesimally small fraction of these "domestic" travelers are bringing heroin, and perhaps provide the major channel of supply for West Berlin's dealers. The situation is further complicated by the fact that international arrivals (not coming from or through the FRG) also use these same points of entry. A car bearing Turkish plates, for example, is stopped and subjected to normal international customs controls. However, persons returning from a trip to Turkey but driving Berlin or FRG-licensed cars are indistinguishable from the mass of "domestic" vehicles with which they merge before entering West Berlin.

The legal and practical situation of Greater Berlin also affects the entry control question. It is a cardinal Western position that, despite the Wall, Berlin remains one city under four-power occupation status, with free circulation among the four sectors. Thousands of persons from the West now cross back and forth through Eastern checkpoints in the middle of the city each day. While we have customs representatives making spot checks, we believe that instituting full-fledged international-type controls would be inconsistent with our legal position that the Sector-Sector (West Berlin-East Berlin) line is not an international border. Our British and French Allies, who share with us occupation responsibilities for the Western Sectors of Berlin, also hold this view.

West Berlin's entry points therefore range considerably in terms of the types of measures against narcotics smugglers which we have been able to pursue. Three general categories have emerged:

(A) *Intra-City* points of entry include the seven Sector-Sector surface crossing points and the U and S-Bahn trains. Thousands of persons pass daily through these points. We have a Western Allied control point at Checkpoint Charlie, which controls Allied personnel. West Berlin customs has personnel at or near all of the seven crossing and/or entry points.[8] These officials perform spot checks only. Travelers arriving on the Eastern-operated S-Bahn trains are now checked on a spot basis by mobile customs teams as they depart the trains and S-Bahn stations.

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[8] Bornholmer Strasse 12
Chausseestrasse 12
Invalidenstrasse 12
Friedrichstrasse (Checkpoint Charlie) 15
Prinzenstrasse 29
Sonnenalle 11
Oberbaumbruecke 10
Bahnhof Zoo (plus mobile teams) 7

(B) *Inland* arrivals who transit the GDR by surface directly from the FRG or come on flights from Western Germany make up the bulk of persons reaching West Berlin. They include travelers arriving daily by the thousands at Tegel Airport as well as cited above at the Dreilinden and Heerstrasse crossing points. While customs and police officials are on duty at all these points,[9] which also receive international arrivals, "inland" traffic is inspected only if probable cause exists to suspect a violation in a specific instance.

(C) *Ausland* arrivals (not coming from Western Germany and not entering West Berlin from East Berlin) by surface use mainly Dreilinden and Heerstrasse, which admit several hundred cars and a greater number of trucks daily in this category. All passenger cars from drug source countries are inspected. The same is true of the cabs of TIR trucks, whose cargos are searched if probable cause exists. Most Ausland arrivals at Tegel are by charter flights. An estimated 25–30,000 persons a year arrive in this manner from Turkey via Laker, Dan Air, Aero America and Pan Am charter flights. All luggage on these flights is subject to inspection. Persons flying to Tegel from abroad on regular, scheduled flights (all of which stop in the FRG) clear customs in the Federal Republic, along with their hand luggage. Any baggage checked through to Berlin is subject to search at Tegel.

Because of cheaper flights, many travelers from the Near East use Schoenefeld Airport in the GDR, located just outside Greater Berlin's city limits. Tens of thousands of travellers fly this route annually from Turkey. Arrival controls at Schoenefeld are reportedly strict. Most persons traveling to West Berlin from Schoenefeld Airport enter on airport buses which arrive at West Berlin's Waltersdorfer Chaussee crossing point. Since all persons (apart from occasional Soviet diplomatic vehicles) arriving at Waltersdorfer Chaussee are considered as coming from abroad, there is no ambiguity about controls. West Berlin customs agents [10] in fact carry out occasional intensive searches of all luggage on a particular flight. (We believe this goes beyond the normal international practice elsewhere at ports of entry of making spot checks only.) While Western controls are comprehensive at Waltersdorfer Chaussee, persons arriving at Schoenefeld in transit to West Berlin have some option to proceed first into East Berlin. From there they can travel to West Berlin via one of the various Sector-Sector crossing points, not regularly controlled from the Western side.

We have sought imaginative ways to cope with the fact of Berlin's open access and high volume of arriving persons and goods. This past summer the Western Allies granted approval for Berlin drug enforcement officals to conduct a greater number of inspections of persons arriving via the S-Bahn trains from East Berlin. At our urging, police and customs authorities at Tegel Airport recently stepped up the use of dogs in checking arriving domestic luggage. We feel that if a qualified narcotics dog reacts positively to a piece of baggage, sufficient probable cause then exists to require the owner to open it for a thorough inspection.

While we feel it is important to try to interdict drugs at their point of arrival, we believe our battle against the Berlin heroin problem depends primarily on: a) efforts by the U.S. and other governments internationally to stop the drugs at the source or en route; and b) active pursuit of major traffickers and organizers behind the drug couriers and streetlevel dealers. Assistant Secretary Falco and Ambassador Stoessel have described for you the international aspects. Berlin indeed needs to be considered in the context of this larger problem.

Meanwhile, in Berlin, we are devoting our efforts towards identifying and going after the organizers accessible to us. We have supported and encouraged active cooperation between Berlin police, customs, and such helpful resources as DEA. Believing that U.S. expertise could be useful, we invited DEA to establish a regular presence in Berlin, so as to be able to work more closely with local enforcement personnel, including U.S. military narcotics experts. DEA has in response increased its attention to West Berlin and we have benefitted from the frequent visits and stays by its Special Agents stationed in the Federal Republic. We have carried out as a result joint operations and collected much information. High-level West Berlin police and customs officials have given us excellent support. During the year police and customs have intensified their joint working methods, and the resulting mixed working group (11 police and 7 customs agents) is to be

[9] Fifty customs agents are assigned to Tegel Airport, 150 agents to Dreilinden, and some 60 at Heerstrasse.

[10] Twenty-two customs agents are assigned to Waltersdorfer Chaussee, with 5–6 on duty during peak periods.

expanded. Information developed in Berlin as a result of police and customs investigations and actions and helpful information from DEA offices in Germany and elsewhere are exchanged, The U.S. Mission serves as the daily coordinating, reporting, and transmission point between DEA and Berlin police and customs. An additional person was added to the Mission staff in January 1978 just to keep up with these increasing demands.

U.S. authorities up and down the line in Berlin have provided strong support for the city's anti-drug efforts. I have referred to the direct role taken by the U.S. Commander, as head of the Berlin Drug Task Force, as well as to the daily work by the U.S. Mission's Republic Safety Section. General Benedict and I have discussed the drug problem with the Governing Mayor and other officials of the West Berlin Government. We are pleased at the cooperative attitude shown by West Berlin's political leaders and authorities dealing with narcotics matters. The increased attention which they are devoting to the problem is producing results, as witnessed by the notable seizures and arrests of key persons in recent weeks and months. It is premature for anyone to state that the Berlin heroin problem has been brought under control. We are, however, along with our West Berlin friends optimistic that our efforts are beginning to pay off.

REMARKS BY LT. GEN. SIDNEY B. BERRY TO CONGRESSMAN GLENN L. ENGLISH, NOVEMBER 15, 1978

I have commanded since July of 1977, one of two U.S. Corps here in the United States Army Europe, one of eight NATO Army Corps in Allied Forces Central Europe.

What is a corps? It is really the highest fighting headquarters within the NATO Command. General Blanchard's United States Army Europe is a logistical command; it supplies resources to the Corps, which are really tactical headquarters, although also are the administrative headquarters for our community system here is Europe. Our Corps consists of two divisions; the 3d Armored Division and the 8th Infantry Division, 11th Armored Cavalry Regiment, which is along the border, 130th Engineer Brigade of which Colonel Butler's battalion is a part, and then other battalions, one of which is the Signal Battalion. That is the unit the other group will visit tomorrow, when your group goes to Darmstadt.

We have almost 70,000 soldiers, almost 70,000 family members and about 10,000 civilian employees, organized in the 9 military communities. Each military community is centered around the large metropolitan areas.

Our mission is to maintain a high state of combat readiness, to be able to support the NATO mission in defending NATO territory, fighting and winning, if it should come to war.

1973–1974, I commanded Fort Campbell, Kentucky and the 101st Airborne Division. As I think about troops here in Germany, and I'll home in on the drugs in just a minute, and as I think about the command at Fort Campbell, I ask myself, "What is different about the environment in which soldiers serve here in Europe as compared to back in any stateside post?" I come up with these major differences: First the soldier is away from home here.

As you know, so many of our soldiers are young, first time away from home, strange country, different language, different background. A lot of them feel strange. And many of them tend to draw up within themselves and become, in soldiers language, barracks rats. Back home, the American military community provides so much of the support of the soldiers life. That's where most of them live, and they are within travel distance from their own homes. Over here it's the Army that's their Daddy and Momma and provides everything for them. But in the different environment of Germany. In so far as physical facilities are concerned, barracks, recreational facilities, family housing, result in a lower standard of living here especially in the barracks, the kasernes, than on the posts back home. There are understandable reasons, one of them being historical. The US Army in 1945, moved into pre World War II German military barracks. The German Army itself in starting to come back to life in 1956, built new kasernes, moved into them.

The decline of the dollar, yes, that has had some influence, a deleterious influence, on the standard of living here for the soldier. Our dependence on the foreign government as we get into the law enforcement and control of the availability of drugs. Even getting into something as simple as alcohol or beer. The higher alcoholic content of German beer, that takes a lot of young soldiers by quick surprise, shortly after they arrive here.

Now going from our mission and combat readiness which is my business and the business of any Corps commander, directly to drug abuse, drug use and abuse. Is it detrimental to combat readiness? The answer has to be "Yes." If I, as Corps Commander, drink too much and have a hangover the next morning, then my abuse of alcohol, or drugs, is detrimental to the readiness of the Corps. The same thing is true of any soldier in the Corps. How much of a detriment? I can't measure that. It is something that we have all been trying to measure, but without success. You'll do well by asking this question, as I's sure you will, of the lower commanders, starting right here with Colonel Butler. We've been talking about it. Our sensing is that there is not a dangerously significant reduction of combat effectiveness.

That's easy to assert. Not easy to prove in any statistical or measurable way. But here are some of the detrimental effects of the drug use and abuse. The effect on the individual, the impairment of the individual. Let's take the 32d Signal Battalion, whose soldiers spread themselves out literally over the V Corps area. We have two and three soldiers out with a key piece of communications equipment. If one of those soldiers uses or abuses drugs, then his individual reaction time is impaired. He can be in a key place that can really play the devil with our communications.

Effect on a unit. Having drug users and especially sellers and pushers and the drug culture within a unit is divisive. You've got the bulk of the soldiers who are good soldiers, want to be good soldiers and you've got a group that is literally outside the law and outside the chain of command exercising group peer pressure on the good soldiers, trying to pull them across the line on the other side of the law. That is divisive. It is divisive to the cohesiveness of the unit, it undermines the morale of the unit, it tends to polarize the unit and certainly that situation distracts leaders. It causes leaders to divert the time they should be spending on building the combat readiness into dealing with the problems of a smaller group of soldiers. So all of this is detrimental to the discipline, law and order, the cohesiveness of a unit. Therefore it is bound to be detrimental to our mission, our combat readiness.

About a year ago, now, in December of 1977, I had a growing sense of uneasiness about the drug situation here in the Corps. Several things combined to create this sense of uneasiness, particularly, as we move now into the year 1979. Reading the German press, I became aware of an increasing number of deaths attributed to drug related causes among German civilians in Frankfurt.

I became more conscious of drug deaths within our own military, overdoses or deaths related to drug misuse. Horrible things, like some young soldier sitting on a commode in a barracks, dying with a needle stuck in an arm or soldiers dying from drowning in their own vomit. I will not give any statistics, knowing that this is something that the doctors have to do since there is a great deal, as you know well, bureaucratic definition about what are drug related deaths. But this was part of my growing sense of unease and I am increasingly aware of these things. Then I read both within our law enforcement publications and the press, about good poppy seasons in the mideast and the growing entry of heroin and the hard drugs into Europe. Both through Rotterdam and Amsterdam and through the aerial port here in Frankfurt. All of this lead me, lead us in V Corps as we came into the year 1978, to focus our attentions, sharpen our sensitivity and seek to mobilize our forces to do something. We were, using a sort of public relations term, to declare war on drugs and drug abuse.

Let me stop now and define what I consider to be our most serious problem. Alcohol. This is supported by both my own sensing and whatever statistics we are coming up with, and those are largely the USAREUR statistics from the USAREUR personnel opinion survey. I tend to be skeptical about the whole of the statistics, knowing that they are at best an approximation. But I'm convinced that alcohol of all the drugs, is the one that presents the largest number of problems for the Corps. Particularly among the officers and noncommissioned officers, but it's not a small problem among our junior soldiers.

Cannabis. I see various figures, 22 percent, 30 percent, use monthly or so. I tend to believe about that type figure. Some of our commanders even estimate 40 percent, 45 percent, perhaps even up to 50 percent use of cannabis among the soldiers, the young soldiers now, within the unit. That is at least possible.

It's the hard drugs, I guess, that we are focusing on. Heroin, in particular, because it can be so quickly dangerous and destructive to the individual. But we are not ignoring the rest of them.

I've talked about our growing awareness. What have we done about it? In December of 1977, as I recreate our growing sense of awareness, we conducted a three day workshop for all of our drug and alcohol abuse and control people, trying to define the problem better, and begin a revitalization of that program. Then in April of this year, talking to the Chief of Staff in the Corps, General Ballantyne, Lieutenant Colonel Patrick and to the GI, I directed the development of something more finite and cohesive as a campaign on drugs.

In May, I approved their conceptual plans to marshal the Corps resources.

In June, we held a meeting of about 75 or 80 of our senior Command Sergeants Major in the Corps to present to them my stimulus as the Commander, for providing more effective, sensitive leadership of soldiers so that we can go after those negative problems. In that same month the presentation of our plan to our nine community commanders. Our plan is not a detailed, general defense type plan. It is more of a general guidance plan for our community commanders.

In September of this year, we hosted for the Army, a multi-command conference on preventative actions to take against drugs and drug abuse.

Those are some of the things that we are doing, but I have to say that, in my opinion, the most effective thing we can do and are seeking to do is to get our commanders at the lower levels closer to the soldiers. To get them personally involved in the actions against drugs and drug abuse. Corps commanders can assist and give some kind of general policy guidance but it is the battalion commanders, company commanders and their noncommissioned offiecers that really do what is necessary.

Our aims in a positive sense: to create a positive climate of leadership in our units in which the good soldiers can flourish and in which the bad soldiers will either perish or become good soldiers. Focusing on the drugs, try to provide the type leadership, create the type of environment that will prevent soldiers from getting into drugs; locate those that are using drugs; rehabilitate them if they want to be rehabilitated; eliminate them as quickly as possible if they do not. Most of all identify the pusher, the profiteer, the businessman that is doing his best to make money from his fellow soldiers.

Last point, we need help and we need help in these ways: We need help in getting the Germans at the Federal level to understand that this is a human problem; a German problem as well as an American problem. At the community level, we increasingly are finding this awareness on the part of the German community leaders, and some of our community commanders have had a greater success than others in working with the community German officials. But it is my perception, and I'm told by those at USAREUR, this is really General Blanchard's talk to make to you rather than mine, that we appear to need more understanding at the Federal level.

Other help we need as well, not only German but International as we are hearing through our informants and the drug pushers that we are picking up, a lot of the drugs which are coming into the hands of our soldiers, are coming in through the low countries, particularly through the Netherlands. Again, my perception in an unsophisticated way, perhaps ignorantly, that the government of the Netherlands, well, it certainly has not been effective in slowing or stopping the drugs that are coming in through there. I don't know what their sensitivity is. The German government, in my opinion, has not been effective in slowing or stopping the drugs coming in from Rhein Main which is bound to be a major source of entry.

On the part of those of you in the congress, we need your understanding of our need for quick discharges of those soldiers, particularly those who are pushers, and the drug abusers who do not have the will to rehabilitate themselves. One other bit of understanding and help we need from the congress, I do not want to overemphasize this, but this has to do with the physical facilities our soldiers are living in. We need to bring our barracks up to a higher state of cleanliness, sanitation and efficiency than they are now. We have many that are overcrowded in which soldiers are sort of packed in like sardines. We need help with improving the recreational facilities.

Having said that, I don't think that is the central issue in what we do to reduce drug abuse. The central issue has to be within our own chain of command. It's how effective our leadership is that we give the soldiers and particularly that we give within the battalion and within the company. It has to be whether we leaders are sensitive and compassionate, but also demanding in a disciplined, military way. I don't really think that it's the best kaserne in a physical way where we have the lowest drug problem. I think it's our units. I think, I can't

prove this statistically either, but I think where we have our smallest drug problem is in those units that have the most effective leadership, have the best training programs, the best physical training programs, where soldiers have a sense of mission and a sense of purpose, and where they derive job satisfaction from what they are doing and have a sense of pride in what they are doing.

One other thing that I think we need to do within USAREUR to help ourselves and we probably need congressional understanding on this, is putting in to pretrial confinement the drug pusher that we pick up. Right now we can put into pretrial confinement, only those soldiers against whom charges have been or are about to be preferred for something like murder, or rape or something that leads us to believe that the continued freedom of the soldier will present an unacceptable risk to someone else. Well, I believe that the pusher presents an unacceptable risk to someone else and therefore he should be put into indefinite pretrial confinement. This is something by the way, that I have not pushed with General Blanchard so that is something to handle within my own chain of command, but I do ask for congressional understanding on that.

The commanders you talk with will tell you their frustrations in directing soldiers in command directed urinalysis and that it will take from three to five weeks to get a read out on that. If we had within right here in Camp Eschborn, portable urinalysis machines, that would permit the commander to direct the driver with the watery eyes to take that urinalysis now, then today or tomorrow the commander could say, "Hey, you're it." Far better than a three to five week wait.

The same is true of the drug pusher. We identify him and he remains in the unit for however long it takes the court, the system of military justice to work and he continues selling.

Another bit of help we need, that same pusher that we convict and discharge from service, very often comes right back here as a civilian and right outside the gates of Camp Eschborn, he is plying his trade. I don't know if that's something for the American government or not to issue a passport or for the German government to deny entry, but somewhere we need help to keep those fellows from coming right back here. I conclude on the note that we can use help, but the solution, the single part of the solution in my opinion, lies in here, within our hands. That's all I have to present to you.

APPENDIX

USAREUR COMMAND PREHEARING DRUG CONFERENCE, NOVEMBER 15, 1978

STATEMENT BY GENERAL GEORGE S. BLANCHARD
COMMANDER IN CHIEF
U.S. ARMY, EUROPE AND 7TH ARMY

Mr. Chairman, Ladies and Gentlemen, on behalf to USAREUR's almost 400,000 soldiers and dependents, welcome to Germany. Your presence here demonstrates the concern we all share for Americans serving their country in a foreign land.

It is our hope that during your time with us, you will have the opportunity to come to know USAREUR, for it is made up of about as diverse and talented group of men and women as you will find anywhere. Further, it is a command that all Americans can be proud to call their own.

Like any big organization, it has plenty of challenges. I think we are aware of most of them.

As we have for nearly thirty years now—since World War II—we are meeting those challenges, and we stand by and ready to do our job as part of the NATO Team.

I have been here in Europe for five and one-half years, first as VII Corps Commander, and since 1975 as Commander in Chief, US Army Europe and Seventh Army; and under my NATO hat as Commander of Central Army Group. I have seen during that time a tremendous resurgence in our capability to do our job, a more professional and growing knowledge and understanding of what a professional Army is all about. The progress has been gratifying.

We have recovered from the austere days of Viet Nam.

Discipline problems are down. In fact, as an example, the 3d Infantry Division has the lowest AWOL rate when compared with the rest of the Army.

Our equipment and material is in better shape than I have seen it in five and one-half years.

Both NCO and officer leadership is good and improving.

Our units spend more and more of their time training for their missions.

In an operational sense, we are doing things today that I wouldn't have thought possible two or even three years ago. And that is solid testimony to the motivation and skill of our soldiers.

In spite of all the progress, there is still much work to be done. One area that concerns all of us—and the primary reason for your visit—is the matter of drug abuse and use.

With your indulgence I would like to give you my views of where we stand in our effort to overcome this very persistent and insidious enemy.

At about the time of my arrival in Europe in 1973, we began to experience a decline in the incidence of drug use from the almost epidemic proportions that existed in the early 70's. The downward trend looked excellent. We continued in a very good way through 1974, 1975, and 1976.

However, we seemed to level off in 1977, and are now experiencing a mild upturn, but nowhere near the situation that existed in the early 70's. Nor do I think we will never see a return to those days.

But let me say categorically, I am concerned, and we are aware of the problems that we face and what needs to be done.

One soldier on drugs is one too many, in my opinion. I am totally committed to reducing drug use to the lowest level possible. I am talking about the application of resources.

In my estimation the upturn in drug use is due in large part to five factors:

The ready availability of high grade, relatively inexpensive heroin and other dangerous drugs here in Europe.

A reduction in resources allocated to the drug fight brought on by a number of budgetary factors, to include the teeth to tail ratio.

Boredom and lack of alternatives for solders who perceive that the quality of life afforded them in Europe isn't nearly up to standards in CONUS.

Tour lengths in excess of eighteen months for our junior enlisted soldiers, and the value of the dollar as it affects the ability of the soldier to get out of the barracks, coupled with an increased effort to exploit our soldiers by pushers whose total motivation is profit notwithstanding the wasteland they create on the human level.

At all levels I think we relied too much on the success we achieved in 1975 and 1976 and misread the trend line for a time in 1977. We began to recognize that drug abuse represents an incipient threat to U.S. Forces. This threat affects not only the working and living conditions, but the individual soldier, his family, their careers and future well-being. We have been moving out for more than a year to do something about drug use in USAREUR and continue to intensify our efforts.

First, we are making maximum use of available assessment tools to quantify the extent of the problem. Special surveys and the USAREUR Personnel Opinion Survey—the so-called UPOS—have been very valuable tools in assessing drug abuse levels and trends here in Europe.

Preliminary drug estimates have been drawn from the early returns of our most recent survey, which was sent to the field for administration in mid-October.

These preliminary data indicate that the total number of people involved in monthly or more frequent drug abuse has not increased significantly during 1978. However, an increase in the use of narcotics is evident in the trend analysis of the survey data.

We have also compared our survey results with the results of our unit urinalysis testing program. Given the difficulty of measuring exact drug abuse prevalence, we find that these two independent sources of information are in very close agreement; and this has reinforced our confidence that we have a fairly accurate assessment of the extent of the problem.

This assessment, however, indicated that drug abuse levels are not uniform throughout the command. They vary from unit to unit, and within the various age and rank groups.

For example, we would expect drug abuse among the young, junior enlisted soldiers of certain units to be much higher than the estimates applied to the entire command.

We think we are beginning to see a clustering effect where our unit urinalysis program reveals in some cases excessive drug use among a given racial or ethnic group in a few units, and just the reverse in other units.

In talking to soldiers, and specifically abusers, one may hear judgmental estimates that 40 per cent or more of the personnel in a given unit are abusing narcotics or dangerous drugs. Our statistical data do not support such estimates which may be made by honest but unskilled observers based on their sphere of association.

Second, we are moving out aggressively to do something about drug use in the command, and the effort is extensive.

Our most active and aggressive effort is to deal with drugs at the source. We have taken strong action to increase our drug suppression capability by shifting MPI assets, emphasizing drug suppression as our first law enforcement priority and requesting assistance from DA as needed. We see it as essential that we reduce the availability of drug to our soldiers.

We have requested the necessary resources to upgrade our 80 outpatient treatment centers and five inpatient facilities for drug patients.

We have intensified our urinalysis program with Selected Unit Urine Testing for Company Size Units (SUUTCO). When we get the portable urinalysis devices, this program will be further enhanced.

Across the board, there has been renewed emphasis on: drug awareness; drug suppression; and treatment and rehabilitation.

Enhanced cooperation with host nation law enforcement agencies.

The measures are sophisticated, and there is good cooperation throughout the command. Also much that we do beyond this point is dependent upon addi-

tional resources to be provided by Department of Army and Department of Defense.

I have strong assurances from Department of Defense and the Army leadership that these will be forthcoming soon. We are seeking an overall increase in resources for this program of about 25 per cent.

You will be hearing a lot more about our drug program from other members of my staff, so I won't dwell in detail on this subject now.

Let me conclude by saying that it would distress me—and I think be a disservice to our soldiers—if a picture were painted that we've got a command of druggies and losers over here.

I'm very proud of the soldiers we have serving in Europe. They are a dedicated group of men and women, and they're making numerous sacrifices in behalf of their country. And I would stack the effectiveness of US Army, Europe today against that of any previous force or that of any of our NATO allies.

Should the need ever arise, I am confident they will do the job that needs to be done.

We are moving in the most aggressive way possible to stamp out the exploiters of our soldiers, and we intend to succeed.

Thank you, Mr. Chairman.

That concludes my statement.

I would welcome questions and comments, or we can move ahead to General Fitts' presentation, who is the Deputy Chief of Staff for Personnel.

Mr. ENGLISH. We would like to ask questions.

First of all, I would like to ask—you are asking for a 25 per cent increase in funds—in what exact area will that additional funding be used.

General BLANCHARD. We have a specific numerical listing. We may save that for General Fitts.

Mr. ENGLISH. Have you been able to determine, or did you do any type of study with regard to the relationship between discipline problems and drug abuse?

This committee about a year ago did undertake a very modest type of survey at Fort Campbell, Kentucky where an awful lot of officers listed a definite connection between discipline problems and drug abuse. That particular survey that we conducted indicated that there was some relationship.

General BLANCHARD. I don't know how you are going to make a totally conclusive study, Mr. Chairman.

We have a great deal of statistics. It would be an excellent question to ask, as you get down the line to the Brigades, etc.

Let me ask my Provost Marshal to respond to that.

General FITTS. Our experience indicates that the same type of individual has disciplinary problems, whether he is on drugs or not. I think our feedback upholds that.

General BLANCHARD. There is no question but what the individual who is experimenting—if he is identified early—can be helped and we avoid the discipline problem. But as a man gets further and further into drugs—particularly hard drugs—it leads towards discipline problems.

I suspect you would recognize this reflected in some way, even if it is not a drug related incident.

Let's take this under advisement.

Mr. ENGLISH. One further aspect.

A lot of problems, discipline problems—analyzed and assumed to be alcohol problems—were in fact probably drug problems, using pills at the same time as alcohol.

All individuals arrested for non-drug offenses were required to undergo urinalysis tests because they were picked up for alcohol problems, and were also using drugs.

As you may know, Dr. Morrow, who did research back in 1974/75 came out with his findings that in the so-called good soldier syndrome, you would have a drug culture with tremendous amounts of peer pressure. Even though they themselves can be good soldiers and not attract attention to themselves, and not appear to be discipline problems among themselves.

Do you have any information on that?

General FITTS. I understand that we get feedback.

Dr. Morrow has commented on it. We also end up being told by commanders. It isn't necessarily that way. They say it is peer pressure among those groups.

Mr. ENGLISH. By company commanders?

General FITTS. Company commanders.

Mr. ENGLISH. General Haig made an observation yesterday.

The way the military is set up—I think it is a fact—a company commander is responsible for what happens to the men that are under him; and given the fact that drug abuse is not caused by the company commander—it is a problem of their source, young people coming into the Army bring it with them—given the fact that you do have those two facts meeting head on, there is an indication that—from the standpoint of the company commander, if he does have drug abuse, he is responsible for it. That if he were the type of commander he should be, it wouldn't be there.

The question I am asking is: Is there any effort being made in Europe, here in Germany, to remove what appears to be an unfair situation? It appears to be unfair for a young company commander in Frankfurt—with a tremendous availability of drugs, a much higher availability of heroin than a comparable company commander would have at Fort Sill—to have his records evaluated on the same basis as another company commander who does not have that problem. If you have one who has a great deal of drug abuse, it has a tendency to put a black mark on his record.

Also, one very difficult problem is the Court decisions.

It has been very hard to catch somebody by either urinalysis or through the use of drug detection dogs. Then they undergo the treatment for a while. You are not going to be able to prosecute.

What I was wondering about, have you found that type of disincentive?

Do you find company commanders that—because of these circumstances—become so frustrated that they don't want to find those soldiers, or apprehend them.

General BLANCHARD. If there are individuals of that kind—and I am sure there must be—I would have to say first, in many commands the opposite is true. And that the battalion commander is charged, and is given credit, for detecting that, much more than he is in any kind of coverup.

This point has been made earlier, as you know. I do not hold to that as a philosophy of the commander.

Secondly, looking at it from the experience of my command thus far, I do not see it within the company.

I think it would be a good question to ask of the military community.

One of the nicer things about today's Army is, they will talk, and they are not scared like I was when I was a private. You will get a response.

Although there may have been individuals, and there may have been isolated incidents where the problem is suppressed, it is neither the philosophy of the command, nor has it been my experience that the identification of a drug problem in a unit may impact adversely on an officer's efficiency report.

Mr. ENGLISH. Under your command, is there any type of special recognition made to the young company commander who does find the drug abusers, to provide that incentive?

General FITTS. I looked at that. We did not find that the company commander felt intimidated in any way. It was voluntary; however, they didn't feel they had all the tools they needed to do the job.

We have gone on record in a very positive way to show that we were supportive of this concept, but to make absolutely certain, General Blanchard went to the field with a letter advocating recognition for the commander who has been successful at identifying and dealing effectively with drug abusers.

Mr. GILMAN. Two years ago, information received at that time indicated that 30 to 40 percent were involved in drug abuse—largely because of the lack of training time available to the Corps—and lack of professional help.

What action has been taken between 1976 and today—as of this date—with regard to the problems we pinpointed back in 1976. What progress has been made in those areas?

General BLANCHARD. Some progress. First of all, the length of time the soldier spends in Europe. 75 per cent of our soldiers are three year enlistees, and 25 per cent are four year enlistees.

Department of Army has just indicated to us that effective 1 January the soldiers who are in that second category—the four year enlistees—will only serve two years in Europe.

We have asked Department of Defense for two year enlistments for Europe, in which the soldier would sign up for Europe, would get his training, and finish his 18 or 19 months in Europe, and then reenlist or leave the Army at that time.

One of my highest priorities is to get the tour shortened for the three year enlistee. I think that would help the situation.

The second problem is that an important difference exists between the soldier who comes into Europe, and the soldier who goes into a Stateside Unit.

In Europe the commander has the responsibility for a soldier 24 hours a day. In the States my parking lots were empty at 6:00 o'clock at night. In Europe there is no place for this young person to go. In the States, the ethnic soldiers could each go into their own environment. A young black man here does not have that opportunity. There are no German Blacks, nor is there a Hispanic population. So we are responsible for that man for 24 hours a day.

Additionally, by increasing our training efforts, and by decreasing the numbers of individuals who are getting court-martialed, and other kinds of disciplinary actions, and as a result of better training methods, we are providing a better training environment.

I think there has been a substantial improvement on the on-duty side, and some improvement on the off-duty side as well, with the consideration of recreation alternatives, with German-American relations, with sports and other activities that help reduce boredom in his off-duty time.

Mr. GILMAN. In that time there has been a need for more professional help. It is obvious that there is also a need for more support of the CI activities. Has any progress been made in that regard?

General BLANCHARD. Not very much. We have had this continuous drive for more effectiveness on the battlefield with the teeth to tail ratio, and the resources available to us have been limited despite the size of the Defense Budget. We have not and will not be able to make significant improvements until we get the funds and personnel we have requested.

Within the resources, available we have increased our capability.

In the Military Police/CID area, General Kanamine will address what we have accomplished to date.

We are going to use this Committee's efforts to help. We have already received indications from the Department of Defense of their willingness to support our efforts.

Mr. GILMAN. We are here generally to be supportive. Very little progress has been made in two years. We are wondering where the lack of attention is.

General BLANCHARD. Mr. Gilman, I indicated in my presentation we did see this when you were here two years ago.

The efforts that we undertook at that time were efforts to increase the professional staff, to increase the capability of 91G, the military counselors that are that are trained in our Army school system.

But we also, at the same time, were getting requirements to decrease—in the sense of maximum application to our combat mission and combat effectiveness—and I don't think in those two years we have seen a lack of progress.

General FITTS. There was some effort to increase the 91G capability by providing additional and more specific drug-oriented training prior to leaving CONUS.

General BLANCHARD. There have been some additional efforts in the medical field, in terms of studies by our doctors to determine the kind of clinical help needed and the drug overdose situation and what it really means.

General REID. For the 91G there has been an absence of supervision, due in part to the shortage of clinical directors.

The fact that we have had a shortage of supervisors has adversely affected the 91G's capability to perform. Hopefully, the 91G will be upgraded. We have done a lot to try to upgrade their training, utilizing the professional people in the hospitals and MEDDAC.

So there has been training to try to develop this group, but have a long way to go.

Colonel KRAAK. We feel that the effort that has been put forth has been adequate, as far as the criminal information and criminal intelligence aspect. We find no let down. We find no problems in that area. This was brought about with the coordination efforts between the CID and various German Police Agencies throughout Europe.

I see no problems—if I understood your point—on criminal intelligence.

Mr. GILMAN. There seems to have been a lack of manpower before.

Do you have sufficient CID men?

Colonel KRAAK. We need 20 additional agents, devoted full time to drug suppression, in conjunction with MPI. Should these be made available, it will definitely increase and enhance our capability.

General JOHNS (Ret). This was approved Monday.

General BLANCHARD. The indication by the Germans is that they have a problem. They recognize that the American contribution to that problem is minimal.

We have made efforts to get their recommendations. The Germans have understood. The Police Chief understands as does the Oberburgermeister in Berlin and within the FRG, probably in both cases.

Mr. GILMAN. Do you feel that there is sufficient recognition by the German Government that it is a German problem?

General BLANCHARD. There is a greatly increased recognition. There are a number of trained people at Bonn and other areas.

[To Mr. Cash] Perhaps if you were to address that very briefly?

Mr. CASH. Berlin recently, in the past year they have increased by 30 per cent their capability of suppression.

At the same time there was a Joint Police Task Force which was not part of that system at all. They are beefing it up. There is always a need for additional personnel. This is something that you are going to have to deal with. But certainly in the larger areas such as Frankfurt, they are coming up with the needed manpower.

Mr. FASSLER. The problem of recognition, as far as the Governments are concerned, is much greater at the lower level.

Mr. GILMAN. Do you feel that there is a greater attention at the Federal level?

Mr. CASH. Absolutely.

General FITTS. I am personally familiar with Frankfurt. They say they have a problem. That would not have happened two years ago.

Major MASON. The 2d Region CID in the first part of 1977 detected a shortage in the availability of heroin.

In September 1977, 34 CID Special Agents were working full time or more than 50 percent of their time on drug suppression. Twenty-two Military Police and MPIs were operating eight Joint Operations Teams.

One year later, we find that we have 44 CID Special Agents spending 50 per cent or more of their time on drug suppression. Our increase in MPI strength went to 33, and 19 Joint Drug Suppression Teams.

We saw the threat come from July 1977 to now, and have requested additional resources.

Mr. GILMAN. You have made requests for additional personnel to Washington over the past three years.

General BLANCHARD. They have related in time to a considerable amount, relating to the interest of this Committee.

As far as the approval level which is necessary to do more than take them out of our hide—I think you realize, Mr. Gilman, that I have the option of taking a man out of his regular combat unit. I don't like to do that.

I am also charged with combat effectiveness. The perception of the problem in terms of its severity becomes an important part of that judgment.

It is not my judgment that drug abuse at this point in time is extensive. At the same time, we recognize through the analysis of the unit personnel opinion surveyed data, plus the use of SUUTCO, where an entire unit is given the urinalysis test based upon an estimate of one of the commands that there is a problem that a serious problem exists.

You may remember we talked informally about the extent of the problem. We have developed the capability to assess the problem magnitude in the past few years far better than we ever had before. We are now quite sure of where we are in the overall numbers and percentages. And in terms of legality, we think we are now better able to determine corrective measures.

Mr. GILMAN. Just one more question.

Are you getting favorable replies to your request for additional personnel?

General BLANCHARD. I will say we have had from the Chief of Staff of the Army within the last month an indication that he did support the request which we submitted earlier for increased resources.

General Johns indicated that it had worked its way to OSD level.

General JOHNS. (Ret). Twenty CID spaces, and four portable Urinalysis units are the authorized increase in the end strength of the Army.

And to make further justification for the 45 MPI.

General BLANCHARD. I would request the Committee and staff, as they move around to the commands, to not only talk to the soldiers, but also to look at the facilities.

The soldier is entitled to better facilities than he has in Europe, and they are not available.

This has been indicated in Washington—Where do you put your money?—we have a 20 year plan for the implementation of that program.

Mr. ENGLISH. Let me say this.

In your opinion, is there any correlation between facilities and the decline of the dollar with regard to the increase of drug abuse which has taken place since 1977?

General BLANCHARD. It could be. I would say yes, there is a correlation, without being able to back it up, statistically.

When there is only one gym for 14,000 troops—We would like to provide the troop an individual place he can go and work off that extra energy. Seventy-five to 80 percent of our troops are 18 or 19.

Mr. ENGLISH. With the decline of the dollar, he cannot provide himself with entertainment. There are very few facilities on post that can take up the slack. He is sitting there in the barracks.

General BLANCHARD. That is strongly put, but that is accurate.

Mr. ENGLISH. Is there any connection in your mind that drug abuse has an impact on combat readiness?

General BLANCHARD. I measure it by the end product, and I look at it in comparison with the 5½ years I have been in Europe.

First, I don't see people in the units who are spaced out—with the exception of one or two per company—that have been already identified, and who are either in the program or have been determined to have been a failure and are on the way out.

Secondly, I look at the exercises—evaluation exercises—being conducted in the major training areas and I find a tremendous difference in the ability of that battalion to do its job in a far better way than we were ever able to do it before. There has been an increase in professionalism; and an increase in participation at that level, which I find very encouraging.

From the standpoint of drug abuse, if there is one soldier—as we have indicated before—it is one too many. But when you are talking basically about the two general categories—one, experimental, and two, the real abusers—you are talking about very small numbers within USAREUR. But you are not talking about something that I would be concerned with if I had to go to war tomorrow.

Mr. ENGLISH. Drug abuse within the Forces here in Germany is not such that you would be concerned about combat readiness? You are basically saying that it has no effect on combat readiness. Is that correct?

General BLANCHARD. I can't measure it in terms of one or two in that company of 150. From the standpoint of the question: Do I believe that drug abuse within Europe is significant in the sense that it would affect ability to go to war, no.

Mr. ENGLISH. Ability of your personnel to perform at the highest level?

General BLANCHARD. That's what I mean.

Mr. ENGLISH. I have to say, General, I am a bit disturbed about that. Within certain units you have clusters of drug abusers.

General BLANCHARD. Three or four people in a group.

Mr. ENGLISH. Given the fact that you have greater responsibility for every individual—there are people who can really screw up the works—causing units who have clusters to be rendered inoperable.

General BLANCHARD. Remember our definition of drug abuse is once a month or more often. Maybe we are confused with definitions. The thing that really bothers me is the increase in heroin. This is really very, very serious. The increase in supplies is part of it. As you know, that is the thing that has me most worried.

Mr. ENGLISH. There is an increase in the availability of drugs here within Europe classified as hard drugs.

General BLANCHARD. I am talking primarily about hard drugs.

Mr. ENGLISH. General Haig gave us the statistic of 7.8 percent that are users.

General BLANCHARD. That is drug abuse as a whole. Heroin abuse is 2.3 percent.

Mr. ENGLISH. We have heard a statistic of 40 percent drug abuse. You are saying that as far as combat readiness is concerned, they are combat ready.

General BLANCHARD. You have to say that drug abuse is bad as a whole. You have to realize that it is against the law totally. And then you have to recognize that some people are pushing.

So you can't say, I'm not going to concentrate on marijuana, hashish; but at the same time you go within that category, at the real cancer, heroin.

If you say, where is your evidence, as Commander in Chief I am really concerned more about heroin and the evidence of increased use.

Mr. ENGLISH. It appears to me if a soldier is spaced out, it doesn't make much difference on what; that soldier, you can't count on him.

General BLANCHARD. I said I have very little evidence to indicate that the soldier who smokes a marijuana cigarette once a month or somewhere in between there would be ineffective.

It would be good if we could come up with a common definition, because you get an entirely exaggerated idea of what we are talking about. 40 percent or three percent.

Mr. ENGLISH. Our definition has been once a week, 40 percent.

General BLANCHARD. We don't see it that way. We are prepared to give you what we have.

Mr. GILMAN. One of the problems is, how realistic and how accurate are the surveys that you have available?

You have a problem in that area as well, and this indicated three percent heroin usage there. Attach to that a narcotics, barbiturates user. What percent before you get into an administration problem?

General FITTS. We have two types of data: 7.8 percent is what our soldiers are telling us by survey that they are taking in terms of those three categories, once a month: Opiates, Barbiturates, Amphetamines.

And what we have done by urinalysis——

Mr. GILMAN. Is that in addition to the three percent heroin?

General FITTS. Back in January they were telling us that out of that 7.8 percent, the heroin usage was 2 percent or less out of that total. The 7.8 percent has not changed, but that there has been a rise of heroin usage within that total. There has been a decline in Amphetamines and a decline in Barbiturates. That is the way that it came out on an average.

Does that help at all?

Mr. GILMAN. Now I am asking another question with regard to your survey. We find that from your own charts almost a doubling of the hepatitis cases and a tripling of the heroin usage.

Some of these statistics don't jibe too well. Your heroin went up from 5 million in 1976 to 17 million in 1978. We found there's a direct correlation between access and usage.

General FITTS. We put over 100 percent increase in that effort in the last year as well.

Mr. GILMAN. If I can just present General Haig's indication that he has a problem of recognition. We find that many governments are not willing to disclose with regard to the extent of usage. I can understand that problem. We discussed that earlier today.

We were in Iran in 1973—they had 400,000 addicts in that country—they executed the traffickers.

How reliable do you find your statistics base right now?

General BLANCHARD. Far more so than two years ago. One reason, we have validated the UPOS with our SUUTCO and other urinalysis data.

To date we have tested 72 company sized units using our SUUTCO procedures. Everyone in that unit, from the company commander on down, have been tested. We find a direct correlation between our SUUTCO data and what our personal opinion survey tells us.

General FITTS. We have our analyst here, LTC Farmer.

Colonel FARMER. Just briefly, as you pointed out, the results of the unit testing is an event in time. Three per cent positive. In the USAREUR Personnel Opinion Survey, we would have 3.8 percent. We are right on the borderline of a perfect correlation.

General BLANCHARD. Who could give me some feeling as to any possibility of change in significant terms if we did this on a basis of once a week?

Colonel FARMER. Our estimated rates of drug abuse have always been monthly or more frequent. Casual use. If we published our rates on weekly abuse, they would be cut approxmiately by one-half.

For example, estimating that approximately seven per cent of the total USAREUR population are involved in casual—monthly or more frequent—use of some drug, if we drop back to a weekly rate, we would come up with about one-half of that.

Mr. ENGLISH. I want you all to understand this Committee is not over here saying that there is an epidemic drug abuse among the US Forces in Europe; and we're not here to put down a black mark. We are here to help.

General BLANCHARD. I understand that.

Mr. ENGLISH. The primary thing we found to be a problem has been the question of trying to get a realistic picture of what is going on.

On the other hand, we find that—I don't think that any information given earlier on was any attmept to be misleading—older officers and older NCOs are involved—between them and the junior officers and younger people—there is a tremendous gap.

General BLANCHARD. I understand that.

Mr. ENGLISH. We recognize and understand—there are four drugs that make up the urinalysis test—the point is, to get into this question of what drugs are taken, what drugs are available in the area, we have a problem of what type of testing is substantially used.

We have run into all these definitions. We need some kind of a handle of exactly what we are dealing with.

General BLANCHARD. Mr. Chairman, I appreciate the Committee's attempt to get at the root of the problem. I believe also that the top management doesn't always know what is going on—which is implicit in your comment—but within our definition of monthly or more frequent use, we have tried to take the guesswork out of it and to come up with realistic accurate estimates of where we are, by scientific means, and in the actual detection of those detected drugs; whereas, previously, we "had" one system which got thrown out of court and another system which was not particularly good.

We think we have a way of bridging that gap.

Mr. GILMAN. I'm sure the staff has some questions.

Mr. LAWRENCE. You mentioned clusters—some of your communities are lower clusters than others—of the four or five most troublesome communities you named, I understand Berlin is one of them.

General BLANCHARD. Berlin, Frankfurt, Nurnberg, and there are other areas—to which you are scheduled to visit in varying degrees.

Mr. LAWRENCE. What other areas were the real troublesome ones?

General FITTS. Stuttgart and Munich are hot spots, whether US troops are there or not.

General BLANCHARD. It is available everywhere, and it is very easy to get.

Mr. ENGLISH. We better move on.

STATEMENT BY BRIG. GEN. WILLIAM H. FITTS, DEPUTY CHIEF OF STAFF, PERSONNEL, HEADQUARTERS, U.S. ARMY, EUROPE AND 7TH ARMY

Mr. Chairman, ladies and gentlemen, we are going to ask our Chief Surgeon and our Provost Marshal to make presentations later on.

Since my testimony before the House Select Committee on Narcotics Abuse and Control in May 1978, USAREUR has taken a number of positive actions to enhance its capability to deal effectively with the drug abuse problem. In our efforts to reduce drug abuse among our soldiers, we have initiated a program that will intensify our identification procedures, improve our methods of assessment, increase our drug suppression activities, and revitalize our rehabilitation and treatment efforts.

The purpose of my statement today is to provide you with an update of the current drug situation in USAREUR, as we perceive it, and to discuss our initiatives for improving identification, assessment, suppression and rehabilitation.

A wide variety of drugs—including narcotics, dangerous drugs, and cannabis—continue to be readily available to our soldiers. Hashish is the drug most widely abused. Our research tells us that more than 30 percent are into hashish at least once a month. This essentially revolves around the E–1 to E–4 population. Although we are concerned about the widespread abuse of hashish, the easy availability of high grade, inexpensive heroin presents a potentially more serious problem to our personnel readiness. The amount of heroin seized by both U.S. and indigenous law enforcement agencies has increased steadily since 1977 and our drug intelligence indicators reflect an even greater increase in the availability of opiates during the next twelve to eighteen months.

Brigadier General Kanamine, the USAREUR Provost Marshal, will elaborate on drug availability and drug suppression activities in a separate statement.

As to problem assessment, although we continually seek new methods to improve our capability to assess drug abuse rates, we believe that our USAREUR Personnel Opinion Survey (UPOS) provides a valid estimate of the drug problem magnitude. The results of our surveys over the past four years are shown on these two graphs. (See figures 1 and 2, pages 162 and 163.)

These figures are based on monthly or more frequent abuse and expressed as a percentage of the total USAREUR population.

Since the survey has been in effect, we have noticed that drug abuse has decreased from its highest level in 1974 to a temporary low in 1976, and began to show signs of upward trend in 1977. In October 1978, we administered our latest UPOS and the results are being tabulated now. Although our final estimates of the abuse rate are not available today, preliminary data based on a 25 per cent return of the survey indicates that drug abuse has not increased substantially in 1978.

In addition to the UPOS, we monitor several other indicators that assist in determining the extent of drug abuse. For example, we track the number of soldiers arrested for both use/possession and sale/trafficking of drugs; the number of personnel identified as drug abusers who are entered into rehabilitation; the number of new hepatitis cases; and the number of alcohol/drug related disciplinary actions and administrative separations. With minor exceptions, these indicators reflected a slight but steady upward trend from mid-1977 through the 2d quarter of 1978. However, our most recent 3d quarter 1978 data show a decline in most of these areas. This is an encouraging sign, but it is too early to ascertain whether this is a trend or only an aberration.

While a number of our indicators suggest an increase in drug abuse over the past twelve months, they should be viewed in light of two factors.

First, the statistics we track are influenced significantly by the amount of effort dedicated to combating the problem and degree of command emphasis placed on identifying drug abusers.

Second, the abuse of drugs by type may vary considerably over time based primarily on factors such as ease of availability, cost, and preferences within peer groups. A thorough analysis of all available indicators has led us to the conclusion that the abuse of heroin is definitely increasing, based primarily on ease of availability and low cost, but the total population of narcotics and dangerous drug abusers has remained about the same during the past year.

The preliminary results of our October UPOS tend to support this analysis.

The apparent increase in the abuse of heroin is of serious concern to this command, and has resulted in the intensification of our total effort to reduce drug abuse throughout USAREUR. Drug suppression is the number one law enforcement priority, and drug problem awareness is receiving more emphasis now than at any time in recent years. Already these increased efforts have produced results as reflected in the increased number of identifications, apprehensions for drug related offenses and the seizure of illegal drugs.

Selected Unit Urine Testing for Company Sized Units (SUUTCO) was initiated in May 1978 to provide USAREUR with an additional assessment capability of drug abuse trends. SUUTCO is an amplification of existing urinalysis and provides for the testing of an entire unit when a demonstrated need exists.

The SUUTCO may be USAREUR-directed or commander-requested, and requires testing of all members of the unit regardless of age, grade, or sex. To date, we have tested over 70 units using this procedure. The results are shown on this chart (see figure 11, page 167). We think that with the SUUTCO procedure, we have a tool that will greatly assist us in monitoring the drug situation.

Identification and Rehabilitation. Our Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) is a balanced effort designed to assist the commander in the vital areas of prevention, identification, and rehabilitation or separation. Commanders utilizing the procedures and facilities provided by the ADAPCP have been moderately successful at identifying drug abusers, entering them into rehabilitation and returning them to duty. During 1977, 2,157 soldiers successfully completed the rehabilitation program. This represents a success rate of more than 50 per cent and a saving to the Army in personnel replacement costs of approximately 23 million dollars.

Thus far, in 1978, our success rate is running about 57 per cent. Despite these successes, we realize there is a need to upgrade the quality of service provided by our Community Drug and Alcohol Assistance Centers (CDAAC). Our goal is to improve program credibility, thereby increasing the number of abusers referred for treatment and our success rate. This gets to the matter of clinical people—we don't have enough—a request for the addition of experienced professional counselors, psychologists, and clinicians is pending approval, as we previously indicated.

Impact on Readiness. We recognize that any degree of drug abuse has some adverse effect on personnel readiness and impacts on the health, welfare, and

morale of our soldiers. Given this known factor, we have attempted to gauge the impact of drug abuse on our total force readiness. In assessing the problem magnitude, we are monitoring several areas.

First, our May 1978 survey of over 300 commanders helped us determine their perception of the effects of drug abuse on readiness.

Second, our SUUTCO data representing a snapshot in time, has been a good indicator of the abuse rate at a particular point in time.

Finally, the high states of personnel, materiel, and training readiness provide useful but imprecise tools for assessing the impact of drug abuse on combat readiness.

Analysis of these indicators tells us that drug abuse does have some adverse effect on individual readiness, but it is not yet of sufficient magnitude to seriously impair the capability of our units to accomplish the mission. We are fully committed to our fight against drug abuse, and realize it could result in a situation where our fighting ability could be degraded. Moreover, we are incensed at the level of exploitation of our soldiers that this represents, and are committed to driving out the pushers by any legal means at our disposal.

USAREUR Initiatives. In July 1978, the Honorable Charles W. Duncan, Jr., Deputy Secretary of Defense, outlined DOD's 12 point plan to reduce drug abuse in the military. We have adapted each of these 12 points to our level of operation.

The remainder of my statement will outline the rapid and decisive action we have taken to comply with these points.

POINT NUMBER 1

Design and administer a comprehensive personnel opinion survey. This is being done at DA level. We will do it here as well.

We feel strongly that our USAREUR Personnel Opinion Survey (UPOS) is a reliable assessment tool for determining the magnitude of the drug abuse problem.

Since 1974, over 40,000 soldiers of all ranks, ages, races and varying social backgrounds have been surveyed on an anonymous basis. Our latest survey was conducted in October 1978 and the completed results will be available within a few days. When the final results are compiled they will be provided to you for the record. In addition to continuing our UPOS on a semiannual basis, we plan to conduct special surveys on an as-needed basis.

Last May we surveyed a group of commanders to assist us in determining the impact of drug abuse on combat readiness. This was a highly successful effort, and we plan to continue administering surveys of this type.

POINT NUMBER 2

Augment existing devices for assessing the extent of drug abuse and locating drug problem areas.

Our recently implemented Selected Unit Urine Testing for Company Size Units (SUUTCO) is proving to be an excellent assessment tool for determining the extent of the problem and identifying areas where drug availability and abuse may be particularly acute. SUUTCO is probably our best device for measuring the impact of drug abuse on combat readiness, since it gives us a good indication of the number of personnel abusing a substance at a point in time. The 3.0 per cent of abuse in the 70 plus units that have undergone SUUTCO tends to nail down the scope of this problem on a unit basis. Additionally, we have improved our capability to analyze the data produced from our regular command-directed urinalysis testing program. Through this effort, we expect to identify high risk drug abuse areas and improve our trend analysis.

One final action in this area, once implemented, is the establishment of a USAREUR Drug Assessment/Assistance Team. A major function of this team will be to identify units/areas with a high incidence of drug abuse so that appropriate preventive action could be taken.

POINT NUMBER 3

Redesigning of the drug reporting system to allow for a more uniform and ready access to trend data.

In August all service components provided their first quarterly report to USEUCOM as required by EUCOM Directive 30-17. One purpose of this directive is to establish standardized reporting of key drug abuse indicators. This

should result in readily available data on drug abuse trends and indicators that present a uniform picture of the drug situation throughout Europe.

I might add, having been in this area for more than a year, it seems to me that the whole matter of definition is the problem that causes the most concern for all of us.

Mr. ENGLISH. That was one of the points we made this Spring. Basically there was a problem—not only between Services—different systems set up. Have you all standardized on your own?

General FITTS. This is for the Army, Air Force, Navy.

Mr. ENGLISH. So you have not received a DOD directive?

General FITTS. No.

Mr. ENGLISH. Are you all doing it on your own?

General JOHNS (Ret). We have not done that yet. We are going to implement an interim probably the 1st of January. We are going to improve on this one.

Mr. ENGLISH. I presume this standard would be available?

General JOHNS (Ret). The judgment that is used by CDAAC, in saying what is a success. Right now it differs from place to place.

General BLANCHARD. General Johns is getting to something else. Everybody is talking about different definitions of what is a drug abuser. The definition of this committee is different than what we are using, or that we are trying to develop within the theater. I think it is important.

Mr. ENGLISH. What would you classify as an abuser—anyone who is taking a substance not prescribed for him?

General BLANCHARD. During what period of time?

Mr. ENGLISH. Any period of time. I think we have been even more liberal than you are. Once a week.

General BLANCHARD. Yet there is no correlation between the figures.

Mr. ENGLISH. That is what I find disturbing. Yours are lower. If both our figures are correct, it would indicate your figures in Germany are based on availability and price, which we agree on, are very critical.

General BLANCHARD. I suspect within different definitions.

Mr. ENGLISH. I was curious about that. Excuse me for interrupting,

General FITTS. Next point, please.

POINT NUMBER 4

Accelerated testing of portable urinalysis equipment.

A pilot program is being developed in conjunction with the 7th Medical Command to determine the advantages and disadvantages of portable urinalysis testing machines at various levels below the central laboratory level to include cost, reliability, maintenance, operator qualification, morale, and regulatory considerations. It is anticipated that the pilot program will commence on or about January 8, 1979 and terminate six months later.

POINT NUMBER 5

We have taken a number of actions to reemphasize the importance of reducing drug abuse to the absolute minimum. The CINCUSAREUR has demonstrated a strong personal commitment to the fight against drug abuse and he has taken action to ensure that subordinate commanders share his concern,

In the last three months, General Blanchard has written two letters that received command-wide distribution emphasizing the importance of our drug related programs. Recently a complete review of the entire Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) was undertaken by several key members of the USAREUR staff. A number of issues needing improvement were identified and a program designed to accomplish our objectives is in various stages of implementation.

Additionally, the USAREUR Surgeon, M. G. Reid, has communicated to his Medical Command a need for increased support of the ADAPCP by physicians and other medical support personnel.

POINT NUMBER 6

Accurately assess the magnitude of drug abuse by dependents and determine how well existing programs are responding to dependent needs.

We recently contracted for the development of a survey instrument to measure drug abuse rates in the dependent sector. Through this means, we hope to learn

more about dependent drug abuse and its relationship to the military problem. We should have the results of our first survey by mid-1979. The availability of treatment for dependents under USAREUR's existing programs has not posed any unique problems. We have a requirement to provide an out-patient rehabilitation service for drug abusers in all of our 35 major communities and most of our subcommunities. Therefore, the service is reasonably available to all dependents.

POINT NUMBER 7

Review our law enforcement capabilities to determine whether we need more and different types of law enforcement personnel.

In recent months, USAREUR law enforcement agencies—Provost Marshal, 2d Region USACIDC, and 42d Military Police Group—have re-examined their drug suppression capabilities and the number of personnel devoted to this effort. A number of initiatives were generated to improve suppression operations and additional resources were identified and requested to support enhanced levels of efficiency.

We designate suppression as our number one effort. We have in advance of authorization applied significant additional resources to suppression activities in the past year.

Additionally, the Second Region USACIDC and the USAREUR Provost Marshal's Office have requested an increase of 20 CID Special Agents and 45 Military Police Investigators (MPI) who will devote full time to drug suppression. We have already assigned the 45 MPIs to these duties in advance of new authorizations. These resources will increase our capability for gathering intelligence, investigating drug activities, and interdicting drug traffic by roughly 100 per cent.

Additionally, a review of the 42d Military Police Group's (Customs) role in drug suppression disclosed several areas where drug interdiction efforts could be improved.

We have requested 53 Military Customs Inspectors/Investigators and 20 dog handlers, who will devote the majority of their effort to drug suppression activities. Primarily, these resource increases will enhance existing border, vehicle processing, mail handling operations, and military customs inspection program for household goods and hold baggage shipments.

As a major new initiative, the CINCUSAREUR has directed the formation of a Drug Suppression Operations Center (DSOC) to coordinate all USAREUR law enforcement drug related activities. The purpose of the DSOC is to optimize our capability to reduce the availability of drugs in USAREUR.

The DSOC will centralize and improve our efforts to acquire, collate, and analyze all available drug data. Operational elements will include representatives from the USAREUR Provost Marshal; Deputy Chief of Staff, Personnel; 2d Region USACIDC, 42d Military Police (Customs), and major subordinate command Provost Marshal Offices. It will operate under the supervision of a Brigadier General who has directive authority in executing all drug suppression activities.

We anticipate that the centralization of our drug suppression operations will result in better coordination among participating agencies, a more rapid response to perishable drug intelligence, and better utilization of available law enforcement resources. In conjunction with this action, the CINCUSAREUR has stressed to his commanders that drug suppression is the top priority in our overall law enforcement effort.

Mr. GILMAN. May I interrupt. The Drug Suppression Operation—who supervises the operation?

General FITTS. General Kanamine heads that. It will be an integrated operation. The CID have agreed to participate in that. The head of the CID will be the deputy of that operation. The customs people themselves are the third source. There will be representatives from all of our field commands. It is a fledgling organization, but it has a promise for the future.

POINT NUMBER 8

Examination of the investigative and prosecutive follow-through in the United States of arrests made on military installations.

This is not a constraint upon our prosecution or enforcement efforts in USAREUR. Nevertheless, in the United States the lack of jurisdiction over drug offenses which are not committed within a military installation is a serious problem.

POINT NUMBER 9

Establish a Berlin Task Force designed to focus on the singular problem of that free port.

On June 30, 1978, the US Commander Berlin (USCOB) convened a meeting of all agencies involved in combating the flow of drugs into and through the western sectors of Berlin.

The objective of the initial meeting was to deterimne the extent of the problem; the impact on the American and German communities; American involvement in drug trafficking; and actions that could be taken from the U.S. military command structure, the U.S. State Department, Drug Enforcement Agency, U.S. military law enforcement agencies, and West German Police and Customs Officials.

The working group established in June was institutionalized and conducted its first official meeting in September. The following task force goals were established:

First, determine measures that can be taken to interdict the drug flow into and through the western sectors of Berlin.

Second, determine measures that can be taken to isolate the American Community from the drug flow.

Third, determine programs or actions that can be taken to assist German law enforcement agencies in improving their capability to combat drugs.

Fourth, provide an overview and direction to assessment, prevention and rehabilitation efforts in Berlin.

The task force will furnish the CINCUSAREUR with periodic progress reports at least quarterly on its achievements and activities. We anticipate that dedicated pursuit of the above goals will enhance our capability to reduce drug availability in Berlin.

POINT NUMBER 10

Contribute to the drug related research effort.

Drug overdose deaths are matters of serious concern. However, little is known about the people at highest risk for overdose, the environments that encourage them, or what might be done to prevent such casualties. The U.S. Army Medical Research Unit, Europe, is conducting a research project to explore three fundamental areas:

Are there personalities or social environments that make death by overdose a higher risk for some people than for others?

Can death by overdose be prevented?

What is the significance of an overdose casualty for either assesing current drug use within the Army or predicting future use?

The research project began in July 1978 and is expected to last through July 1980. Anticipated results include:

Psychological profiles of overdose casualties.

Description of high risk environments.

Suggestions for prevention.

POINT NUMBER 11

Evaluation of our drug-related programs.

We have re-examined the drug situation in USAREUR and the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) and identified specific actions to reduce the availability and abuse of drugs and upgrade the quality of our programs.

The following objectives have been identified as essential to accomplishing this task:

First, we must reduce the availability of drugs to USAREUR soldiers through increased drug suppression efforts. It should be no surprise that we list this objective as first in our efforts.

Second, we should reduce alcohol and drug abuse to the absolute minimum; to 1976 levels or lower.

Third, we should improve USAREUR's drug education program through compliance with Department of Defense directives.

Fourth, we should improve the quality of the Community Drug and Alcohol Assistance Centers, thereby restoring commander confidence in the ADAPCP and subsequently increasing abuser referral rates by at least ten per cent.

Fifth, we should increase alcohol/drug abuser rehabilitation rates by at least ten per cent.

Using the foregoing objectives as guidance, a study group consisting of representatives from the Office of Deputy Chief of Staff, Personnel; Provost Marshal; 2d Region USACIDC; Judge Advocate; Public Affairs; Office of Deputy Chief of Staff Resource Management, and 7th Medical Command developed a comprehensive drug abuse reduction plan.

Where possible our initiatives were aligned with DOD's 12 point plan and have been addressed in previous portions of this testimony. Naturally, any significant improvement in our ADAPCP or overall capability to combat the drug problem will be somewhat dependent on the acquisition of additional resources. Resources required to fully implement our Drug Abuse Reduction Plan are addressed in our response to point number 12.

POINT NUMBER 12

Increase the number of quality of personnel assigned drug prevention and control related duties.

In addition to the increased number of CID Special Agents, Military Police, and Customs Investigators mentioned earlier, we have requested a substantial increase in manpower and fiscal resources to enhance our capability to identify and rehabilitate drug abusers. Essentially, we are seeking a 25 per cent increase in manpower and dollars over current levels.

The following resources have been identified as necessary to achieving our objectives:

Basically, six officers and 17 enlisted personnel to support USAREUR's Drug Education and Assessment/Assistance Teams; 50 Clinical Directors; 40 Additional Civilian Counselors; 4 Physicians; 4 Social Workers/Psychologists; 8 Social Service Assistants; and 2 Secretary/Administrative Assistant types.

The funding comes to 2.6 million dollars, and just about that much for succeeding years.

We believe that adding these resources to an already effective program should increase commander confidence in the ADAPCP and should result in increased numbers of soldiers referred for treatment and improved rehabilitation rates.

This mix of law enforcement personnel, professional counselors and ADAPCP staffers will give our total program the credibility and balance necessary to attack the drug abuse problem on all fronts and win.

You should know that all of these requests for resources are in Washington at the present time.

Mr. ENGLISH. Could we see the last screen bar graphs? [Figures 1 and 2, pages 162 and 163.]

When we left Washington, Don Duskie I believe had some later figures than you have.

Mr. DUSKIE. What I have is January 1978.

General FITTS. This is January 1978.

We have just done another one for October. There are more people saying they are involved in opiates and fewer in amphetamines.

Mr. ENGLISH. With regard to this information on Cannabis users. It is your finding that Cannabis users are also users of hard drugs?

General FITTS. Some do; some don't.

There are figures where you have alcohol with Cannabis. We can make this available to you.

Mr. LAWRENCE. There is a table presented here, discussing the rate with the E–1 through E–4 population. For the age group we are addressing, it is 12.5. And 7.8 for USAREUR as a whole.

Mr. ENGLISH. What would it do with regard to heroin?

Mr. LAWRENCE. Opiates are 2.6 per cent.

Mr. ENGLISH. What did that run in Cannabis use? That might be where the difficulty is.

General FITTS. Not only the age group, but also the educational level.

Mr. ENGLISH. Would you say then that * * * Is there a correlation * * * all volunteer versus draft?

General BLANCHARD. You can't really say that. We are furnishing to this committee figures which show very positively that the high school graduates use drugs less frequently than non-high school graduates. The Army has gotten better in the past couple of years, more professional. It is an extended

number of influences. But in terms of the capability of the Army in Europe—With this group, can I do my mission?—I say, yes.

When you try to compare Reserves and National Guard—primarily in CONUS—I can tell you from an overall standpoint of ability to do the job, that the average soldier we are getting is willing and capable of doing the job.

Is that responsive to your question?

Mr. ENGLISH. It seems to me—12.5 per cent that are using hard drugs; over 30 per cent using some type of Cannabis—it appears to me that it does have an effect. It has an effect on an individual as a human being; it cannot help but affect the way the individual does his job.

I don't care whether he is driving a taxi, or a truck, or whatever; the thing that alarms me most is, we don't know—We flat don't know—We don't know what it does to a soldier.

With the numbers it is a little dangerous to make assumptions that these people are going to do their job. The young officer who is going to lead these E–1's to E–4's, it is a serious question whether or not their units are ready to go into combat because of drug use.

This disturbs me. Since 1976, we haven't had any resolution with regard to the effect of drugs. This is unforgiveable.

General FITTS. I have seen some of that. When their own commander indicates that * * *

Mr. ENGLISH. I realize that credibility is a factor.

General FITTS. Good hard facts are needed.

Mr. ENGLISH. It seems to me, given the fact that these young people—whether officers or enlisted personnel—are going to be placing their lives on the line with that guy next to them, just how reliable is he? If it is nothing else but his reaction time. That has a bearing. I am very disturbed that DOD is doing nothing to find out.

The thing I am asking is,—is it really that important?—if drug use doesn't have any bearing on combat readiness, that it has a very low priority so we will forget it.

But it does have a bearing—it is important—and it is going to have an impact on how you do your job.

General BLANCHARD. Certainly—as indicated by General Fitts in his presentation on the 12 points—DOD is taking this seriously. There is no question.

There was a lack of knowledge overall as to where this is going to lead to. We saw and were comforted by a decrease in abuse levels in 1976, but now we see an increase.

That is one reason why we are so happy to see you, because you can help us.

Mr. ENGLISH. We want to.

Gen. BLANCHARD. We now know fairly accurately—for several years we did not know—we can see some reasons for moving toward the drug increase in the hard drugs, and specifically an increase in heroin usage.

I am bothered considerably by people who say, "We don't believe Generals, but we believe Privates."

I was a Private, then a Corporal, and as I went up that chain I probably acquired a little more perspective as I moved up the line. Hopefully, I acquired an ability to understand a little more of how well a command can function. I have been in several wars as well.

I feel that people have a tendency not to believe Generals. They have to believe somebody, the Captain, the First Sergeant. Or they believe, particularly the Private, whose education in our modern Army is not as high as we would like.

Recently, in a press interview lasting one-half hour, the highest ranking person that was asked to comment on combat readiness was a Sergeant Photographer from Intelligence. But the amount of perspective he had of combat capability of Europe was very limited. There must be somebody we can listen to. Let's find him! He is probably a composite.

Mr. ENGLISH. On the other hand, there is an enlisted man telling you everything he knows about what is happening in drugs. The thing that we have heard all along is that we don't know. That is a fact that troubles us. We don't know.

We got extremely disturbed. We don't believe DOD either. The thing we are trying to get at here is some handle on the 12 points that moves us in the right direction.

The other point that I am raising for now:

If it is really important to go before the Committee and convince our colleagues that it is not important, we have to know what we are talking about. If it does not have an effect upon combat readiness.

It appears to me that there is no way it cannot affect, but the priorities are vastly different. We have additional information that is coming out of the civilian sectors. Is this important enough for us to go before the Appropriations Committee that DOD has to have additional funds?

General BLANCHARD. I don't think there is any question. I think it is important. We look at the curves. They are going in the wrong direction.

I am even more interested than you are in the combat effectiveness of my command. I hope you believe that. I think the committee is here to help us.

Mr. ENGLISH. With regard to believability, politicians certainly appreciate your problem.

Mr. GILMAN. Is there any undertaking to try to reach into the barracks? Are we getting Sergeants involved?

General FITTS. We are talking about drug education, drug assessment. We certainly share that view. What we are saying is, to get that kind of message over to eleven hundred companies, there has been a considerable effort on our part.

We expect to put some teams out to train, brief, and educate, so that people will fully understand the problem.

Mr. GILMAN. Are we doing any of that now?

General BLANCHARD. Sergeant Major Tracey, would you comment on the NCO's?

Sergeant TRACEY. We play a very active role in the support, education, and rehabilitation; and I think I speak for all the sergeants in the command.

General BLANCHARD. Mr. Gilman is thinking about the barracks—the bachelor living in the barracks—what is the NCO involvement, in your opinion, as far as the troops in the barracks are concerned?

Sergeant TRACEY. At one time the NCO returned to the barracks in the evening—and I think it has happened again—he knows his soldiers. He is involved with his soldiers both on and off duty. We have a great counseling program going. I think you will find it is happening. The NCO is involved.

Mr. GILMAN. Is there any training program going on for the NCO? Recognition of the drug problem.

Sergeant TRACEY. Yes. The program has been going on for the past two years.

Mr. GILMAN. How much time is spent in training?

Sergeant TRACEY. The First Sergeant has a portion of a two week course on drug abuse; and a Sergeant Major has a one hour course.

Mr. GILMAN. Is that the whole works?

Sergeant TRACEY. He is detailed to his responsibility in that connection.

Mr. GILMAN. Who oversees that responsibility—counseling and giving advice?

Sergeant TRACEY. It is requested by the Command Sergeant Major in that Battalion, who coordinates with the First Sergeant.

Mr. GILMAN. Is that being followed through? Do you get a report back?

Sergeant TRACEY. A full report in writing, no. The way I check it is when I visit the unit.

Mr. GILMAN. It seems to me, General, the whole effectiveness of the program is how you reach down into the barracks.

General FITTS. We do need to do that more.

General BLANCHARD. What has happened has been the increase in responsibility of the officers. The young officers picked up a great deal of that. And it has to be done by the NCOs. The special program is handled by the Command Sergeant Majors themselves; to identify all the problems in the barracks that the soldiers have themselves, with the assistance of their chain of command. Plus the chief of section and the supervisors. And though it has not been specifically addressed in terms of more than the hour or two hours of class attendance, it comes on a daily and weekly basis.

I hope you will also check that when you go down to the units. We can use some additional effort in this regard. It is the fellow down there, and it also is through the official chain of command.

Mr. GILMAN. Is any professional advice being given to the Sergeants?

General BLANCHARD. The Sergeant has within his community the professional adviser, in each of the community assistance centers. We have a number of professional counselors within those 80 facilities. We are requesting additional assistance. Those people are available within that community, as well as to the company commander and the battalion commander.

Mr. GILMAN. Are they being utilized now out in the field?

General FITTS. We don't believe that the present staffing of the COAAC provides the optimum counselling and educational services for our soldiers. That is why we are asking for 50 civilian Clinical Directors, and 40 additional civilian Counselors.

General BLANCHARD. With the younger Counselor, you have to get somebody experienced, and you have to get money to do it.

Mr. GILMAN. Is the military now training, in-house?

General FITTS. Yes, the 91G.

Mr. GILMAN. That stresses human behavior.

General REID. He gets training in behavioral science skills at Fort Sam Houston. He can work for a psychologist, a social worker, or a psychiatrist, as a technician.

General JOHNS (Ret). Many 91Gs have completed only their training. They have no experience and therefore no credibility with senior NCO's.

The Air Force requires them to have four years of service.

Mr. PICKENS. As an E-5, going to the National Institute on Drug Abuse—even after you began to implement it—the elements that you describe today, how are we going to evaluate the effectiveness?

For instance, 32,000 individuals were arrested on drug charges, and they did a urinalysis; they only came up with 13 per cent positive of those arrested for drug charges.

Looking at heroin versus crime, there is a 19 per cent correlation between heroin use and crime.

If you are going to use bar graphs without dealing with that question, it is going to be very hard to really have a good handle on it.

I think a lot of us feel we will see the increase of heroin; there is no shortage in the United States. I don't think the 12 point program will reduce the problem.

Without the humanistic element, and being able to refer an individual, you can't help someone feel better about themselves.

If there is one gymnasium for 14,000 individuals, we are going to have a hard time.

General REID. I can address the humanistic element in rehabilitation.

There is a subjective portion of the success determination, which includes not only a Counselor's evaluation but also the company commander's evaluation of the quality of the rehabilitation product.

We are ultimately trying to go to a point where there is no longer a positive urinalysis.

Mr. PICKENS. You are coming back with a success ratio of 57 per cent, when I had less than 5 per cent success.

I realize there are different levels of success. You are returning a man back to duty, and if he does not have three Article 15s in the next 90 days, he is a success.

General REID. Keeping a man working is very important. Many civilian programs consider an individual a success, if the man is working, even though he may still be on narcotics. We consider this as a part of our success criteria.

We recognize too that, we are not dealing with the same type of patients. Seldom will we see a total hardcore drug addict—where they are totally inefficient; they can't walk—we seldom see that type.

Mr. ENGLISH. Your success ratio does not include those.

General REID. We don't have that group in the Army.

On our treatment in the CDAAC, where we show per cent of effective soldiers, that is the per cent that are maintained on their job with a rating of effective by his commander.

Mr. ENGLISH. Where their CO referred them to the program—what per cent of them had used hashish or marijuana?

Major HOLSENBECK. About 30 per cent.

Mr. ENGLISH. Do you have a breakdown at what the others used?

Major HOLSENBECK. Hard drugs, 15 per cent. Alcohol. . . .

Mr. ENGLISH. What is the breakdown of those?

General JOHNS (Ret). May I interject an anecdote? I have been around to all Services. An Air Force commander was asked, how many clients have you referred to your program?

He replied, 53 alcoholics, 51 drug abusers.
How many for hashish or marijuana?
Forty-one.
Of those 41, how many would you say were good airmen?
Thirty-five.
Now when those 35 are through with the program, he is a success.
We have an inflated success rate, because we turn back good soldiers listed as successes.
Mr. ENGLISH. Those figures are misleading.
Isn't it also true that people are not addicted to drugs—so they are using drugs by choice and not because they are dependent on them.
General BLANCHARD. May we go to General Kanamine's presentation now. He is also the head of the Drug Suppression Operations Center.

STATEMENT BY BRIG. GEN. THEODORE S. KANAMINE, PROVOST MARSHAL, HEADQUARTERS, U.S. ARMY, EUROPE, AND 7TH ARMY

Mr. Chairman, I would like to take a few minutes to review some of the significant points of the drug law enforcement program currently in effect in USAREUR's operational area and to highlight a few of the factors which impact on drug offenses among U.S. Forces here in Europe. This brief presentation should be of assistance to your committee before you visit field locations.

You will be hearing from me again during the hearings in Stuttgart where I shall appear as part of a law enforcement panel consisting of myself and representatives from the Drug Enforcement Administration and Headquarters, 2d Region CID.

As the Chief Law Enforcement Officer for the United States Army in Europe, I am responsible for the total military drug enforcement program within our area of operations. The drug enforcement program is an integral part of the total USAREUR Command Drug and Alcohol Prevention Program. Our principal effort in this regard is the suppression and interdiction of drug traffickers through an aggressive and coordinated drug suppression program. The degree of drug enforcement is influenced by availability and developed law enforcement intelligence. Here in Germany, drugs are readily available and we have a great deal of intelligence to act on. Cannabis is the overwhelming drug of choice and it is readily available to U.S. Forces personnel. However, our principal concern is the availability of low cost, high grade heroin throughout the Federal Republic of Germany.

Drugs reach the FRG through a variety of routes. Hashish originates in the mideast and North African countries and arrives in the FRG via Northern German seaports, other Atlantic coast countries, and land routes through Italy and Austria. Most heroin seized in Germany today is of near and mideast origin. It is transshipped through Turkey, Bulgaria, Yugoslavia and Austria into Germany. Italy, France, Belgium and Luxemburg are also suspected routes. Contrary to earlier belief, DEA Intelligence has revealed that the majority of heroin in Berlin comes from locations other than the German Democratic Republic and East Berlin. Narcotics are entering Berlin via normal transit routes by automobile and truck from and through the FRG, by air via Tegel Airport, and by train from Frankfurt. A certain percentage, estimated at 20% to 30%, comes from the East, but the exact amount is not known.

Our current drug suppression activities encompass a coordinated effort between elements of CID Agents, MPI, Military Police in the miiltary communities and 42d MP Group (Customs) personnel involved in border operations and the Military Customs Inspection (MCI) Program.

We currently have 39 CID Agents and 75 MPI and MPs, a recent increase of 45, dedicated to drug suppression operating in joint teams in 28, a recent increase of nine, different locations. Twenty additional CID Agents have also been requested to supplement this effort. Five special CID Agents are involved in Level One drug operations throughout Germany, targeting international traffickers who intend to sell drugs to U.S. Forces.

Additionally, the 42d MP Group (Customs) has 30 personnel involved in joint operations with their FRG counterparts at the international border crossing sites of Germany. Nineteen additional personnel have been requested to enhance this aspect of the program. Also, this unit is totally involved in a detailed military customs inspection program which includes: Rhein/Main Air base, Vehicle Processing Point at Bremerhaven, APO inspections and household goods and hold

baggage inspections. Twenty-three narcotic detector dog teams are assigned in this unit throughout Germany, and 20 additional dog teams have been requested.

I would now like to show a few charts which will illustrate law enforcement trends in use and possession of drugs and sale and trafficking cases.

[See chart on Law Offenses-Founded Offenses: Use/Possession, page 180.]

This first chart shows the monthly average of use and possession offenses for all categories of drugs. As I stated earlier, Cannabis offenses represent the overwhelming majority of cases. Dangerous drug offenses remain at relatively low levels. Our chief concern is the increase in narcotic cases. A portion of the increase can be attributed to our intensified law enforcement program. However, the statistics reflect the degree of heroin availability and the potential threat that it poses to our troop population.

We are monitoring our narcotics cases closely to determine if the modest decline in the latest quarter is reflective of a stabilizing trend or merely an aberration of the previously established upward trend.

[See chart on Identified Offenders, page 181.]

The second chart reflects the average monthly offenders identified in the cases shown on the previous chart. Here we experienced another increase in narcotic offenders, but it is relatively modest compared to the previous three quarters.

[See chart on Law Enforcement-Founded Offenders-Sale/Trafficking, page 181.]

The third chart shows the average number of sale and trafficking cases involving military traffickers. Military drug trafficking cases are not significant and usually represent small amounts of drugs. Approximately one-third of our cases involve narcotics which reflects the level of emphasis on our heroin suppression effort.

In addition to these military cases, approximately 560 cases were developed in the past year which involved German and third country nationals.

[See chart on Identified Offenders-Sale and Trafficking, page 182.]

The fourth chart identifies the monthly average of military offenders associated with the cases in the previous chart. In addition, Level I and Level II operations have resulted in the apprehension of 255 German and 141 third country nationals in the first nine months of 1978. This compares to 181 Germans and 99 third country nationals during the same period in 1977.

[See table on Drug Seizures, below.]

DRUG SEIZURES

[Street value]

Period	Cannabis	Dangerous drugs	Heroin	Other opiates	Total
1976	$1,378,681	$796,169	$5,180,084	$58,825	$7,413,760
1977	1,584,670	2,850,251	6,819,813	3,116,416	14,368,150
1978 [1]	1,762,949	2,696,965	17,417,733	423,037	22,300,684

[1] Jan. 1 to Sept. 30, 1978.

The fifth chart shows the street value of drugs seized for the past three years. Approximately 22 kilos of heroin were seized in the first nine months of 1978. This is almost double the amount seized in all of 1977. Approximately 70% of this heroin was obtained through Level I operations.

I wish to emphasize the excellent relationship we enjoy with our Host Nation and other U.S. Military and Civilian Law Enforcement counterparts. We are mutually supportive and have deep ties at the international, federal, state and local levels.

We have recently taken several initiatives to improve our suppression efforts in the future. I have already identified the CID/MPI and MP assets which were added or requested to augment our effort. We have also established a USAREUR Drug Suppression Operations Center in Mannheim, which will centralize all drug suppression operations within the Theater. The Center will also facilitate the drug information collection, analysis and dissemination process.

Further, we have established a mobile task force of CID and MPI/MPs on a trial basis. This task force, entitled "Operation Snow White" was inserted into a drug "Hot Spot" to saturate the area for a brief period of time. The preliminary results have been overwhelming. In the first ten days of the operation, the task force seized over $800,000 in drugs and apprehended 35 military and 12 German and third country national traffickers.

To emphasize a point made earlier about insignificant involvement by military traffickers, the total drugs seized from the 35 military subjects amounted to only $1,200 of the $800,000.

We are pleased with the success of our drug suppression program and anticipate even greater results in the near future. We shall continue to take all steps necessary to curb the flow of drugs to U.S. Forces personnel in Germany, because drug suppression has been identified as our principal law enforcement priority.

Are there any questions prior to the hearings in Stuttgart?

Mr. ENGLISH. With regard to the heroin seized here in Germany, what is the percentage that it has been running?

Major MASON. In 1976 the purity of heroin seized ranged from 11% to 73% pure with an average of 48%. In 1978 the purity ranges from 8% to 92% with an average of 46.4%.

The quality control has gone down, sir. We have a wider scale.

Mr. ENGLISH. It appears to me that the strength of heroin varies.

With regard to the cooperation you have with the Government here in Germany, even taking into account some of the rivalries, it would still be much more difficult in working with the host government—such a large portion of it being sold by German Nationals and some other non-U.S. Government personnel—do you have a conflict?

You have a buyer, a U.S. Serviceman, and a seller.

General KANAMINE. The working relationship that I have—as far as developing information with them—is excellent.

Mr. ENGLISH. With regard to the fact that the local government seemed to be doing—like gangbusters, in cooperation and working on the program—but there seemed to be some problems with the national government.

From what I understand, what the West German government is like, is there really that much that the Federal Government can do? Is it pretty much what the States can do?

General BLANCHARD. Would you comment on that, Mr. Cash?

Mr. CASH. We were talking about the interest at higher level Government, vis-a-vis the Federal enforcement; but the high interest that brings these points to the fore, a more united agreement of what action the law enforcement should take—specifically with terrorist groups—has become integrated at all levels.

General BLANCHARD. Agreements made by the Ambassador and the German Government.

We did make an agreement between the United States and the FRG on June 7, which was involved in more input. We believe that we will have an opportunity to escalate interest at all levels.

This is where our priorities lie at the moment.

Mr. GILMAN. General, do you feel that 20 additional CID people will suffice?

General KANAMINE. We analyzed that. We feel it is adequate.

Mr. GILMAN. Have you had any narcotic traffic inside the military?

General KANAMINE. There is some small trafficking going on. One, two, three, five servicemen are involved in this.

They need lots of money.

Major MASON. The military trafficker is rather insignificant. It is more of a transfer where they would pool money, and one man would go out and make a contact.

Mr. GILMAN. Are any military police involved in the traffic?

General KANAMINE. Yes, but the numbers are small.

General BLANCHARD. General Heiser at EUCOM, at a meeting that we were at the other day, indicated that he had planned to set up a very small group of three or four to oversee—with the notion of trying to pool together Army, Navy and Air Force—he indicated that they had not decided how they were going to do it.

I established the Drug Suppression Operations Center with General Kanamine in charge, since I had most of the Theater responsibility—and he already had the contacts with the officers at the various levels, plus the assistance of the commands and other individuals.

But this looks like the usual percentage of population here in Germany in trafficking, and abusing as well. So I don't know what they are planning to do at the EUCOM level, which might surface in the next couple of weeks.

ADDRESS BY MAJ. GEN. SPENCER B. REID, M.D., CHIEF SURGEON, HEADQUARTERS, U.S. ARMY, EUROPE, AND 7TH ARMY

Mr. Chairman, Ladies and Gentlemen:

As Chief Surgeon I exercise responsibility in seven major areas of the Alcohol and Drug Abuse Prevention and Control Program.

CHIEF SURGEON RESPONSIBILITIES

1. Technical supervision of community drug/alcohol assistance centers.
2. Detoxification.
3. Inpatient rehabilitation.
4. Medical complications of drug/alcohol abuse.
5. Medical statistics gathering, review, analysis.
6. Research.
7. Urinalysis testing.

I will talk about these areas in sequence.

I. Technical Supervision of Community Drug and Alcohol Assistance Centers (CDAAC).

There are 80 CDAACs, plus a number of satellite centers in USAREUR. The Chief Surgeon provides technical and clinical supervision of all rehabilitation, as well as assessment of clinical effectiveness. This supervision is exercised by my office through 12 regional clinical consultants to the 80 CDAACs in the field.

When present, the primary supervisee is the CDAAC Clinical Director, who in turn supervises the counselors in the CDAAC. Each of those centers is supposed to have a clinical director. At the present time, there are only 19 of these, which affects the ability of those units to do that job.

My office has recently completed an initial analysis of the clinical effectiveness of 79 of 80 CDAACs, treating 3,913 substance abusers during the 1st and 2nd quarters of FY 1978.

FOLLOWUP SUCCESS RATES ON 79 CDAAC'S TREATING 3,913 SUBSTANCE ABUSERS

A. Using quantitative success criteria (retention on active duty), the ADAPCP successfully rehabilitated:

1. 60 percent of 3,913 Substance Abusers;
2. 65 percent of 1,565 Alcohol Abusers (improper users of alcohol and alcoholics); and
3. 57 percent of 2,348 Drug Abusers (improper users of drugs and drug dependent).

B. Using qualitative success criteria (retention on active duty and were "effective soldiers"):

47 percent (847) of 1,817 program terminators were "effective" soldiers (in second quarter fiscal year 1978).

Using a quantitative success criteria of retention of a soldier on active duty was simply one criteria that was used. We successfully rehabilitated 60 percent of these 3,913 substance abusers; 65 percent of the 1,565 Alcohol abusers; and 57 percent of the 2,348 drug abusers.

Now the rationale of using retention as a criteria for success is one that has been stressed by a number of researchers in civilian life. They have used retention in the job as a definition of success.

This is where we used the concept of retention, plus the opinion of the company commanders and the counselors, that the man is an effective soldier. Forty-seven percent of those 1,817 soldiers terminating the program during the period of study were successfully rehabilitated to "effective" status.

CATEGORIZATION OF 79 CDAAC'S IN TERMS OF THEIR EFFECTIVENESS

A. Based on quantitative criteria of success:

77 percent of all CDAAC's had MODERATE SUCCESS RATES in the range of 40 percent to 80 percent retention on active duty.

15 percent of all CDAAC's had HIGH SUCCESS RATES in the range of 83 percent to 86 percent retention on active duty.

B. Based on qualitative criteria of success:

81 percent of all CDAAC's had MODERATE SUCCESS RATES in the range of 28 percent to 68 percent effective soldiers on duty.

14 percent of all CDAAC's had HIGH SUCCESS RATES in the range of 78 percent to 80 percent effective soldiers on duty.

Now here is the categorization of 79 CDAACs in terms of their effectiveness, comparing one CDAAC against the other, our own comparisons.

Again, based on retention criteria 77 percent of CDAACs had a moderate success rate and 15 percent had a high success rate.

Based on the concept of retention as being an "effective" soldier, 81 percent of CDAACs had moderate success rates and 14 percent had high success rates.

I should point out that these are simply methods of comparing CDAACs. We were not comparing them to civilians. We are first to admit that comparing these soldiers with civilians is impossible. In fact, in my opinion, I think it is very, very poor. I think that we can do a lot better than that in this area.

II. DETOXIFICATION

Every USAREUR MEDDAC provides detoxification services to substance abusers suffering withdrawal symptoms or adverse reaction to drugs or alcohol. We have detoxified 1,121 patients for drugs and 921 for alcohol in FY 1978.

III. INPATIENT REHABILITATION

There are five Extended Care Facilities for the young drug and alcohol abuser in USAREUR: Berlin, Frankfurt, Heidelberg, Landstuhl, and Nurnberg. These are hospitals where we admit the patients.

In addition, we have the specialized Alcohol Treatment Facility at Bad Cannstatt designed for the older, senior alcoholics. Medical personnel number 190, with 90 being full time, having full time employment in the drug program.

These rehabilitation centers deliver a variety of therapeutic modalities generally stressing development of individual responsibility for behavior, improvement of social skills, and a chemical free existence within an external framework of a four week, residential, group setting in which military standards are maintained.

We have had 336 drug and 596 alcohol rehabilitation patients in our Extended Care Facilities in FY 1978. (See Extended Care Facilities chart, page 172.) The Alcohol Treatment Facility opened in January of this year. Thus far, we have had 327 graduates, 200 alcoholics, and 127 co-alcoholics. Twenty alcoholic graduates have been officers, ten have been NCOs from our two highest grades. Eighteen alcoholics have been women.

Figure 13.—*Alcoholism treatment facility discharges, January 1, 1978 to October 18, 1978*

Total discharges	327
Alcoholics	200
Co-alcoholics	127
Officers	20
05	3
04	5
03	5
01+02	4
W2+W3	3
Senior NCO's:	
E-9	4
E-8	6
Females	18

We are just as concerned with the effectiveness of our inpatient program as we are with community programs. There have been three locally done follow-up studies on three different Extended Care Facilities during the past year. There is an overall success rate of about 50 percent.

Mr. LAWRENCE. What is a co-alcoholic?

General REID. It is not an alcoholic. This is a program which brings in a teenager or a wife. At some point in time the wife will come in for a week, and maybe even a teenaged child.

Mr. LAWRENCE. Then co-alcoholic is not necessarily an alcoholic?

General REID. No. These will be a group of people who are brought in to help the patients.

Our criteria for bringing anyone into the entire program is certainly lower than in civilian life. So it is very bad to try to compare our status.

IV. MEDICAL COMPLICATIONS

Medical literature indicates that a large portion of patients requesting emergency room treatment will be substance abusers. "Bad Trips," Hallucinogen precipitated psychoses, amphetamine psychoses are treated in our psychiatric services. Trauma cases are in our intensive care and surgical wards. Hepatitis is a prevalent medical illness often associated with intravenous drug use. Our hepatitis rates have returned to 1976 levels during the past few months. [See chart on Rate of Hepatitis, page 173.]

V. MEDICAL STATISTICS

Overdose is, of course, the most serious adverse consequence of drug use. Our Patient Administration Division has recently developed a computerized recording system for collating overdose incidents. In 1977 we recorded 26 active duty deaths. This figure is as close to absolutely accurate as possible. [See table on Drug Deaths:]

Drug Deaths

1977: U.S. Army active duty	26
Other	5
Total	31
1978: (September 10, 1978) U.S. Army active duty	25
Other	1
Total	26

Mr. ENGLISH. I have a question.

How many of those drug overdoses deaths are diagnosed as drug overdoses when they initially occur?

Is he diagnosed as a drug overdoser at that point?

General REID. No. The final diagnosis is made on the basis of an autopsy. Actually, the final locked-in diagnosis is generally three months behind.

Mr. ENGLISH. The preliminary diagnosis?

General REID. Yes, the preliminary diagnosis may or may not be correct.

Mr. ENGLISH. What percent of preliminary diagnoses of drug overdose would be accurate?

General REID. 80 percent is the ball park figure.

Mr. ENGLISH. There have been some indications that perhaps drug overdose diagnoses were not accurate coming out of Europe, simply because the preliminary diagnosis was incorrect, and was not changed.

There was another explanation offered that possibly in some areas—given the stigma attached and the effect upon the family back home—that the original diagnosis was allowed to stand simply for that purpose.

Have you found that to be correct?

General REID. There is some truth in that.

I would say that in 1977 where we had set up a special group to look at old medical charts—they went through the charts—and that represents about as close to an accurate figure as possible.

It is one thing to talk about a drug overdose or drug related death—we had an individual a while back who was diagnosed as a drug-associated death—he was killed in an automobile accident. We then find out that he was sitting in the back seat and was not driving the car.

Mr. ENGLISH. Do you have any figures for 1978?

General REID. The 1978 figures are from our new computerized recording system. There is an average 90 day lag in reporting while toxicology studies are completed and records processed. As of 10 September we had recorded 25 active duty deaths. This indicates a substantial increase in deaths resulting from overdoses of abuseable substances.

Since there is a three month lag, that really represents about 6 months. We are talking about in the 2 times 26.

Mr. GILMAN. How many of these were drug abusers?

General REID. These are overdose deaths.

Mr. GILMAN. How many of those were known to be drug abusers in the past?

General REID. The vast majority of these have some evidence of being drug users previously.

Captain PEACOCK. We don't have the exact figures on 1978. In 1977 about 60 per cent of them were known drug abusers.

Mr. GILMAN. Had they been under treatment?

Captain PEACOCK. Yes.

General REID. One of the factors of overdose had been the purity of the available heroin. You can kill yourself here on a very small amount.

Mr. ENGLISH. Were any of those overdose deaths from prescription drugs?

General REID. To my knowledge, no.

Captain PEACOCK. It is possible that an individual had a prescription, but whether he did or not, we don't know.

Mr. ENGLISH. Were any of these 60 known to be drug abusers?

General REID. Yes. All of the 60 were in the CDAAC program at one time or another.

Mr. ENGLISH. That doesn't say much to me for the success of that program.

General JOHNS (Ret). You probably had 2,000 people in the program.

Mr. ENGLISH. Numerically, the number of people that are going to get killed through drug overdose.

General REID. During the year around 10,000 people were in the program.

Mr. GILMAN. In one year?

General REID. Approximately.

Mr. GILMAN. How many psychiatrists do you have? In the CDAACS.

General REID. None.

Mr. GILMAN. Who does the counseling?

General REID. The social workers, psychologists, 91G technicians who have had previous training.

Mr. GILMAN. How many psychologists do you have?

Major HOLSENBECK. We have 19 who can be social workers or psychologists, most are social workers.

General REID. Of the 19 CDAACs that have clinical directors, they are either social workers or psychologists.

So in CDAAC, we have 19 of one or the other.

Mr. GILMAN. Of the 19 clinical directors that you have—I think the gentleman said most of them were social workers.

General REID. All 19 could be social workers.

Mr. GILMAN. Apparently then you are undermanned in CDAAC.

General REID. No question about it.

Mr. GILMAN. With 10,000 of these people going through.

General REID. One of the requests that General Fitts mentioned was for 50 additional personnel, either psychologist or social worker.

Mr. LAWRENCE. One question I have on the individual that died in the automobile accident, would that individual's diagnosis indicate being tested for drugs?

General REID. Yes.

Mr. LAWRENCE. Thank you.

General Reid. Urine Testing.

We operate what is believed to be the largest urine testing laboratory in the world, averaging nearly 25,000 specimens per month during FY 1978—in fact, 10,000 gallons of urine.

The laboratory has maintained a remarkable Zero per cent of false positive rate on Armed Forces Institute of Pathology double blind controls for seven consecutive years.

We have never called a negative urine positive. This is terribly important.

One of the problems is the credibility of EMIT, where the credibility is not that great.

Complete results for FY 1978 have just been compiled.

[See chart on Monthly Average of two most frequent and two least drugs yielding laboratory positives for fiscal year 1978, page 174.]

This graph takes total positives, breaks them down by drug for four major drugs and plots them on a monthly basis. There have been striking shifts in composition of Total Positives with Opiates and Barbiturates increasing, and Amphetamines and Methaqualone decreasing. This would seem to indicate shifts in patterns of usage.

If you take the Total Positive figures, 52 per cent positive for Opiates—19.6 per cent for Amphetamines; 6.4 per cent for Barbiturates; about 18 per cent for Methaqualone—you can show an increase here in Opiates that is very significant.

One thing you cannot do with this, is transpose those figures to total numbers. We can look at these only in terms of our own comparison.

One of the suggestions made by DA is that we drop Barbiturates and start testing for PCP. in view of the fact that Barbiturates are showing an increase, we are not in favor of that.

Drug and Alcohol Use Prior To Entry On Active Duty

1. Based on self-admissions of 5,059 new Alcohol and Drug Abuse Prevention and Control Program clients:
   A. 3 out of 4 new clients used alcohol.
   B. 1 out of 3 men clients used a single illegal drug.
   C. 1 out of 2 new clients were polydrug users.
2. Prior drug use by drug:

	Percent
Marihuana	55
Hashish	27
Amphetamines	20
Hallucinogens	16
Cocaine	13
Barbiturates	13
Opiates	10

My last slide, gives an answer to how much drug abuse is caused by the Army—it is not as bad as some of the abusers themselves would have us believe—it is bad enough to give us a little concern.

How this was done, we took 5,000 clients who reported their prior drug use. (21 percent of our clients entered themselves into the CDAAC. About 21 percent come in under apprehensions. Twenty-one percent by urine testing.)

In hopes of getting a more realistic answer, we asked the question:

Have you used drugs before entering the Army?

Three out of four had used alcohol.

One out of three used a single drug before coming into the Army; 55 percent used marijuana; 20 percent used hashish; and 10 percent used Opiates.

That completes my presentation.

CLOSING REMARKS BY GEN. GEORGE S. BLANCHARD, COMMANDER IN CHIEF, U.S. ARMY, EUROPE AND 7TH ARMY

Mr. Chairman, Members of the Committee, Ladies and Gentlemen, we do have a drug problem, and we know it. We think we are reacting to it in a way that is significant. We hope so. And we will be very much interested in this Committee's evaluation of it, not only from the standpoint of the Department of Defense and Congress, but what we can do. We have defined the problem. However, we can well see that we do need more information in that regard. We will be interested in obtaining your views on the data you acquire as you move through the command.

Certainly we need common definitions. Let us keep our assessment capabilities that we think are beginning to make some sense; apply our resources that are made available and the kind of help that you can give.

In the meantime, we will deal with the problem across the board. We are thinking positively, and we welcome the opportunity to work with you in this situation.

If you were to ask what you can do for us today, I would say assist us in writing a common definition; help us obtain the necessary money and manpower for drug apprehension, suppression, and so forth; improving the conditions of life for our soldiers—not necessarily totally where they play, but where they work and where they live.

We agree that drug abuse has a direct adverse effect on the individual and therefore on individual readiness. We know that it can have a similar effect on unit readiness—that is an elastic relationship, one we don't fully understand—yet, it does not significantly impair the ability of our units to perform their combat missions.

What can we do here for you?—We stand ready—We think the program that we have outlined will be of great benefit to you and to us.

Any further questions, Mr. Chairman?

Mr. ENGLISH. We would simply like to thank you, and all of you that took the afternoon off. It has been most helpful to us. This will be very helpful in looking at the entire situation.

We are certainly not out to try to make headlines. The Forces here, for the most part, are extremely fine people who don't use drugs.

Drug abuse is an extremely dangerous problem for all—as well as for civilians—and certainly cannot be pushed aside and cannot be viewed as in the civilian population.

We are positive we will be able to assist, and will be able to plan. We don't know the effect that it has upon combat readiness, and those are the important criteria that we must have.

We are hopeful that people will recognize that this is an extremely difficult problem, one difficult to identify; one extremely difficult to deal with.

Certainly I don't think that any of us expect miracles. The civilian population has had such trouble themselves.

Again I want to thank you very much for your hospitality. We will be doing everything that we can in Washington to assist you.

Mr. GILMAN. Thank you. I want to join my thanks in giving us so much of your time today. I think all of us recognize the extent of it. Hopefully by working together, we can help solve some of the problems. Certainly it is a serious and critical one.

General BLANCHARD. Thank you very much.

Thank you, Mr. Chairman.

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