

CHAPTER 3

PROGRAMS AND POLICIES

LEARNING OBJECTIVES

Upon completion of this chapter, you should be able to do the following:

1. Describe the Navy's Command Managed Equal Opportunity (CMEO) Program.
 2. Describe the duties of the command assessment team (CAT) and command training team (CTT).
 3. Describe the procedures for the conduct of mast.
 4. Describe the programs and policies for identifying and providing treatment for drug and alcohol abusers.
 5. Describe your responsibilities in support of the Navy's Drug and Alcohol Abuse Program in achieving "zero tolerance."
 6. Identify various types and classes of drugs.
 7. Describe some of the common identifiable signs of drug and alcohol abuse.
 8. Describe the difference between problem drinking and alcohol abuse.
 9. Identify the rehabilitation services available for drug and alcohol abusers.
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Today's Navy emphasizes equal opportunity. We will discuss the Command Managed Equal Opportunity program including the command assessment team and command training teams. We will discuss conduct of mast in relationship to equal opportunity and will close with programs and policies for drug and alcohol abuse.

A command must have an environment of equal opportunity to attain and maintain high morale, discipline, and effectiveness. Positive actions to counter discrimination will help achieve that environment. The policy of the Navy is to ensure equal opportunity and treatment for all military and civilian personnel of the Department of the Navy, regardless of race, religion, color, gender, age, or national origin. The prevention of discrimination based on educational, cultural, and ethnic differences and the promotion of sexual equity within the Navy are command responsibilities. The Navy will not tolerate discrimination resulting in the denial of equal opportunity to any individual. Persistent discrimination is cause for disciplinary action and ultimately may result in dismissal or discharge from the Navy.

COMMAND MANAGED EQUAL OPPORTUNITY

Command Managed Equal Opportunity (CMEO) ensures that commands do not wait for discriminatory incidents to occur before taking corrective action. Commands must assess themselves as often as possible to problem-solve and to develop their own plans of action to correct any deficiencies. Equal opportunity is an integral part of each command's leadership and management activities.

As a supervisor you must lead the way by demonstrating those behaviors you require of subordinates. You must show a general respect for all people through what you say and what you do—especially with respect to equal opportunity.

All Navy units must have a CMEO program. CMEO was preceded by Phase I and Phase II of the equal opportunity program. Phase I was a race relations education program; Phase II was designed to translate the awareness generated by Phase I into positive affirmative actions.

CMEO redefines the self-sustaining aspects of Phase II and reestablishes minimum program requirements. The purpose of CMEO is as follows:

1. To emphasize the commanding officer's responsibility for creating and maintaining a positive equal opportunity climate within the command
2. To underscore the chain of command's responsibility for identifying and resolving equal opportunity and sexual harassment problems and concerns
3. To provide commands with the capability to monitor equal opportunity issues, maintain the flexibility to address their own needs, and allocate resources as the situation demands
4. To provide commands with a system for monitoring all personnel issues that affect individual promotion; duty assignments; or other actions emphasizing merit, ability, performance, and potential

CMEO is an equal opportunity management system controlled primarily at the command level. Command-level control makes equal opportunity a reality in each command.

SUPERVISOR'S RESPONSIBILITIES

One of the trademarks of a good supervisor is the ability to develop subordinates by helping them grow both personally and professionally. To develop subordinates, first identify their strengths and weaknesses. Then counsel, coach, and provide on-the-job training. Last, give timely feedback on their performance as well as fair and constructive evaluations.

Conflict is inevitable in any group of people who work or live closely together. Racial, sexual, ethnic, and religious differences among people can be irritants that cause conflict. Accept the fact that your people will have conflicts; then concentrate on managing the conflict rather than ignoring or suppressing it.

Support the Navy's equal opportunity program at your own command by evaluating and resolving discrimination complaints at the lowest level possible. Never suppress legitimate equal opportunity complaints or retaliate against personnel who express a sincere grievance in this area.

Responsibility to Subordinates

Your subordinates should never doubt that you fully support the Navy's equal opportunity program. To accomplish that, lead by example; that will set a standard for them to follow.

ENSURE SUBORDINATES' KNOWLEDGE OF YOUR SUPPORT OF EQUAL OPPORTUNITY. -Clearly state to subordinates that you support and require them to support equal opportunity. Deal positively and directly with all your people equally, and consider each one individually.

You can recognize poor supervisors easily. They typically are unable to understand any point of view but their own. They often make derogatory remarks about groups of people, frequently stereotype people, and feel free to harass or intimidate members of particular groups.

MAINTAIN CLEAR COMMUNICATIONS WITH SUBORDINATES. -You must communicate clearly with your people if you are to manage them effectively. One of the barriers of supervising people who are different from you is dealing with unknowns. If you do not understand how people think, feel, and act, you might avoid them. You might substitute what you don't know with generalized ideas and stereotypes. Therefore, your equal opportunity skills should include the ability to listen and understand what people say.

Responsibility to Command

As a senior petty officer, you have a responsibility to communicate your support of equal opportunity throughout the command. Your support of equal opportunity does not end with responsibility for your division; you are the example throughout your command. Every time you venture into other areas, others learn a lot about your support of equal opportunity simply by the way you handle yourself outside your divisional spaces.

PROJECT YOUR SUPPORT. -As a senior petty officer within your command, you may be called upon to give command lectures regarding the responsibilities of equal opportunity. When giving lectures, project your support as strongly as possible. After all, your view may be the first intensive look at equal opportunity subordinates have had since entering the naval service.

ENFORCE EQUAL OPPORTUNITY. -An equal opportunity program can succeed only if the command identifies, weighs, and corrects insensitive practices. Any person, military or civilian, who directly or

indirectly commits an act of discrimination based on race, religion, color, gender, age, or national origin is subject to disciplinary action. The commanding officer may take one or more of the following actions:

- Counsel individuals concerning their responsibilities.
- If counseling is not effective, or if further action is warranted, take the following administrative or disciplinary actions:
 - Give a warning
 - Lower evaluation marks
 - Award nonjudicial punishment (NJP)
 - Submit a recommendation for separation for the best interest of the service

EVALUATE AND RESOLVE COMPLAINTS AT THE LOWEST POSSIBLE LEVEL. -If you received a complaint concerning equal opportunity, handle it swiftly and fairly. Make sure it is resolved at the lowest competent level the situation will allow. In extreme cases you may have to ask someone above you in the chain of command to help resolve the problem. Others in your command will judge your maturity as a senior petty officer based on how you handle these situations.

COMMAND RESPONSIBILITIES

Commands are responsible for teaching their personnel about the different forms of equal opportunity discrimination and what they can do about them. They also must teach personnel their rights and responsibilities in regard to the Navy's equal opportunity program. Equal opportunity can be observed from two perspectives:

1. Personnel
2. Administration

Personnel

Command personnel make up two teams that evaluate and assess its equal opportunity status. The command assessment team (CAT) evaluates how much command members actually know about equal opportunity. The command training team (CTT) assesses the command's compliance with the Navy's equal opportunity objectives as a whole.

COMMAND ASSESSMENT TEAM (CAT) . -The effectiveness and success of CMEO depends on several elements. However, the most critical is the ability of a command to accurately assess its own equal opportunity status. Commands make that assessment through a command assessment team (CAT). A cross-section of people of different ranks, genders, races, and departments within the command compose the CAT.

COMMAND TRAINING TEAM. -Many people in the Navy do not know their military rights and responsibilities. Therefore, each command forms a command training team to provide CMEO Navy Rights and Responsibilities (NR&R) workshops. The CTT conducts training periodically or when the command receives a great enough assignment of new personnel to warrant training.

The standard CMEO Navy Rights and Responsibilities (NR&R) workshop covers basic Navy equal opportunity principles, policies, and procedures that all hands should understand. It is a 1-day workshop about the following subjects:

1. Enlistment contracts
2. Communications
3. Rights, responsibilities, and privileges
4. Pertinent Navy regulations
5. Authority of officers and petty officers
6. Sexual harassment prevention
7. Perceived barriers of race, gender, and culture
8. Grievance and redress procedures
9. Chief of Naval Operations (CNO) and command-specific issues

Administration

In the administration of CMEO, commands compile data to determine measures needed to ensure equal opportunity. They collect data through surveys, command records, interviews, and observations. They then must determine how to use that data.

SURVEYS. -Surveys are an efficient way to collect data. Although commands can design them to gather information about a variety of topics, they are not as sensitive as interviews in uncovering real issues and problems. Like observations, surveys often produce findings that can be validly interpreted only when considered along with other sources.

COMMAND RECORDS. -Command records contain information relevant to equal opportunity such as training, sailor of the month/quarter/year, awards, meritorious mast, and discrimination complaints.

INTERVIEWS. -Interviews provide information that is not available in command records. Interviews reveal not only what is actually happening at a command, but also what people perceive to be happening and how they feel about it. In a sensitive area like equal opportunity, information about what people think and feel is often as important as documented facts.

OBSERVATIONS. -Observations are a means of determining what people actually do or how they behave and interact. They are also an indirect way of collecting data on what people think and feel. As an unbiased observer, the CAT must be able to distinguish between facts, opinions, and judgments. To avoid bias, the team must also use other data sources from which to draw conclusions.

USE OF DATA COLLECTED. -Information collected from records, interviews, observations, and surveys provides managers with CMEO-related data about specific groups of people within the command. As a minimum, commands maintain specific data on retention, advancement, and discipline of the crew. If the data shows the existence of disproportionate numbers of minorities, commands investigate and take precautions to ensure they are not the result of discriminatory practices.

COMMAND ENFORCEMENT

Commands may use three methods to enforce equal opportunity:

1. Warning (counseling)
2. Nonjudicial punishment (NJP), commonly called captain's mast
3. Separation from the Navy

With warning being the lesser and separation the higher extreme.

Warning (Counseling)

Commands may use a variety of counseling methods to instill in a subordinate the serious nature of the Navy's equal opportunity program. The following are some of those methods, listed in the order of their severity:

1. Verbal counseling

2. Counseling through the use of locally prepared counseling sheets
3. A letter of Instruction (LOI)
4. A page 13
5. A special evaluation

In some cases you may be required to document facts by entering them as a page 13 service record entry or as a special evaluation. Since page 13 entries and special evaluations become a permanent part of a member's record, you should use the less severe counseling methods first.

Nonjudicial Punishment

The Navy awards nonjudicial punishment in equal opportunity cases involving repeat offenders. You will be put on report and must appear before the commanding officer (captain's mast). Some of the punishments that may be given at captain's mast are:

- Restriction
- Correctional Custody
- Confinement on diminished rations
- Extra duty
- Forfeiture of pay
- Reduction in grade

Recommendation for Separation

A member's command must recommend a member for separation in cases of equal opportunity discrimination as well as misconduct.

CONDUCT OF MAST

Nonjudicial punishment is better known in the Navy as captain's mast. The term derived from the early sailing days when the usual setting for this type of naval justice was held on the weather deck at the front of the ship's main mast.

Based on article 15 of the *Uniform Code of Military Justice (UCMJ)*, commanding officers may award punishment for minor offenses without the intervention of a court-martial. They may award that punishment to both officer and enlisted members. The article likewise empowers officers in charge to impose nonjudicial punishment upon enlisted members assigned to the unit of which the officer is in charge. Similarly, the commander of a multiservice command, to whose

command members of the naval service are assigned, may designate one or more naval units for the purpose of administering NJP. For each such unit, the commander must designate in writing a commissioned naval officer as commanding officer for the administration of discipline under article 15. In addition, a flag or general officer in command may delegate all or part of his or her powers under article 15 to a senior officer on the staff. However, the senior officer must be eligible to succeed to command in the absence of the flag or general officer. In addition, those powers can only be delegated with the express approval of the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate. Punishment must be imposed within 2 years of the offense. If it is not imposed within that period the offender may not later be punished for the offense.

MAST PROCEDURES

You can receive notification that someone has committed an offense in a variety of ways—a shore patrol report a verbal complaint by a victim, or a local report chit, to name a few. Except when serious crimes are involved, document charges on the Report and Disposition of Offense(s), NAVPERS 1626/7. Then process the form in the manner prescribed by the form itself.

The NAVPERS 1626/7 is a one-sheet (back and front) form. It serves several functions; among them are the following:

1. It reports the offense(s).
2. It records that the accused has been advised of his or her rights under article 31.
3. It records any pre-mast restraint.
4. It serves as a preliminary inquiry report.
5. It records the action of the executive officer (XO) at screening mast.
6. It records that the accused has been advised of his or her rights to refuse NJP (if he or she has the right under the circumstances of the case).
7. It shows the action of the CO at mast.
8. It records that the accused's appeal rights have been explained.

Remember, however, that NAVPERS 1626/7 does not include all of the required premast advice you must give the accused.

Reviewing the Report Chit

Regardless of how the commission of a minor offense is brought to your attention, you will probably need to prepare a rough NAVPERS 1626/7. (The legal office or administration office normally prepares the smooth.) Always address the report to the officer in charge or the commanding officer of the accused. If the offender has violated more than one article of the UCMJ, identify the separate offenses by Arabic numerals in the section entitled Details of the Offense. If the offender has violated a single article more than once, identify successive violations by Arabic numerals in parentheses. In each instance, be sure to give enough details to describe the offense fully and give the *UCMJ* article number violated. Use numerals in the blocks marked Place of Offense(s) and Date of Offense(s) that correspond to those used in identifying the offenses in Details of Offense(s).

List military witnesses to the offense in the order of their seniority, followed by civilian witnesses, if any. Include the command or address of all witnesses. If a witness is attached to the same command as the offender, give only his or her division or department. If attached to another command, identify that command completely. Give civilian witnesses' complete business and home addresses if available. Finally, be sure to obtain the signature of the person placing the accused on report.

Reading of Rights

The officer contemplating imposing NJP must ensure the accused is fully advised concerning all legal rights associated with the possible imposition of NJP. The accused must be advised within a reasonable time of the report of an offense. Failure to advise the accused properly may render any subsequent nonjudicial punishment invalid.

The *Judge Advocate General (JAG) Manual* contains details concerning required premast advice to an accused. The advice must include the following as a minimum:

1. The offense(s) the accused is suspected of having committed
2. That the commanding officer is contemplating mast for the alleged offense(s)
3. That, if the accused is not attached to or embarked in a vessel, he or she has a right to demand court-martial in lieu of mast

4. That, if the accused will attend mast, he or she will receive a hearing at which time he or she will be accorded the following rights:
 - a. To be present before the officer conducting the hearing
 - b. To have the rights of the accused under article 31 of the *UCMJ* explained to him or her
 - c. To be advised of the offense(s) of which he or she is suspected
 - d. To be present at the presentation of all information against him or her either by testimony of a witness or by the receipt of copies of the witness's written statement(s)
 - e. To have available for his or her inspection all physical information or documentary evidence to be considered by the hearing officer
 - f. To have full opportunity to present any matter in mitigation, extenuation, or defense of the offense(s) of which he or she is suspected
 - g. To be accompanied at the hearing by a personal representative (provided by the accused) to speak in his or her behalf, who may, but need not, be a lawyer
5. That, if punishment is imposed, the accused has the right of appeal
6. That, if the accused demands trial by court-martial, the charges against him or her may be referred to court-martial

No preset forms exist for the accused to use to acknowledge receipt of the above premast advice. However some commands may design their own forms for local use. In addition, the first page of the NAVPERS 1626/7 reflects acknowledgement of some of the above premast advice. For example, it contains a place for the accused to acknowledge he or she has been advised of the nature of the offense(s) charged against him or her and of his or her right to remain silent under article 31b. In any event, when provisions are made for acknowledgment in writing by an accused of premast advice, the accused should acknowledge in writing, when available, the receipt of premast advice and make sure someone witnesses the acknowledgement. If the accused refuses to sign an acknowledgment, have the witness attest to the giving of the warnings and the refusal of the accused to acknowledge. In such cases,

using someone as a witness who has no connection with the issuing of discipline would probably be a good procedure.

Premast Screenings

Before the commanding officer hears a person's case, it is referred to an officer for a preliminary inquiry after which it will be screened by the executive officer at executive officer's investigation (XOI).

At small commands, cases will be referred almost automatically to division officers for the preliminary inquiry. At large commands, the disciplinary officer or the legal officer will be delegated authority to appoint the preliminary inquiry officer (PIO). The job of the PIO is not to develop a case against the accused. Rather, the PIO must collect all available facts concerning the offense itself and the background of the accused. The PIO completes Section E of the NAVPERS 1626/7 as follows:

1. Inserts a short resume of the division officer's opinion of the accused.
2. Lists the names of the witnesses whose presence the PIO thinks is necessary to dispose of the case at mast.
3. Recommends disposition of the case.
4. Summarizes the evidence that supports the recommendation.

The recommendation of the PIO is not binding. The commanding officer will evaluate each recommendation separately.

The XO may screen the case by holding an informal hearing or may merely review the record of the accused and the report *chit*. If given the power by the commanding officer, the XO may dismiss the case, but may NEVER impose punishment.

At XO's screening mast, the accused is advised again of the right to refuse NJP and to demand a trial by court-martial. Article 15 does not give that right to persons attached to vessels. The accused may elect not to be tried by court-martial at XO's mast, but then demand trial by court-martial at captain's mast. The only requirement is that the accused make the demand before punishment is imposed. Case law requires that a suspect be provided the opportunity to discuss with counsel the legal consequences of accepting or refusing NJP. If he or she is not provided that opportunity, the record of any punishment imposed will not be admissible in any subsequent court-martial proceeding.

Punishment

If the commanding officer is convinced by the evidence that the accused is guilty of the offense and deems punishment appropriate, article 15 provides wide latitude.

The rank of the commanding officer and the status of the offender limit the type of punishment the CO can impose. However, under appropriate circumstances, the commanding officer may impose nine types of punishment:

1. **RESTRICTION** -Restriction is the least severe form of denying liberty. It involves moral rather than physical restraint. Generally, while restricted, the member will continue to perform his or her military duties but may be required to report to a specified place for muster during the period of restriction. The commanding officer may restrict both officers and enlisted members.

2. **ARREST IN QUARTERS** -Arrest in quarters also involves moral rather than physical restraint. An arrest in quarters restricts the offender to his or her living quarters unless the restriction is specifically broadened. Although this punishment may require the offender to perform certain duties, article 1020 of Navy Regulations prohibits that person from exercising military authority over subordinates. Flag or general officers in command or an officer exercising general court-martial (GCM) authority may impose this type of punishment on commissioned or warrant officers only.

3. **CORRECTIONAL CUSTODY** -Correctional custody is the physical restraint of persons during duty or nonduty hours, or both. It may be awarded only to nonrated persons. It could include extra duty, fatigue duty, or hard labor.

4. **CONFINEMENT ON BREAD AND WATER** -Confinement on bread and water may be imposed only on nonrated personnel attached to or embarked in vessels. Maximum duration is 3 days.

5. **ADMONITION AND REPRIMAND** -The two degrees of punitive censure, in their increasing order of severity, are admonition and reprimand. The commanding officer may impose punitive censure on enlisted personnel either orally or in writing but must impose it on commissioned and warrant officers in writing.

6. **REDUCTION IN GRADE** -A reduction in grade, or "bust," is considered the most severe form of NJP. It means a member may be reduced one grade.

However, the member may only be reduced one grade as a result of a single mast appearance.

7. **EXTRA DUTY** -Extra duty means offenders must perform duties in addition to their normal duties. Only enlisted members may receive this type of punishment. Extra duty normally may not exceed 2 hours a day, after which offenders are granted liberty—unless, of course, their liberty has been curtailed. Personnel may not perform extra duty on Sundays, although Sundays count in the computation of the number of days worked. However, they may perform extra duty on holidays.

8. **FORFEITURE OF PAY** -A forfeiture of pay is the permanent loss of entitlement to a specific amount of pay. Only basic pay, sea pay, or foreign duty pay is subject to forfeiture.

9. **DETENTION OF PAY** -A detention of pay is much less severe than the forfeiture, because the member will get the detained money back at the end of the detention period. The detention period may not exceed 1 year and may not extend beyond the expiration of the member's current enlistment. Only sea pay, foreign duty pay, and basic pay may be detained. The maximum amount subject to detention is computed in the same fashion as that for a forfeiture.

FINES. -A fine is not an authorized punishment at NJP and cannot be awarded.

EFFECTIVE DATES OF PUNISHMENTS. -As a general rule, punishments awarded at mast take effect immediately upon imposition, unless they are suspended, stayed, or otherwise deferred. An offender may receive a new nonjudicial punishment while serving a nonjudicial punishment of restraint. In such cases, the offender interrupts the original punishment of restraint to begin serving the new punishment. After the completion of the new punishment, the person will complete the remainder of the original punishment. Before a second forfeiture or detention of pay may take effect, the offender must complete all previous forfeitures. Commanders may defer confinement on bread and water or correctional custody for a period of up to 15 days if the needs of the naval service dictate such deferment. For example, the commanding officer may award a person confinement on bread and water while the ship is at sea if the ship has no confinement facility. Therefore, the commanding officer may defer the sentence until an ashore confinement facility becomes available, but not for more than 15 days.

APPEALS PROCEDURE. -A member awarded NJP who believes the punishment unjust or

disproportionate to the offense has the right to appeal the award to higher authority. The member must submit the appeal in writing and include the reasons he or she considers the punishment unjust or disproportionate. Normally, members must submit the appeal to the area coordinator having GCM authority.

Article 15 requires the appeal to be made "promptly," which means within 5 days of imposition—except under the most unusual circumstances. Appeals not brought within this period may be rejected on that basis.

DRUG AND ALCOHOL ABUSE

Drug abuse is incompatible with naval service. It is costly in lost man-hours and unnecessary administrative and judicial processing and is a critical drawdown on morale and esprit de corps. It undermines the very fiber of combat readiness, safety, discipline, judgment, and loyalty. For those reasons, the United States Navy has taken a zero tolerance stand on drug abuse. Zero tolerance is a compassionate policy that offers help to drug abusers who want help. However, it is also a tough policy that separates from the naval service those who defy authority through continued abuse.

The Department of Defense authorizes the use of urinalysis for disciplinary purposes. Urinalysis has become the most valuable detection and deterrence tool used by the Navy. New technology enables wide-scale testing for the use of drugs. Today, recruits are tested within 48 hours of arrival at basic training. Those testing positive for any drug other than marijuana (THC) are immediately discharged. Those testing positive for THC are charged with a first drug offense, which is documented in their record. They are randomly retested for the next 6 months; if found positive again, they are discharged. The recruits are tested again as they report to their first technical school and then tested three times annually throughout their naval service. Knowledge of the certainty of this testing and the severe personal and career consequences for drug abuse act as a powerful deterrent.

The Navy has taken a firm stand against drug abuse. It processes for immediate separation from service any officer, chief petty officer, or petty officer identified as a drug abuser or as drug dependent.

The Navy's five drug screening laboratories are located at Norfolk, Virginia; Jacksonville, Florida; Great Lakes, Illinois; Oakland, California; and San Diego, California. In fiscal year 1986, these laboratories tested close to 2 million urine samples for six drugs:

marijuana, cocaine, amphetamines, barbiturates, FCP, and opiates. They tested each sample three times—twice using radio immunoassay and once using highly specific gas chromatography or mass spectrometry. These technical procedures are designed to protect the individual. They are standardized at all laboratories and centrally monitored through a blind sample quality control program. Facilities using these procedures are subject to frequent inspections. These inspections are one part of the Navy's care and expense in ensuring the credibility of the urinalysis program.

DRUG ABUSE EDUCATION

The Navy emphasizes drug abuse prevention. Education programs make up the largest segment of prevention. General military training on drug abuse prevention and control is annually delivered to over 500,000 enlisted personnel. Other specific education programs include the Navy Alcohol and Drug Safety Action Program (36 hours of prevention and remedial instruction) with an average annual attendance of 53,000. Supervisory personnel attend an 8-hour policy, identification, and referral seminar. In addition to providing general drug abuse education to every person in the Navy, the Navy trains its own command drug and alcohol program advisors, aftercare program coordinators, drug and alcohol counselors, and program managers.

Results from the Department of Defense worldwide surveys of drug and alcohol use among military personnel have shown a gratifying decrease in the use of illicit drugs among naval personnel. Drug use among all personnel within the 30 days before each survey was reduced from 33% in 1980, to 16% in 1982, to 10% in 1985.

Because drug abuse is incompatible with naval service, the Navy will always maintain its zero tolerance stand and will continue to wage war on drugs.

TYPES OF DRUGS AND THEIR EFFECTS

This section describes different types of drugs and how they affect the user. There are medicinal drugs used to treat illness or to relieve pain. Without them there would be a lot of pain and suffering. These drugs include aspirin, antihistamines, antacids, penicillins, and a variety of others. Drugs have a definite purpose in our society especially when they are prescribed by physicians to cure illness. When used as prescribed by physicians, drugs are legal.

Then there are illicit drugs, DRUGS PROHIBITED BY LAW. Illicit drugs and some legal drugs normally available only by a doctor's prescription are manufactured by unscrupulous individuals for sale to underground buyers. These drugs are usually inferior products prepared in unsanitary laboratories for future marketing on our nation's streets.

Some types of drugs that are used legally and illegally are narcotics, stimulants, depressants, hallucinogens, and deliriant. These drugs are described as follows:

NARCOTICS. -Narcotic drugs include some of the most valuable medicines known, as well as some of the most abused. The term narcotics originally referred to opium and the drugs made from opium, such as heroin, codeine, and morphine. Opium is obtained from the opium poppy plant; morphine and codeine are extracted from opium. Medical science has developed synthesized drugs, called opiates, that have properties similar to heroin, codeine, or morphine. Those drugs are also classified as narcotic drugs.

A drug abuser under the influence of narcotics usually appears lethargic and drowsy or displays symptoms of deep intoxication. The pupils of the eyes are often constricted and fail to respond to light.

Some abusers may drink paregoric or cough medicines containing narcotics. The person's breath often has the medicinal odor of these preparations. Other "beginner" narcotic abusers inhale narcotic drugs, such as heroin. They sometimes have traces of this white powder around their nostrils. Constant inhaling of narcotic drugs makes their nostrils red and raw.

The drug addict usually injects narcotics directly into a vein. The most common site of the injection is the inner surface of the arm at the elbow. After repeated injections, scar tissue (tracks) develops along the veins. Because of the easy identification of these marks, narcotic abusers usually wear long sleeves at odd times. Females sometimes use makeup to cover the marks. Some males get tattooed at injection sites. Abusers who inject narcotics under unsterile conditions often get blood poisoning. They often contract diseases such as hepatitis and acquired immune deficiency syndrome (AIDS) and tropical diseases such as malaria.

Those who inject drugs must keep the equipment they used to inject the drugs handy. Therefore, they may hide the equipment on themselves or in a place where they will have temporary privacy, such as a nearby locker or washroom. Some commonly used instruments and accessories are bent spoons, bottle caps, small balls

of cotton, syringes, eyedroppers, and hypodermic needles. Abusers use them all in the injection process. Spoons or bottle caps hold the narcotic in a little water for heating over a match or lighter; cotton filters the narcotic as it is drawn through the needle into a syringe or an eyedropper. Abusers usually keep the used cotton because it retains a small amount of the narcotic. They can then extract it if unable to obtain additional drugs. You can easily identify a bent spoon or bottle cap used to heat the narcotic because it becomes blackened by the heating process.

Under federal law, some preparations containing small amounts of narcotic drugs maybe sold without a prescription; for example, cough mixtures containing codeine. Although these preparations are relatively free of addiction potential when used as directed, they have been abused.

Opiates. -Natural and synthetic morphine-like drugs derived from opiates are the most effective pain relievers known. Physicians often prescribe them for short-term acute pain resulting from surgery, fractures, burns, and the latter stages of terminal illnesses such as cancer.

Since opiates depress the central nervous system, they produce a marked reduction in sensitivity to pain, create drowsiness, and reduce physical activity. Side effects can include nausea and vomiting, constipation, itching, flushing, constriction of pupils, and respiratory depression.

Heroin. -Heroin is a white or brown powder known to the addict as H, horse, caballo, white stuff, white lade, Harry, joy powder, doojee, sugar, stag, or smack. It produces an intense euphoria resulting in an easing of fears and relief from worry; however, a state of inactivity bordering on stupor often follows. Since abusers rapidly develop a tolerance for the drug, they must ingest increasingly large quantities to get a "kick."

Abusers ingest heroin in a variety of ways, including sniffing (snorting), smoking, or injecting it into a vein (mainlining) or just under the skin (joy popping). The latter two methods require the abuser to liquify the powder before using it.

Heroin is manufactured from morphine and, weight for weight, is up to 10 times more potent than morphine. Users "cut" or dilute pure heroin with other substances such as milk sugar (lactose) or quinine, or both. The drug sold to the addict as heroin usually contains one part heroin plus nine parts or more of other substances. Since those other substances are quite often toxic to the human system, they can result in the death of the user.

Morphine. -For many years morphine was the drug of choice for the relief of pain. The street addict calls it white stuff, M, hard stuff, morpho, untie, and Miss Emma. Addicts use it when they have difficulty getting heroin. Small doses produce euphoria. The body's tolerance for the drug and physical dependence on it build rapidly.

Codeine. -More commonly abused in the form of cough preparations, codeine is less addictive than morphine or heroin. It is also less potent in inducing euphoria. When withdrawal symptoms occur, they are less severe than with more potent drugs.

Methadone. -Methadone was invented by German chemists in 1941 when the supply of morphine to Germany ran low. It has many properties similar to those of morphine-it relieves pain and produces physical and psychological dependence. Methadone has one major difference from morphine and heroin-when methadone is taken orally, under medical supervision, it prevents withdrawal symptoms for approximately 24 hours.

STIMULANTS. -Stimulants are drugs that stimulate the central nervous system. The most widely known stimulant in this country is caffeine, an ingredient of coffee, tea, cola, and other beverages. Since the effects of caffeine are relatively mild, its use is socially acceptable and not an abuse problem. However, the use of the more potent synthetic stimulants such as amphetamines, methyl phenidate, and phenmetrazine can result in abuse problems. Stimulants produce excitation, increased activity, and an ability to go without sleep for extended periods.

The main trait of stimulant abusers is excessive activity. They are irritable and argumentative, appear extremely nervous, and have difficulty sitting. In some cases, the pupils of their eyes will be dilated even in a brightly lit place.

Stimulant abusers often go for long periods without sleeping or eating and usually cannot resist letting others know about it.

Cocaine. -Cocaine is a white or colorless crystalline powder. Persons who abuse cocaine either inhale the powder or inject it directly into the bloodstream. It can induce euphoria, excitation, anxiety, a sense of increased muscular strength, and talkativeness; it can also reduce the feeling of fatigue. It causes the pupils to become dilated and the heart rate and blood pressure to increase. In larger doses, cocaine can produce fever, vomiting, convulsions, hallucinations, and paranoid delusions. An overdose can depress the heart and breathing functions so much that death results. "

Crack. -Crack is a relatively new form of cocaine. Crack is a street cocaine mixed with baking soda and water to remove impurities. It is about 50 to 60 percent pure, while street cocaine is 20 to 40 percent pure. Users can smoke crack without the fire hazard involved in free-basing. Crack produces a feeling of euphoria more quickly and with more intensity than cocaine snorted into the nasal passages. The high comes in 4 to 6 seconds versus 6 to 8 minutes from snorting.

Crack causes blood vessels to constrict and the heart rate to rapidly increase, which leads to high blood pressure. Those changes can cause the heart or arteries to burst and can cause massive heart attacks.

In the brain, crack triggers the release of neurotransmitters, causing the euphoric effect. Cocaine blocks the reuse of the neurotransmitters by the brain, thus leaving the brain in a depressed state. The more a person gets high, the more their supply of neurotransmitters is depleted, and the deeper the depression that follows the euphoria. That rapidly progresses to a psychological dependence on the drug just for the person to feel normal.

One reaction to crack is called excited delirium. In this state, a person becomes paranoid and starts shouting and thrashing. The person also becomes violent, with unexpected strength, often breaking mirrors, glass, and other objects. The pupils in the eyes dilate. The body also undergoes hyperthermia (overheating), causing the person to disrobe to cool off. Such episodes last about an hour. Sudden tranquility or a transition to a depressed state may follow, which can lead to respiratory arrest followed by death.

Amphetamines. -Amphetamines are often called "uppers" or pep pills. Amphetamine and methamphetamine drugs provide help for various disorders. They help overweight patients reduce their appetites and provide relief for patients with narcolepsy, a disorder characterized by an overwhelming need for sleep. They also benefit selected patients with aggressive psychiatric or neurological disorders.

Amphetamines have a drying effect on the mucous membranes of the mouth and nose and cause bad breath that is unidentifiable as to a specific odor such as onion, garlic, or alcohol. Because of the dryness of mouth, amphetamine abusers lick their lips to keep them moist. That often results in chapped and reddened lips, which, in severe cases, may become cracked and raw.

Abusers may rub and scratch their nose vigorously and frequently to relieve the itching sensation caused by dryness of the mucous membrane in the nose. They often

talk incessantly about any subject at hand and often chain-smoke.

Because the body develops a tolerance to amphetamines, abusers must increase their dosages to obtain the psychic effects they desire. Tolerance to all the effects does not develop uniformly. Even a "tolerant" abuser can experience high blood pressure, abnormal heart rhythms, loss of appetite, excitability, talkativeness, trembling hands, enlarged pupils, heavy perspiration, and stereotypic compulsive behavior. In serious cases, a drug psychosis resembling paranoid psychosis develops. In addition, violent behavior may follow the use of amphetamines because of unpredictable mood changes.

Amphetamines for medical purposes are available by prescription under a variety of trade names. They are also manufactured in clandestine laboratories as crystalline powder, as tablets, and in a variety of liquid forms; they are then sold through illicit channels.

DEPRESSANTS. -The drugs depress the central nervous system. Abusers of depressants, such as barbiturates and certain tranquilizers, exhibit most of the symptoms of alcohol intoxication with one important exception: no odor of alcohol is detected on their breath. Depressant abusers may stagger or stumble and frequently fall into a deep sleep. In general, depressant abusers lack interest in activity, are drowsy, and may appear to be disoriented.

Since depressants depress the central nervous system, they are prescribed in small doses to reduce restlessness and emotional tension and to induce sleep. Some are valuable in the treatment of certain types of epilepsy.

Continued and excessive dosages of depressants result in slurred speech, faulty judgment, a quick temper, and a quarrelsome disposition. Overdoses, particularly when taken in conjunction with alcohol, result in unconsciousness and death unless the user receives proper medical treatment.

Therapeutic doses cause minimal amounts of psychological dependence, whereas excessive doses taken over a period of time result in both physical and psychological dependence. Abrupt withdrawal, particularly from barbiturates, can produce convulsions. Depressants are exceedingly dangerous.

HALLUCINOGENS. -Hallucinogens are chemicals extracted from plants or synthesized in laboratories. LSD, mescaline, psilocybin and psilocin, and PCP (phencyclidine) are all examples of

hallucinogens. Although openly and irresponsibly promoted as a means of expanding consciousness, hallucinogens have yet to be proved valuable medically. Hence, neither standard dosage forms nor markings exist that make visual identification possible.

Illicit labs produce hallucinogens in the form of capsules, tablets, powders, or liquids; peddlers and users use many methods to transport or hide the drugs. For example, LSD has been found in sugar cubes, candy, paper, aspirin, jewelry, liquor, cloth, and even on the back of postage stamps.

Persons who use hallucinogenic drugs (such as LSD) are highly unlikely to do so while at work. They usually use such drugs in a group situation under special conditions designed to enhance their effect. Hallucinogens distort the user's perception of objective reality. They produce illusions involving the various senses and, if taken in large doses, can produce hallucinations. Persons under the influence of hallucinogens usually sit or recline quietly in a trance-like state. On occasion, users become fearful and experience a degree of terror that may cause them to attempt to escape from the group situation. An important point to remember is that the effects of LSD may recur days, or even months, after someone has taken it.

The effects of hallucinogens are not solely related to the drug. They are modified by the mood, mental attitude, and environment of the user. Hallucinogens usually distort or intensify the sense of perception and lessen the user's ability to discriminate between fact and fantasy. Users may speak of "seeing" sounds and "hearing" colors. Their judgment of direction and distance is generally out of proportion. Their pupils dilate and their eyes become extremely sensitive to light. They commonly experience restlessness and sleeplessness until the drug wears off. The drugs have an unpredictable mental effect on persons each time they take them. As with stimulants and depressants, the user of hallucinogens may develop a psychological dependence. However, unlike depressants, hallucinogens have not been shown to produce a physical dependence.

VOLATILE CHEMICALS. -The volatile chemicals include model airplane glue, lacquer thinner, gasoline, fingernail polish remover, and lighter fluid. The substances contain xylol, creosol, naphtha, benzol, tetraethyl lead, and other chemicals that can cause severe damage to the body by attacking the oxygen level.

Abusers usually retain the odor of the substance that they have inhaled on their breath and in their clothes. Irritation of the mucous membranes in the mouth and nose may result in excessive nasal secretions. Redness and watering of the eyes commonly occur. The user may appear intoxicated or lack muscular control and may complain of double vision, ringing in the ears, vivid dreams, and even hallucinations. Drowsiness, stupor, and unconsciousness may follow excessive use of the substance.

Abusers usually inhale these drugs from the container or from plastic or paper bags. Therefore, discovery of plastic or paper bags or handkerchiefs containing dried plastic cement is a telltale sign of this form of drug abuse.

MARIJUANA. –Marijuana is a greenish, tobacco-like material consisting of the leaves, flowers, small stems, and seeds of the plant *Cannabis Sativa L*, which grows throughout the world. Its fibers have been used to manufacture twine, rope, bags, clothing, and paper. The sterilized seeds are used in various feed mixtures, particularly bird seed. Traffic in, and use of, drugs from the cannabis plant are now restricted by law in most countries, including the United States.

Although known to exist for nearly 5,000 years, we probably know less about marijuana than any other natural drug. In the past, it has been used in the treatment of a variety of clinical disorders. Very early in China's history, it was used to relieve pain during surgery. In India it was used as medicine; in the United States it was used as an analgesic, a poultice for corns, and a component in a variety of patented medicines.

You can identify marijuana smokers by their possession of such cigarettes, often called sticks, reefers, or joints. A marijuana cigarette is often rolled in a double thickness of brownish or off-white cigarette paper. Smaller than a regular cigarette, with the paper twisted or tucked in on both ends, the marijuana cigarette often contains seeds and stems and is greener in color than regular tobacco.

Another clue to the presence of "reefers" is the way in which they are often smoked. Typically, such smoking occurs in a group situation. Because of the rapid burning and harshness of the marijuana cigarette, it is generally passed rapidly, after one or two puffs, to another person. Users inhale the smoke deeply and hold it in the lungs as long as possible. When inhaling, persons often cup the cigarette in the palms of both hands to save all the smoke possible. An additional clue to marijuana use is

an odor similar to that of burnt rope. You can readily detect the odor on the person's breath and clothing.

When smoked, marijuana appears to enter the bloodstream quickly because the onset of symptoms is rapid. It affects the user's mood and thinking. The effects of the drug on the emotions and senses vary widely, depending on the amount and strength of the marijuana used. The social setting in which it is taken and the effects anticipated by the user also influence the person's reaction to the drug.

You probably will not recognize marijuana (pot) users unless they are heavily under the influence. In early stages, when the drug acts as a stimulant, users may be very animated and appear almost hysterical. They commonly talk loudly and rapidly and easily burst into laughter.

Usually, the effects of the drug start about 15 minutes after the person inhales the smoke of the cigarette. The effects can last from 2 to 4 hours. At low doses of one or two cigarettes, persons who become intoxicated may experience an increased sense of well-being, initial restlessness, and hilarity. That stage is followed by a dreamy, carefree state of relaxation and an alteration of sensory perceptions, including expansion of space and time. Users also experience a more vivid sense of touch, sight, smell, taste, and sound; a feeling of hunger, especially a craving for sweets; and subtle changes in thought formation and expression. To an unknowing observer, a person in this state of consciousness would not appear noticeably different from a normal state.

At higher but moderate doses, the user experiences the same reactions experienced with the use of low doses, only they are intensified. Still, you would scarcely notice the changes. The person may also experience altered thought formation and expression, such as fragmented thoughts, sudden loss of ideas, impaired immediate memory, disturbed associations, and an altered sense of self-identity. Some perceive a feeling of enhanced insight. Such distortions can produce feelings of panic and anxiety in those who have little experience with drugs. The panic and anxiety can cause persons to fear they are dying or going crazy. That panic reaction usually disappears as the effects of the drug wear off. Low to moderate doses of the drug produce minimal changes in body functions.

At very high doses, effects may include distortions of body images, loss of personal identity, fantasies, and hallucinations. In addition, toxic psychoses can occur

after extremely high doses. This state clears as the user eliminates the drug from the body.

A person under the influence of marijuana has a harder time making decisions that require clear thinking; therefore, the user becomes more open to other people's suggestions. Since marijuana affects people's reflexes and thinking, their performance of some tasks while under the influence of the drug is dangerous, such as driving.

ABUSER IDENTIFICATION

Drug abuse in its various forms can produce identifiable effects. However, persons taking drugs under a physician's instructions may sometimes experience side effects that may be mistaken as signs of drug abuse. For example, such disorders as epilepsy, diabetes, or asthma may require maintenance drug therapy that will produce low-level side effects; or a person might be drowsy from taking a nonprescription product, such as an antihistamine. Many people use legitimate drugs following a physician's instructions—but without the knowledge of their associates. Therefore, finding tablets, capsules, or other forms of drugs on a person suspected of being an abuser does not necessarily mean the drugs are narcotics or some other dangerous drug. A clue to the possibility of drug abuse comes with seeing the same symptoms over and over again.

No instant tests exist for identification of most drugs. The only way many drugs can be identified is through a series of complicated laboratory procedures performed by a trained technician. Simple visual inspection cannot be relied upon for drug identification. Many potent drugs that are misused are identical in appearance to relatively harmless drugs—many of which people can easily get without a prescription.

Not all drug abuse-related character changes appear harmful in the initial stages. For example, a person who is normally bored and sleepy may, while using amphetamines, become more alert and thereby improve performance. A nervous, high-strung person may, while using barbiturates, be more imperative and easier to manage. Consequently, you must not look only for changes for the worse, but you must look for any sudden changes in behavior. The cause could be drug abuse.

Signs that may suggest drug abuse include sudden and dramatic changes in discipline and job performance, unusual degrees of activity or inactivity, and sudden displays of emotion. Abusers may show significant changes for the worse in personal appearance; they often

become indifferent to their appearance and health habits.

Other more specific signs should also arouse suspicion, especially if a person exhibits more than one of these signs. Among them is secretive behavior regarding actions and possessions (fear of discovery). For example, abusers may wear sunglasses at inappropriate times and places to hide dilated or constricted pupils; they may also wear long-sleeve garments, even on hot days, to hide needle marks. Of course, when a person associates with known drug abusers, that is a sign of potential trouble.

Because of the expense of supporting a drug habit, abusers may try to borrow money from a number of people. If they fail to get money that way, abusers will often steal items, such as cameras, radios, or jewelry, that can easily be converted to cash.

Persons with a severe habit will use drugs while on duty. In such cases, you may find them at odd times in places such as closets or storage rooms.

Generally, drugs have indirect harmful effects. Because abusers may not feel hungry, they often suffer from malnutrition; and because they are so involved with taking the drug, they usually neglect themselves. They are more likely to contract infections because of their poor nutrition and because they may inject contaminated drugs intravenously. They are also likely to use poor or unsterile injection techniques. That may result in serious or fatal septicemia (blood-poisoning), hepatitis, and abscesses at the point of injection as well as in internal organs. Contaminated needles are also known to spread AIDS.

Although you may have difficulty recognizing drug abusers, you should take the steps needed to provide them with help when you realize they have a drug problem. Spotting drug abuse in its early stages (when professional help can be effective) can result in the rehabilitation of many potential hard-core addicts.

Urinalysis Testing

The Navy has adopted the use of urinalysis testing as a major means of detecting and deterring drug abuse. The main objective of urinalysis testing programs is to detect and deter abuse. This ensures the continued visibility of the command's drug abuse program. The term random sampling applies to any command urinalysis testing program in which the individuals to be tested are selected at random. All members, regardless

of rank or age, are subject to participation in the urinalysis testing program.

The urinalysis program uses a system of biochemical testing of urine samples to achieve the following:

1. Establish a valid and reliable means for the detection of drug abuse
2. Serve as a strong deterrent against drug abuse
3. Monitor the status of personnel in drug and alcohol abuse rehabilitation programs
4. Provide statistical data on the prevalence and demographics of drug abuse

Drug Detection Dogs

Commands can request, through the security department, the use of drug detection dog (DDD) teams to help identify drug abusers. Dogs are effective, and the possibility of their repeated use increases their effectiveness as a deterrent. The only persons needing prior knowledge of a DDD inspection or an authorized search are the commanding officer and the dog handler. DDDs may conduct inspections anywhere under naval jurisdiction at any time.

Dogs are trained to inspect for controlled substances and will not harm humans unless provoked. No matter how effective a dog-and-handler team is in detecting drugs, the physical presence of the team alone is often the best deterrent to drug abuse. Abusers can seldom fool dogs; they rarely succeed in their efforts to mask the trace odors the dogs are capable of detecting.

DRUG ABUSE PREVENTION

Today, the basic approach to drug abuse prevention calls for understanding that goes beyond information about drugs. You need to understand people, their feelings, their needs, their goals, and their reasons for taking drugs. You also need to understand the effects of a family or group situation upon human behavior. Showing people you care about them is the most important tool of all for preventing the abuse of drugs.

Learn how to recognize the potential drug abuser and the situations that might contribute to a person's choice to abuse drugs. Offer the abuser or potential abuser alternatives to drugs. Help your people to develop attitudes and value that oppose the acceptance of drug abuse. Help them to see that drugs provide only transitory, counterfeit experiences that can never change the real world, but constructive activity can. Encourage

them to become involved in constructive activities such as volunteer work, sports, clubs, divisional outings, divisional tours, off-duty education, community service activities, part-time jobs, and hobbies.

For nonusers who have never used drugs or who have merely experimented with them, drug abuse education can highlight valid reasons for not using drugs. This type of education also offers alternative ways of achieving satisfaction. Use the basic alternative appeal to "turn on" to life.

One former user who is a recognized antidrug authority suggests four basic steps in dealing with people who already may be using drugs regularly:

1. Develop a sympathetic and an honest attitude.
2. Provide accurate information.
3. Provide information from sources that are credible to the user, such as ex-users.
4. Give people alternatives to the use of drugs.

The young member, particularly on board ship, may need special counseling. When members walk up the gangplank upon reporting for duty, they are apprehensive and have a strong desire to be accepted. They may alter their beliefs and actions in an effort to be accepted by their peers, even if acceptance includes using drugs.

You can control this situation and eliminate many of the problems that may occur by providing proper guidance at this crucial time. When you receive new members in your division, assign one of your most competent division personnel to help them adapt to their new environment. That person will encourage and guide the young members to develop acceptable values and specific goals.

ALCOHOL ABUSE

Alcohol is the number one drug problem in the United States today. The leading causes of death for the 17- to 25-year age group are alcohol-related driving accidents, suicides, and homicides. About 55 percent of all fatal auto accidents are alcohol related, and 60 percent of all motorcycle deaths involve alcohol.

Historically, alcohol has had widespread use in our society. Throughout history, alcoholic drinks have been used with meals, at social gatherings, in religious ceremonies, and at celebrations. Alcohol does have some acceptable uses, but it also can be abused.

Small amounts of alcohol produce a feeling of well-being and light headedness. However, since alcohol is a depressant that slows down the central nervous system, those good feelings quickly wear off. Large amounts of alcohol over a long period of time cause anxiety. Just as with other dangerous drugs, alcohol may cause physical and psychological dependence. This dependence is an illness called alcoholism.

The Navy's age-old problem with alcohol is epitomized in the lyrics of an old drinking song, "What do you do with a drunken sailor?" Until the last few years, the answer was, You let him go down the hatch or down the tubes. For a long time we have contributed to the career demise of the alcohol abuser because of our own traditional involvement in alcohol use. We have not accepted the evidence that alcohol, although legal, is a drug that some people cannot handle. Until recently, alcoholism was considered a disciplinary or administrative problem, which, if unresolved, could only lead to a discharge from the Navy.

Navy Policy Regarding Alcoholism

Various SECNAV and OPNAV instructions set forth Navy policy regarding alcoholism. *Alcohol and Drug Abuse Prevention and Control* OPNAVINST 5350.4B, provides the Navy's policy on drug and alcohol abuse. The Navy Alcohol and Drug Abuse Program (NADAP) uses this instruction as a guide.

The Navy acknowledges its responsibility for counseling all members regarding the dangers of alcohol by providing information to help alcoholics recover. The Navy meets its responsibility by providing alcoholism treatment centers and specialized counseling. You share the responsibility of assisting the command in referring those who are alcoholic to treatment facilities.

Military members are responsible for their own drinking habits; if they believe they have an alcohol problem, they are responsible for seeking treatment. Each member remains accountable for any deterioration of performance caused by his or her own alcoholism.

Firmly maintain and affirm the Navy's drug and alcohol abuse policies as they relate to standards of behavior, performance, and discipline. Do not consider alcoholism, in itself, as grounds for disciplinary action; however, do evaluate a member's demonstrated conduct resulting from the use or abuse of alcohol. Then, if needed, take disciplinary or administrative action as

required. In each case, the appropriate action will depend upon the facts and circumstances.

The Navy recognizes that society has often associated a stigma with alcoholism that has little basis in fact and is counterproductive to successful rehabilitation. The effects of this stigma have reinforced the alcoholic's or alcohol abuser's denial of any problem. The effects of this stigma have also encouraged supervisory and medical personnel to cover up in an attempt to protect the member's career. To bring the alcohol problem into the open where it can be treated, the Navy must reduce the effects of the stigma to the minimum.

Members who have undergone successful alcohol treatment and recovery have the same job security and opportunities for continued service and promotion as other Navy members. However, any misconduct, misbehavior, or reduction in performance caused by alcohol will affect performance evaluations, duty assignments, continued service, job security, and promotion opportunity.

Because alcohol abuse involves the family of the abuser, the Navy encourages the development of programs and activities that contribute to a healthy family life. The Navy also encourages the development of programs to help restore to a healthy state those families who are suffering from the effects of alcoholism. Immediate members of the family of the alcohol-dependent person may receive those rehabilitation services available at their command.

Persons must make their own decision to use or not to use alcoholic beverages lawfully. Department of the Navy policy toward alcohol consists of three courses of action. The first is to promote responsible attitudes about alcohol in those who choose to drink. The second is to promote the social acceptance of those who choose not to drink. The third is to provide both drinkers and nondrinkers with realistic information about alcohol and alcoholism.

Understanding Alcohol and Its Effects

Surprisingly, many experienced drinkers are relatively ignorant of the way their favorite beverages affect them, for better or worse. The same applies to their nondrinking families and friends who may be concerned about why drinkers behave as they do.

Until recent years, when drinking problems forced public concern, little factual alcohol- and health-related information was available. Although people could find

a library of information on how to mix exotic drinks, they could find little about what happens after the drinking starts.

The person who wants to drink responsibly must know the short-term and long-term effects of alcohol on the body. Those who want to understand the social custom of drinking, problem drinking, and alcoholism must also know these effects.

SHORT-TERM EFFECTS. –Most people drink alcoholic beverages to get feelings of pleasure as well as to relieve tension. No doubt that is the reason for the popularity of alcohol as a social beverage. Drinking has become such a familiar part of our society that we do not think of alcohol as a drug. However, it is as much a drug as one prescribed in carefully regulated dosages by a physician.

Alcohol affects the whole body through the central nervous system—the brain. Alcohol does not act directly on the tongue or legs to cause the familiar signs of slurred speech and an unsteady gait connected with drunkenness. Instead, it affects the parts of the brain that control those parts of the body.

Alcohol can act as a stimulant at low doses and as a brain depressant at higher doses. The speed with which alcohol brings on drunkenness and drunken behavior depends upon the rate of its absorption into the bloodstream and a person's tolerance for alcohol.

Although the body must digest food before it can enter the bloodstream, it does not have to digest alcohol. Alcohol immediately passes directly through the wall of the stomach and small intestines into the bloodstream. Then the blood rapidly carries it to the brain.

Even the first few sips of an alcoholic beverage may cause changes in mood and behavior. These changes may be influenced by what the person has learned to expect from previous drink experiences.

Alcohol is metabolized (burned and broken down) in the body at a fairly constant rate. As a person drinks faster than the alcohol can be burned, the drug accumulates in the body. That results in higher and higher levels of alcohol in the blood.

BLOOD-ALCOHOL LEVELS AND BEHAVIOR. –The first consistent changes in mood and behavior appear at blood-alcohol levels of approximately 0.05 percent; that is, 1 part alcohol to 2,000 parts blood. That level would result if a 150-pound person took two drinks in succession. A blood-alcohol level of 0.05 percent can affect a person's thought, judgment, and restraint and cause the person to feel

carefree. The person feels a release from many ordinary tensions and inhibitions; in other words, the person loosens up. Most people drink in moderation mainly to achieve this relaxed state.

As more alcohol enters the blood, the depressant action of alcohol involves more functions of the brain. At a level of 0.10 percent (1 part to 1,000), voluntary motor actions—hand and arm movements, walking, and sometimes speech—become clumsy.

A level of 0.20 percent (1 part to 500) measurably impairs the controls of the entire motor area of the brain as well as that part of the brain that guides emotional behavior. At this stage the person will stagger and may want to lie down. The person may also become easily angered, may become boisterous, or may weep. The person is drunk.

A concentration of 0.30 percent (1 part to 300) dulls the person's response to stimulus and understanding controlled by the deeper areas of the brain. At this level a person may be confused or may lapse into a stupor. Although aware of surrounding sights and sounds, the person has poor understanding of what he or she sees or hears.

With 0.40 to 0.50 percent alcohol in the blood (1 part to 250 or 200), the person becomes unconscious and may go into a coma. Still higher levels of alcohol block the center portions of the lower brain that control breathing and heartbeat, causing death to occur.

This progression of effects is not unique to alcohol. Other hypnotic-sedative drugs, such as barbiturates, ether, and chloral hydrate, can also produce this progression of effects.

Blood-alcohol levels have important legal implications. In most states, a person with a blood-alcohol level of 0.05 percent or less is legally presumed sober and in condition to drive a motor vehicle. However, in some states, a person with a level of 0.10 percent or 0.08 percent is legally presumed intoxicated or under the influence; in others, the 0.15-percent level means legal impairment.

CHRONIC HEAVY DRINKING. –Drinking large amounts of alcohol for an extended length of time reduces the brain's sensitivity to the alcohol. Therefore, a person must drink greater amounts of alcohol to feel its effects. This change in the sensitivity of the brain is called *tolerance*. Increased tolerance is a symptom of all chronic users of addictive drugs and is believed to be the basis of addiction or dependence.

Since alcohol-dependent persons have an increased tolerance for alcohol, they react differently than moderate or heavy drinkers to the effects of alcohol. They can drink large quantities of alcohol without losing control of their actions, while the moderate or heavy drinker cannot. Instead of becoming more pleasant and relaxed as do the moderate or heavy drinkers, alcoholics may become progressively more tense and anxious while drinking. They may accurately perform complex tasks at blood-alcohol levels several times as great as those that would incapacitate moderate to heavy drinkers. At one stage of their alcoholism, they may drink a fifth of whiskey a day without showing signs of drunkenness. Later, in the chronic stage, their tolerance decreases to the point that they may become drunk on relatively small amounts of alcohol.

Alcoholics also differ from moderate to heavy drinkers in their reactions to the abrupt removal of alcohol. The normal drinker may only experience the prosing misery of the hangover. Alcoholics may suffer severe mental and bodily distress, such as severe trembling, hallucinations, confusion, convulsions, delirium (the alcohol withdrawal syndrome), and delirium tremens. Both the alcohol withdrawal syndrome and delirium tremens involve shaking, sweating, nausea, and anxiety. However, delirium tremens can cause death. The average person would have difficulty distinguishing between the alcohol withdrawal syndrome and the delirium tremens. Both require immediate medical attention.

At present, no one knows the reason for the increased tolerance of the alcohol-dependent person to alcohol. At one time tolerance levels were thought to depend on differences in people's rates of alcohol metabolism. However, overall rates of alcohol metabolism were later found not to differ much in normal drinkers and alcoholics. That fact indicated changes in tolerance levels must occur in the brain rather than in the liver.

DRUG INTERACTIONS WITH ALCOHOL. – Alcohol works on the same brain areas as some other drugs. Drinking alcohol within a short time before or after taking those drugs can multiply the normal effects of either the drug or the alcohol taken alone. For example, alcohol and barbiturates taken in combination increase the effects of each other on the central nervous system, which can be particularly dangerous. Alcohol taken in combination with any drug that has a depressant effect on the central nervous system is likewise dangerous. These dangerous reactions are the result of

metabolism—the way our bodies chemically process what we consume.

If drugs were not metabolized within the body, their effect would continue for the remainder of a person's life. In the metabolic process, our bodies transform drugs into other substances and eventually eliminate them through normal bodily functions. The more rapid the rate of metabolism, the lower the impact of the drug. When drugs are forced to compete with alcohol for processing by the body, alcohol is metabolized first; the other drug then remains active in the blood for an extended time. As a result, the effect of the drug on the body is exaggerated since its metabolism is slowed down by the body's tendency to take care of the alcohol first. When added to the normal depressant consequence of alcohol, further depression of the nervous system, which regulates vital body functions, occurs. That serious condition can result in death.

Although anyone's body metabolizes drugs more slowly when the blood contains alcohol, the alcoholic's [or heavy drinker's] body metabolizes drugs more rapidly during sober periods. Therefore, heavy drinkers commonly take even larger doses of drugs. The usual quantities taken by nondrinkers or moderate drinkers would have little effect on the heavy drinker. The results of taking large doses of drugs and then drinking can place these persons in even greater jeopardy; the results can be fatal.

LONG-TERM EFFECTS. –Drinking alcohol in moderation apparently does the body little permanent harm. But when taken in large doses over long periods, alcohol can prove disastrous; it can reduce both the quality and length of life. Damage to the heart, brain, liver, and other major organs may result.

Prolonged heavy drinking has long been known to be connected with various types of muscle diseases and tremors. One essential muscle affected by alcohol is the heart. Some recent research suggests that alcohol may be toxic to the heart and to the lungs as well. Liver damage especially may result from heavy drinking. Cirrhosis of the liver occurs about eight times more often among alcoholics as among nonalcoholics.

Heavy drinkers have long been known to have lowered resistance to pneumonia and other infectious diseases, usually because of malnutrition. However, recent research showing well-nourished heavy drinkers may also have lowered resistance indicates that alcohol directly interferes with the immunity system. People with blood-alcohol levels of 0.15 to 0.25 percent have a

reduced white blood cell mobilization as great as that in people suffering from severe shock.

Heavy drinking over many years may result in serious mental disorders or permanent, irreversible damage to the brain or peripheral nervous system. It can severely diminish mental functions, such as memory, judgment, and learning ability, as well as a person's personality structure and grasp on reality.

PROBLEM DRINKING AND ALCOHOLISM

A nationwide survey of American drinking practices showed that more than two-thirds of the adult population drink alcoholic beverages at least occasionally. Adding the number of younger drinkers to that population gives a total of about 100 million people who drink. The overwhelming majority of those who drink do so responsibly. But what of the others, far too many, whose drinking gets out of hand and endangers others and themselves?

Distinctions are sometimes made between people with drinking problems and those suffering from alcoholism-alcoholic persons being considered the more uncontrollable group. However, since distinguishing between the two is difficult, we seldom use hard-and-fast labels.

Society usually labels persons as problem drinkers when they drink to such an excess that they lose the ability to control their actions and maintain a socially acceptable lifestyle. One authority describes problem drinkers as follows:

1. Anyone who must drink to function or cope with life
2. Persons who, by their own personal definition or that of their family and friends, frequently drink to a state of intoxication
3. Anyone who goes to work intoxicated
4. Anyone who drives a car while intoxicated
5. Anyone who sustains bodily injury requiring medical attention as a consequence of an intoxicated state
6. Persons who, under the influence of alcohol, do something they contend they would never do without alcohol

Other warning signs also indicate problem drinking. They include a person's need (to drink before facing certain situations, frequent drinking sprees, a steady increase in intake, solitary drinking, and early morning

drinking. Some heavy drinkers experience blackouts. During a blackout, drinkers do not pass out (or become unconscious) but are able to walk, talk, and perform other actions. However, afterwards they have no memory of that period. Such blackouts may be one of the early signs of the more serious form of alcoholism.

At present no definition of alcoholism satisfies all; however, the following one is widely accepted:

Alcoholism is a chronic disease, or disorder of behavior, characterized by the repeated drinking of alcoholic beverages to an extent that exceeds compliance with the social drinking customs of the community and which interferes with the drinker's health, interpersonal relations, or economic functioning.

OPNAVINST 5350.4B defines alcoholism as "a disease characterized by psychological and/or physical/physiological dependence on alcohol."

That instruction defines alcohol abuse as "the use of alcohol to an extent that it has an adverse effect on the user's health or behavior, family, community, or the Navy, or leads to unacceptable behavior as evidenced by one or more alcohol-induced incidents."

Whichever definition you agree with, you will find that all alcoholics have one trait in common: they are alcohol dependent.

Diagnosing Alcoholism

Those who could refer people for help with alcohol problems often don't recognize the symptoms until the illness is in its advanced stages. By that time the disease may have advanced to the point that victims are unable to control their drinking. They may no longer have an established family life or may be unable to hold a job. In addition, the alcohol may have caused malnutrition or organic damage.

Unfortunately, no simple diagnostic procedure exists for detecting alcoholism. Some of the factors involved in diagnosing an alcoholic person include the following:

1. The quantity of alcohol consumed. However, quantity alone is an insufficient measure.
2. The rate of consumption. One pint of distilled spirits consumed during a 10-hour period causes different behavior than that caused by a pint consumed in 1 hour. Drunkenness depends on the rate of consumption as well as the quantity consumed.

3. Frequency of drinking episodes. One who gets drunk three or four times a year is less liable to be labeled alcoholic than someone who gets drunk every week.

4. The effect of drunkenness upon self and others. Persons who commit deviant sexual acts or beat their mates while drunk are more likely to be labeled alcoholic than those who quietly get drunk without bothering others. The effects of drunkenness on others and the reactions of others to the drunkenness determine if and how the person is labeled alcoholic.

5. Visibility to labeling agents. The police; the courts; school personnel; welfare workers; employers; and, in some situations, family, friends, and helping agents—psychiatrists, physicians, lawyers—are the key sources of alcoholic labeling.

6. The social situation of the person. Each class and status group in our society has set different standards. How one does or does not conform to the standards of one's own group determines whether a person is labeled an alcoholic and, therefore, is reacted to as an alcoholic.

The following sources can help you sort out the specific traits of alcoholism in a person:

- The person's family physician or clergyman
- An Alcoholics Anonymous or Al-Anon group
- An alcoholism clinic or alcoholism information and referral center
- A public health nurse or a social worker
- A community mental health center
- The Department of Veterans Affairs or a general hospital
- A health, welfare, or family service agency
- The person's employer or labor union
- Local affiliates of the National Council on Alcoholism

Only a physician or clinical psychologist can make a medical diagnosis of alcoholism.

Treating Alcoholism

About 70 percent of alcoholic people are married and live with their families; hold a job, often an important one; and still are accepted and reasonably respected members of their communities. For those of this group who seek treatment, the outlook is optimistic. Alcoholism is a treatable illness from which as many as

two-thirds of its victims can recover. Yet because a number of myths and misunderstandings persist, the problem drinker has difficulty seeking and getting needed help.

We still think of alcoholism as a form of moral weakness rather than an illness. That stigma causes problem drinkers and their families to hide their "sins" rather than tell of their problems and seek treatment. In addition, many people, laymen and medical personnel alike, still consider alcoholism to be untreatable. They regard the person with alcohol problems as unmanageable and unwilling to be helped. None of those assumptions are true.

Generally, the treatment of alcoholism involves three steps, although all persons may not need all three:

1. Managing acute episodes of intoxication to save the person's life and to help the person overcome the immediate effects of excess alcohol
2. Correcting the chronic health problems associated with alcoholism
3. Changing the long-term behavior of alcoholics so that they don't continue destructive drinking patterns

The Navy provides numerous kinds of treatment techniques for the many different types of drinking problems. Its main challenge is to identify the needs of each person and to match the needs with the most appropriate therapy. The Navy is meeting that challenge through the Navy Alcohol and Drug Abuse Program.

Preventing Alcohol Problems and Alcoholism

The primary responsibility for alcohol abuse prevention rests with the individual. The Navy, however, sets and firmly enforces policies, programs, and procedures designed to prevent alcohol abuse.

Consumption of alcoholic beverages just before or during working hours reduces productivity. Each Navy member has the freedom to make a personal choice about whether to use alcoholic beverages. However, the use of alcohol must not have the following effects:

1. Interfere with the efficient and safe performance of the individual's military duties
2. Reduce the person's dependability
3. Reflect discredit upon the individual personally or upon the Navy

To minimize the incidence of alcoholism, commands should make every effort to eliminate

practices and customs that encourage personnel to drink. Old naval customs encouraged members to drink excessive quantities of alcohol as a badge of courage or a mark of respect. Those customs also encouraged young sailors to engage in that practice to prove their adulthood and virility. Today's Navy tries to develop customs contrary to those beliefs. It recognizes that an increasing tolerance for alcohol in large amounts is a positive symptom of alcoholism. Consequently, commands should emphasize drinking in moderation at such functions as ships' parties and picnics, advancement celebrations, initiations, hail and fare well parties, and graduations. Commands should ensure functions that serve alcoholic beverages also offer nonalcoholic and low-calorie beverages for those who choose not to drink. Educational programs, as well as leadership and example set by officers and petty officers, are essential to changing attitudes about alcohol consumption.

Helping Resources for Drug and Alcohol Problems

Specialized alcoholism clinics and programs reach some of those in need of help. However, many more people with alcohol problems are already in contact with other agencies. Although those agencies are not primarily devoted to caring for alcoholics, they do or could offer important services to these persons. These agencies include hospitals, welfare agencies, family and community services, legal aid, employment, and other care-giving service organizations. General hospitals, for example, admit many alcoholics for conditions unrelated to alcoholism-or for alcohol-related problems covered by other diagnoses. Similarly, many patients in tuberculosis hospitals have alcohol problems. The prison system holds many men and women with drinking problems. An estimated 10 to 25 percent of welfare cases involve alcoholism.

Recognition of the alcoholism problems of patients, clients, and inmates and referral to treatment resources would bring help to many more who need it.

DEPARTMENT OF THE NAVY PROGRAMS. –The Navy recognizes that drug and alcohol abuse is preventable and treatable through education, identification, counseling, and rehabilitation programs. These are cost-effective ways to retain personnel with potential for continued useful service but whose continued abuse would render them unfit.

The Navy provides alcohol abuse prevention and rehabilitation programs on three levels.

Level I. –Local command programs. These programs consist of both prevention and intervention efforts. The programs involve discipline, inspections, awareness education, leadership by positive role modeling, administrative screening, referral, and medical identification and intervention. The Navy Alcohol and Drug Safety Action Program (NADSAP) is available at some local commands.

Level II. –Counseling and Assistance Center (CAAC) programs. This level of therapeutic nonresidential counseling and referral is designed for those personnel whose degree of abuse or denial requires attention beyond the capacity of Level I programs. This level may be used for referral of persons to Level III and for persons waiting for space at a Level III facility. The length of the program at Level II is determined by the member's commanding officer after recommendation from the local counseling staff. The maximum time allotted to a Level II counseling program, however, will not exceed 4 weeks in length. Programs at this level consist of clinical screening and referral at all program levels; therapeutic nonresidential counseling; outreach assistance; and education.

Level III. –Residential rehabilitation programs. Residential rehabilitation is designed for those members who have been formally evaluated and diagnosed as alcohol dependent and who require rehabilitation on a full-time, live-in basis. They must, in the opinion of their commanding officers, show potential for continued naval service. Four Navy alcohol rehabilitation centers (NAVALREHCENS) and 27 naval hospital alcohol rehabilitation departments (ARDs) provide Level III care. Residential rehabilitation involves a multidisciplinary therapeutic approach that normally lasts 6 weeks.

In general, persons may take part in Level I and II programs on more than one occasion, as long as they meet the basic criteria for admittance. However, they normally have only one opportunity per Navy career to take part in the Level III program. Sometimes the Navy may have a great investment in a person who has a relapse. In those cases, the commanding officer may recommend the person for a second period in the Level III program, not to exceed 3 weeks.

For personnel to complete recovery following residential treatment, the Level II program recommends they abstain from alcohol and attend Alcoholics Anonymous meetings. The Navy views a person's abuse of alcohol after residential treatment as a failure at rehabilitation or as a failure to complete an alcoholism treatment program.

Aftercare. –Following successful completion of a Level II or III alcohol abuse program and return to their command, persons remain in an "aftercare" status for 180 days. The nature of the aftercare program varies from case to case. Most programs require close observation of the persons during the 180-day period. They also require the persons to attend Alcoholics Anonymous meetings and, if medically authorized, to take part in Antiabuse (disulfiram) therapy.

The Navy's Alcohol and Drug Abuse Prevention and Control Program includes education and rehabilitation. It takes a preventative educational approach by providing information on the effects of alcohol and alcohol addiction through multimedia presentations. Through this program, every naval hospital provides evaluation, detoxification, and primary rehabilitation. The alcohol rehabilitation centers and the smaller alcohol rehabilitation units conduct more extensive treatment and rehabilitation. These centers and units are strategically located in areas with a large concentration of Navy personnel.

The Navy's Alcohol and Drug Abuse Prevention and Control Program has a referral network of voluntary collateral duty counselors. These counselors try to identify specific cases of problem drinking in the early stages. If a counselor spots persons whose performance or health indicates a drinking problem, a medical officer examines them. After drying out in a hospital, if needed, they are admitted to a rehabilitation facility.

NAVY DRUG AND ALCOHOL COUNSELOR. –Drug and alcohol counselors are graduates of the Navy Drug and Alcohol Counselor School. The counselors have successfully completed a 1-year supervised internship and have earned a secondary Navy Enlisted Classification (SNEC) 9519 through successful completion of the certification examination. They provide evaluation and referral services at the local CAAC to assist local commands in the processing of persons identified as drug or alcohol abusers. They also provide individual and group counseling services to drug and alcohol abusers. Commands and individuals seeking help or information concerning alcohol or drug abuse and abuse control programs may contact these counselors.

DRUG AND ALCOHOL PROGRAM ADVISOR (DAPA). –The DAPA is the command representative responsible to the commanding officer for carrying out the NADAP. The DAPA conducts onboard administrative screening as directed by the commanding officer and coordinates or assists in conducting command awareness education. The DAPA

assists in monitoring aftercare when required and serves as the command's self-referral agent. The DAPA is assisted by a Navy aftercare coordinator (NAC) who helps establish and monitor aftercare programs for recovering individuals.

COUNSELING AND ASSISTANCE CENTER (CAAC). –The CAAC is a nonresidential facility providing counseling services, clinical screebubg/referral, and local outreach programs for commands in the immediate geographic area. The Navy Alcohol and Drug Safety Action Program (NADSAP) office is located at the CAAC. NADSAP is a command prevention/remedial education tool, providing 36 hours of education about alcohol and drug abuse. The NADSAP office also provides civilian court liaison for personnel accused of DWI and similar offenses. NADSAP supports and coordinates alcohol and drug abuse prevention programs for local and afloat commands. The CAAC sends a representative to the regional Navy Drug and Alcohol Advisory Council (NDAAC).

NAVAL ALCOHOL REHABILITATION CENTERS (NAVALREHCEN). –Alcohol rehabilitation centers (NAVALREHCEN) provide a program of intense and comprehensive rehabilitation for active-duty Navy and Marine Corps personnel suffering from alcoholism. These centers, located at Norfolk, Virginia; Miramar, California; Jacksonville, Florida; and Pearl Harbor, Hawaii, are under the command of a medical officer.

ALCOHOL REHABILITATION DEPARTMENT (ARDs). –Alcohol rehabilitation departments (ARDs) have been established at different Navy hospitals in the United States and some foreign countries. These departments are staffed by a drug and alcohol abuse treatment specialist in addition to medical personnel. The ARD is available to active-duty personnel of the Navy and Marine Corps.

OTHER HELPING RESOURCES. –Other helping resources available to you are the senior Navy people around you. Your division chief, command master chief, or chaplain has the experience, seniority, and knowledge necessary to give you the proper guidance. That doesn't mean you should jump the chain of command; you should know that is never a good practice. However, if you find yourself in a situation in which your experience or knowledge will not permit you to make an informed decision, you should inform your seniors of the problem and request their assistance. Unless the situation requires complete confidentiality, don't keep your senior petty officer out of the picture. If

the problem is serious enough, such as an incident that could be a violation of the UCMJ, inform your supervisor even if the situation requires confidentiality. Then ensure the problem gets to the proper level within the chain of command for proper action.

Apply common sense in the handling of any problem, whether your own problem or a subordinate's problem. You can then reach a proper solution that is best for all concerned.

SUMMARY

In this chapter we discussed some of the Navy's programs in support of equal opportunity and drug and alcohol abuse prevention, treatment, and rehabilitation.

The thousands of hours and millions of dollars invested in the pursuit of equal opportunity over the past decade reflect the Navy's total commitment to equal opportunity (EO). During that time, the Navy has focused firmly on the principle that individual achievement should be limited only by ability and aspiration.

New Navy programs make EO a more integral part of leadership and management. Command managed equal opportunity focuses on the prevention of discriminatory incidents before they occur. Commands assess themselves as often as needed to problem-solve and to develop their own plans of action to correct any deficiencies. Commanding officers have the responsibility to ensure their commands take the initiative to make equal opportunity a reality for all naval personnel.

As a senior petty officer, you have the responsibility to maintain good order and discipline. Therefore, you must know the possible punishments for discriminatory practices. Since you will complete and file investigative report chits, you must also know the rights of the accused.

The history of drug abuse proves that it has a destructive effect on society. However, some people defend the use of drugs, even if they have decided not to try drugs themselves. They say people have a "right" to use drugs if they wish, regardless of the law. Others look the other way, saying it is none of their business. Some are afraid to say anything about it at all.

What about the older generation that warns about drugs but then uses alcohol? Those people may wish they had never started using alcohol and want to save the younger generation from the pain and anguish they have experienced.

Over 800,000 die annually from heart disease and strokes, nearly one-fourth of which are caused by alcohol. Over 50,000 die each year in automobile accidents, over half of which are caused by drunk driving. Why build up similar statistics on drugs too? Why not be smarter and seek to have along, healthy life?

How can anyone defend marijuana by saying it is no worse than alcohol? Alcohol is now the nation's number one drug problem. Why develop another drug problem that is equally as bad as alcoholism?

One argument in favor of drugs is that hallucinogens "expand the mind." Actually they produce illusions and distortions. They cause the senses to distort reality so that mental work becomes more difficult-or even impossible. Why not face reality so that problems can be solved?

Some have said that stimulants increase your mental abilities-more alert for tests, more zip for athletics, and so forth. Actually, they draw on the body's reserve energy. Using stimulants too much will exhaust your mind and body. Why not find your capabilities by natural means? That way, what you do will really be your own accomplishment.

Some have said that depressants slow the world down and make problems smaller. Actually, they slow the abuser down, not the world. They dull the abuser's senses and make the abuser less effective-less able to respond to normal demands and emergencies. Isn't it silly to think that by not caring, you will either solve problems or make them go away?

Many people say that trying "just once" never hurt anyone. That is not so. The law makes few exceptions for the first error. Most addicts started by trying "just once." Why should you think you are smarter or luckier than those other poor souls who got hooked?

Is drug use in your command none of your business? How can that be so when it involves criminals and criminal acts and affects the security, safety, and good health of you and your shipmates? Are you concerned that your life may be endangered by some drunk or doped-up person the next time you drive your car on the street? The Constitution does not give lawbreakers the right to deprive law-abiding citizens of their health and happiness.

Remember this too-the consequences of drug abuse may greatly affect your career in the Navy. Under military law, drug abuse is "conduct prejudicial to good order and discipline." Abusers will be disciplined at Captain's mast or tried by courts-martial. Such cases

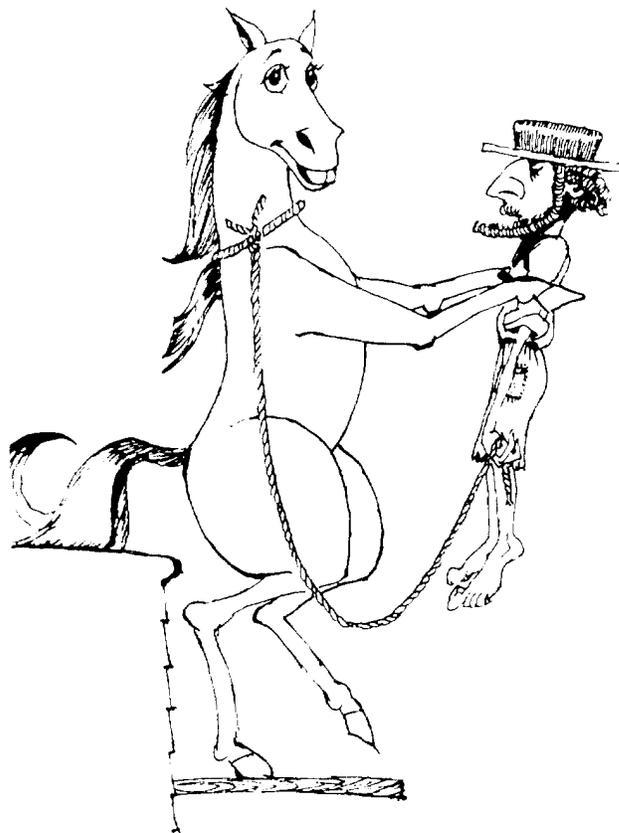
may result in a dishonorable discharge or extended imprisonment.

Far more than civilians, we in military service depend on each other. The lives of all hands on a Navy ship or aircraft may depend on the alertness of one person and that person's assignment. Commanding officers cannot trust their units, ships, or planes to a person who may be under the influence of drugs, may be ill from hangover or withdrawal symptoms, or may have a drug flashback in a moment of tension or combat. The safety of the ship and the independence of America depend on the top performance of everyone in the crew.

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HORSE LATITUDES

THE WORDS OF SAMUEL TAYLOR COLERIDGE "IDLE AS A PAINTED SHIP UPON A PAINTED OCEAN" WELL DESCRIBE A SAILING SHIPS SITUATION WHEN IT ENTERED THE HORSE LATITUDES. LOCATED NEAR THE WEST INDIES BETWEEN 30 AND 40 DEGREES NORTH LATITUDE, THESE WATERS WERE NOTED FOR UNFAVORABLE WINDS THAT BECALMED CATTLE SHIPS HEADING FROM EUROPE TO AMERICA.

OFTEN SHIPS CARRYING HORSES WOULD HAVE TO CAST SEVERAL OVERBOARD TO CONSERVE DRINKING WATER FOR THE REST AS THE SHIP RODE OUT THE UNFAVORABLE WINDS. BECAUSE SO MANY HORSES AND OTHER CATTLE WERE TOSSED TO THE SEA, THE AREA CAME TO BE KNOWN AS THE "HORSE LATITUDES."

