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S/S 3 Nov 1986

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Headquarters  
Department of the Army  
Washington, DC  
17 April 1986

Immediate Action  
INTERIM CHANGE

AR 600-85  
Interim Change  
No. 1012  
Expires: 17 April 1988

Personnel - General

Alcohol and Drug Abuse Prevention and Control Program

Justification: This interim change authorizes Reserve Component (RC) Commanders to urine test Reserve Component aviation personnel during any training period.

Expiration: This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

1. AR 600-85, 1 December 1981, is changed as follows:

Page 9-3. Paragraph 9-6a is superseded as follows:

a. Urine testing is authorized during annual training (AT) or inactive duty training (IDT) for all USAR and ARNG personnel assigned to aviation positions. Such testing will be administered following the procedures set forth in Chapter 3 and Appendix H of this regulation.

2. Post these changes per DA PAM 310-3.

3. File this interim change in front of AR 600 85.

(DAPE-HRL-A)

By Order of the Secretary of the Army:

JOHN A. WICKHAM, JR.  
General, United States Army  
Chief of Staff

Official:

R. L. DILLWORTH  
Brigadier General, United States Army  
The Adjutant General

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 Headquarters  
 Department of the Army  
 Washington, DC  
 10 February 1986

5/S  
 34 Nov 1986  
 Immediate Action  
 INTERIM CHANGE

AR 600-85  
 Interim Change  
 No. 111  
 Expires 10 February 1988

Personnel - General  
 Alcohol and Drug Abuse Prevention and Control Program

Justification: This interim change authorizes drug abuse testing for selected civilian employees of the Department of the Army working in critical jobs. This change implements DOD Directive 1010.9, dated 8 April 1985, subject: DOD Civilian Employees Drug Abuse Testing Program.

Expiration: This interim change expires 2 years from the date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change or Update regulation.

1. AR 600-85, 1 December 1981, is changed as follows:

Page 5-8. Paragraph 5-14 is added as follows:

5-14. Civilian drug abuse testing.

a. The Department of the Army has established a drug abuse testing program for civilian employees in critical jobs (as defined in subparagraph b of this paragraph). The program has the following objectives:

- (1) To assist in determining fitness for, appointment to, or retention in a critical job.
- (2) To identify drug abusers and notify them of the availability of appropriate counseling, referral, rehabilitation services, or other medical treatment.
- (3) To assist in maintaining national security and the internal security of the Department of the Army by identifying individuals whose drug abuse could cause disruption in operations, destruction of property, threats to safety for themselves or others, or the potential for unwarranted disclosure of classified information through drug-related blackmail.

b. Certain specific jobs or classes of jobs important enough to the mission or to protection of public safety that screening to detect the presence of drugs is warranted as a job-related requirement have been designated by the Department of the Army as "critical" for the purpose of drug abuse testing. A complete listing of jobs including occupational series, when possible, is found at Appendix K, section 1. These jobs fall into one or more of the following categories:

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(1) Law enforcement.

(2) Positions involving national security or the internal security of the Army at a level of responsibility in which drug abuse could cause disruption of operations or the disclosure of classified information that could result in serious impairment of national defense.

(3) Jobs involving the protection of property or persons from harm, or those where drug abuse could lead to serious threats to the safety of personnel.

c. The following applies to all employees covered by this testing program:

(1) Civilians employed in jobs identified as critical will be screened under the Civilian Drug Abuse Testing Program. This requirement is considered a condition of employment and applies to:

(a) Prospective employees being considered for critical jobs.

(b) Current employees in jobs designated as critical.

(2) Individuals being considered for or currently in jobs covered by this program must sign the DA Form 5019-R titled "Condition of Employment for Certain Civilian Positions Identified as Critical Under the Drug Abuse Testing Program". Completion of the form acknowledges the Department of the Army's right to require the applicant or employee to participate in urinalysis testing. The form will be reproduced locally on 8-1/2 x 11 inch paper. Information concerning this form is found at Appendix C.

(3) In the event of a confirmed positive urinalysis test result or refusal to submit a specimen --

(a) Prospective employees will be denied further consideration for appointment to the critical job.

(b) Current employees may be subject to adverse action proceedings under FPM chapter 752, FPM Supplement 752-1, and AR 690-700, chapter 751. If eligible, they may be offered counseling and treatment as described in subparagraph e(4) below.

(4) Current employees who previously were not covered by and refuse to enter the Drug Abuse Testing Program by signing the Condition of Employment form or who sign the form but refuse testing may be --

(a) Voluntarily or involuntarily reassigned or demoted to noncritical jobs at the activity or in the command.

(b) Removed from Federal Service.

(5) Any attempt to substitute another person's urine for one's own, adulterate a sample given, or fraudulently affect reported results will result in actions consistent with those outlined above and other applicable actions outlined in AR 690-700, chapter 751.

d. There may be certain specific jobs that are critical at a local or installation level, but that do not fall within the broader categories of those listed in Appendix K. Specific jobs that a commander identifies as critical on a local basis, but that are not critical Army-wide may be included in testing with the prior approval of MACOM, DA, and DOD. A formal request for authorization to test such specific jobs must be forwarded, thru channels, and all requirements in Appendix K, section 2 must be satisfied. Decisions will be made on a case-by-case basis.

e. The following guidelines for the use of drug abuse testing for civilian employees will be followed in all cases.

(1) Employees working in or tentatively selected for positions designated as critical jobs may be required to participate in urinalysis testing in the following circumstances:

(a) Before appointment or selection. (All prospective employees will be tested prior to accession).

(b) Periodically after appointment or selection on a random basis.

(c) When there is probable cause to believe that an employee is under the influence of a controlled substance while on duty.

(d) As part of examination authorized by the Department of Defense or Department of the Army regarding a mishap or safety investigation undertaken for the purpose of accident analysis and the development of countermeasures.

(2) At least 90 days before the initial urinalysis test, each employee in a critical job must be informed, in writing, of the following:

(a) The reasons for the urinalysis test.

(b) The consequences of a positive result or refusal to cooperate, including adverse action.

(c) That there will be an opportunity for them to submit supplemental medical documentation to support the legitimate use of a specific drug.

(d) That there are drug abuse counseling and referral services available. This will include the name and phone number of the local employee assistance program counselor.

(e) The requirement for execution of DA Form 5019-R (Condition of Employment for Certain Civilian Positions Identified as Critical Under the Drug Abuse Testing Program).

(3) The same information except for e(2)(d) above will be given, in writing, to each applicant tentatively selected for a critical job.

(4) An employee whose urinalysis has been confirmed as positive shall, if eligible, be offered counseling or treatment through the local employee assistance program in accordance with Federal Personnel Manual Supplement 792-2. This may be done in conjunction with other actions outlined in subparagraph c(3) above. Nothing in this provision precludes the use of a confirmed positive urinalysis result in an authorized adverse action proceeding or for other appropriate purposes, except as otherwise limited by rules issued by the Department of the Army.

(5) The results of field tests may not be used in administrative or disciplinary proceedings except as permitted in subsection f(5) below.

f. Following are the general procedures for urinalysis testing. Should questions or procedures arise, they should be directed to the Installation Alcohol and Drug Control Officer (ADCO) or the Installation Biochemical Test Coordinator (IBTC).

(1) Urine samples shall be processed under the strict chain of custody procedures as set forth in Appendix H. These requirements will be followed with the following word or title substitutions.

(a) Unit Commander means Installation commander, senior supervisor, or designee.

(b) UADC-see 3-17e of AR 600-85. Grade should be GS-7 or higher or the equivalent.

(c) Observer-see appendix H-5 of AR 600-85.

(d) Service member and soldier mean employee.

(e) Section leader means supervisor or designee.

(f) Any questions concerning terminology should be directed to the civilian personnel office and/or the ADAPCP.

(2) Urine samples shall be tested only at a laboratory certified under enclosure 4 of DOD Directive 1010.1 "Drug Abuse Testing Program", dated 28 December 1984; and only using procedures set forth in enclosure 3 of that Directive.

(3) In the event that a sample tested and confirmed as positive must be retained beyond the time frame specified in paragraph 3-15 and 3-17e of AR 600-85, the requirements found there must be followed.

(4) In the event that a re-test is required, the requirements found in DODD 1010.1 will be followed.

(5) Field testing may be conducted, but the following guidelines are to be strictly adhered to:

(a) All positive results from field tests of current employees are preliminary results until confirmed as positive by both initial and confirmatory testing or by an admission by the employee.

(b) Before the receipt of final test results or admission by the employee, positive results of field tests of current employees may only be used for temporary referral to a civilian employee assistance program, temporary detail to other non-critical duties or administrative leave, or temporary suspension of access to classified information.

(c) If a positive field test result of a current employee is not confirmed as positive by a certified laboratory or by admission of the employee, the result may not be used to take further action against the employee and any temporary action must be rescinded.

(d) If an applicant is not a current federal employee, and does not have re-employment rights, an admission of drug use may be used as a valid reason for non-selection of that applicant for a critical job. If the accession sample of an applicant is found to be positive by a certified field test and the applicant does not admit drug use, the sample must be forwarded for confirmation. The hiring action for applicants in this circumstance will be held in abeyance until the confirmatory testing is complete. If the final result is negative, the hiring action can be completed. However; if the final result confirms the field test positive, the applicant will not be assigned to any critical job. This does not preclude that individual from at some later date applying for and being considered for a critical job.

(6) AR 600-85, in the sections covering biochemical testing for illegal drugs, clearly delineates the responsibilities of unit commanders in the conduct of testing (para 10-4-e). With the simple substitution of the term "supervisor" for "unit commander", all these guidelines apply. There are obvious areas where examples given do not apply. Supervisors must consult with the management-employee labor relations office of civilian personnel instead of the military judge advocate, and different penalties (adverse actions) apply for civilians. Any questions concerning testing procedures should be directed to the ADCO or IBTC. Questions that concern management responsibilities, disciplinary actions, and other related areas should be directed to the Civilian Personnel Office.

(7) The decision to require an individual covered by the biochemical testing program to undergo such testing to detect drug abuse is the commander's prerogative. The management of available quotas, both for field and laboratory tests, is the commander's responsibility. He or she must decide which segments of the total population, civilian and military, are most at risk and allocate quotas accordingly. Beyond the pre-accession test for civilian employees in critical positions, subsequent testing is left to the commander's discretion.

g. Drug testing of civilian employees is not negotiable with recognized labor organizations because it involves the Army's internal security practices within the meaning of 5 U.S.C. § 7106(a)(1). Questions regarding labor relations implications of the civilian drug abuse testing program should be addressed through command channels to HQDA (DAPE-CPL).

Appendix C. Appendix C is superseded by a revised Appendix C that covers all critical jobs. It is available through Civilian Personnel and ADAPCP channels.

Appendix K. Appendix K is added and lists jobs/classes of jobs to be included in the Army Civilian Employee Drug Abuse Testing Program. It also outlines the procedure for requesting that additional jobs be identified as critical.

2. Post these changes per DA PAM 310-3.
3. File this Interim change in front of the publication.

(DAPE-HRL-A)

By Order of the Secretary of the Army:

JOHN A. WICKHAM, JR.  
General, United States Army  
Chief of Staff

Official:

MILDRED E. HEDBERG  
Brigadier General, United States Army  
The Adjutant General

Distribution:

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APPENDIX C

CONDITION OF EMPLOYMENT FOR CERTAIN CIVILIAN POSITIONS

IDENTIFIED AS CRITICAL

UNDER THE DRUG ABUSE TESTING PROGRAM

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C-1. Only those civilian employees in jobs identified as critical for the purpose of drug abuse testing under the guidelines of this change and DODD 1010.9 are subject to commander/supervisor directed urinalysis. Civilian employees falling within these guidelines must remain drug free and, therefore, will be tested as a condition of employment.

C-2. DA Form 5019-R (Condition of Employment for Certain Civilian Employee Positions Identified as Critical Under the Drug Abuse Testing Program), shown in figure C-1, will be used as the condition of employment for all such employees. Fig. C-1 (DA Form 5019-R) is attached.

## APPENDIX K

JOBS/CLASSES OF JOBS TO BE INCLUDED IN THE  
ARMY CIVILIAN EMPLOYEE DRUG ABUSE TESTING PROGRAM

## SECTION I

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	<u>JOB/JOB CLASS</u>	<u>OCCUPATIONAL SERIES</u>
(1)	AVIATION POSITIONS	
	--AIR TRAFFIC CONTROLLER	2152
	--PILOT	2181
	--AIRCRAFT ENGINE MECHANIC	8602
	--AIRCRAFT OVERHALL SPECIALIST	8801
	--PROP AND MOTOR MECHANIC	8807
	--AIRCRAFT MECHANIC	8853
	--AIRCRAFT SERVICER	8862
(2)	GUARD AND POLICE POSITIONS	
	--GUARD	085
	--POLICE	083
	--CRIMINAL INVESTIGATOR	1181
	--CORRECTIONAL OFFICER	06/07
(3)	PERSONNEL RELIABILITY PROGRAM PERSONNEL	N/A
	--CHEMICAL AND NUCLEAR SURETY POSITIONS	
(4)	ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM DIRECT SERVICE STAFF	N/A
(5)	ALL EMPLOYEES AT ARMY FORENSIC DRUG TESTING LABORATORIES	N/A

## APPENDIX K

## SECTION II

PROCEDURE FOR REQUESTING THAT ADDITIONAL  
JOBS BE IDENTIFIED AS CRITICAL

There may be certain specific jobs which a local commander considers as critical for the purpose of drug abuse testing, but do not fall within those jobs listed in Section I of this appendix. The purpose of this section is to specify the procedures that must be followed to request that additional jobs be identified as critical for this purpose. Procedures specified below must be followed completely. Any request that does not satisfy all requirements will be returned without action. Decisions will be made on a case-by-case basis. Under no circumstances does an earlier decision to identify a specific job as critical carry over to any other job or job class, or to a similar job in any other location or situation.

(1) Any request for identification of a specific job as critical for the purpose of drug abuse testing must clearly fall within the parameters of paragraph 5-14b. The request for inclusion must specify that the primary duties of the job meet the criteria of one of the three categories described in subparagraph 5-14b (1), (2), or (3).

(2) The rationale for testing must be clearly stated and must be completely justified. The justification must indicate why the job is critical and specify negative outcomes that would likely occur if an incumbent in that job abused drugs.

(3) A copy of the job description must be provided, with a schematic of the chain of supervision attached. The job description must be current and properly executed. If more than one individual is to be included in testing, the total number of employees covered will be provided. If the positions are being established or a change in the number of employees is expected, it must be so stated. Under no circumstances should the inclusion of a small number of employees be requested when rapid growth in that job class is forecast. If turnover is a problem, turnover rates should be specified.

(4) The location where the sample will be taken (work site, CPO, CCS) must be specified and a statement from the local Installation Biochemical Test Coordinator (IBTC) concerning field test capability must be attached. The Drug Testing Laboratory (DTL) that would normally test the sample must also be specified.

(5) Any request for designation of jobs as critical must be submitted thru the respective MACOM for HQDA and DOD approval before testing is authorized. Requests should be sent to HQDA (DAPE-CP), Washington, DC 20310-0300.

**CONDITION OF EMPLOYMENT FOR CERTAIN CIVILIAN POSITIONS  
IDENTIFIED AS CRITICAL UNDER THE DRUG ABUSE TESTING PROGRAM**

For use of this form, see AR 600-85; the proponent agency is DCSPER

**SECTION A - REQUIREMENTS**

As a prospective or current employee in a position designated by the Department of the Army and approved by the Office of the Secretary of Defense as critical to national or internal security or to the protection of persons or property, you are required to read and sign this statement as a condition of employment. If you are an applicant for a critical job and fail to sign this agreement, you will not be selected for the position. If you are currently in a critical job and refuse to sign the condition of employment, you will be voluntarily or involuntarily reassigned or demoted to a noncritical job or separated from Federal employment. If you sign the condition of employment and later refuse to submit to urinalysis testing, you will be non-selected, reassigned, demoted, or separated according to applicable regulations. To verify that you are not currently using drugs, you will be required, as a condition of your continued employment, to submit a urine sample for testing purposes; (1) periodically, on an unannounced basis, (2) when there is probable cause to believe that you are under the influence of drugs, and/or (3) when there is a mishap or safety investigation being conducted in relation to an accident involving government-owned vehicles, aircraft, or equipment. To assure the validity of these tests, a staff member of the same sex will observe you while you are providing the sample. Detection of drug usage through confirmed positive urinalysis test results may be cause for a determination that you have failed to meet the conditions necessary for your continued employment in the position. Medically prescribed drugs authorized by a physician and confirmed by appropriate evidence are excluded from such determinations. The results of urinalysis will be used only for clinical and necessary administrative purposes. You are entitled to any additional and reasonable information or clarification you desire prior to signing the agreement. A copy of the signed agreement will be given to you and your supervisor. The original will be placed in your Official Personnel Folder.

**SECTION B - AGREEMENT**

This is to certify that I understand the contents of the policy described above and the reasons therefore, and that I agree to adhere to the terms of this policy as a continuing condition of my employment in positions to which this agreement applies.

SIGNATURE OF EMPLOYEE/APPLICANT

DATE SIGNED



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Headquarters  
Department of the Army  
Washington, DC  
1 February 1986

# Immediate Action INTERIM CHANGE

AR 600-85  
Interim Change  
No. I10  
Expires: 1 February 1987

## Personnel - General

### Alcohol and Drug Abuse Prevention and Control Program

Justification: This interim change continues the policies established by changes I06, I07 and I08 to AR 600-85. ✓

*Posted 20 Feb 1986 [initials]*

Expiration: This interim change expires on 1 February 1987 and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

(DAPE-HRL-A)

By Order of the Secretary of the Army:

JOHN A. WICKHAM, JR.  
General, United States Army  
Chief of Staff

Official:

MILDRED E. HEDBERG  
Brigadier General, United States Army  
The Adjutant General

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# Immediate Action INTERIM CHANGE

Headquarters  
Department of the Army  
Washington, DC  
9 May 1985

AR 600-85  
Interim Change  
No. 109  
Expires 9 May 1987

## Personnel - General

### Alcohol and Drug Abuse Prevention and Control Program

Justification: This interim change authorizes urinalysis testing for USAR and ARNG personnel assigned to aviation positions when attending annual training.

Expiration: This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

1. AR 600-85, 1 January 1982, is changed as follows:

Page 1-1. Paragraph 1-2b is superseded as follows:

b. The provisions of chapter 9 apply to members of the ARNG and USAR when -

(1) not on AD or any type of ADT (other than during annual training) or

(2) attending annual training in accordance with AR 140-1 or NGR 350-1, regardless of whether the members are in a state or federal status during such training.

Page 9-1. Paragraph 9-2a is superseded as follows:

a. The provisions of this chapter are applicable to members of the ARNG and USAR when -

(1) not on AD or any type of ADT (other than during annual training) or

(2) attending annual training in accordance with AR 140-1 or NGR 350-1, regardless of whether the members are in a state or federal status during such training.

Page 9-3 Paragraph 9-6 is added as follows:

9-6. Urinalysis Testing. a. Urine testing is authorized of all USAR and ARNG personnel assigned to aviation positions when attending annual training. The initial test will be conducted as an inspection during the initial stages of AT, and if possible, prior to performance of aviation duties. Additional testing of aviation personnel during annual training

may be authorized by the commander as appropriate. Urine test will be administered following the procedures set forth in Chapter 3 and Appendix H, AR 600-85.

b. Positive test results from field tests are preliminary results until confirmed as positive by a drug testing laboratory. Prior to receipt of the laboratory report or an admission by the service member, positive results from field tests may only be used for temporary referral to ADAPCP, temporary transfer, removal, or suspension from aviation duty and for temporary suspension of access to classified information. If a positive field test result is not reported as positive by a certified laboratory or an admission by the service member, the result may not be used to take further adverse action and any temporary action based upon the field test must be rescinded.

c. Cases involving aviation personnel with positive test results confirmed by a certified drug testing laboratory will be processed as follows:

(1) Pilots will be suspended from duties involving flying and will be referred to a flying evaluation board.

(2) Enlisted aviation personnel, as a minimum, will be reassigned from duties involving aviation.

(3) Any additional administrative and/or disciplinary actions required or authorized by other regulations will also be considered. Individuals may be processed for administrative separation based upon positive test results. See AR 135-175, AR 135-178 (USAR), NGR 635-100, NGR 635-101 or NGR 635-200 (ARNG).

2. Post these changes per DA Pam 310-3.

3. File this interim change in front of AR 600-85.

(DAPE-HRL-A)

By Order of the Secretary of the Army:

JOHN A. WICKHAM, JR.  
General, United States Army  
Chief of Staff

Official:

DONALD J. DELANDRO  
Brigadier General, United States Army  
The Adjutant General

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4 February 1985

Immediate Action  
INTERIM CHANGE

AR 600-85

Interim Change

No. I08

Expires 4 February 1986

Personnel - General

17 Feb 1987 (extended by I10; Feb 1, 1986)

Alcohol and Drug Abuse Prevention and Control Program

Justification: This interim change continues the policies established by changes I02; I03; I04; and I05 to AR 600-85.

Expiration: This interim change expires on 4 February 1986 and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

(DAPE-HRL-A)

By Order of the Secretary of the Army:

JOHN A. WICKHAM, JR.  
General, United States Army  
Chief of Staff

Official:

DONALD J. DELANDRO  
Brigadier General, United States Army  
The Adjutant General

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# Immediate Action INTERIM CHANGE

Headquarters  
Department of the Army  
Washington, DC  
10 September 1984

AR 600-85  
Interim Change  
No. I07

Expires 10 September 1986

17 Feb 1987 (extended by I10, 17 Feb 1986)  
Personnel - General

## Alcohol and Drug Abuse Prevention and Control Program

Justification: This interim change revises references to procedures used in the Urinalysis drug testing laboratories and is required to clarify authorized procedures within the drug testing laboratories.

Expiration. This interim change expires two years from date of publication and will be destroyed at that time, unless sooner rescinded, or superseded by a permanent change.

1. AR 600-85, 1 January 1982 is changed as follow:

Page 3-4 Para 3-15 is superseded as follows:

The DOD biochemical testing program was established in 1971 by the Secretary of Defense and is promulgated by DOD Instruction 1010.1, dated March 16, 1983. Each of the Services is required to implement procedures for biochemical testing to screen for drug abuse of detectable drugs. Procedures are established for commander and physician directed testing. Biochemical testing of urine can detect various drugs, including amphetamines, barbiturates, opiates, methaqualone, phencyclidine, cannabis, and cocaine, with a high degree of specificity. Therefore, a product containing any of these drugs even if taken into the body several days prior to the test, may yield a positive result. All positive urine specimens are retained automatically by the laboratory for a period of 60 days after the date the Urinalysis Custody and Report Record is signed by the laboratory official. If retention is required beyond this period, because of pending disciplinary or adverse administrative action, it is the responsibility of the command that submitted the specimen to request further retention (see 3-17e).

Page 3-7. Paragraph 3-17 g (2) and (3) are superseded as follows:

(2) Exercise internal quality control surveillance to ensure maintenance of the minimum drug detection sensitivity screening levels as prescribed by Assistant Secretary of Defense(Health Affairs).

(3) Evaluate all urine specimens in accordance with DODI 1010.1.

Page 3-8. Table 3-1 is deleted.

2. Post these changes per DA Pam 310-3.
3. File this interim change in front of AR 600-85

(DAPE-HRL-A)

By Order of the Secretary of the Army

JOHN A. WICKHAM, JR.  
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Major General, United States Army  
The Adjutant General

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Headquarters  
Department of the Army  
Washington, DC  
1 February 1984

S/S 3 Nov 1984

Immediate Action  
INTERIM CHANGE

AR 600-85  
Interim Change  
No. IO6

Expires 1 February 1986

1 February 1987 (PERSONNEL-GENERAL extended by IIO; 788, 1987)

Alcohol and Drug Abuse Prevention and Control  
Program (ADAPCP)

Justification. This interim change aligns AR 600-85 with other regulations and Army Policy in terms of retention criteria, and aligns AR 600-85 with previously issued guidance concerning biochemical testing for personnel in sensitive duty positions. The policy changes contained in this interim change are effective 1 February 1984.

Expiration. This interim change expires two years from date of publication and will be destroyed at that time, unless sooner rescinded, or superseded by a permanent change.

1. AR 600-85, 1 January 1982, is changed as follows:

Page 1-3 Para 1-8h is superseded as follows:

h. An active and aggressive urinalysis program serves as a valuable identification tool and an effective deterrent against drug abuse. Installation, community, and activity commanders will ensure that adequate testing levels are maintained, particularly in high risk areas or situations, and in all oversea areas. Because of the sensitive nature of the duties performed by personnel with aviation, military police specialities, and personnel who are members of the Nuclear or Chemical Personnel Reliability Program, all personnel in these categories will be tested a minimum of once a year.

Page 1-4 Para 1-10c is superseded as follows:

c. Officers, Warrant Officers, and enlisted persons (E5-E9) who are identified as illegal drug abusers will be processed for separation from the service. These individuals have violated the special trust and confidence the Army has placed in them.

Page 3-4 Para 3-16b(1)(d) superseded as follows:

(d) A urine test of all personnel assigned to aviation, military police positions, and personnel who are members of the Nuclear or Chemical Personnel Reliability Program as part of an inspection under Military Rules of Evidence 313 a minimum of once a year (See paragraph 3-16b(1) (c), above). Testing can be conducted on an individual basis.

Page 4-7 Para 4-25b is superseded as follows:

b. Enlisted soldiers (E5-E9) identified as illegal drug abusers will be processed for separation IAW Chap 14, AR 635-200 or Chapter 13, AR 635-200, as appropriate. The decision as to which chapter to use should be based upon the individual SM record, performance, and circumstances surrounding abuse.

1 February 1984

2. Post these changes per DA Pam 310-3.
3. File this interim change in front of AR 600-85.

(DAPE-HRL-A)

By Order of the Secretary of the Army

JOHN A. WICKHAM, JR.  
General, United States Army  
Chief of Staff

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ROBERT M. JOYCE  
Major General, United States Army  
The Adjutant General

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Headquarters  
Department of the Army  
Washington, DC, 11 August 1983

S/S 3 Nov 1980

# Immediate Action INTERIM CHANGE

AR 600-85  
Interim Change  
No. 105

Expires ~~11 August 1985~~

extended by Int ch. #108

4 Feb 1985

~~4 Feb 1986~~  
~~1 Feb 1987~~

Personnel - General

Alcohol and Drug Abuse Prevention and Control Program

**Justification:** Interim change clarifies the standard for blood alcohol level for soldiers on duty that was prescribed in Interim Change No. 103 to AR 600-85, dated 29 April 1983. The clarification is required to expand on the regulatory prohibition to the standard originally stated, which provides a basis for disciplinary action under the UCMJ and basis for administrative action, to include characterization of discharge. Failure to make this change could result in a judicial ruling against the Army.

**Expiration:** This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superceded by a permanent change.

1. AR 600-85, 1 January 1982, is changed as follows:

Page 1-4. The following sentences supercede the first sentence of paragraph 1-9.1:

Military Personnel on duty shall not have a blood alcohol level of .05% or above. Percent shall be based on milligrams of alcohol per 100 milliliters of blood (.05% is equivalent to 50 milligrams of alcohol per 100 milliliters of blood).

(DAPE-HRA)

By Order of the Secretary of the Army:

John A. Wickham, Jr.  
General, United States Army  
Chief of Staff

Official:

Robert M. Joyce  
Major General, United States Army  
The Adjutant General

Distribution: Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A requirements for AR. Personnel General - A.

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315 3 no 1980

# Immediate Action INTERIM CHANGE

Department of the Army  
Washington, D.C., 28 June 1983  
AR 600-85

Interim Change I04  
Expires 28 June 1985

*extended by Int. Ch. # I08*

*4 Feb 1980 | 7 Feb 1987 (extended by I10 4 Feb 1985)*  
Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)

Justification. This interim change aligns AR 600-85 with other regulations and Army policy in terms of retention criteria, personnel administration and policy regarding alcohol and drug abusers. The policy changes contained in this interim change are effective 1 July, and are not to be retroactive.

Expiration. This interim change expires two years from date of publication and will be destroyed at that time, unless sooner rescinded, or superseded by a permanent change.

1. AR 600-85, 1 January 1982 is changed as follow:

Page 1-2 Para 1-8a is superseded as follows.

a. Alcohol and drug abuse are incompatible with military service. Service members identified as alcohol and illegal drug abusers who, in the opinion of their commanders warrant retention, will be afforded the opportunity for rehabilitation. Those service members identified as alcohol or other drug abusers who do not warrant retention will be processed for separation from the military.

Page 1-3 Para 1-8d is superseded as follows:

d. Rehabilitation or treatment of alcohol and drug abusers will not be the sole basis for denial of continued service, permanent security clearances, job security, or career advancement.

Page 1-3 Para 1-8h is superseded as follows:

h. An active and aggressive urinalysis program serves as a valuable identification tool and an effective deterrent against drug abuse. Installation, community, and activity commanders will ensure that adequate testing levels are maintained, particularly in high risk areas or situations, and in all oversea areas. Because of the sensitive nature of the duties performed by personnel with aviation specialties, personnel assigned to aviation positions will be tested a minimum of once a year (see Appendix I). (This requirement does not apply to personnel who are not serving in aviation assignments.)

Page 1-4 Para 1-10 superseded as follows;

Title-Other Drugs

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- a. Any soldier involved with trafficking, distributing and selling drugs will be considered for disciplinary action under the UCMJ and/or for separation for misconduct.
- b. Soldiers identified as illegal drug abusers may be considered for disciplinary action under the UCMJ in addition to separation actions.
- c. Officers, Warrant Officers, and senior enlisted (E6-E9) who are identified as illegal drug abusers will be processed for separation from the service. These individuals have violated the special trust and confidence the Army has placed in them.
- d. Soldiers who have been identified in two separate instances occurring since 1 July 1983 as illegal drug abusers will be processed for separation from the service.
- e. Individuals diagnosed as physically drug dependent (other than alcohol), will not generally possess the potential for future service and will be processed for separation. These individuals will be detoxified, given medical treatment, and afforded the opportunity for rehabilitative treatment through the Veterans Administration, or a civilian program (See para 4-14).
- f. Soldiers identified as nondependent illegal drug abusers, who in the opinion of their commander warrant retention, should be enrolled in the ADAPCP when enrollment is recommended by the ADAPCP.

.Page 3-1 paragraph 3-2c is superseded as follows:

c. A limited use policy that restricts the consequences of the service-member's (SM) involvement in the ADAPCP is described in Chapter 6, Section II of this regulation. The provisions of the limited use policy are unchanged by the mandatory separation processing of drug abusers, and such separation processing must comply with its provisions.

d. Commanders will determine soldiers to be illegal drug abusers based upon the evidence provided by biochemical testing, law enforcement apprehension, command investigation, or other reliable sources.

Page 3-4 paragraph 3-16b(1) add as follows:

(d) A urine test of all personnel assigned to aviation positions (Appendix I) as part of an inspection under Military Rules of Evidence 313 a minimum of once a year (See paragraph 3-16b(1) (c), above). Testing can be conducted on an individual basis.

Page 4-7, para 4-25 is superseded as follows:

4-25 Separation Actions.

a. Commissioned officers and warrant officers determined to be illegal drug abusers will be processed for separation IAW Chap 5, AR 635-100.

b. Senior enlisted soldiers (E6-E9) identified as illegal drug abusers will be processed for separation IAW Chap 14, AR 635-200 or Chapter 13, AR 635-200, as appropriate. The decision as to which chapter to use should be based upon the individual SM record, performance, and circumstances surrounding abuse.

c. Soldiers initially retained, who are identified as second time illegal drug abusers will be processed for separation IAW Chap 14, AR 635-200 or Chap 5, AR 635-100.

d. Soldiers diagnosed as being physiologically drug dependent by a physician will be detoxified and processed for separation IAW Chap 14, AR 635-100 or Chap 5, AR 635-100. These individuals will be referred to the Veterans Administration:

- (1) within 30 days of separation
- (2) when requested by the SM in writing.

e. Soldiers who are enrolled in a rehabilitation program who in the opinion of their commanders do not possess potential based upon not meeting rehabilitation objectives may be processed for separation IAW Chap 9, AR 635-200 or Chap 5, AR 635-100.

2. Post these changes per DA Pam 310-3.

3. File this interim change in front of AR 600-85.

(DAPE-HRA)

By Order of the Secretary of the Army

JOHN A. WICKHAM, JR.  
General, United States Army  
Chief of Staff

Official:

ROBERT M. JOYCE  
Major General, United States Army  
The Adjutant General

DISTRIBUTION: Active Army, ARNG, USAR: to be distributed in accordance with DA Form 12-9A requirements for AR. Personnel General - A.

Add Appendix I

Aviation Specialties

Enlisted

67G Airplane Repairer  
67H Observation Airplane Repairer  
67N Utility Helicopter Repairer  
67U Medium Helicopter Repairer  
67Y Attack Helicopter Repairer  
67W Aircraft Quality Control Supervisor  
67X Heavy Lift Helicopter Repairer  
67T Tactical Transport Helicopter Repairer  
67Z Aircraft Maintenance Senior Sergeant  
68B Aircraft Powerplant Repairer  
68D Aircraft Powertrain Repairer  
68F Aircraft Electrician  
68G Aircraft Structural Repairer  
68J Aircraft Fire Control Repairer  
68K Aircraft Component Repairer Supervisor  
68M Aircraft Weapons System Repairer  
71P Flight Operations Coordinator  
93H Air Traffic Control (Tower Operator)  
93J Air Traffic Control Radar Controller

Warrant Officer

100A Multiengine Utility Helicopter Pilot  
100B Utility/Observation Helicopter Pilot  
100C Cargo Helicopter Pilot  
100E Attack Helicopter Pilot  
100K Multiengine Attack Pilot  
100Q Combat Services/Support Fixed Wing Pilot  
100R Combat Surveillance Fixed Wing Pilot  
150A Air Traffic Control Technician  
160A Aviation Maintenance Technician

Officers Specialties

15 Specialties  
71 Specialties  
67F Specialty

Copy

*2/S 3 Nov 1980*

Headquarters  
Department of the Army  
Washington, DC, 29 April 1983

# Immediate Action INTERIM CHANGE

AR 600-85  
Interim Change  
No. IO3  
Expires ~~29 April 1985~~

*extended by Int. Ch. # IO8  
4 Feb 1985*

*Personnel - General  
1 Feb 1987 (extended by IO1, Feb 1, 1986)*  
Alcohol and Drug Abuse Prevention and Control Program

Justification. Interim change aligns the policy and use of alcohol breath measuring devices with that of urinalysis. It establishes a standard that a soldier will not have a blood alcohol level of .050% (milligrams of alcohol per 100 milliliters of blood) or above while on duty. The violation of this standard provides a basis for disciplinary action under the UCMJ and basis for administrative action, to include the characterization of a discharge.

Expiration. This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

1. AR 600-85, 1 January 1982, is changed as follows:

Page 1-4. Paragraph 1-9.1 is added as follows:

1-9.1. Alcohol impairment. Military personnel on duty shall not have a blood alcohol level of .050% (milligrams of alcohol per 100 milliliters of blood) or above. Any violation of this provision provides a basis for disciplinary action under the UCMJ and a basis for administrative action, to include the characterization of discharge. Nothing in this regulation shall be interpreted to mean that impairment does not exist if the blood alcohol level is less than .050%. To be in violation of this provision, a service member must have known or should reasonably have known prior to becoming impaired that he or she had duties to perform.

Page 3-2. The following sentence is added to the beginning of paragraph 3-5:

Biochemical identification can be accomplished by either urinalysis or alcohol breath testing methods.

Page 3-2. The following sentence supersedes the first sentence of paragraph 3-8b:

The commander will refer all individuals who are suspected or identified as drug and/or alcohol abusers, this includes identification through urinalysis and blood alcohol tests.

Page 3-3. The following sentence supersedes the next to the last sentence of paragraph 3-12:

Service members with blood alcohol levels of .050% or above while on duty will be referred to the ADAPCP.

Page 3-4. Paragraph 3-16a is superseded as follows:

Concept. Biochemical testing for controlled substances or alcohol is a tool for the commander to use for the purposes listed in (1) through (6) below. In addition, biochemical testing is also a tool for the physician to use for the purposes listed in (1), (2), and (5) below. Individuals may use alcohol breath test for the purpose listed in (6) below. Biochemical testing will be conducted with maximum respect and concern for human dignity. Tests may be taken:

- (1) To determine a member's fitness for duty and the need for counseling, rehabilitation, or other medical treatment.
- (2) To determine the presence of controlled substances in a member's urine or blood alcohol content during participation in the ADAPCP.
- (3) To gather evidence to be used in actions under the Uniform Code of Military Justice (UCMJ).
- (4) To gather evidence to be used in administrative actions.
- (5) To determine the presence of controlled substance in a member's urine or blood alcohol content for a valid medical purpose.
- (6) To serve as a safeguard at social gatherings where alcohol beverages are served to individuals who might otherwise not realize how much alcohol they have consumed.

Page 3-6. The following sentences supersede the first three sentences in paragraph 3-16b(1):

(1) Commander - directed. Commanders may direct individual service members, parts of units, or entire units to submit to urine or alcohol breath testing in one or more of the ways listed below. The decision to test is a command judgement. Urine and alcohol tests will be conducted at the unit, or elsewhere the commander directs.

Page 3-6. Paragraphs 3-16b(1)(a) to 3-16b(2)(a) are superseded as follows:

(a) When there is reasonable suspicion a member is using a controlled substance or has a blood alcohol level of .050% or above while on duty, a urine or alcohol test for the medical purpose under Military Rule of Evidence 312(f) of determining the member's fitness for duty and the need for counseling, rehabilitation, or other medical treatment. (See Table 6-1 for limitations on use of the results produced by this method)

(b) A urine or alcohol breath test as a search or seizure under Military Rules of Evidence 312, 314, 315, and 316.

(c) A urine or alcohol breath test of part of the unit, or entire unit, as an inspection under Military Rule of Evidence 313 for the purpose of preserving the health of the service member inspected (Military Rule of Evidence 312(f)), or for any other inspection purpose.

(2) Physician - directed. Physicians may direct a service member patient to submit to a urine or alcohol breath testing:

(a) When the physician suspects the member of using a controlled substance or abusing alcohol to ascertain whether the member requires counseling, treatment, or rehabilitation in the ADAPCP (See Table 6-1 for limitations on the use of results produced by this method);

Page 3-8. Section V, paragraph 3-19 to 3-21 are added as follows:

SECTION V ALCOHOL BREATH MEASURING DEVICES

3-19. Distribution. Distribution will be IAW CTA 50-909.

3-20. Operator certification. If the alcohol breath measuring device results are to be used in disciplinary or administrative proceedings, the operator must be certified. Certification training should be in accordance with Appendix E, AR 190-5. The installation is responsible for the certification of operators.

3-21. Maintenance. The maintenance of the purchased device is the responsibility of the purchasing installations.

Page 6-2. Paragraph 6-3a(5) is superseded as follows:

Evidence concerning illegal drug or alcohol use or possession of drugs incidental to personal use obtained as a result of a member's emergency medical care for an actual or possible drug or alcohol overdose, unless such treatment resulted from apprehension by law enforcement officials, military or civilian.

Page 6-2. Paragraph 6-3a(1) is superseded as follows:

(1) Mandatory urine or alcohol breath test results taken to determine a member's fitness for duty and to ascertain whether a member requires counseling, rehabilitation, or other medical treatment; or in conjunction with a member's participation in ADAPCP. (See paragraph 3-16b and Table 6-1.)

Page 6-5. Table 6-1 is superseded with attached table 6-1.

2. Post these changes per DA Pam 310-13.

3. File this interim change in front of AR 600-85.

(DAPE-HRA)

29 April 1983

By Order of the Secretary of the Army:

E. C. MEYER  
General, United States Army  
Chief of Staff

Official:

ROBERT M. JOYCE  
Major General, United States Army  
The Adjutant General

Distribution: Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A requirements for AR. Personnel General - A.

TABLE 6-1 USE OF MANDATORY URINE OR ALCOHOL BREATH TESTING RESULTS

<u>WAYS A COMMANDER MAY DIRECT URINE OR ALCOHOL BREATH TEST</u>	<u>REFERRAL TO ADAPCP</u>	<u>DISCIPLINARY ACTION UNDER UCMJ</u>	<u>CHARACTERIZATION OF DISCHARGE</u>	<u>OTHER<sup>1</sup> ADMINISTRATION ACTION</u>
TO DETERMINE <sup>2</sup> FITNESS FOR DUTY AND THE NEED FOR COUNSELING, REHABILITATION, OR OTHER MEDICAL TREATMENT	YES	NO	NO	YES
PARTICIPATION IN ADAPCP	YES <sup>3</sup>	NO	NO	YES <sup>4</sup>
SEARCH OR SEIZURE UNDER MILITARY RULES OF EVIDENCE 312, 314, 315 AND 316	YES	YES	YES	YES
AS PART OF A MILITARY INSPECTION UNDER MILITARY RULE OF EVIDENCE 313	YES	YES	YES	YES

WAYS A PHYSICIAN  
MAY DIRECT URINE OR  
ALCOHOL BREATH TESTS:

ASCERTAIN WHETHER A MEMBER REQUIRES COUNSELING, TREATMENT, OR REHABILITATION FOR DRUG OR ALCOHOL ABUSE	YES	NO	NO	YES
OTHER VALID MEDICAL PURPOSE	YES	YES	YES	YES

<sup>1</sup>For example, withholding pass privileges (AR 630-5); admonition and reprimand (Chapter 2, AR 600-37); revocation of security clearances (Chapter 10, AR 604-5); bar to reenlistment (AR 600-80); and suspension of PRP certification (AR 50-5, AR 50-6); see generally FM 27-10, Legal Guide for Commanders.

<sup>2</sup>This category refers to a soldier for whom the commander has a reasonable belief has ingested drugs or alcohol as opposed to probable cause that the soldier has ingested drugs or alcohol. See your local SJA if in doubt.

<sup>3</sup>For members enrolled in ADAPCP, can be used to determine whether further rehabilitation efforts are practical UP Chapter 9, AR 635-200.

<sup>4</sup>However, for members enrolled in ADAPCP, discussion of ADAPCP participation in EERs and OERs must be in accordance with AR 623-105 or AR 623-205. In addition, the fact that a member is participating in ADAPCP should be revealed only to those with an official need to know, see paragraph 6-1b.

Headquarters  
Department of Army  
Washington, DC 11 February 1983

S/S 3700/1980

# Immediate Action INTERIM CHANGE

\*AR 600-85

Interim Change

No. I02

Expires ~~11 February 1985~~

extended by Int. Ch. # I08

~~4 Feb 1986~~

4 Feb 1985

Personnel-General  
1 Feb 1987 (extended by Int Ch I10 1 Feb 1986)  
Alcohol and Drug Abuse Prevention and Control Programs

Justification: This Interim Change implements a 28 Dec 81 Deputy Secretary of Defense memorandum, subject: Alcohol and Drug Abuse, pertaining to use of evidence obtained from mandatory urinalysis tests in disciplinary proceedings and for administrative actions. It aligns chapters 3 and 6, AR 600-85, with that portion of the referenced memorandum relating to mandatory urine testing under Military Rules of Evidence 312 through 316. This change implements the remaining provision of the referenced memorandum that deals with using mandatory urine test results for evidence obtained during a military inspection (Military Rules of Evidence 313).

Expiration. This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

1. AR 600-85, 1 January 1982, is changed as follows:

Page 3-1. Para 3-1 and 3-2 are superseded as follows:

~~This interim change supersedes I01, AR 600-85, 27 April 1982.~~

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3-1. Objectives. The objectives of identification are to discover alcohol and other drug abuse as early as possible and to:

a. Refer for treatment service members who desire to be rehabilitated and who demonstrate the potential for retention.

b. Identify and consider for separation service members who do not desire to be rehabilitated or do not show potential for retention.

3-2. Scope. a. Identification is accomplished through a variety of methods described in section II. One of these methods, biochemical testing, is discussed in detail in section II and section IV of this chapter.

b. The responsibility of the commander, the ADAPCP staff and the physician in the referral and screening process are outlined in section III. Also, see figure 3-1.

c. A limited use policy (formerly Exemption Policy) that restricts the consequences of the service member's involvement in the ADAPCP is described in Chapter 6, section II of this regulation.

Page 3-2. Paragraph 3-5 is superseded as follows:

#### 3-5. Biochemical Identification.

When a service member has a positive urinalysis, mandatory referral for ADAPCP screening is required. Medical evaluation is also required following ADAPCP screening except for individuals with positive test for cannabinoids (THC) when there is no reason to believe, after ADAPCP screening, the member is cannabis dependent. Medical evaluations determine whether serious medical illness is indicated because of drug usage. Commanders should be alert to positive urine tests for drugs that are seldom or never used for military outpatients, e.g., cocaine, amphetamines, THC, or PCP.

Page 3-2. Section III. Referral and Screening is superseded as follows:

#### Section III. REFERRAL AND SCREENING

3-8. Responsibilities of commanders for referral. a. When individuals are

identified, voluntarily or involuntarily, as possible alcohol or other drug abusers, their unit commander or designated representative, will--

(1) Using DA Form 3881 (Rights Warning Procedure/Waiver Certificate) advise them of their rights under Article 31 UCMJ.

(2) Explain the provisions of the limited use policy.

(3) Interview them and inform them of the evidence.

(4) Give them the opportunity to provide additional evidence, including information on drug sources, if they desire. (However, such disclosure is voluntary and will not be made a requirement for treatment or rehabilitation.)

(5) Collect any illegal drugs or drug paraphernalia that the service member voluntarily relinquishes and turn them over to the local provost marshal according to AR 190-22.

b. The commander will refer all individuals with urine positives to the ADAPCP for a formal initial screening interview. All individuals with urine positives will be referred to the ADAPCP for initial screening and medical evaluation by a physician unless the urine positive is for THC alone (See 3-5 above). Service members that are referred by the commander for an initial screening interview, regardless of the means of identification, will be referred with DA Form 2496 Subject: ADAPCP Military Client Referral and Screening Record. (See fig. B-1.) The referral and screening record will be signed by the commander. The initial screening interview will be accomplished by the ADAPCP staff at the earliest opportunity (not to exceed 2 working days) with emergency referrals receiving priority.

c. If, after the initial ADAPCP screening, a commander believes that a member does not have the desire to be rehabilitated or, based on the member's overall record, does not have the potential for future service, the service member will be considered for separation. Present paragraphs 3-9 to 3-11

should not be deleted.

3-12. Medical evaluation. The commander, supervisor, clinical director, counselor, or the service member may request a medical evaluation by a physician at any time to determine the extent of alcohol or other drug abuse by a service member. A medical evaluation is not required in all cases, but is always required in instances of a positive urinalysis for personnel not enrolled in the ADAPCP unless the positive is for THC alone. A medical evaluation is also required in cases of suspected alcohol or other drug dependency, and prior to entry in Track III (residential treatment). Service members with blood alcohol tests that reflect a high level of alcohol intake should be considered for referral for medical evaluation and assessment. Medical evaluations will be conducted by physicians using table B-4 of this regulation as general guidance and TB MED 290.

3-13. Rehabilitation team. The rehabilitation team will convene as soon as possible after the ADAPCP initial screening is completed. The team will, at a minimum, be composed of the client, his commander or the commander's designee, and the ADAPCP counselor. Other appropriate members of the team may be the ADAPCP clinical director, a physician, chaplain, social workers, psychologist, appropriate family members, the client's immediate supervisor, or other community human services personnel. Following the initial screening process (to include medical evaluation, if required) the ADAPCP counselor will recommend to the commander appropriate disposition of the referral during the first meeting of the rehabilitation team. One of the following or a combination of the following will be recommended:

- a. Unit counseling by the commander or the commander's designated representative.
- b. Other action (e.g., referral to another agency).
- c. No ADAPCP services required at the present time.

d. Enrollment in one of the following:

(1) Track I, Rehabilitation (nonresidential) awareness education and group counseling, as required. Enrollment in this track will not exceed 30 days.

(2) Track II, Rehabilitation (nonresidential). Intensive individual or group counseling (may include awareness education). Enrollment in this track is for a minimum of 30 days.

(3) Track III, Rehabilitation. Residential medical treatment with nonresidential follow-up. Enrollment in this track is limited to those clients who have been evaluated by a physician as requiring residential treatment. Generally, residential care will be reserved for those individuals with long standing problems of abuse, but for whom prognosis for recovery is favorable with proper treatment. Enrollment in this track is for 360 days.

Note: For civilian employees and other clients, see chapter 5 of this regulation for identification, referral and screening procedures.

Page 3-4. Paragraph 3-15 add the following: after the word "phencycline," add the word "cannabis,"

Page 3-4. Paragraph 3-15: delete the last sentence and substitute the following sentences, "All positive urine specimens are retained automatically by the laboratory for a period of 60 days after the date the Urinalysis Custody and Report Record is signed by the laboratory official. If retention is required beyond this period, because of pending disciplinary or adverse administrative action, it is the responsibility of the command that submitted the specimen to request further retention (See 3-17e).

Page 3-4. Paragraph 3-16 is superseded as follows:

3-16. Policies. a. Concept. Biochemical testing for controlled substances is a tool for the commander to use for the purposes listed in (1) through (6) below. In addition, biochemical testing is also a tool for the physician to

use for the purposes listed in (1), (2), (3) and (6) below. Biochemical testing will be conducted with maximum respect and concern for human dignity. Tests may be taken:

- (1) To determine a member's fitness for duty.
- (2) To identify personnel for referral to counseling, treatment, and rehabilitation.
- (3) To determine the presence of controlled substances in a member's urine during participation in the ADAPCP.
- (4) To gather evidence to be used in actions under the Uniform Code of Military Justice (UCMJ).
- (5) To gather evidence to be used in administrative actions.
- (6) To determine the presence of controlled substance in a member's urine for a valid medical purpose.

b. Testing programs.

(1) Commander-directed. Commanders may direct individual service members, parts of units, or entire units to submit to urine testing in one or more of the ways listed below. The decision to test is a command judgment. Urine tests will be conducted at the unit, or elsewhere the commander directs. Commander-directed urine tests will be administered by the unit ADC following the procedure set forth in paragraph 3-18. Coordination with the ADCO is necessary to insure that adequate laboratory support and supplies are on hand to support the planned testings.

(a) When there is reasonable suspicion a member is using a controlled substance:

1. A urine test for the valid medical purpose of determining the member's fitness for duty (see Table 6-1 for limitations on use of the results produced by this method);
2. A urine test to ascertain whether a member requires counseling,

treatment, or rehabilitation for drug abuse. (See Table 6-1 for limitations on use of the results produced by this method);

(b) A urine test as a search or seizure under Military Rules of Evidence 312, 314, 315 and 316.

(c) A urine test of part of the unit, or the entire unit, as an inspection under Military Rule of Evidence 313 for the purpose of preserving the health of the servicemembers inspected (Military Rule of Evidence 312(f)), or for any other inspection purpose.

(2) Physician-directed. Physicians may direct a service member patient to submit to urine testing:

(a) When the physician suspects the member of using a controlled substance to ascertain whether the member requires counseling, treatment, or rehabilitation in the ADAPCP (See Table 6-1 for limitations on use of results produced by this method);

(b) For any other valid medical purpose.

(3) Rehabilitation testing. Testing during rehabilitation or treatment will be performed for the following categories:

(a) While in detoxification -- upon entry and then at the discretion of the physician, regardless of age or primary substance of abuse.

(b) If detoxification is not required -- during the medical evaluation when entering a residential rehabilitation program, regardless of age and substance of abuse.

(c) During any phase of rehabilitation, regardless of age and substance of abuse -- once a week on an unannounced basis for the first month of rehabilitation is recommended; however, the number and intervals of tests will be determined by the rehabilitation team.

(4) ADAPCP staff testing. Military and civilian alcohol and other drug treatment staff personnel whose duties involve direct contact with

clients will be tested periodically at the discretion of the ADCO on an unannounced basis. Applicants for civilian positions must be notified before they are employed that their position in the ADAPCP will require urinalysis as a continuing condition of employment. A current listing by name, position, title and position description number of those to be tested will be posted on the staff bulletin board by the ADCO and a copy will be furnished to CPO. The ADCO will be responsible for furnishing the CPO with any changes to the list for use in processing new employees required to sign the written condition of employment (See app C).

Page 3-7. Paragraph 3-17d added as follows:

(5) Establish a biochemical collection point, administered by the Installation Biochemical Test Coordinator, to receive, package for shipment, and ship urine specimens in accordance with procedures in this regulation (Para 3-18).

Page 3-7. Paragraph 3-17e and f are superseded as follows:

e. Unit commanders will:

(1) Appoint one or more soldiers, grade E-5 or above, to act as unit Alcohol and Drug Coordinators (ADC).

(2) Insure that commander-directed urine tests conform to the policy contained in this regulation (para 3-16 and 3-18).

(3) Coordinate with ADCO for required support for command-directed urine test, e.g., availability of urine specimen bottles, and to ascertain if the servicing drug testing laboratory can process the number of specimens to be collected.

(4) Ensure that those positive specimens which will be used in UCMJ actions or adverse administrative actions are retained by the Drug Testing Laboratory that determined the results until such action is complete. Servicing staff judge advocates should be consulted regarding when UCMJ and

adverse administrative actions are complete for the purpose of retaining positive specimens. Examples of when some of these types of actions are complete for this purpose are: Nonjudicial punishment under Article 15, UCMJ, is complete on the date punishment is imposed; courts-martial are complete on the date sentence is adjudged; administrative separation actions are complete on the date approved by the approving authority. The Drug Testing Laboratory will automatically retain positive specimens for a period of 60 days from the date the laboratory certifying official signs DA Form 5180-R(Test) (Urinalysis Custody and Report Record) containing the results for the particular specimen. DA Form 5180-R(Test) will be reproduced locally on 8½ by 11 inch paper. A copy of DA Form 5180-R(Test) for local reproduction purposes can be found at fig 3-2. If retention beyond this 60 day period is necessary, the unit commander will cause an electronic message to be transmitted to the laboratory requesting the positive specimen to be retained. In response to this message, the Drug Testing Laboratory will retain the specimen for an additional 120 days after the end of the initial 60 day period. Should retention beyond this total period of 180 days be necessary, the unit commander will cause an electronic message to be transmitted to the Drug Testing Laboratory. This message must specify the period for which retention is requested and explain the justification for requesting this additional period.

f. Trial counsel will insure that personnel from drug testing laboratories required to testify in courts-martial are given a minimum of 10 days notice before the trial date. Notice will be given by electronic message. The message will include a fund cite for travel and TDY.

Page 3-7. Paragraph 3-17 g and h added as follows:

g. Drug Testing laboratories will--

(1) Provide testing service to all Army and Air Force installations and activities within the geographic area of responsibility as published by monthly quota messages from DA.

(2) Exercise internal quality control surveillance to insure

maintenance of the minimum drug detection sensitivity levels shown in table 3-1.

(3) Evaluate all urine specimens for testing detectable drugs of abuse using Radioimmunoassay (RIA). All specimens positive for detectable drugs of abuse will be confirmed by the use of gas liquid chromatography (GLC). Laboratory reports will be based only upon positive results confirmed by GLC.

(4) Ensure that all urine specimens are processed according to chain of custody procedures (as published by OTSG) and that chain of custody documents are properly annotated.

(5) Within five duty days after receipt of specimens, report to the originating unit, electrically or telephonically, confirmed positive results. The completed DA Form 5180-R(Test) (Urinalysis Custody and Report Record) (Figure 3-2) will also be dispatched at this time to the originating unit. If MINIMIZE is in effect, data will continue to be transmitted via electrical means or by telephone.

(6) Establish and maintain direct technical liaison, to the extent considered necessary and desirable, with other testing laboratories. This is for purposes of standardization of methodology and the exchange of technical information which may be of mutual benefit.

Page 3-7. Paragraph 3-18 is superseded as follows:

3-18. Collection and transportation of urine specimens. a. The installation commander has the overall responsibility for the collection, packaging for shipment, and shipment of urine samples. In situations where MEDDAC/MEDCOM TDAs include resources for this function, they will continue to provide these personnel to the ADCO to assist in urine collection procedures.

b. All urine specimens must be handled following a formal chain of custody. The chain of custody must account for each individual urine specimen in groups

of 12 or less from the time of the urine test until final analysis at the drug testing laboratory.

(1) The number of persons handling each specimen should be kept to a minimum because all such persons are in the chain of custody.

(2) All urine tests will follow the standard operating procedure set forth in Appendix H.

c. Urine testing will be accomplished in a manner and under circumstances conducive to the preservation of human dignity.

(1) Specimens will be collected in Bottle, Urine Specimen, Shipping, 120s: U/1 - Package, NSN 6650-DD-165-5778.

(2) Each urine specimen bottle will contain a minimum volume of 60 milliliters (one half of the volume of the bottle).

(3) The Urinalysis Custody and Report Record, DA Form 5180-R (Test), will be forwarded with the specimens as set forth in Appendix H. Local reproduction of the Urinalysis Custody and Report Record Form is authorized.

d. Urine specimens will be shipped without preservatives or refrigeration to the appropriate test laboratory by the method of expedited transportation. It is necessary to ensure delivery at the earliest date and, where possible, not later than three days after sample collection.

(1) Shipments will be assigned transportation Priority 1 with a required delivery date (RDD) 3 days after the date on which the specimen was taken. The priority and RDD will be entered in the appropriate blocks of DD Form 1384 (Transportation Control and Movement Document) or in the "Description of Contents" block of the US Government bill of lading.

(2) Transportation officers will arrange for movement of these samples by any of the following:

- (a) Expedited surface transportation.
- (b) US Postal Service.
- (c) The Military Airlift Command transportation system:  
nonindustrially funded military organic aircraft.
- (d) US Flag commercial air freight; air express, air freight  
forwarder.
- (e) When none of the above can satisfy the movement requirement, by  
foreign flag air carriers.

Figure 3-2 is added and can be found at the end of this interim change.

Page 6-1 paragraph 6-1c and d: Delete the word "Exemption" where used and  
substitute in its place the words "The Limited Use Policy".

Page 6-2. Section II. Exemption Policy is superseded as follows:

## Section II. LIMITED USE POLICY

6-2. Objective. The objective of the limited use policy is to facilitate the identification of alcohol and drug abusers through self-referral, and the treatment and rehabilitation of those abusers who desire to be rehabilitated and who demonstrate the potential for retention. It is not intended to protect a member who is attempting to avoid disciplinary or adverse administrative action.

## 6-3. Definition of the Limited Use Policy.

a. Limited use prohibits the use of the following evidence against a member in actions under the Uniform Code of Military Justice (UCMJ), or on the issue of characterization of service in separation proceedings:

(1) Mandatory urine or breath test results taken to determine a member's fitness for duty (Paragraph 3-16 b(1)(a)1); to ascertain whether a member requires counseling, treatment, or rehabilitation for drug abuse; or in conjunction with a member's participation in ADAPCP (Paragraph 3-16b (1)(a)2 (see Table 6-1).

(2) A member's self-referral to ADAPCP;

(3) Admissions and other evidence concerning illegal drug or alcohol use or possession of drugs incidental to personal use occurring prior to the date of initial referral to ADAPCP provided voluntarily by a member as part of his initial entry into ADAPCP;

(4) Admissions made by a member enrolled in ADAPCP to a physician or ADAPCP counselor at a scheduled interview, concerning illegal drug or alcohol use or possession of drugs incidental to personal use occurring prior to the date of his initial referral to ADAPCP; and

45 (5) Evidence obtained as a result of a member's emergency medical care for an actual or possible drug or alcohol overdose, unless such treatment resulted from apprehension by law enforcement officials, military or civilian.

b. The limited use policy does not grant total immunity. It does not prevent the counselor from revealing, to the appropriate authority, knowledge of illegal acts. These would be acts which may have an adverse impact on mission, national security, or the health and welfare of others. The reporting in such an instance is from counselor, to clinical director, to ADCO, to the client's commander. The commander will report the information to the appropriate authority. Likewise, information that the client presently possesses illegal drugs or that the client committed an offense while under the influence of illegal drugs or alcohol is not covered under this policy.

c. Limited use is automatic. It is not granted and it cannot be vacated or withdrawn.

d. An order from competent authority to submit to urinalysis or breath test is a lawful order. Failure to obey such an order may be the subject of appropriate disciplinary action under the UCMJ.

6-4. Implementation. a. Commanders will explain the limited use policy to members during the commander's interview as set forth in paragraph 3-8. Commanders will not make any agreement or compromise expanding the limited use policy in any way.

b. When a service member receives emergency treatment from a military medical facility for an actual or possible alcohol or other drug overdose, his or her commander is notified of the event as a routine matter. When a service member receives such emergency treatment from a civilian medical facility, however, there is no routine procedure to notify the service member's commander. Further, physicians at any federally supported civilian alcohol or other drug treatment facility are prohibited by statute from releasing such information without written consent of the patient. Hence, in cases where information of the emergency treatment does not otherwise come to the attention of the service member's unit commander, the following requirements

must be met before the policy becomes effective--

(1) The service member must inform his or her commander of the facts and circumstances concerning the actual or possible overdose. This must be done as soon after receiving emergency treatment as is reasonably possible.

(2) The service member must give written consent to the treating civilian physician or facility for release of information verifying that emergency treatment was rendered.

(3) If the civilian physician verifies emergency treatment, limited use is effective as of the time the treatment was rendered, unless such treatment resulted from apprehension by law enforcement officials, military or civilian.

(4) If the civilian physician refuses to release the information in spite of the service member's written consent, the commander will interpret the member's action described in (1) above as an act of volunteering for treatment in the ADAPCP. The limited use policy will be effective as of the time the treatment was rendered.

c. One or more military associates of an actual or possible alcohol or other drug overdose victim might be reluctant to assist the victim in obtaining emergency treatment from a medical treatment facility because they themselves are abusers of alcohol or other drugs. Such a person may, therefore, fear possible adverse consequences from becoming involved. Although limited use protection is not automatically extended to such a person, the availability of the following options to that service member and his or her commander should reduce reluctance to assist the victim.

(1) The service member may seek help for his or her own alcohol or drug problem from--

(a) His or her commander.

(b) The physician at the military medical treatment facility.

(c) Any other agency or individual described in paragraph 3-3.

(2) If the commander, because of a service member's assistance to an actual or possible alcohol or other drug overdose victim, suspects that member of alcohol or other drug abuse, the commander will:

(a) Inform the member of these suspicions.

(b) Insure that the member is aware of the treatment and rehabilitation services available.

(c) Give the member an opportunity to volunteer for help.

(3) If the member admits to alcohol or other drug abuse and volunteers for help, limited use becomes effective as of the time the member asks for help.

d. A service member protected by the limited use policy may be recommended for administrative discharge on the basis of evidence other than information obtained directly or indirectly from the member's involvement in the ADAPCP. Such a member may receive a discharge characterized as honorable, general, or under other than honorable conditions. (See AR 635-100, AR 635-200, and other regulations authorizing separation with less than an honorable discharge certificate.) The member will receive an honorable discharge certificate, regardless of his overall performance of duty, if discharge is based on a proceeding where the Government initially introduces evidence prohibited above. The Government includes the following:

(1) The commander (in his or her recommendation for discharge or in documents forwarded with his or her recommendation).

(2) Any member of the board of officers adjudicating the service.

member's case before the board.

(3) The investigating officer or recorder presenting the case before the board.

e. Alternatively, if the prohibited evidence is introduced by the Government before the board convenes, the elimination proceedings may be reinitiated, excluding all references to information protected by the Limited Use Policy. If the prohibited evidence is introduced by the Government after the board convenes, only a general courts-martial convening authority who is a general officer may set aside the board proceedings and refer the case to a new board for rehearing. The normal rules governing rehearings and permissible actions thereafter will apply in accordance with AR 635-100 or AR 635-200, as appropriate.

f. On the other hand, if the service member (respondent) or his counsel initially introduces such evidence, the type of discharge certificate issued is not restricted to an honorable discharge certificate.

g. All situations which could possibly arise in applying the limited use policy in the field cannot be foreseen. As in other instances in which the commander applies regulatory guidance in an actual case, he or she should seek advice from the supporting staff judge advocate.

Table 6-1 is superseded as follows:

TABLE 6-1 USE OF MANDATORY URINE TESTING RESULTS

WAYS A COMMANDER MAY DIRECT URINE TEST	REFERRAL TO ADAPCP	DISCIPLINARY ACTION UNDER UCMJ	RESULTS MAY BE USED FOR	
			CHARACTERIZATION OF DISCHARGE	OTHER ADMINISTRATIVE ACTION <sub>2</sub>
TO DETERMINE FITNESS FOR DUTY	YES	NO	NO	YES
EVALUATION TO ASCERTAIN WHETHER A MEMBER REQUIRES COUNSELING, TREATMENT, OR REHABILITATION FOR DRUG ABUSE	YES	NO	NO	YES
PARTICIPATION IN USP OR ADAPCP	YES <sup>1</sup>	NO	NO	YES <sup>3</sup>
SEARCH OR SEIZURE UNDER MILITARY RULES OF EVIDENCE 312, 314, 315, and 316	YES	YES	YES	YES
AS PART OF A MILITARY INSPECTION UNDER MILITARY RULE OF EVIDENCE 313	YES	YES	YES	YES
WAYS A PHYSICIAN MAY DIRECT URINE TESTS:				
ASCERTAIN WHETHER A MEMBER REQUIRES COUNSELING, TREATMENT, OR REHABILITATION FOR DRUG ABUSE	YES	NO	NO	YES
OTHER VALID MEDICAL PURPOSES	YES	YES	YES	YES

<sup>1</sup> For members enrolled in ADAPCP, can be used to determine whether further rehabilitation efforts are practical UP Chapter 9, AR 635-200.

<sup>2</sup> For example, withholding pass privileges (AR 630-5); admonition and reprimand (Chapter 2, AR 600-37); revocation of security clearances (Chapter 10, AR 604-5); and bar to reenlistment (AR 600-80), see generally FM 27-10, Legal Guide for Commanders.

<sup>3</sup> However, for members enrolled in ADAPCP, discussion of ADAPCP participation in EERs and OERs must be in accordance with AR 23-105 or AR 623-205. In addition, the fact that a member is participating in ADAPCP should be revealed only to those with an official need to know, see paragraph 6-1b.

Appendix H is added as follows:

APPENDIX H  
STANDARD OPERATING PROCEDURES  
FOR  
CHAIN OF CUSTODY FOR COMMANDER-DIRECTED URINALYSIS

H-1. Unit commander directs that a urine test be conducted and identifies individual service member, parts of a unit, and or entire unit for testing. (See para 3-16 a and b).

H-2. Unit ADC receives urine specimen bottles and labels them as follows:

a. Adheres gum label on body of bottle.

b. Records on gum label.

(1) month

(2) year

(3) batch number

(4) specimen number

(5) individual's social security number

c. Records individual's social security number on top of urine specimen bottle.

d. Initiate and records appropriate information on one Urinalysis Custody and Report Record (DA Form 5180-R(Test)) for each 12 specimens. If less than 12 specimens are to be gathered use only one form for each section leader (See paragraph H-5, below) for those specimens he/she gathers. (See example of executed executed Urinalysis Custody and Report (DA Form 5180-R(Test)) fig H-1).

H-3. Unit ADC maintains a urinalysis ledger documenting all individuals submitting test samples with the following identifying information:

(a) month

(b) year

- (c) batch number
- (d) specimen number
- (e) individual's social security number
- (f) Name of section leader that observed the member urinating (see

H-5, below).

H-4. Unit ADC distributes urine specimen bottle to member who verifies identifying information in the presence of his/her section leader who also verifies information. Unit ADC directs service member to sign his/her payroll signature in the urinalysis ledger and to initial the gum label as verification of the information.

H-5. Section leader (E-5 and above, same sex) has the responsibility to ensure that the specimens provided are not contaminated or altered in any way. Section leader observes members urinating into specimen bottles and placing lids on bottles. He/she also ensures bottles are not reopened by servicemembers.

H-6. Section leader takes urine specimen bottles from servicemembers, returns them to the unit ADC, and signs the prepared chain of custody document, DA Form 5180-R(Test) (Urinalysis Custody and Report Record) releasing up to 12 bottles for each (Urinalysis Custody and Report Record) to unit ADC and authenticating actions specified in H-5, above.

H-7. Unit ADC initials the gum labels on all bottles received and signs chain of custody section of DA Form 5180-R(Test) receiving up to 12 urine specimen bottles for each Urinalysis Custody and Report Record from section leader.

H-8. Unit ADC seals all sides, edges, and flaps of 12 bottle specimen boxes or padded mailers, if box is not used, with adhesive paper tape. Unit ADC signs his/her payroll signature across the tape on the top and bottom of each box or mailer.

H-9. Unit ADC affixes an envelope to applicable sealed box or mailer. Unit ADC places DA Form 5180-R(Test) (Urinalysis Custody and Report Record) for that box or mailer inside the envelope leaving the envelope unsealed so that the individual at the biochemical collection point can sign receiving the specimen boxes or mailers.

H-10. Unit ADC secures boxes or mailers ensuring they are not opened or tampered with in any way and transports them within 24 hours to the installation biochemical test coordinator at the installation collection point.

H-11. Unit ADC signs chain of custody section of the Urinalysis Custody and Report Record Forms releasing packaged and sealed specimens to the installation biochemical test coordinator (IBTC) who signs the chain of custody section of DA Form 5180-R(Test) verifying receipt of urine specimens.

H-12. Installation biochemical test coordinator signs each Urinalysis Custody and Report Record Form releasing it to one of the authorized modes of transportation. For example:

a. "Released to Registered Mail, Reg #12697."

b. "Released to SP4 Smith to Hand carry to Drug Testing Lab." NOTE: SP4 Smith must sign DA Form 5180-R(Test) Urinalysis Custody and Report Record receiving specimens.

c. "Released to Military Airlift Command Bill of Lading Number XXXX."

d. "Released to United Airlines Flight 554, Bill of Lading number XXXX."

e. "Released to Swiss Air Freight 52, Bill of Lading number XXXX."

H-13. Installation biochemical test coordinator at the collection point secure boxes or mailers ensuring they are not opened or tampered with in any way and packages them as required for shipment. All packages will be wrapped with brown mailing paper ensuring that the Urinalysis Custody and Report Record (DA Form 5180-R(Test)) remain inside the wrapper, affixed in its envelope to the specimen boxes. The outside of the package will be plainly marked "chain of custody" to alert drug testing lab that chain of custody specimens are

contained in package. IBTC ships boxes or mailers to the drug testing laboratory by priority one with a required delivery date NLT three days after specimens were taken. One of the following transportation modes will be used:

- a. US Postal Service via registered mail.
- b. Hand-carried via surface transportation.
- c. Military Airlift Command transportation system.
- d. US Flag commercial air Freight; air express, air freight forwarder.
- e. When none of the above can satisfy the movement requirement, by foreign flag air carrier.

H-14. Supplies for Commander-Directed Urinalysis

Book, Memorandum-Record ruled, 14 x 8 1/2", not indexed

7530-00-286-8363

Bottle, Urine Specimen, Shipping 120's

6640-00-165-5778

Envelope, Mailing, Plain white-4 1/8 x 9 1/2"

7530-00-286-6970

Label, Pressure sensitive

7530-00-082-2662

Paper, Kraft-Untreated, Wrapping

8135-00-290-3407 (24")

8135-00-160-7764 (36")

Sack, Shipping-Water resistant cushioned, double wall, kraft

8105-00-281-1169 (14 1/2" x 20")

8105-00-281-1168 (9 1/2" x 14 1/2")

8105-00-281-1167 (12 1/2" x 9")

Tape, Gummed Kraft - 3" wide medium weight

8135-00-270-8717

11 February 1983

I02, AR 600-85

Tape, Gummed Packaging - 3" wide

8135-00-598-6097

URINALYSIS CUSTODY AND REPORT RECORD			
<b>SUBMITTING UNIT:</b> Troop A, 1st Squadron, 14th ACR Ft. Bliss, LA 94386		<b>SHIPPED TO:</b>	
SPECIMEN NUMBER	COMPLETE URIN	LABORATORY ACCESSION NUMBER	LABORATORY RESULTS <small>(See Number 1 of Special Instructions)</small>
83-1-1			
83-1-2			
83-1-3			
83-1-4			
83-1-5			
83-1-6			
83-1-7			
83-1-8			
83-1-9			
83-1-10			
83-1-11			
83-1-12			

**CERTIFICATION OF LABORATORY OFFICIAL RECORDS CUSTODIAN**

I certify that I am a laboratory certifying official, that the laboratory results indicated above were correctly determined by proper laboratory procedures, and that they are correctly annotated therein. I further certify that I am the official records custodian of this laboratory, that this form has been prepared in accordance with regulations in the regular course of business of this laboratory, and that it is **(THE ORIGINAL FORM)** **(A TRUE AND ACCURATE COPY OF THE ORIGINAL)** kept in the official files of this laboratory and maintained by me.

\_\_\_\_\_  
 (Date) (Signature and Rank)

**SPECIAL INSTRUCTIONS**

1. Report positive results for specific drug(s), (i.e., positive for THC, positive for Cocaine and THC). Report results as negative only if all drugs tested are found to be negative. A negative result may be recorded with a rubber stamp.
2. Certifying official will line through inappropriate language in certification statement to identify this form as the original or a true copy thereof.
3. The testing laboratory will retain the original and return a certified copy to the submitting unit.

CHAIN OF CUSTODY			
DATE	RELEASED BY	RECEIVED BY	PURPOSE OF CHANGE/REMARKS
3 Jan 83	SIGNATURE <i>Jess DeValley</i> TYPED NAME Jess DeValley <sup>Squad Leader</sup>	SIGNATURE <i>Donny Kerr</i> TYPED NAME Donny Kerr ADC	Received specimens from Squad leader
3 Jan 83	SIGNATURE <i>Donny Kerr</i> TYPED NAME Donny Kerr ADC	SIGNATURE <i>Jordan Almond</i> TYPED NAME Jordan Almond IBTC	Received packages and sealed specimen boxes for shipping
4 Jan 83	SIGNATURE <i>Jordan Almond</i> TYPED NAME Jordan Almond IBTC	SIGNATURE <i>Registered Mail</i> TYPED NAME Reg#12362	Shipped to Drug Testing Lab at Wiesbaden, FRG
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
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	TYPED NAME	TYPED NAME	



**CHAIN OF CUSTODY**

DATE	RELEASED BY	RECEIVED BY	PURPOSE OF CHANGE/REMARKS
	SIGNATURE	SIGNATURE	
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	TYPED NAME	TYPED NAME	
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S/S INT Ch. 102 11 Feb 83

Headquarters  
Department of the Army  
Washington, DC, 27 April 1982

# Immediate Action INTERIM CHANGE

AR 600-85  
Interim Change  
No. 101  
Expires 27 April 1984

Personnel - General

## Alcohol and Drug Abuse Prevention and Control Program

Justification. Interim change implements a 28 Dec 81 Deputy Secretary of Defense memorandum, subject: Alcohol and Drug Abuse, pertaining to use of evidence obtained from mandatory urinalysis tests in disciplinary proceedings and for administrative actions. It aligns Chapters 3 and 6, AR 600-85, with that portion of the referenced memorandum relating to mandatory urine testing as a search or seizure under Military Rules of Evidence 312, 315 and 316 (Probable Cause). The remaining provisions of the memorandum that deal with using mandatory urine test results for evidence obtained during a "health and welfare" inspection (Military Rules of Evidence, 313) are to be implemented as labs become certified and staffed to manage the workload under a "chain-of-custody".

Expiration. This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

1. AR 600-85, 1 January 1982, is changed as follows:

Page 3-4. Paragraph 3-14e is added as follows: *NOTE: THIS SHOULD BE PART 3-16b(6)*

e. To provide urine test results for specimens taken during a search or seizure under Military Rules of Evidence 312, 315, 316.

Page 3-6. Paragraph 3-14b(6) is added as follows:

(6) Urine testing for evidence. A urine test as a result of search under Military Rules of Evidence 312, 315, 316.

Page 3-7. Paragraph 3-17d(5) added as follows:

(5) Establish a Biochemical Collection Point, administered by the Installation Biochemical Test Coordinator, to receive, package for shipment, and ship urine specimens in accordance with policy in this regulation (para 3-18).

The Army Library (ANPAL)  
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Room 1A613 Pentagon  
Washington DC 20310

Page 3-7. Paragraph 3-17d(6) is added as follows:

(6) After consultation with servicing staff judge advocate, ensure that the Lab Officer, Drug Testing Lab, Department of Pathology (WRAMC), Ft Meade, MD is notified by electrical message or telephone within 60 days of the lab report, of those cases which UCMJ action is pending based upon the laboratory report. The message will include instructions regarding disposition of the urine specimen bottle, e.g., destroy or send back to unit for use as evidence.

Page 3-7. Paragraph 3-17e(4) is superseded as follows:

(4) Within two days after receipt of specimens, report to the originating agency by electrically transmitted message, confirmed positive results and a statement that the balance of the specimens were negative. The completed DD Form 1892 (Drug Screening Urinalysis Record) and the DA Form 4137 will also be dispatched at this time to the originating unit. Ensure that all urine specimens marked "chain-of-custody" are handled according to procedures established by local SOPs and that chain-of-custody documents are properly annotated. Chain-of-custody specimens should be processed as soon as possible after receipt and processing time should not exceed 24 hours.

Page 3-7. Paragraph 3-17g is added as follows:

g. Staff Judge Advocate. Trial counsel will ensure that personnel from drug testing labs required to testify in court-martial are given a minimum of 10 days notice before the trial date. Notice will be given by electrically transmitted message. The message will include a fund cite for travel and TDY.

Page 3-7. Paragraph 3-18a is superseded as follows:

a. The installation commander has overall responsibility for the collection of urine specimens. When the specimen has been collected for possible use as evidence (para 3-16b(6)) the specimen will be shipped by the most expeditious air transportation available. For CONUS units, these specimens should be processed to arrive at the lab at Ft. Meade, MD, NLT 24 hours after collection.

Page 3-8. The following sentence is added to the end of paragraph 3-18d:

Specimens that are collected as a search or seizure under Military Rules of Evidence 312, 315, 316 will take precedence over all routine, "rehab" or "PRP" specimens.

Page 3-8. Paragraph 3-18e is added as follows:

e. In order for the results of urine tests to be used as evidence in UCMJ or administrative actions, urine specimens must be handled following a formal chain-of-custody (See Appendix H). The chain-of-custody must account for each individual urine specimen from the time of the urine test until analysis at the drug testing lab.

(1) The number of persons handling each specimen should be kept to a minimum because all such persons are in the chain-of-custody and may be called to testify in UCMJ or administrative actions.

(2) DA Form 4137 will be appropriately completed and forwarded along with the DD Form 1892 for all urine specimens taken as result of a search or seizure under Military Rules of Evidence 312, 315, 316.

(3) The Drug Testing Lab, Department of Pathology (URAMC) Ft. Meade, MD 20755, Autovon 923-4076/6075, is designated to support the chain-of-custody testing Army-wide. Specimens that are taken as a result of a search or seizure under Military Rules of Evidence 312, 315, 316 should be clearly marked on the outside of the shipping container ("chain-of-custody").

Page 6-2. The following sentence is added to paragraph 6-4a:

Exemption does not apply to urine test directed as a search or seizure under Military Rules of Evidence 312, 315, 316.

Page 6-5. Table 6-1, rule 3, footnote 2, is added as follows:

<sup>2</sup>Exemption does not apply to urine test directed as a search or seizure under Military Rules of Evidence 312, 315, 316.

Page H-1. Appendix H is added as follows:

#### APPENDIX H

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### STANDING OPERATING PROCEDURES

#### FOR

#### CHAIN-OF-CUSTODY FOR COMMAND DIRECTED URINALYSIS

H-1. Unit commander directs that a urine test be conducted and identifies individual service member, parts of a unit, and or an entire unit for testing. (See para 3-16 a and b).

H-2. Unit <sup>ACD</sup> receives urine specimen bottles and labels them as follows:

- a. Adheres gum label on body of bottle.
- b. Records on gum label:
  - (1) Month.
  - (2) Year.
  - (3) Batch number.

(4) Specimen number.

(5) Individual's last four social security digits.

c. Records individual's last four social security digits on top of urine specimen bottle.

H-3. Unit ADC maintains a urinalysis ledger documenting all individuals submitting test samples with the following identifying information:

a. Month.

b. Year.

c. Batch number.

d. Specimen number.

e. Individual's last four social security digits.

H-4. Unit ADC distributes urine specimen bottle to member who verifies identifying information in the presence of his/her section leader who also verified information.

H-5. Section leader (E5 and above, same sex) has the responsibility to ensure that the specimen provided is not contaminated or altered in any way. Section leader observes member urinating into specimen bottle and placing lid on bottle. He also ensures bottle is not reopened by member.

H-6. Section leader takes urine specimen bottle from member, returns it to the unit ADC, and signs the prepared chain-of-custody document releasing specimen to unit ADC and authenticating actions specified in H-5.

H-7. Unit ADC signs chain-of-custody document receiving member's urine specimen bottle from section leader.

H-8. Unit ADC seals all sides, edges, and flaps of 12 bottle specimen boxes or padded mailers with adhesive paper tape. Unit ADC signs his/her payroll signature across the tape on the top and bottom of each box or mailer.

H-9. Unit ADC affixes an envelope to applicable sealed box, mailer or container. Unit ADC places the chain-of-custody document inside the envelope leaving the envelope unsealed so that the individual at the biochemical collection point can sign receiving specimen boxes, mailers, and containers.

H-10. Unit ADC secures boxes or mailers ensuring they are not opened or tampered with in any way and transports within 8 hours the specimen boxes or mailers to the installation biochemical test coordinator at the installation collection point.

H-11. Unit ADC signs chain-of-custody document releasing specimens to the biochemical test coordinator who signs the chain-of-custody document verifying receipt of urine specimens.

H-12. Installation biochemical test coordinator (IBTC) at the collection point secures boxes or mailers ensuring they are not opened or tampered with in any way and packaged as required. All packages will be wrapped with brown mailing paper (kraft) ensuring that the chain-of-custody document remains inside the wrapper affixed to the specimen boxes. The outside of the package will be plainly marked "chain-of-custody" to alert drug testing lab that chain-of-custody specimens are contained in package. IBTC ships boxes or mailers to the drug testing laboratory by priority-one with a required delivery date NLT three days after specimens were taken. One of the following transportation modes will be used:

- a. US Postal Service via registered mail.
- b. Hand-carried via surface transportation.
- c. Military airlift command transportation system.
- d. US flag commercial air freight; air express, air freight forwarded.
- e. When none of the above can satisfy the movement requirement, by foreign flag air carrier.

H-13. Installation biochemical test coordinator signs each change of custody document releasing it to one of the authorized modes of transportation. For example:

- a. "Released to registered mail (1304)".
  - b. "Released to SP4 Smith to handcarry to drug testing lab."
  - c. "Released to military airlift command bill of lading number XXXX".
  - d. "Released to United Airlines Flight 554, bill of lading number XXXX".
  - e. "Released to Swiss Air Flight 52, bill of lading number XXXX".
2. Post these changes per DA Pam 310-13.
  3. File this interim change in front of AR 600-85.

(DAPE-HRA)

By Order of the Secretary of the Army

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Distribution: Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A requirements for AR. Personnel General - A.

S/S 3 Nov 1980

ARMY REGULATION

No. 600-85

HEADQUARTERS  
DEPARTMENT OF THE ARMY  
WASHINGTON, DC, 1 December 1981

PERSONNEL—GENERAL

ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM

Effective 1 January 1982

*This revision updates the Army's Alcohol and Drug Abuse Prevention and Control Program (ADAPCP), defines Army policy on alcohol and other drug abuse, and defines responsibilities for implementation of the program. Supplementation of this regulation is prohibited, except upon approval of the Deputy Chief of Staff for Personnel. Request for exception with justification will be sent through command channels to HQDA (DAPE-HRA), WASH, DC 20310.*

*Interim changes to this regulation are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.*

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## CHAPTER 1 GENERAL

### Section I. INTRODUCTION

**1-1. Purpose.** This regulation prescribes policies and procedures needed to implement, operate, and evaluate the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).

**1-2. Applicability.** *a.* The regulation applies to all Active Army personnel. It also applies to members of the Army National Guard (ARNG) and the US Army Reserve (USAR) who are serving on—

- (1) Active duty (AD).
- (2) Initial active duty training (IADT).
- (3) Special tours of active duty training (special ADT).
- (4) 45 days' involuntary active duty training (45 days' ADT).

*b.* The provisions of chapter 9 apply to members of the ARNG and USAR when not on AD or any type of ADT.

*c.* ADAPCP services are authorized for personnel who are entitled to military medical services or eligible for medical services under the Federal Civilian Employees Occupational Health Services Program. This includes the following personnel:

- (1) US citizen civilian employees of the Army. This includes nonappropriated fund (NAF) employees.
- (2) Military and civilian dependents.
- (3) Retired military personnel.
- (4) Other DOD personnel who may be deemed eligible on a case-by-case basis.
- (5) Foreign nationals where Status of Forces Agreements or other treaty arrangements provide for medical services.
- (6) Family members of eligible personnel.

*d.* Chapter 5 details the aspects of ADAPCP for civilian employees and family members.

Policies and guidance described in other than chapter 5 are applicable to all civilian clients including retired personnel.

*e.* Other Service personnel under the administrative jurisdiction of an Army installation commander are subject to this regulation. When Army service members are under the administrative jurisdiction of another Service, they will comply with the alcohol and drug program of that Service. But they will also be reported through Army biostatistical channels. In some cases elements of the Army and another Service are so located that cost effectiveness, efficiency, and combat readiness can be achieved by combining facilities. In such cases the Service to receive the support will be responsible for initiating a local memorandum of understanding (MOU) interservice support agreement. (See AR 1-35).

**1-3. Background.** *a.* On 28 September 1971, Public Law 92-129 mandated a program for the identification and treatment of drug and alcohol dependent persons in the Armed Forces. In turn, the Secretary of Defense directed each of the Services to develop drug abuse prevention and control programs that would identify, treat, and rehabilitate all service members dependent on drugs. In response to this mandate and to the escalating use of drugs by Army personnel, the US Army initiated a comprehensive program to prevent and control the abuse of alcohol and drugs. The civilian aspects of the ADAPCP are mandated by Public Laws 91-616 and 92-255. These statutes, and their subsequent amendments, require that all Federal agencies provide alcohol and other drug abuse services to their employees using existing facilities and services in so far as possible.

b. Worldwide implementation of the ADAPCP as a means to conserve manpower and insure individual readiness, was influenced by three policy decisions. These decisions, listed below, continue to provide the basis for the ADAPCP:

(1) The program would be a command program.

(2) The program would be decentralized.

(3) Alcohol and other drug abuse and related activities would be addressed in a single program.

1-4. **Concept.** a. The ADAPCP is a manpower conservation program comprised of the following functional areas:

(1) Prevention.

(2) Education.

(3) Identification.

(4) Rehabilitation.

(5) Treatment

(6) Program evaluation.

(7) Research.

b. This regulation implements the alcohol and drug program DOD Directives 1010.4, 1332.14, 5210.42, and DOD Instructions 1010.1, 1010.3, 1010.5, and 1010.6.

1-5. **Objectives.** The objectives of the ADAPCP are the following:

a. Prevent alcohol and other drug abuse.

b. Identify alcohol and other drug abusers as early as possible.

c. Restore both military and civilian employee alcohol and other drug abusers to effective duty. Or, identify rehabilitation failures for separation from Government service.

d. Provide for program evaluation and research.

e. Insure that effective alcohol and drug abuse prevention education is provided at all levels. This education must be included in all three tracks of rehabilitation as a necessary part of the ADAPCP and as required of DOD. (See chap. 4, para 4-5, b for a discussion of rehabilitation tracks.)

f. Insure that adequate resources and facilities are provided to successfully and effectively accomplish the ADAPCP mission.

g. Insure that all military and civilian personnel assigned to ADAPCP staffs are appropriately trained and experienced to effectively accomplish their mission.

h. Achieve maximum productivity, reduced absenteeism and attrition among DA civilian employees by preventing and controlling abuse of alcohol and other drugs.

1-6. **Explanation of terms.** ADAPCP terms and acronyms are defined in the glossary. To improve program management and evaluation, all ADAPCP terms and acronyms will be standardized Army-wide.

1-7. **References.** See appendix A for required and related references.

1-8. **General policy.** a. A sustained effort to prevent alcohol abuse, alcoholism, and misuse or abuse of other drugs is required of all elements of the DA. An attempt must be made to restore the effective and reliable duty individuals who fail to function properly in a military environment because of the abuse of alcohol or other drugs. Those who cannot be effectively restored to duty within a reasonable period of time will be referred to the commander for discharge or termination.

b. The ADAPCP provides services for both alcohol and other drug abusers in the same counseling program. The *facility* at which these services are provided will be known as the *Community Counseling Center (CCC)* (e.g., Fort Hood Counseling Center, Yongson Counseling Center).

c. Commanders and supervisors must confront suspected alcohol or other drug abusing individuals under their supervision with the specifics of their behavior, inadequate performance, or unacceptable conduct. Knowledgeable commanders and supervisors provide the necessary support for motivating personnel to recognize the advantages of obtaining assistance. All levels of the chain of command must take prompt action in identifying personnel, regardless of rank or grade, if alcohol or other drug abuse is suspected.

d. Continued military service, permanent access to classified information, job security, or promotion opportunities normally will not be denied solely on the basis of past or present alcohol or other drug abuse, rehabilitation or treatment.

e. Officer and enlisted evaluation reports or employee performance appraisals normally will not mention current or past enrollment in the ADAPCP (See AR 623-205 or AR 623-105.)

f. Incidents of domestic or family violence involving alcohol or other drug abuse brought to the attention of any other agency, whether or not the incident resulted in a report, must be brought to the attention of the unit commander. The unit commander will immediately refer the individual to the ADAPCP for evaluation.

g. ADAPCP rehabilitation services will include the client's family, whenever possible. The client's permission must be obtained before his family members are provided information about ADAPCP participation.

h. An active and aggressive urinalysis program serves as a valuable identification tool and an effective deterrent against drug abuse. While there are no minimum testing levels, installation, community and activity commanders will insure that adequate testing levels are maintained, particularly in high risk areas or situations and in *all* overseas areas.

i. ADAPCP rehabilitation services for both alcohol and other drug abusers usually will be short-term. These services will be conducted in the military environment to which DA personnel must adapt. Participation in the ADAPCP, to include any one or more of the three tracks (para 4-5), is mandatory for all service members who are enrolled in the ADAPCP by their commanders. To refuse evaluation upon referral or enrollment constitutes violation of a direct order for service members.

j. Commanders may be prohibited by the exemption policy from taking some types of administrative and disciplinary actions against service members who are enrolled in the ADAPCP. However, a service member cannot

request enrollment in the ADAPCP to avoid a pending or threatened disciplinary or administrative action. For further guidance see exemption policy in chapter 6 of this regulation.

k. Except under specified conditions, commanders are prohibited from releasing information that an individual is, or has been, an abuser of alcohol or other drugs. The fact that a service member is or has been enrolled in the ADAPCP cannot be revealed without the individual's permission. (See chap. 6.)

l. Implementation of an ADAPCP capability is required for installations, communities and activities within the DA. Such capability is required to deliver standardized treatment and rehabilitation services and to conduct local program prevention activities in education, training, law enforcement and community action. Although in-house ADAPCP capability and broad objectives of the ADAPCP are being achieved, continued emphasis and support by the chain of command, to the lowest level, are necessary.

m. The Army encourages the support of recognized labor organizations for civilian employee aspects of the ADAPCP.

n. Alcohol and drug abuse policy will be given adequate publicity to insure that eligible civilians and family members are aware of the following:

- (1) Command support.
- (2) Available information.
- (3) Referral procedures.
- (4) Rehabilitation services of the ADAPCP.

o. Job security or promotion action for civilian employees will not be jeopardized by a request for counseling or referral assistance.

p. Enrollment of civilian employees and family members is voluntary. However, supervisors may utilize referral for screening services as an alternative to disciplinary action. Disciplinary or administrative action may be suspended in such cases for a period of 90 days. Employees will be offered assistance for alcohol or drug abuse related problems. They may refuse such assistance and accept the conse-

quences for continued substandard performance. Civilian employees have the option of participating in either the installation rehabilitation program or of being referred to an approved program in the civilian community. Exceptions are oversea commands where they will always utilize the services of the local ADAPCP.

g. The Commander of the servicing installation or activity is responsible for developing procedures by which civilian employees may utilize ADAPCP facilities and services. Proposals to provide services which deviate from procedures prescribed by this regulation must be approved by the Office of the Deputy Chief of Staff for Personnel (ODCSPER) *prior* to establishing alternative plans for services (as required for isolated or remote areas, or special organizational structures).

1-9. **Alcohol.** The use of alcohol is legal and socially acceptable, but it should not become the purpose or focus of any military social activity. Abuse or excessive use of alcohol will not be condoned or accepted as part of any military tradition, ceremony, or event. It is Army policy to encourage service members and civilian employees to examine their personal use of alcohol; if necessary, they should seek assistance without fear or damage to their careers. Commanders are responsible for informing personnel of inappropriate performance or social conduct associated with problem drinking. Peers are encouraged to provide positive support by calling attention to problem drinking and getting their peers to volunteer for assistance. Command leadership will promote responsible attitudes by those who drink and acceptance of those who do not drink. Commanders will insure that subordinates are educated about alcoholism and its early signs and symptoms. It is the responsibility of each individual, military and civilian, to conform to Army standards of conduct and performance of duty. Publicity that glamorizes or encourages alcohol abuse is prohibited.

1-10. **Cannabis.** a. The DA is faced with the high probability that many of those who volunteer for military service have used cannabis

and may continue to use it after entering the military. Within the DA, current identification efforts and responses to identified cannabis use vary widely. In some organizations, there are active and intense efforts to locate cannabis users; in others, the user is strongly disciplined and placed in treatment for up to 1 year. It is important that a clear and consistent policy regarding cannabis use be established which emphasizes the Army's commitment to the highest standards of discipline, health, and respect for the law.

b. **Pre-service use:** Limited or experimental pre-service use of cannabis will not be a mandatory disqualification for enlistment or appointment in the Army; however, dependence on marijuana, a court conviction or juvenile court adjudication for selling or trafficking in marijuana is a nonwaivable disqualification for enlistment or appointment in the Army. Any use of cannabis during the 90-day period immediately preceding application for enlistment is disqualifying and a waiver will be required prior to enlistment. Appointment to specialties or to positions requiring certification of acceptability for the nuclear or chemical reliability programs (Personnel Reliability Program (PRP)) as outlined in AR 50-5 or AR 50-6, to career management field 95 (Military Police), or to other sensitive positions is disqualifying if it can be shown that there has been cannabis use. A waiver will be required prior to appointment.

c. **In-service use:** The use of cannabis is a violation of the Uniform Code of Military Justice (UCMJ). Commanders will enforce the law and take appropriate action against those in violation. Army law enforcement operations will continue to detect, identify, report, and investigate instances of illegal use, possession, trafficking, or sale of cannabis.

d. **Appropriate disposition:** Within the Army, there is a wide range of alternatives for restoring the abuser to duty. These include disciplinary action, personnel security and other administrative action, preventive and motivational education or nonresidential counseling. The appropriate response must be tailored to the level of abuse. The response should be

arrived at through a screening procedure which normally involves the commander, the immediate supervisor, ADAPCP personnel, and a medical or legal representative as necessary. When the drug of abuse is cannabis, commanders should usually confine their response to administrative actions, disciplinary action, and motivational education. Other actions would be needed if there is serious involvement with the drug, or if the individual holds a special security clearance or is assigned to special access program duties.

*e.* Motivational education has proved to be an effective method for assisting abusers who may be unaware of the consequences of abuse. Commanders are, therefore, advised to use this approach rather than more lengthy treatment responses for the cannabis abuser. In considering the disposition of the cannabis offender, as in considering the disposition of any other offender, all administrative, punitive, and non-judicial punishment measures should be evaluated to determine which are most appropriate. The facts and circumstances surrounding the commission of the alleged offense, the length and character of service, and any mitigating circumstances should be considered. All personnel should be informed periodically that cannabis use will not be tolerated in the Army.

**1-11. Prevention.** The commander will—

*a.* Insure that prevention programs are aimed specifically at individual target groups (discussed in chap. 2). These prevention activities should be integrated with other mission-related efforts within the military community setting. Such related efforts may be combat training activities, safety campaigns, and law enforcement actions.

*b.* Insure that the ADAPCP prevention program is coordinated with local civilian community efforts in drug and alcohol prevention.

*c.* Encourage a high degree of involvement of military community members in local civilian community prevention efforts.

*d.* Coordinate quality of life initiatives with prevention activities by providing alternatives.

**1-12. Education.** Commanders will insure that information on alcohol and other drug abuse and prevention aspects of the ADAPCP are provided to all members. This includes civilian employees and dependents. Commanders will insure that leaders at all levels are knowledgeable about ADAPCP policies, procedures, and prevention strategies. Alcohol and drug education doctrine is developed by the US Army Training and Doctrine Command (TRADOC) with input from the major Army commands (MACOMs), in coordination with HQDA.

**1-13. Personnel in sensitive positions.** (See AR 604-5, AR 690-1.)

*a.* Participation in an alcohol or drug rehabilitation program is not of itself sufficient cause to identify the participant as a security risk; however, severity of a given case may warrant suspension of an individual's access to classified material. The need for suspension and notification should be determined on a case-by-case basis by the immediate commander.

*b.* When a case surfaces which the commander decides warrants suspension action, the commander will notify the Central Personnel Security Clearance Facility (CCF) by the most expeditious means in support of the latter's official need to know. The commander must also concurrently initiate an investigation or inquiry as required by AR 604-5.

*c.* Individuals participating in a rehabilitation program who are ultimately determined to be rehabilitation failures will be reported to the CCF so that revocation of clearance action may be taken concurrently with initiation of separation action. Revocation of clearance should not occur until, in the judgment of the commander, every reasonable effort toward rehabilitation has been afforded and the individual has failed to respond satisfactorily.

*d.* Upon successful completion of the ADAPCP or within 90 days of suspension (whichever occurs first), action will be taken by the commander to notify the CCF of all pertinent details in order to provide the basis for reinstatement of access.

*e.* The foregoing comments apply only to dis-

closure within the Armed Forces of ADAPCP records pertaining to military service members. Disclosure of ADAPCP information pertaining to civilian employees, however, is subject to the further restrictions of Public Laws 92-255 and 93-282 and 42 CFR chapter 1, part 2. Without a court order, disclosure even within the Armed Forces of such records requires the written consent of the individual and then is permissible only for purposes expressly authorized by the cited laws and regulations.

**1-14. Aviation personnel.** *a.* Alcohol and other drug abuse by aviation personnel is of special concern because of its impact on aviation safety. AR 40-501 establishes medical fitness standards for aviation personnel. These include rated aviators and flight surgeons, air traffic controllers and others.

*b.* Criteria concerning drug and alcohol abuse are contained in AR 40-501. For the purpose of this regulation, a service member given a diagnosis of alcohol dependency will be considered medically unfit for flight duty. Appropriate commanders, acting on the medical recommendation of the flight surgeon, must follow procedures contained in AR 40-501 and AR 600-107. These procedures restrict or suspend medically unfit personnel from aviation duties. AR 600-107 provides for the termination of medical restriction or suspension and the return of rehabilitated abusers to aviation service and flying status.

*c.* Aviation personnel identified as a non-dependent alcohol abusers who are otherwise considered fit do not necessarily have to be restricted from flying duties, except for any period of time spent in a residential treatment program. This would be provided their abuse of alcohol has not interfered with their performance of duty. In such cases, commanders, flight surgeons, and the ADAPCP clinical director must closely coordinate with each other and provide appropriate recommendations to commanders. After careful consideration of the advice of the clinical director and a medical recommendation from the flight surgeon, commanders will determine appropriate action regarding aviation service or flying status.

*d.* Aviation personnel who use drugs illegally, whether or not determined by aviation medical authorities to be medically fit, are subject to suspension from flying duties. Cases indicating the nonhabitual use of marijuana or the casual or experimental use of other dangerous drugs, may be recommended for waiver by competent medical authority. The waiver may be provided if there is no history of repeated drug use, if there is evidence of abstinence from current drug abuse, and if the individual is otherwise qualified. Nonprescription use of any narcotic or dangerous drug within a 1 year period is disqualifying for flight status. Aviators may be suspended for nonmedical reasons per AR 600-107. The commander, ADAPCP clinical director, and flight surgeons should coordinate with one another as to the proper course of action on a case-by-case basis using guidelines in regulations cited above. Persons considered medically unfit who are rehabilitated must obtain a waiver as outlined in AR 40-501.

*e.* Aviation personnel, including air traffic controllers, who hold Federal Aviation Administration (FAA) medical certificates must comply with FAA standards on alcohol and other drug use.

**1-15. Personnel Reliability Program (PRP).** (See AR 50-5 and AR 50-6).

*a.* The commander's actions with regard to members of the PRP who are enrolled in the ADAPCP will depend primarily upon the diagnostic term assigned by a physician. (See app B, table B-4 for definitions.) Since a number code is no longer assigned by the physician, the following descriptive terms apply:

(1) Personnel identified in the following categories may or may not be removed from the PRP, based on the commander's evaluation of reliable duty performance and other qualifying or disqualifying evidence:

(a) *Nondependent Abuse.*

(b) *No Diagnosis Apparent.*

(c) *Personnel Enrolled in the ADAPCP without a Medical Evaluation.*

(2) Personnel identified in the following categories will not be selected for or retained in a PRP position:

(a) *Medically Diagnosed Dependence on Alcohol or Other Drugs.*

(b) *Hallucinogen Abuse.* Persons who have used a hallucinogenic drug with potential for flashback, e.g., LSD, PCP, Psilocybin, mescaline or other substances with similar properties, will not be selected or retained in the PRP under any circumstances.

b. AR 50-5 and AR 50-6 allow for reinstatement of persons disqualified in the PRP, provided the cause for disqualification no longer exists. An individual or the commander of an individual who successfully completes rehabilitation as evidenced on a DA Form 4466 (Client Progress Report); may request requalification in accordance with AR 50-5 or AR 50-6.

c. The PRP is a commander's program and is supported by the ADAPCP. Personnel involved in screening, counseling, and continuing evaluation of clients will insure that all potential disqualifying information is forwarded immediately to the individual's commander for consideration. ADAPCP personnel should become familiar with the provisions of AR 50-5 and AR 50-6 and their responsibilities with regard to the PRP.

**1-16. Reenlistment during enrollment in the ADAPCP.** a. Individuals currently enrolled in the ADAPCP require a waiver to reenlist in the Army; however, persons who need additional service to complete their enrollment in the ADAPCP may be extended for the number of months necessary to permit completion.

b. A waiver for reenlistment is no longer required if the individual:

- (1) Completes Track I and is returned to duty.
- (2) Completes Track II successfully as indicated on DA Form 4466.
- (3) Completes Track III successfully (360 days) as indicated on DA Form 4466.

**1-17. Responsibilities.** a. Commanders at all levels are responsible for the ADAPCP implementation and accomplishment of objectives, including evaluation of the program and its impact within their organizations.

b. As the proponent, the Deputy Chief of Staff for Personnel (DCSPER) HQDA has General Staff responsibility for plans, policy, programs, budget formulation and behavioral research pertaining to alcohol and other drug abuse in the Army. The US Army Drug and Alcohol Technical Activity (USADATA), a field operating agency, is assigned to ODCSPER and reports through the Alcohol and Drug Policy Office. (See AR 10-78.) USADATA provides technical assistance and training development in support of the ADAPCP.

c. The Surgeon General (TSG) has Army staff responsibility for the medical aspects of alcohol and other drug abuse in the Army. TSG will provide required resources, professional services, and technical assistance, required to support the ADAPCP, as follows:

(1) Policy, procedures, standards, and doctrine concerning the medical aspects of treatment and rehabilitation. This includes participation in the technical aspects of preventive education and training, and identification related to alcohol and other drug abuse in the Army.

(2) Medical doctrine for specialized training of physicians and other clinical personnel in the areas of alcohol and other drug abuse prevention education, identification, and rehabilitation.

(3) Technical guidance and logistical support of all aspects of biochemical testing required by DOD.

(4) Collection of biostatistical and analysis of relevant program management data.

(5) Overall standards for quality control testing, and staff supervision for all Army laboratories supporting the DOD drug abuse testing program.

d. The Chief of Public Affairs, HQDA will provide policy guidance and procedures applicable to program information and public affairs activities in support of the ADAPCP.

e. The Chief of Chaplains, will provide religious, spiritual, and moral support of the ADAPCP.

f. MACOM commanders will—

- (1) Provide program management and

operational supervision of the ADAPCP. MACOMs will also monitor major elements of prevention, education, identification, rehabilitation, and evaluation within their command.

(2) Provide continuous planning, programming, and budgeting for the ADAPCP.

(3) Provide on-site evaluation of all major subordinate command and installation programs at least once a year.

(4) Designate a full-time Alcohol and Drug Control Officer (ADCO), Civilian Program Administrator (CPA), Educational Coordinator (EDCO) and adequate additional staffing at MACOM level to manage effectively and provide assistance to the ADAPCP within the command.

(a) Insure there are full-time ADCOs, Civilian Program Coordinators (CPC), EDCOs and adequate additional staffing authorized and assigned at installation level to provide an effective program.

(b) Insure that all appointed personnel are of sufficient grade or rank and appropriate Military Occupational Specialty (MOS) to provide credibility for the ADAPCP and to comply with this regulation.

*g.* Special responsibilities of specific MACOM commanders:

(1) Commander, United States Army Criminal Investigation Command (USACIDC) will—

(a) Investigate offenses involving illegal use, possession, sale or trafficking of narcotic drugs and the sale or trafficking of non-narcotic controlled substances (21 USC 812). (See AR 195-2.) Illegal use or possession of non-narcotic controlled substances will be investigated by military police. (See AR 190-30.)

(b) Conduct crime prevention surveys of facilities used for storage and handling of authorized drugs. (See AR 195-2.)

(c) In conjunction with appropriate state, Federal, host country, and international law enforcement agencies, conduct and support operations, programs, and activities designed to deter, prevent and suppress traffic in controlled substances.

(d) Prepare periodic drug availability threat assessments both worldwide and for specific regions or commands, as appropriate. Provide threat assessment data to HQDA law enforcement and ADAPCP offices and to appropriate commanders for use in determining resource requirements and developing drug suppression and enforcement programs.

(2) Commanding General, US Army Health Services Command (HSC) (Medical Command Commanders OCONUS) will—

(a) Provide input for content and assist in providing technical aspects of prevention education and training, to include technical aspects of Track I rehabilitation.

(b) Develop and provide relevant in-service technical training for counselors and clinical directors assigned to HSC or Medical Command (MEDCOM) supported CCCs.

(c) Provide clinical personnel resources, funds and professional services as required to operate the ADAPCP effectively and efficiently at all levels within the geographic area of responsibility.

(d) Collect, report and analyze client-oriented statistical data according to chapter 7.

*h.* Installation level responsibilities: Commanders of installations, communities or equivalent organizations, areas, units, and heads of agencies will—

(1) Establish a local ADAPCP and insure that services are available for all eligible personnel.

(2) Insure that commanders and supervisors are knowledgeable of ADAPCP services, legal issues, and DA policies through appropriate education. (See chap. 2.)

(3) Insure that funding for facilities and manpower are adequate, in compliance with DA policy, and meet activities and local needs required for the effective operation of the ADAPCP.

(4) Insure that the ADAPCP is staffed with an adequate number of qualified personnel of sufficient grade or rank to operate an effective program with continuity in ADAPCP management. Specifically—

(a) Designate an ADCO. Military per-

sonnel should be of sufficient rank to provide program credibility, normally field grade at installation level and O3 at unit levels. They should also be of sufficient retainability, normally 18 months; 11 months short tour. Civilians serving as ADCO should be of comparable grade level, should be management oriented and have experience commensurate with the responsibilities of the position. The management of the ADAPCP is a command function, therefore, Army Medical Department (AMEDD) or other clinical personnel will not be appointed as ADCO, except those installations that are specific HSC installations.

(b) Insure there is a full-time CPC for the installation ADAPCP.

(c) Designate a full-time military or civilian EDCO to administer education activities and Track I of the ADAPCP.

(5) Insure that the law enforcement activity commander or provost marshal of each installation—

(a) Maintains liaison and coordinates all alcohol and other drug abuse countermeasures with the ADCO.

(b) Screens all incident reports for cases of possible alcohol or other drug abuse involvement and provides these to the ADCO on a regular basis.

(6) Insure that the installation safety officer maintains coordination with the ADCO and provides data on the incidence of alcohol and drug involvement in accidents or other safety incidents.

i. The Medical Center (MEDCEN)/Medical Activity (MEDDAC) Commander will—

(1) Insure adequate and appropriate medical services and clinical support are provided the ADAPCP. These include medical evaluation, diagnostic assessment, detoxification and treatment.

(2) Appoint, in writing, a physician as

the clinical program consultant. This medical officer will be responsible for providing, coordinating and supervising consultative and other medical support for the ADAPCP.

(3) Designate a physician to perform medical evaluations and diagnostic services for the ADAPCP. This individual may also serve as the clinical consultant in paragraph (2) above.

(4) Provide clinical personnel for the ADAPCP based on manpower authorization documents and with due consideration for the workload generated by the population at risk. (In OCONUS locations, clinical personnel are generally on the command TDA rather than the MEDCOM/MEDDAC TDA.)

(5) Provide supervision for professional development and in-service training for the ADAPCP rehabilitation and counseling staff.

(6) Insure client records are maintained and disposed of in accordance with applicable regulations.

(7) Establish procedures for insuring that commanders are notified when alcohol or other drug abuse is suspected and clients are medically referred to the ADAPCP.

(8) Provide notification to commanders when drugs are prescribed that could necessitate limiting of access in PRP or other sensitive positions.

(9) At MEDDAC or MEDCEN where residential treatment facilities (RTF) are located, insure that medical, logistical, and administrative support are provided as required.

(10) Provide designated laboratory support and resources for the DOD urinalysis testing program and urinalysis aspects of the ADAPCP.

j. Responsibilities of other staff contributing to the ADAPCP efforts are discussed in chapter 2. CPO responsibilities are provided in chapter 5.

## Section II. ORGANIZATION FUNCTIONS

1-18. **General.** An Alcohol and Drug Program Office will be established at MACOM and installation levels for the purpose of operating the Army's ADAPCP. The Alcohol and Drug Program Office will be organized to attain the ob-

jectives of the ADAPCP and to respond to the needs of commanders and supervisors. Effective and efficient use of manpower and dollar resources are essential.

1-19. **Manpower and staffing policies.** The guid-

ance for determining manpower requirements of ADAPCP activities in TDA organizations are DA Pamphlets 570-551, 570-553, 570-557, and 570-566. The staffing guides are generally applicable to CONUS activities; however, they may be applied to oversea organizations when similar conditions exist. AR 570-4 and DA Pam 570-4 prescribe policy and procedures for manpower requirements.

**1-20. Functions by type organization.** *a.* The functions of MACOMs in the ADAPCP are the following: (See fig. 1-1).

(1) Provide overall management of program activities, resources and administration.

(2) Administer civilian aspects of the ADAPCP in close coordination with the Office of Personnel Management (OPM) and Army Civilian Personnel Directorate.

(3) Assess and assist installation or activity ADAPCPs throughout the MACOM.

(4) Collect and maintain necessary management information to assess program effectiveness.

*b.* The functions of the installations and communities in the ADAPCP are the following: (See fig. 1-2).

(1) Provide appropriately trained personnel of sufficient rank or grade and MOS discipline or profession to insure quality, effective ADAPCP services are available.

(2) Provide overall management of program activities resources and administration at local installation or community activity.

(3) Monitor and evaluate the quality of ADAPCP services to military, civilian employees, and family members of the installation, community, or activity.

(4) Insure that there is a comprehensive plan for staff training and professional development, on a continuing basis, for all ADAPCP personnel.

(5) Establish communication, referral networks and administrative coordination between military units and civilian activities that facilitate the effectiveness of the local ADAPCP.

(6) Provide commanders and supervisors with ADAPCP consultation to assist in the im-

plementation, prevention and educational functions of the Army's program.

(7) Maintain accurate and efficient management and client information records.

*c.* The functions of TOE and TDA units in the ADAPCP are the following:

(1) Larger unit commanders are responsible for monitoring the implementation of appropriate initiatives of the ADAPCP by their subordinate units. These larger units include corps, divisions and separate brigades which are tenant on an installation.

(2) Battalion and separate company commanders are responsible for implementing ADAPCP related prevention and education initiatives. Battalion commanders are responsible for monitoring the implementation of ADAPCP initiatives by their subordinate companies, batteries, and squadrons. They are also responsible for assigning the function of ADCO to an officer as a collateral duty during mobilization and combat. Generally, this will be the Adjutant (S-1).

(3) Company level unit commanders will implement ADAPCP initiatives. These initiatives include appointment of an Alcohol and Drug Coordinator (ADC), and identification of personnel needing referral to the ADAPCP. They also include urinalysis testing and monitoring of personnel who are ADAPCP clients.

*d.* Employee assistance aspects of the ADAPCP: At locations where a fully staffed CCC is not feasible or readily available (i.e., depot, research center, or DA civilian intensive organization), ADAPCP management and rehabilitation assistance or referral is provided through a CPC. The CPC will—

(1) Provide management assistance and resources for commanders and supervisors for the rehabilitation of alcohol and other drug abusers.

(2) Plan, assess and provide comprehensive employee assistance services for eligible DA civilian employees and family members with alcohol and drug abuse problems.

(3) Collect and maintain necessary administrative information to effectively manage the local ADAPCP.

### Section III. ADAPCP STAFF ORGANIZATION AND MANAGEMENT

**1-21. General.** *a.* This section prescribes policies, procedures and responsibilities for military and civilian personnel serving on ADAPCP staffs.

*b.* Accomplishment of the ADAPCP mission is mandatory Army-wide. Resources for the ADAPCP have been provided at all levels. Re-programing of manpower resources originally allocated for ADAPCP functions does not relieve commanders of the performance of assigned ADAPCP missions. Commanders may not program or request manpower resources to replace those moved to other functions. Required and authorized manpower will be documented in unit authorization documents in accordance with AR 310-49. This regulation along with AR 570-4, DA Pamphlet 570-551 will be used in determining manpower requirements.

**1-22. MACOM level.** *a.* Each MACOM will implement and operate an ADAPCP in accordance with the provisions of this regulation.

*b.* The ADCO will exercise staff responsibility for program management of the MACOM ADAPCP. Staff supervision of the ADCO is normally exercised by the Chief, Human Resources Division (HRD).

*c.* The CPA will coordinate all civilian aspects of the MACOM ADAPCP and be of sufficient grade to insure credibility with installation CPC. Responsibilities are prescribed in chapter 5.

**1-23. Installation level.** *a.* Army installations and activities will implement and operate an ADAPCP in accordance with the provisions of this regulation. Consultation and technical supervision of ADAPCP professional and para-professional counselors will be provided by the MEDCEN/MEDDAC commander.

*b.* Staff supervision of the installation ADCO is exercised by the Chief of Staff or Director of Personnel and Community Activities. The ADCO will not be placed under the staff supervision of any other general or special staff officer or under the CPO.

*c.* Responsibilities of the installation ADAPCP staff are as follows:

(1) The ADCO, as the installation ADAPCP manager, following command guidance and instructions from higher authority, will—

(*a.*) Coordinate the command, staff, and clinical aspects of the ADAPCP.

(*b.*) Exercise supervision and operational control of all ADAPCP personnel, facilities, and funds. This does not include RTF personnel who are under operational supervision of the MEDDAC Commander.

(*c.*) Develop, coordinate, and recommend local ADAPCP policies and procedures for implementation.

(*d.*) Establish communication, referral, and processing channels with and between military and civilian activities that can contribute to the effectiveness of the ADAPCP.

(*e.*) Serve on the Alcohol and Drug Intervention Council (ADIC) or similar council.

(*f.*) Provide periodic program evaluation to the commander.

(*g.*) Be responsible for the administrative maintenance of all ADAPCP records and reports.

(*h.*) Authenticate all ADAPCP reports furnished to higher headquarters.

(*i.*) Provide data for budget and manpower planning, and maintain appropriate records of resource transactions.

(2) The CPC will—

(*a.*) Coordinate all civilian employee aspects of the ADAPCP through the ADCO.

(*b.*) Maintain close working relationship with civilian personnel office and appropriate health program personnel.

(*c.*) Evaluate, on a periodic basis, local (community) rehabilitation resources used for referral, in consultation with the ADCO, clinical director, or MEDCEN/MEDDAC personnel, as required.

(*d.*) Periodically provide the ADCO with an evaluation of the civilian aspects of the ADAPCP.

(e) Develop and provide, in coordination with the education coordinator, education and training programs for supervisors, other civilian employees and Army personnel.

(f) On behalf of civilian employees and the ADAPCP, coordinate with treatment and rehabilitation personnel and with law enforcement agencies, both on and off post.

(3) The EDCO will—

(a) Implement, administer and, with the assistance of the CPC, provide instruction in Track I. Technical instruction will be provided by clinical personnel as determined by the ADCO.

(b) Develop, administer and supervise a comprehensive, target-group oriented, preventive education and training program on alcohol and other drug abuse and related areas.

(c) Maintain liaison with schools serving dependents of military personnel, civic organizations, civilian agencies, and military organizations, for the purpose of integrating the efforts of all community preventive education resources.

(d) Coordinate allocations for military and civilian training courses.

(e) Periodically provide the ADCO with an evaluation of Track I and other preventive education and training aspects of the local ADAPCP.

(f) Maintain liaison and coordination with the installation training officer to assist in integration of the preventive education and training effort in the overall installation training program.

(4) Clinical director: The clinical director, under the operational supervision of the ADCO and technical supervision of the MEDCEN/MEDDAC clinical consultant, will—

(a) Administer the clinical rehabilitative aspects of the ADAPCP.

(b) Supervise the alcohol and drug abuse counselors assigned to the local ADAPCP. In accordance with the MEDCEN/MEDDAC clinical consultant, supervise the in-service training and professional development of the rehabilitation staff.

(c) Insure that the highest ethical stand-

ards are maintained by the ADAPCP clinical staff in terms of the client, the quality of client case notes, and personal conduct of ADAPCP staff members.

(d) Insure that all individual client case files are maintained in accordance with procedures prescribed in chapters 3, 4, and 7 and appendix B of this regulation.

(e) Periodically provide the ADCO with an evaluation of rehabilitation efforts.

(f) Maintain liaison with the MEDDAC clinical consultant and with other military and civilian agencies to facilitate coordinate of support for the ADAPCP.

(g) Insure that ADAPCP screening and evaluations are performed as required.

(5) ADAPCP rehabilitation counselors. Counselors will—

(a) Conduct the initial ADAPCP screening of individuals and provide results to commanders and physicians. Request medical evaluations if indicated or requested.

(b) Conduct individual and group counseling sessions for clients in all phases of rehabilitation.

(c) Consult with commanders regarding client progress in rehabilitation.

(d) Provide input for ADAPCP recommendations regarding client progress in rehabilitation.

(e) Participate in ADAPCP crisis intervention efforts, as appropriate.

(f) Prepare and maintain required client records and reports in accordance with procedures prescribed in chapters 3, 4, and 7 and appendix B of this regulation.

(g) Provide information about other Army programs and recommend referral of clients to other agencies, as appropriate.

(h) Assist in providing technical aspects of Track I and other ADAPCP preventive education and training efforts as directed by the ADCO.

(i) Provide data to the clinical director for evaluation of the rehabilitation program.

(j) Participate in in-service training programs.

(k) Maintain the integrity and credibility of the ADAPCP by insuring that high ethical standards are observed in clinical practice.

1-24. Unit level. *a.* Corps, divisions, and brigades which are tenant on an installation will assign or appoint an officer to serve as the unit ADCO. The unit ADCO will be responsible for monitoring the implementation of all aspects of the ADAPCP within the command. The unit ADCO will refer personnel suspected or identified as abusers to medical units for attention during mobilization or combat. He or she will also be responsible for developing organizational initiatives in support of the ADAPCP and the Army mission which reduce the adverse affects of alcohol and other drug abuse to the lowest possible level.

*b.* Battalions and separate companies will appoint at least one enlisted person, NCO, as the ADC. This individual must be thoroughly familiar with the ADAPCP and other services available in the community to assist alcohol and other drug abusers. The ADC will assist the officer assigned collateral duties as ADCO, the commanders, the subordinate units in all aspects of the ADAPCP by performing the following functions:

(1) Develop, coordinate, and/or deliver informed preventive education and training within the unit.

(2) Assist with in-briefing all new personnel regarding Army policy related to alcohol and other drug abuse and functions and services designed to combat alcohol and other drug abuse.

(3) Coordinate the urinalysis testing program.

(4) Keep the commander informed of the status of the ADAPCP and of the trends in alcohol and other drug abuse in the unit.

(5) Maintain liaison with the servicing CCC (or medical unit in combat).

(6) Perform other administrative functions related to the ADAPCP.

1-25. Selection of ADAPCP personnel. Consistent with military necessity, commanders will

select ADAPCP personnel in accordance with the following guidance:

*a.* In so far as possible, Military ADCO positions will have a Specialty Skill Identifier (SSI) of 41A and an Additional Skill Identifier (ASI) of 7S (Alcohol and Drug Abuse Prevention and Control Program). In keeping with the philosophy of the command program, officers selected for assignment to ADCO positions will generally hold specialty 41 (Personnel Program Management). AMEDD or clinical personnel will not be appointed as ADCO except within HSC or within MEDCOM activities oversea. Additionally, the complex issues associated with alcohol and other drug abuse at installation or MACOM levels require an officer with broad experience, preferably in the grade of O4 or above. Recommended tour for an ADCO is at least 18 months (11 months in short tour areas). All ADCOs will attend the US Army Drug and Alcohol Team Training (USADATT) course at the Academy of Health Sciences, Fort Sam Houston, Texas, or equivalent training approved by ODCSPER HQDA, within 60 days of assuming duties. Officers selected to be an ADCO in short-tour oversea areas will be scheduled for attendance at USADATT or approved equivalent training while en route to their new assignment.

*b.* ADAPCP enlisted counseling personnel should be E 5 or above, and. MOS-qualified.

*c.* Recovering alcoholics and drug abusers selected as counselors will be alcohol or drug free for a minimum of 2 years. They will meet all other criteria for qualification and training; however, the HOS may be immaterial. They will generally occupy a military or civilian counselor position on the TDA.

*d.* Civilian personnel will meet the qualification requirements established in the OPM X-118 Qualification Standards. Exceptions are those positions designated excepted service. Qualification standards for excepted service positions will be developed in accordance with the Federal Personnel Manual (FPM) and Civilian Personnel Regulation (CPR) 302.2. All recruitment actions will be reviewed by the ADCO. Clinical directors also will have program management

experience and specialized training in alcohol and other drug abuse rehabilitation and treatment. If otherwise clinically qualified according to the GS-180 or GS-185 series, other GS series may be qualified for clinical director positions. Prior to employment or placement in positions as social workers or clinical psychologists, an appraisal of professional qualifications and approval of the appointments will be obtained from TSG, HQDA (DASG-PSC), WASH DC 20310. This is in accordance with AR 40-1, appendix D. All civilians employed in the ADAPCP will sign the Condition of Employment Form which authorizes them to be directed to submit to urinalysis. (See app B.) Due to the sensitive nature of the ADAPCP and special skills involved for providing rehabilitation services in the military environment, civilian personnel considered as fully qualified will be interviewed and approved by the ADCO, clinical director and clinical consultant prior to final selection. The ADCO makes the final decision to hire all ADAPCP civilian personnel.

*e.* Award of additional skill identifier:

(1) The ASI "7S" identifies officer who have completed the USADATT course, or equivalent training, and have 6 months assigned as an ADAPCP staff member.

(2) The ASI can be awarded to any officer involved in the ADAPCP who meets the requirements above.

**1-26. Training for the ADAPCP staff.** Sustaining and improving the skills and proficiency of the ADAPCP staff requires a training program which is continuing, imaginative, and meets the complex technical needs of the entire staff.

*a.* Enlisted military personnel will receive the necessary training to sustain skill proficiency for their Skill Qualification Tests (SQT).

*b.* CPCs will receive training through DA, major command, and civilian agency-sponsored training programs.

*c.* Personnel responsible for education coordination will attend USADATT at the Academy of Health Sciences, Fort Sam Houston, Texas or equivalent training provided by MACOM in OCONUS areas. In addition, they will participate in scheduled training programs established by the MACOM and the installation. This is needed to sustain the necessary skill proficiency to effectively coordinate alcohol and drug education programs for their respective command.

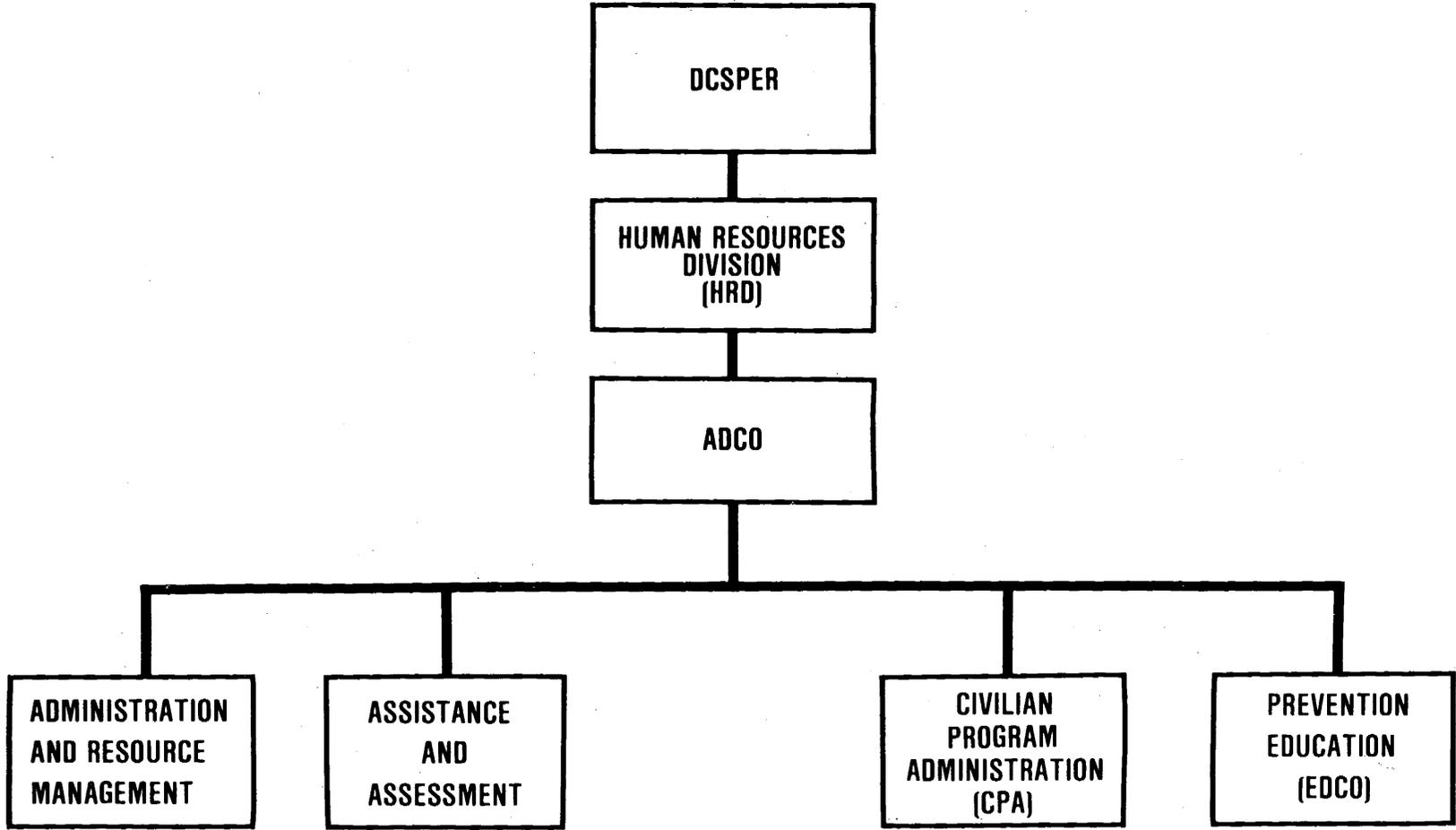


Figure 1-1. Typical MACOM headquarters organization chart for ADAPCP.

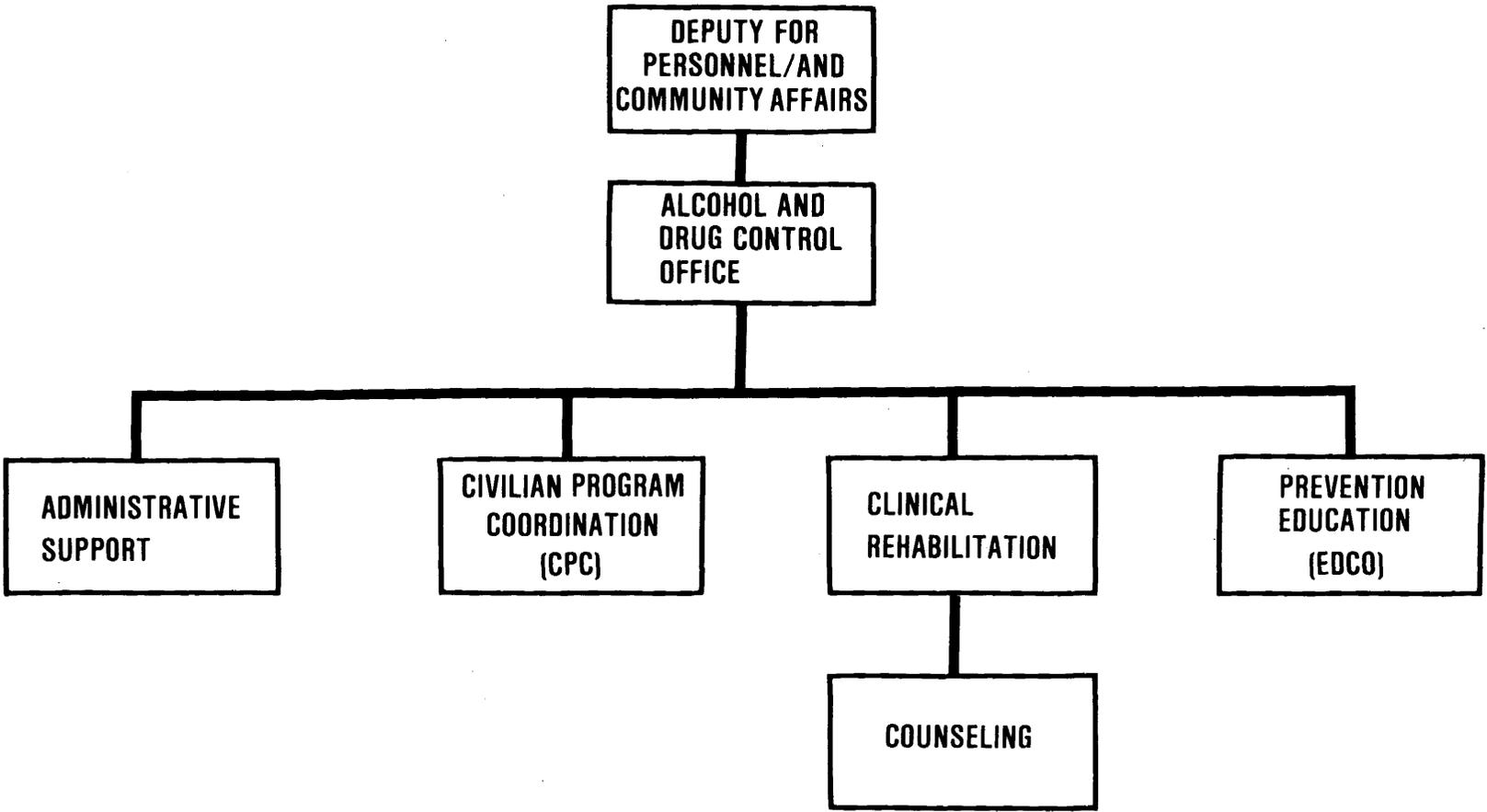


Figure 1-2. Typical installation/community organization chart for ADAPCP.

## CHAPTER 2

### PREVENTION AND CONTROL

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#### Section I. INTRODUCTION

**2-1. General.** Alcohol and other drug abuse prevention includes all measures taken to reduce to the lowest possible level, the abuse or misuse of alcohol and other drugs. This chapter prescribes prevention policy and procedures and establishes responsibility for the following three major areas of prevention efforts:

- a.* Alcohol and other drug abuse control actions.
- b.* Prevention education.
- c.* Law enforcement.

**2-2. Responsibilities for prevention.** *a.* Commanders at all levels are responsible for insuring that there are effective, local alcohol and other drug abuse prevention efforts. These efforts must be developed and implemented in accordance with this regulation and include public awareness activities within the military community and individual units.

*b.* The following ADAPCP personnel will assist the commander in accomplishing these responsibilities:

(1) The ADCO, the ADAPCP EDCO and the unit level ADC are the commander's principal staff members for the design, execution, and evaluation of prevention aspects of the ADAPCP and related command initiatives.

(2) The clinical director, CPC, ADAPCP counselors, and local law enforcement personnel will assist the ADCO in the installation prevention effort.

(3) The USADATA is available to assist commanders in designing and implementing prevention and educational aspects of the ADAPCP. Formal requests for information or services of the USADATA will be coordinated with the appropriate MACOM and directed to HQDA (DAPE-HRA), WASH DC 20310. (See AR 10-78.)

#### Section II. ALCOHOL AND OTHER DRUG ABUSE CONTROL ACTIONS

**2-3. Objectives.** *a.* Reduce the abuse of alcohol and the availability and abuse of other drugs within the military community.

*b.* Insure that the adverse consequences of alcohol and other drug abuse within the military community are publicized.

*c.* Promote coordinated community or installation involvement in activities which stress prevention and control of alcohol and other drug abuse.

*d.* Provide alternatives to the use of alcohol and other drugs at social functions.

*e.* Encourage cooperation between military and adjacent civilian communities for the pre-

vention and control of alcohol and other drug abuse.

*f.* Emphasize the incompatibility of alcohol and other drug abuse with physical and mental fitness.

**2-4. Commander actions.** *a.* Commanders will publicize the fact that the abuse of alcohol or other drugs will not be condoned within the unit.

*b.* Officers and NCOs who choose to drink will set the example of responsible drinking practices.

**2-5. De-glamorization of alcohol.** *a.* Military and civilian personnel will not promote any official

function or unofficial function which glamorizes the abuse of alcohol through drinking contests, games or initiations, or the awarding of alcoholic beverages as prizes for contests. Military personnel violating this prohibition may be subject to disciplinary action under the provisions of Article 92, UCMJ, or administrative action, as appropriate; civilian personnel may be subject to administrative sanctions under applicable regulations.

b. Nonalcoholic beverages will be readily available at military functions to provide a clear choice for those who prefer not to drink alcohol.

c. See AR 210-65 for club policies on the de-glamorization of alcohol.

**2-6. Alternatives to abuse.** Commanders and the chain of command will promote and encourage off-duty sports, educational, cultural, religious, or spiritual pursuits as alternatives to abuse of alcohol and other drugs.

**2-7. Community involvement. a. Councils:**

(1) The installation commander will insure that a local ADIC or other appropriate human service coordinating forum is established. It may be a separate ADIC or a council concerned with a variety of special activities such as a human resources council. If alcohol and other drug matters are considered by a human resources council or similar type council, the ADCO will be a member of the council. As with a separate ADIC, minutes concerning alcohol and other drug issues discussed will be recorded and approved by the commander.

(2) The composition of the council will be determined locally and will be representative of units or activities on the installation. The chairperson of the council should be a senior officer such as the Chief of Staff, Deputy Installation Commander or other officer designated by the commander. Key personnel from the civilian community may be invited to attend meetings. When other Service installations are located in close proximity, reciprocal membership is encouraged. As a minimum, the following key personnel should be members:

(a) Director of Personnel and Community Activities/Assistant Chief of Staff, G1, Personnel (DPCA/G1).

- (b) Provost Marshal.
- (c) Staff chaplain.
- (d) MEDCEN/MEDDAC commander.
- (e) Staff Judge Advocate.
- (f) Public Affairs Officer.
- (g) Major unit commanders.
- (h) Moral support officer.
- (i) Post education officer.
- (j) ADCO.
- (k) Army Community Services (ACS) officer.
- (l) Dependent schools officer.
- (m) CPO.
- (n) CPC.

(3) The council functions in an advisory capacity to the commander. The ADCO will provide the council with an ongoing assessment of the alcohol and drug abuse environment in the community. The council will use this assessment to assist the ADCO in meeting the ADAPCP objectives and in providing recommendations to the commander. The council will also review and make recommendations concerning any changes to policy or initiation of new policy.

(4) The council will meet on a regular basis. Minutes of each council meeting will be forwarded to the installation commander for approval and will be distributed to the next lower level and to the next higher level command.

b. A variety of resources and activities are available to every command, installation, and community to assist in the alcohol and other drug prevention effort. The following personnel provide support:

(1) Chaplains who provide religious activities and spiritual and moral support for service members and their families.

(2) Organizational effectiveness staff officers who can assist in improving the organizational structure or provide assistance in evaluation design or staff training.

(3) Safety officers who can analyze and publicize the impact of alcohol and other drug abuse on mission safety and safety within the military community.

(4) Civilian personnel officers who conduct training programs for civilian supervisors and other employees.

(5) Moral support activities (MSA) personnel who can assist by providing off-duty programs.

(6) Directors or coordinators of youth activities or programs who have access to youth groups and who assist the program staff in providing special prevention and education programs (schools, youth activities, and scouts).

(7) Provost marshals who direct law enforcement and drug suppression activities.

(8) Army community services personnel who are familiar with human services and problem areas within the military community.

(9) Public Affairs Officers who serve the military community.

(10) Community Mental Health Activity (CMHA) and Medical Treatment Facility (MTF) staff who are familiar with clinical aspects of alcohol or other drug abuse.

(11) Other human service personnel, groups, and private organizations who have access to various groups of people within the mili-

tary community such as wives clubs, rod and gun clubs, parent-teacher associations.

**2-8. Youth and family involvement.** Training for youth program directors in the area of alcohol and other drug abuse prevention will be provided through the ADAPCP. Peer counseling techniques such as Teen Involvement which encourage youths to participate in the ADAPCP have been shown to be effective. Trained service members, parents, teachers, and chaplains are encouraged to assist in such activities.

a. The USADATA will provide professional consultation, training, and materials upon formal request.

b. The local ADAPCP staff will provide trained speakers and professional presentations to school officials.

c. Unit leaders will encourage service member participation in youth programs and activities as part of overall installation prevention efforts.

d. Youth groups, school officials, and youth health care facilities will be made aware of the availability of ADAPCP services to family members. The evaluation of overall resources for youth will include a review of the outreach programs to youth and a review of the incidence of alcohol or other drug abuse problems among younger age groups.

### Section III. PREVENTION EDUCATION

**2-9. General.** This section prescribes policy for alcohol and other drug abuse prevention education programs.

**2-10. The objectives of prevention education.** These objectives are—

a. Inform all members of the Army about policy and operations of ADAPCP and the extent of alcohol and drug abuse problems.

b. Inform all members of the installation about ADAPCP services to prevent and control alcohol and other drug abuse.

c. Provide commanders and supervisors with the information and skills they need to con-

duct effective alcohol and other drug abuse prevention, control, and rehabilitation activities within their units.

d. Inform all members of the military community about ADAPCP services available to individuals desiring to overcome their own problems with alcohol and other drug abuse.

e. Provide all members of the military community with the information they need to make responsible decisions about their personal use of alcohol and to avoid the misuse or abuse of other drugs.

**2-11. Policy.** a. Commanders at all levels will provide education and training on ADAPCP

policy and on effective measures to alleviate problems associated with alcohol and drug abuse. This will be provided in accordance with paragraph 2-12f of this regulation and in compliance with DOD Instruction 1010.5.

b. The ADCO, the EDCO and the ADC are the commander's principal staff members for the design, execution and evaluation of the prevention aspects of the ADAPCP. The clinical director and clinical consultant have primary responsibility for in-service training of ADAPCP clinical personnel and will assist in the clinical aspects of the prevention education efforts as required. The CPC will assist in prevention education efforts for civilian personnel.

c. Alcohol and drug abuse education will be conducted throughout the Army Training System, and will observe the guidelines indicated below. This education is considered part of leader development and may be included in leadership instruction.

(1) Enlisted initial entry training: The emphasis of initial entry alcohol and drug abuse education will be on prevention. Desired behavior, credible role models and health alternatives to alcohol and other drug abuse will be presented. Included will be the disciplinary, career, and health consequences of abuse. Recruits will also be made aware of counseling and treatment resources and procedures, and of their responsibilities not only to themselves but to their peers. Alcohol and drug abuse instruction will be compatible with the indoctrination of recruits in the standards of discipline, performance and behavior required by the Army. This education will be completed prior to the award of MOS.

(2) Cadet, warrant officer, and officer candidates: Education for cadet, officer and warrant officer candidates will, in addition to (1) above, emphasize the duties and responsibilities of junior leaders in the alcohol and drug abuse prevention effort. This will include their responsibilities in creating and maintaining military discipline and enforcement of the law. The causes, symptoms and prevalence of abuse, intervention and referral techniques, and post-treatment responsibilities of junior leaders will also be addressed. Education will be completed

before commissioning or within 90 days after entry on active duty.

(3) Education for officers and non-commissioned officers should emphasize their roles and responsibilities as leaders. Education should be tailored to the audience. For individuals with primarily first-line supervisory responsibilities, education should focus upon identification and referral of service members with problems and strategies for deterring drug use. For officers and noncommissioned officers with command or management responsibilities, education should focus on strategies a senior leader can employ to create a command or unit environment which will prevent alcohol and drug abuse and which will encourage those with problems to seek treatment. Specifically, leadership training will include—

(a) *Roles and responsibilities of leaders.* Include responsibilities for deterrence and detection, identification of problems, and intervention and referral techniques. Intervention and referral techniques for senior and executive level people should be specifically discussed with those audiences.

(b) *The impact of alcohol and drug abuse.* Include law enforcement and performance aspects.

(c) *The ADAPCP and Army Policy.* Include an overview of benefits derived from the ADAPCP.

(d) *Strategies for preventing alcohol and drug abuse.* Include a discussion of ways of diminishing the problem of stigma.

**2-12. Responsibilities for education and training.** a. Deputy Chief of Staff for Personnel (ODCSPER), HQDA. The DCSPER will—

(1) Formulate overall Army policy governing the development and administration of alcohol and other drug training and education.

(2) Establish selection criteria and allocations for nominees to attend HQDA-sponsored alcohol and other drug training and educational programs.

(3) Plan, establish, and administer special alcohol and drug training and educational programs as required.

*b. The Surgeon General (TSG), HQDA.* TSG will—

(1) Support Army alcohol and other drug training and education.

(2) Provide doctrinal guidance for the development of medical aspects of alcohol and other drug training and education.

*c. Commanding General, TRADOC.* In addition to responsibility contained in paragraph 2-11 and in *e*, *f*, and *g* below, the Commanding General, TRADOC will—

(1) Develop and evaluate training and training support materials on the non-medical aspects of alcohol and other drug abuse for Army-wide use.

(2) Insure that alcohol and other drug abuse training and education is developed, updated, and incorporated in appropriate Service school and training center instruction.

*d. Commanding General, Health Services Command (HSC).* In addition to responsibilities contained in paragraph 2-11 and *e*, *f*, and *g* below, the Commanding General, HSC will—

(1) Develop medical aspects of alcohol and other drug abuse training and education doctrine.

(2) Conduct ongoing US Army Alcohol and Drug Abuse Team Training (USADATT) and US Army Drug and Alcohol Rehabilitation Training (USADART) in support of the ADA-PCP.

(3) Train AMEDD Officers during initial orientation courses in the diagnosis, counseling, treatment, and referral of alcohol and other drug abusers and in Army policy on alcohol and other drug abuse. This will include the health care professional's roles in the ADAPCP.

(4) Provide behavioral science specialists (MOS, 91G) whose assignment is as ADAPCP counselor and who have not previously served as ADAPCP counselor with the 4-week USADART en route to or within 180 days after assignment.

(5) Provide continuing education and training for assigned health care professional and paraprofessional personnel in those areas of alcohol and drug abuse relevant to their

duties. Areas of particular focus will be identification intervention, treatment and referral.

*e. Major commanders.* Major commanders will—

(1) Insure that all installations, organizations, agencies, and activities under their jurisdiction conduct ongoing alcohol and other drug training and educational programs.

(2) Establish a monitoring and evaluation system to insure that alcohol and other drug training and educational programs are managed effectively. Insure that programs comply with HQDA goals, objectives, and guidelines.

*f. Commanders at all levels.* Commanders at all levels will—

(1) Conduct alcohol and other drug prevention education and training for military personnel on a regular basis. Focus will be on the command-unique elements of the ADAPCP and local prevention and treatment resources.

(2) Insure that all alcohol and other drug abuse prevention education programs are designed for and presented to carefully selected target groups. Insure that such programs comply with HQDA alcohol and other drug abuse prevention education, objectives, and guidelines. (See app D.)

(3) Insure that all alcohol and other drug abuse prevention education is presented by qualified instructors.

(4) Conduct the following education and training:

(a) *At permanent change of station (PCS).*

1. *Service members (E1 through E4).* Education will be conducted within 60 days after each PCS and will emphasize the legal consequences of abuse under both the UCMJ and the local laws. Emphasis will be on the availability of an ADAPCP at the installation to include location, referral procedures, and types of treatment available. Emphasis will also be on alternatives to abuse available at the local installation and neighboring communities.

2. *Leaders (E5 through E9 and officers).* Education will be conducted within 60 days after PCS and will emphasize the command-unique elements of the alcohol and drug

abuse problem and local military and civilian resources. Emphasis will also be on the availability of an ADAPCP to include location, leaders' responsibilities in the identification and referral process, their opportunities for continuing education and training, and their responsibilities for the maintenance of military discipline and the enforcement of the UCMJ.

(b) *DA civilian employees.* Prevention education for civilian employees will be provided in conjunction with, but not be limited to, existing civilian personnel orientation and training programs.

1. *Nonsupervisors.* Orientation will be conducted on DA policy and programs regarding alcohol and drug abuse. This will be within 60 days of initial employment by the DA. Orientation will emphasize the legal, career, and health consequences of abuse and the counseling, treatment, and rehabilitation opportunities available.

2. *Supervisors.* Orientation will be conducted within 60 days after designation of supervisory responsibilities. Orientation will emphasize the role of the supervisor in the alcohol and drug abuse prevention program and the symptoms of abuse, especially as they relate to job performance. Emphasis will also be on intervention and referral techniques and the post-treatment responsibilities of the supervisor. Continuing education will be made available on a regular basis by local commands, with the focus on the command-unique elements of the program and local prevention and treatment resources.

(c) *ADAPCP staff.* Training will be conducted within 60 days after assignment for professionals and paraprofessionals (military and civilian) assigned to alcohol and drug abuse program staff in those areas relevant to their specific duties. Continuing education and training will also be made available for the ADAPCP staff, especially for those involved in the rehabilitation process. Areas of particular focus will be intervention, counseling, and educational techniques.

(d) *Family members of military civilian personnel.*

1. *Family members OCONUS.* Education will be provided on a voluntary basis and will emphasize the following:

(a) The local alcohol and drug abuse situation.

(b) Local alcohol and drug abuse laws.

(c) Counseling.

(d) Treatment.

(e) Rehabilitation opportunities and procedures.

(f) Alternatives to abuse available at the local installation and neighboring community.

2. *Family members in US locations.* Education will be offered on a voluntary basis to the extent feasible.

*g. Installation and military community commanders.* They will provide education programs and activities that may be used to augment unit alcohol and other drug abuse prevention and control strategies.

**2-13. Alcohol and other drug awareness education.** *a.* The installation or community commander will provide alcohol and other drug awareness education for clients entered into ADAPCP Track I (para 4-5) in accordance with the standards listed in appendix D. This education is designed for personnel whose involvement with alcohol or other drugs has been identified early. Examples of such personnel are those identified as involved for the first time in alcohol or other drug related incidents such as driving while intoxicated (DWI), job accidents, safety violations, fights and other breaches of discipline and decreasing job performance. Commanders may also request alcohol and other drug awareness education for personnel suspected of involvement with drugs or of abusing alcohol, but without a specific incident upon which to base the referral. In any case, the commander must enroll the individual in the ADAPCP. An ADAPCP screening is required prior to beginning Track I.

*b.* On those installations where alcohol or other drug safety action (traffic) programs are

not available, the alcohol or other drug awareness education should be designed to include traffic safety subjects. Coordination with the Provost Marshal Office (PMO), Safety Office

and local law enforcement agencies and courts must be made to ascertain teaching requirements and to obtain expert technical assistance and avoid duplication of effort.

#### Section IV. LAW ENFORCEMENT AND DRUG SUPPRESSION

**2-14. Objectives.** Law enforcement objectives are the following:

- a. Eliminate the supply of illegal drugs.
- b. Identify and apprehend individuals who illegally possess, use, or traffic in drugs.
- c. Prevent alcohol and other drug-related crimes, incidents, and traffic accidents.

**2-15. Procedures.** a. Commanders at MACOM and installation level will—

(1) Develop and implement procedures to suppress drug trafficking, misuse, or abuse and to reduce crimes and traffic accidents resulting from alcohol and other drug abuse.

(2) Insure that law enforcement procedures are consistent with status of forces agreements (SOFA) or treaties to prevent the importation of drugs and the movement of contraband into the United States. (See AR 190-41.)

(3) Insure procedures for securing and accounting for alcohol and other drugs and medical supplies are in compliance with the following:

- (a) TB MED 291.
- (b) AR 40-2.
- (c) AR 40-61.
- (d) AR 190-50.

(4) Insure that controlled substances which are seized as evidence, or for which ownership or possession cannot be established, are safeguarded, processed, and disposed of in accordance with AR 195-5 or AR 190-22.

b. Installation commanders will—

(1) Insure continuous command presence in installation living, work, and recreational areas to reduce alcohol and other drug abuse.

(2) Insure that all offenses involving illegal possession, use, sale, or trafficking in drugs

or drug paraphernalia are reported to the military police for investigation or referral to USA-CIDC.

(3) Insure that the ADCO or another appropriate representative of the ADAPCP is provided information on all alcohol and other drug-related incidents on a daily basis from the military police blotter, DA Form 3997 (Military Police Desk Blotter).

(4) Insure that all suspected alcohol and other drug abusers, including those in military confinement facilities, are promptly referred to their commanders for followup action. (The CCC will also refer such cases to the commander.)

c. The provost marshal of each installation or the commander of law enforcement activities will—

(1) Maintain liaison and coordinate alcohol and other drug abuse countermeasures with the local elements of the USACIDC and with Federal, State, and local law enforcement traffic safety and customs agencies. When appropriate, this will include host-country agencies in order to minimize the contribution of alcohol and other drugs as causative factors in traffic accidents and criminal acts.

(2) Investigate offenses involving use or possession of nonnarcotic controlled substances when the amount involved is sufficient only for personal use and is not indicative of intent to supply persons other than the individual possessing it. (See AR 190-30.)

(3) Insure that all incidents reported to the military police are assessed for possible alcohol or other drug involvement. Insure that those incidents which are determined or suspected to be alcohol or other drug related are brought to the attention of the ADCO and the unit commander who will determine if referral to the ADAPCP is appropriate. (For example, assaults, domestic disturbances, child or spouse abuse). All alcohol and driving related inci-

dents will be a mandatory referral for evaluation and education per AR 190-5.

**2-16. Law enforcement in relationship to the ADAPCP.** *a.* Army policy is to encourage voluntary entry into the ADAPCP. Military police, Criminal Investigation Division (CID) special agents, and other investigative personnel will not solicit information from clients in the program, unless they volunteer to provide information and assistance. If the client volunteers, the information will not be obtained in the CCC or in such a manner as to jeopardize the safety of sources of the information or compromise the confidentiality and credibility of the ADAPCP. (AR 190-30 and 195-2.)

*b.* Chapter 1, Title 42, Code of Federal Regulations, prohibits undercover agents from enrolling in or otherwise infiltrating an alcohol or other drug treatment or rehabilitation pro-

gram for the purpose of law enforcement activities. This restriction does not preclude the enrollment in the ADAPCP, for rehabilitation purposes, of military police, CID, or other investigative personnel who have an actual alcohol or other drug abuse problem. Their law enforcement status must be made known to the ADCO at the time of their enrollment. These measures are for the protection of the law enforcement client as well as the ADAPCP.

*c.* The provost marshal and the ADCO will exchange information for the purpose of identifying drug abuse trends, drug "trouble spots," and high-risk areas to increase specific prevention efforts. This may include information on drug prevalence by type of drug, cost, strength and purity, and current drugs of choice. This exchange of information will be specific and will not mention names of any client or violate program confidentiality.

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S/S 3 Nov 1986

Headquarters  
Department of the Army  
Washington, DC, 11 August 1983

# Immediate Action INTERIM CHANGE

AR 600-85  
Interim Change  
No. 105  
Expires 11 August 1985

*extended by Int. Ch. # IO8*

*4 Feb 1985*

*4 Feb 1986*

Personnel - General  
*(extended by IO, 17 Feb 1986)*  
Alcohol and Drug Abuse Prevention and Control Program

Justification: Interim change clarifies the standard for blood alcohol level for soldiers on duty that was prescribed in Interim Change No. 103 to AR 600-85, dated 29 April 1983. The clarification is required to expand on the regulatory prohibition to the standard originally stated, which provides a basis for disciplinary action under the UCMJ and basis for administrative action, to include characterization of discharge. Failure to make this change could result in a judicial ruling against the Army.

Expiration: This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superceded by a permanent change.

1. AR 600-85, 1 January 1982, is changed as follows:

Page 1-4. The following sentences supercede the first sentence of paragraph 1-9.1:

Military Personnel on duty shall not have a blood alcohol level of .05% or above. Percent shall be based on milligrams of alcohol per 100 milliliters of blood (.05% is equivalent to 50 milligrams of alcohol per 100 milliliters of blood).

(DAPE-HRA)

By Order of the Secretary of the Army:

John A. Wickham, Jr.  
General, United States Army  
Chief of Staff

Official:

Robert M. Joyce  
Major General, United States Army  
The Adjutant General

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## CHAPTER 3

### IDENTIFICATION, REFERRAL AND SCREENING

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#### Section I. GENERAL

**3-1. Objectives.** The objectives of identification is to surface alcohol and other drug abuse as early as possible and to refer the abuser to the commander for—

- a.* Administrative action, as appropriate.
- b.* Referral to the ADAPCP for evaluation and assistance.

**3-2. Scope.** *a.* Identification is accomplished through a variety of methods which are described in section II. One of these methods, bio-

chemical testing, is discussed in detail in section II and section IV of this chapter.

*b.* The commander's, the ADAPCP staff's and the physician's responsibilities in the referral and screening process are outlined in section III. Also, see figure 3-1.

*c.* On exemption policy that restricts the consequences of the service member's involvement in the ADAPCP is described in chapter 6, section II of this regulation.

#### Section II. METHODS OF IDENTIFICATION

**3-3. Voluntary (self) identification.** *a.* This is the most desirable method of discovering alcohol or other drug abuse. The individual whose performance, social conduct, interpersonal relations, or health becomes impaired because of the abuse of alcohol or other drugs has the personal obligation to seek treatment and rehabilitation. Command policies will encourage service members and civilian employees to volunteer for assistance and will avoid actions that would discourage these individuals from seeking help. Normally, members with an alcohol or other drug problem should seek help from their unit commander; however, they may initially request help from their installation ADAPCP or medical treatment facility, a chaplain, or any officer or noncommissioned officer in their chain of command. If a service member initially seeks help from an activity or individual other than his or her unit commander, the individual contacted will immediately notify the service member's unit commander and installation ADCO.

*b.* The requirement that the individual contacted must notify the service member's unit commander and installation ADCO is not in

conflict with a chaplain's right of privileged communication. The situation in which the service member is seeking assistance is addressed in paragraph *a*, but the situation in which the member merely reveals to a chaplain that he or she is abusing or has abused alcohol or other drugs is not addressed. In the latter instance, it is expected that the chaplain would inform the member that—

(1) Professional alcohol and drug treatment and rehabilitation counseling is available through the ADAPCP.

(2) The Army requires that the member's unit commander become involved in the rehabilitation process.

(3) The chaplain cannot assist the member's entry into the ADAPCP without going through the member's unit commander.

*c.* Identifications resulting from a service member seeking emergency medical treatment for an actual or possible alcohol or other drug overdose are considered to be a variation of volunteering. For reporting purposes, such cases will be classified as volunteer (self) iden-

tifications. See chapter 6 of this regulation concerning applicability of the exemption policy to such cases.

*d.* A service member or family member may seek assistance from other agencies for problems in which the abuse of alcohol or other drugs is a factor. Every effort will be made to insure that these agencies, military or civil human services, such as ACS and chaplains, are aware of the ADAPCP services and procedures for referral, if appropriate. Such cases will be classified as volunteer (self) identification.

*e.* For civilian employee volunteers, see chapter 5.

**3-4. Command identification.** This is identification which occurs when a commander observes, suspects, or otherwise becomes aware of an individual whose job performance, social conduct, interpersonal relations, physical fitness, or health appears to be adversely affected because of abuse of alcohol or other drugs (apparent or suspected). When abusers or suspected abusers are identified, they will be interviewed by their unit commander or designated representative. If appropriate, they will be referred to the ADAPCP for an initial screening interview.

**3-5. Biochemical identification.** When a service member has a positive urinalysis as a result of drug screen testing, mandatory referral for ADAPCP screening and medical evaluation is required. This is to determine whether the positive urinalysis was the result of administrative

error, medically prescribed use of the substance, or actual drug abuse. If the positive urinalysis reflects drug abuse, medical evaluators should attempt to determine the extent of drug abuse. Commanders should be alert to positive urine tests for drugs that are not generally authorized for military outpatient use, e.g., cocaine, LSD, or PCP. Individuals with urine positives for these type drugs will be placed, at a minimum, in the urine surveillance program (USP). (See section IV of this chapter.)

**3-6. Medical identification.** Apparent alcohol or other drug abuse may be noted by a physician during routine or emergency medical treatment. In such instances, the physician will refer the individual to the ADAPCP, utilizing the SF 513 (Medical Record-Consultation Sheet). The ADCO will immediately notify the client's unit commander of the physician's referral. In the case of a civilian employee or family member, the CPC will contact the patient in an attempt to set up an interview.

**3-7. Investigation/apprehension.** A service member's alcohol or other drug abuse may be identified through military or civilian law enforcement investigation or apprehension. Upon notification of apprehension of a service member for apparent alcohol or other drug abuse, the commander will refer the individual to the ADAPCP for an initial screening interview. Referral for screening or enrollment does not interfere with or preclude pending legal or administrative actions in any way.

### Section III. REFERRAL AND SCREENING

**3-8. Responsibilities of commanders for referral.** *a.* When individuals are identified, voluntarily or involuntarily, as possible alcohol or other drug abusers, their unit commander or designated representative, will—

(1) Interview them and inform them of the evidence.

(2) Advise them of their rights under Article 31 UCMJ.

(3) Explain the provisions of the exemption policy.

(4) Give them the opportunity to provide additional evidence, if they desire.

*b.* If, at the conclusion of the interview there remains a reasonable possibility of abuse, the commander will refer the individual to the ADAPCP for a formal initial screening interview. All individuals with urine positives will be referred with DA Form 2496 to the ADAPCP for initial screening and medical evaluation by a physician. Service members that are referred by the commander for an initial screening inter-

view, regardless of the means of identification, will be referred with DA Form 2496 (ADAPCP Military Client Referral and Screening Record). (See fig. B-1.) The referral and screening record will be signed by the commander. The initial screening interview will be accomplished by the ADAPCP staff at the earliest opportunity (not to exceed 2 working days) with emergency referrals receiving priority.

**3-9. Self-referrals.** The ADAPCP staff will conduct an initial screening interview with all eligible personnel that self-refer to the ADAPCP for assistance. During the initial screening interview, the counselor will advise the service member of the commander's role in the rehabilitation process and provide information about the ADAPCP. The commander will be a part of the rehabilitation program and will be directly involved in the decision of whether rehabilitation is required. The commander will also provide recommendations for the appropriate rehabilitation track and establish standards of behavior and goals for evaluation of the service member's progress in rehabilitation and in the unit. Civilian employees will sign a consent form if they wish their supervisor involved. The ADAPCP staff will contact the commander and coordinate the service member's referral, if ADAPCP services are required. After coordination with the service member's commander, the referral is processed in the same manner as any other command referral; however, the type of referral will be annotated on the ADAPCP Military Client Referral and Screening Record as a self-referral.

**3-10. Other referrals.** In addition to medical referral (para 3-6) or referrals from law enforcement agencies (para 3-7), agencies of various types may be a source of identification and means of referral of service members suspected of alcohol or other drug abuse. These referrals will be enrolled following the initial screening interview only after notification and concurrence of the commander. Referrals from sources other than command, medical, investigation/apprehension, will be handled in the same manner as a self-referral.

**3-11. Screening and recommendations.** An initial screening interview will be conducted with all individuals who are either referred for screening or who voluntarily seek treatment in the program. This interview will be conducted by a member of the ADAPCP staff, skilled in alcohol or other drug abuse counseling techniques. The initial screening interview will take place within 2 duty days after referral. The ADAPCP counselor will inform the service member of the applicability of the exemption policy to the disclosure of information concerning past drug use, or possession of drugs incidental to personal use. If referral for medical evaluation is required, DA Form 4465 (ADAPCP Client Intake Record (CIR)) (fig. B-3) and the ADAPCP Military Client Referral and Screening Record will be provided to the evaluating physician for review prior to medical evaluation. Any other comments or recommendations made to the physician conducting the medical evaluation will be recorded on a SF 600 (Health Record—Chronological Record of Medical Care) and accompany the Client Intake Record and the ADAPCP Referral and Screening Record. Upon completion of medical evaluation, all forms will be returned to the ADAPCP for inclusion in the ADAPCP client case file.

**3-12. Medical evaluation.** The commander, clinical director, counselor, or the service member may request a medical evaluation by a physician at any time to determine the extent of alcohol or other drug abuse by a service member. A medical evaluation is not required in all cases, but is always required in instances of a positive urinalysis for personnel not enrolled in the ADAPCP, and in cases of suspected alcohol or other drug dependency, and prior to entry in Track III (residential treatment). Service members with blood alcohol tests that reflect a high level of alcohol intake should be considered for referral for medical evaluation and assessment. Medical evaluations will be conducted by physicians using table B-4 of this regulation as general guidance and TB MED 290.

**3-13. Rehabilitation team.** The rehabilitation team will convene as soon as possible after the

ADAPCP initial screening is completed. The team will, at a minimum, be composed of the client, his commander or the commander's designee, and the ADAPCP counselor. Other appropriate members of the team may be the ADAPCP clinical director, a physician, chaplain, social workers, psychologist, appropriate family members, the client's immediate supervisor, or other community human services personnel. Following the initial screening process (to include medical evaluation, if required) the ADAPCP counselor will recommend to the commander appropriate disposition of the referral during the first meeting of the rehabilitation team. One of the following or a combination of the following will be recommended:

a. Unit counseling by the commander or the commander's designated representative.

b. Placement into the Urine Surveillance Program (USP).

c. Other action (e.g., referral to another agency).

d. No ADAPCP services required at the present time.

e. Enrollment in one of the following:

(1) *Track I, Awareness education and group counseling, as required (nonresidential)*. Enrollment in this track will not exceed 30 days.

(2) *Track II, Rehabilitation (nonresidential)*. Intensive individual or group counseling (may include awareness education). Enrollment in this track is for a minimum of 30 days.

(3) *Track III, Rehabilitation*. Residential medical treatment with nonresidential followup. Enrollment in this track is limited to those clients who have been evaluated by a physician as requiring residential treatment. Generally, residential care will be reserved for those individuals with long standing problems of abuse, but for whom prognosis for recovery is favorable with proper treatment. Enrollment in this track is for 360 days.

*Note.* For civilian employees and other clients, see chapter 5 of this regulation for identification, referral and screening procedures.

#### Section IV. BIOCHEMICAL TESTING

**3-14. Objectives:** The objectives of biochemical testing are as follows:

a. Early identification of drug abuse.

b. Deterrence of experimental and casual drug use.

c. Monitoring of rehabilitation progress for those who require testing as part of their rehabilitation plan.

d. Development of data on the prevalence of drug abuse within the Army.

**3-15. Background.** The DOD biochemical testing program was established in 1971 by the Secretary of Defense and is promulgated by DOD Instruction 1010.1, dated April 4, 1974, with changes. Each of the Services are required to implement procedures for biochemical testing to screen for drug abuse of detectable drugs. Procedures are established for commander and physician directed testing. Biochemical testing of urine can detect various drugs, including amphetamines, barbiturates, opiates, methaqua-

lone, phencycline, and cocaine, with a high degree of specificity. Therefore, a product containing any of these drugs even if taken into the body several days prior to the test, may yield a positive result. Urine samples found positive for a potential drug of abuse by radioimmunoassay (RIA) will have the positive confirmed by another methodology before it is reported to the donor's unit. Therefore, the number of false positives reported out of the laboratory will be almost nonexistent. All positives are retained in the laboratory for 60 days, and if use is denied, the laboratory will recheck its findings upon request.

**3-16. Policies.** a. *Concept.* Biochemical testing is a tool for a commander or physician to identify individuals who need rehabilitation and treatment. Urine testing will be conducted with maximum respect and concern for human dignity. All urine specimens will be collected under the direct observation of responsible personnel (E5 or above) of the same sex to insure that no substitutions are made.

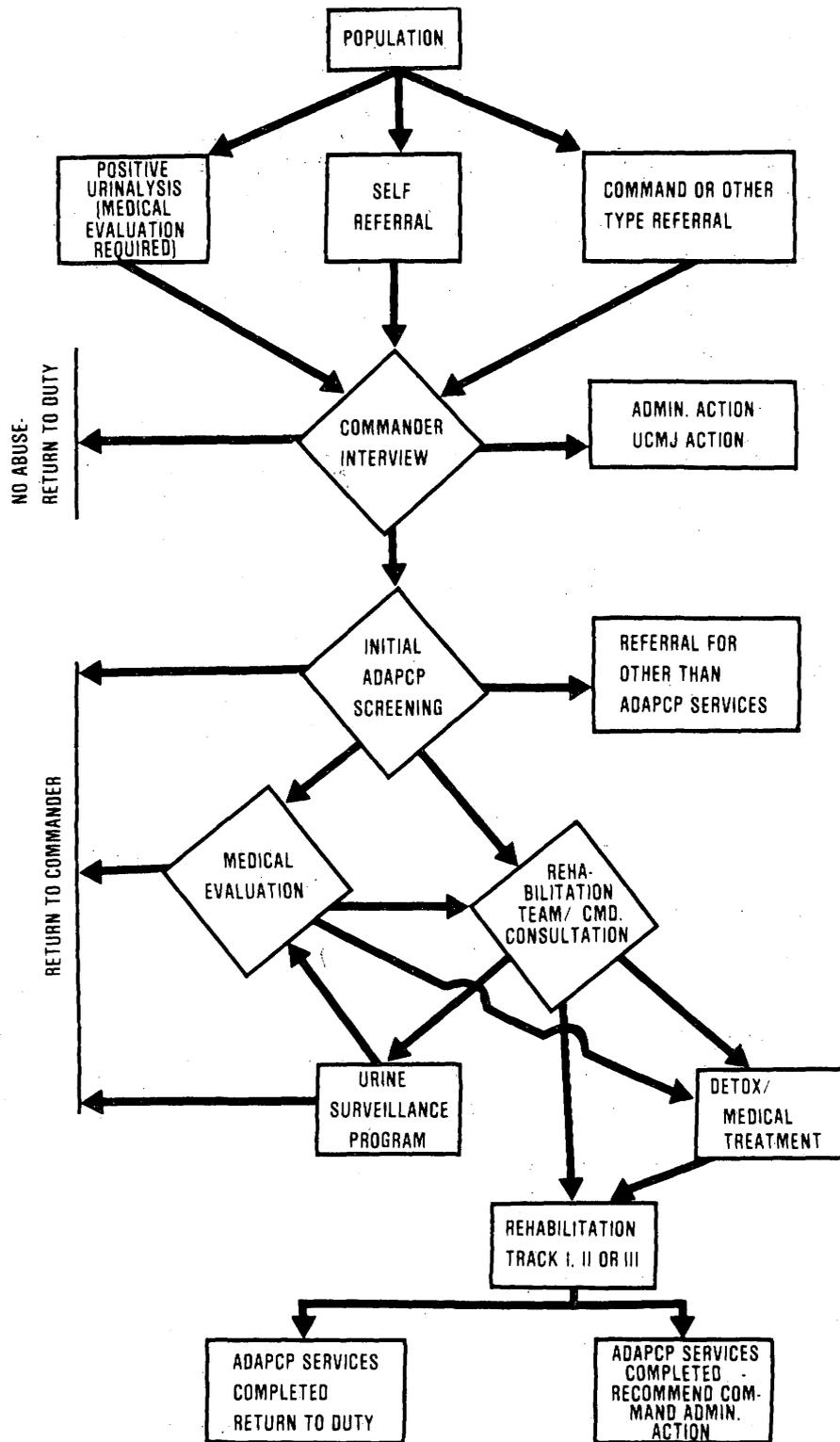


Figure 3-1. Referral and screening process.

*b. Testing programs.*

(1) *Commander-directed.* Commanders may direct individual service members, parts of units, or entire units to submit to urine testing when there is reason to suspect abuse by unit members. The decision to test is a command judgment; however, incidents involving repeated or serious breaches of discipline should be examined in the context of all the circumstances to determine if there is a probable involvement of alcohol or other drug abuse. Examples of possible incidents include, but are not limited to, crimes of violence, accidents, drunkenness, disorderly conduct, AWOLs, or other unusual behavior. "Unit sweeps" (SUTTCO in Europe) are commander-directed unit testing of an entire unit. They may be directed by the commander at any time the commander suspects drug abuse among unit members and entire unit testing is deemed appropriate. Coordination with the ADCO is necessary to insure that adequate laboratory support and supplies are on hand to support the testing of the entire unit.

(2) *Physician-directed.* Physicians may at any time direct a service member patient to be tested when drug abuse is suspected. This urine specimen will be processed through the ADAPCP in the same manner as commander directed specimens.

(3) *Urine Surveillance Program (USP).* All service members who have positive urine test results that are not determined by medical evaluation to be authorized usage and are not enrolled as a client in the ADAPCP will, at a minimum, be placed in the USP. Individuals are placed in the USP for a period of 30 days. During this time, unannounced urinalysis will be made twice weekly, or a total of eight times. If the individual has a total of eight consecutive drug-free urines, he or she may be considered drug free and removed from the USP. If a test is positive during USP, the member will be re-evaluated by the ADAPCP staff. The ADAPCP staff will monitor the test results for the commander and recommend enrollment or release from the program accordingly.

(4) *Rehabilitation testing.* Testing during rehabilitation or treatment will be performed for the following categories:

(a) While in detoxification—upon entry and then at the discretion of the physician, regardless of age or primary substance of abuse.

(b) If detoxification is not required—during the medical evaluation when entering a residential rehabilitation program, regardless of age and substance of abuse.

(c) During any phase of rehabilitation, regardless of age and substance of abuse—once a week on an unannounced basis for the first month of rehabilitation. Thereafter, the number of tests is determined by the rehabilitation team.

(5) *ADAPCP staff testing.* Military and civilian alcohol and other drug treatment and rehabilitation staff personnel whose duties involve direct contact, at least weekly, with clients enrolled in treatment or rehabilitation for alcohol or other drug abuse will be tested a minimum of two times per month, on days selected at random. Applicants for civilian positions must be notified before they are employed that their position in the ADAPCP will require urinalysis as a continuing condition of employment. A current listing by name, position, title and position description number of those to be tested will be posted on the staff bulletin board by the ADCO and a copy will be furnished to the CPO. The ADCO will be responsible for furnishing the CPO with any changes to the list for use in processing new employees required to sign the written condition of employment (see app C).

**3-17. Responsibilities.** *a.* The DCSPER will provide General Staff supervision of biochemical testing.

*b.* TSG will—

(1) Provide the laboratory testing capability to support Army's responsibilities.

(2) Prescribe the methodology to be used by the laboratories supporting biochemical testing.

(3) Provide technical guidance for the collection and shipment of specimens.

(4) Collect and evaluate biostatistical data related to testing.

*c.* MACOM commanders will—

(1) Coordinate and monitor biochemical testing within their command.

(2) Monitor the implementation of biochemical testing at installations and activities over which they exercise jurisdiction.

(3) Designate points at appropriate locations to collect and ship specimens to the servicing laboratory identified in appendix E.

(4) Establish contact and coordination with servicing laboratories as appropriate.

*d.* Installation commanders will—

(1) Appoint an officer, normally the ADCO, as installation biochemical test coordinator and installation point of contact.

(2) Establish and maintain coordination with the laboratory providing support to the installation.

(3) Insure that the installation biochemical testing conforms to DA policy in this regulation (para 3-18).

(4) Establish procedures whereby unit commanders are informed of all laboratory positive results concerning personnel in their units in the most expeditious way possible, to include "For Official Use Only" electronic messages or telephone.

*e.* Drug testing laboratories will—

(1) Provide testing service to all Army, Navy, Air Force, and Marine Corps installations and activities within the geographic area of responsibility shown in appendix E. (Air Force and Navy laboratories will provide testing service to Army installations and activities located within the laboratories' geographic areas of responsibility.)

(2) Exercise internal quality control surveillance to insure maintenance of the minimum drug detection sensitivity levels shown in table 3-1.

(3) Evaluate all urine specimens for test detectable drugs of abuse using RIA. All specimens positive for detectable drugs of abuse will be confirmed by the use of gas liquid chromatography (GLC). Laboratory reports will be based only upon positive results confirmed by GLC.

(4) Within two duty days after receipt of specimens, report to the originating agency,

electrically or telephonically (never by routine mail), confirmed positive results and a statement that the balance of the specimens were negative. The completed DD Form 1892 (Drug Screening Urinalysis Record) will also be dispatched at this time to the originating agency. If MINIMIZE is in effect, data will continue to be transmitted via electrical means or by telephone.

(5) Establish and maintain direct technical liaison, to the extent considered necessary and desirable, with other testing laboratories. This is for purposes of standardization of methodology and the exchange of technical information which may be of mutual benefit.

*f.* The Armed Forces Institute of Pathology will—

(1) Perform quality control testing for all Army, Air Force, Navy, and commercially operated laboratories.

(2) Provide laboratory quality control reports for the use of military departments and the Office of the Assistant Secretary of Defense (Health Affairs) in determining laboratory proficiency.

**3-18. Collection and transportation of urine specimens.** *a.* The installation commander has the overall responsibility for the collection of urine samples. In situations where MEDDAC/MEDCOM TDAs include resources for this function, they will continue to provide these personnel to the ADCO to assist in urine collection procedures.

*b.* To prevent substitution of urine or other substances, urine specimens will be collected for testing under direct observation. Collection of urine specimens will be accomplished in a manner and under circumstances conducive to the preservation of human dignity.

(1) Samples will contain a minimum volume of 60 milliliters.

(2) Samples will be properly labeled and forwarded for transportation within 24 hours of collection.

(3) Bottle, Urine Specimen, Shipping, 120s; U/1—Package, NSN 6650-00-165-5778,

will be used exclusively in shipping urine samples.

(4) DD Form 1892 (Drug Screening Urinalysis Record) will be completed and forwarded with specimens by the submitting unit. In addition, a DD Form 1155 (Order for Supplies for Services Request for Quotations) will be included with specimens forwarded to a civilian contract laboratory.

c. Urine specimens will be shipped without preservatives or refrigeration to the appropriate test laboratory by the method of expedited transportation. It is necessary to insure delivery at the earliest date and not later than 3 days after sample collection.

(1) Shipments will be assigned transportation Priority 1 with a required delivery date (RDD) 3 days after the date on which the specimen was taken. The priority and RDD will be entered in the appropriate blocks of DD Form 1384 (Transportation Control and Movement Document or in the "Description of Contents" block of the US Government bill of lading.

(2) Transportation officers will arrange for movement of these samples by any of the following:

(a) Expedited surface transportation.

(b) US Postal Service.

(c) The Military Airlift Command transportation system: nonindustrially funded military organic aircraft.

(d) US flag commercial air freight; air express, air freight forwarder.

(e) When none of the above can satisfy the movement requirement, by foreign flag air carriers.

d. Specimens which have been collected from individuals participating in rehabilitation programs or Personnel Reliability Programs (PRP) will be clearly identified by the collecting agency with the word "REHAB" or "PRP" at the top of each DD Form 1892 and on each specimen bottle. "REHAB" or "PRP" specimens will be shipped in cardboard containers separate from routine specimens so that they may be easily identified on receipt at the laboratories. Drug testing laboratories will accord all "REHAB" or "PRP" specimens priority testing by inserting them in production lines ahead of all routine drug urine specimens awaiting testing.

Table 3-1. Minimum Drug Detection Sensitivity Levels

<i>Drug Class</i>	<i>RIA/GLC</i>
Opiates	(In nanograms per milliliter-ng/ml)
Total Morphine	300ng/ml
Methadone/Codeine	300ng/ml
Amphetamines	1000ng/ml
Barbiturates	200ng/ml
Methaqualone	750ng/ml
Cocaine	750ng/ml
Cannabis	100ng/ml

## CHAPTER 4 REHABILITATION

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### Section I. INTRODUCTION

**4-1. General.** *a.* Rehabilitation of alcohol and other drug abusers is a command responsibility. All commanders must have a working knowledge of the various program elements within the ADAPCP. They will insure that all community resources are used in assisting individuals during rehabilitation. Commanders must also insure that individuals are assisted in coping with the environment in which they are expected to function. The commander's attitude and direct involvement with the rehabilitation process will influence the entire effort; therefore, command support and the support of the first-line supervisor, whether civilian or military, must be positive and clearly visible.

*b.* Rehabilitation begins when an individual is identified as being involved with alcohol and other drug abuse, or illegal use. Initial efforts should begin with counseling by the commander or supervisor in the case of civilian employees, with counseling by the supervisor for job performance problems. In some instances, special expertise is needed to bring about the desired changes in an individual's performance or conduct. In these instances the commander or supervisor will refer the individual to the ADAPCP for screening and professional assistance as required.

**4-2. Objectives.** The objectives of the rehabilitation program are—

*a. For military personnel.*

(1) Restore individuals identified as alcohol or other drug abusers to effective duty.

(2) Identify individuals who cannot be rehabilitated within the scope of this regulation.

*b. For civilian employees.* Restore civilian employees with job performance problems re-

lated to alcohol or drug abuse to effective performance. (See chap. 5.)

*c. For military and civilian family members.* Resolve alcohol and drug abuse problems in the family with the ultimate goal of enabling the service member or employee to perform more effectively.

**4-3. Coordination.** The program for alcohol and other drug abuse rehabilitation is comprised of a variety of operating elements. It is essential that careful coordination and open communication between these elements be maintained to insure the smooth transition of the individual through the rehabilitation process. These elements are—

*a.* Prevention and education.

*b.* Identification and referral.

*c.* Screening, medical evaluation, and command consultation.

*d.* Rehabilitation treatment and followup.

**4-4. Concept.** In the interest of determining the best rehabilitation program for the client, the responsible ADAPCP staff member will always employ the "rehabilitation team" concept. A record of the rehabilitation team's meetings, discussions, and decisions will be maintained in the client's ADAPCP case file. No other record of the proceedings will be maintained. In the case of civilian clients, this concept will only be used if the client has given consent to involve the supervisor by signing the Civilian Employee Consent Statement (DA Form 5017-R). (See app B.) DA Form 5017-R will be reproduced locally on 8½" x 11" paper.

## Section II. REHABILITATION AND TREATMENT

4-5. **General.** *a.* After the initial screening interview has been completed, the rehabilitation team will meet to make a determination of what rehabilitation approach will best meet the needs of the individual and achieve his or her earliest possible return to full effective duty. Frequency and length of counseling sessions will be determined by the rehabilitation team if enrollment is required. The rehabilitation team will insure the compatibility of the therapeutic plan with the mission requirements of the individual's unit or organization.

*b.* Rehabilitation tracks: The Army's rehabilitation program has now been divided into three tracks. This provides more flexibility for the commander and more appropriate client case management. These tracks are based upon the degree and severity of involvement with substance abuse. (See fig. 4-1 through 4-5). Any one or all of the following tracks can be a part of an individual's rehabilitation plan:

(1) *Track I.* Provides alcohol and other drug awareness education and individual or group counseling or assessment as required. The education and discussion effort should be designed to focus the client's attention on the adverse effects and consequences of alcohol or other drug abuse. It should also emphasize the Army policy regarding alcohol and drug abuse. The benefits of the educational focus may be enhanced by brief individual or group assessments. Participation in this track will normally not exceed thirty days. The client will be transferred to one of the other tracks or referred to another agency or resource for other counseling services if more intensive rehabilitation is required. Track I does not require a medical evaluation, although the client, the commander, the clinical director or ADAPCP counselor may request one at any time during the rehabilitative process. In any event, an ADAPCP screening is required prior to Track I enrollment. Clients enrolled in Track I are counted as regular ADAPCP cases. The overall management and design of Track I educational services as well as other installation or community prevention efforts are the responsibility of the EDCO and the CPC. However, ADAPCP clinical personnel

(i.e., the clinical director, psychologists, social workers and other counselor personnel) will provide instruction in Track I which is technical or clinical in nature. Such personnel will also provide any clinical assessment of clients that may be required. Caseload or work unit credit will be provided for Track I clients to the same extent as they are provided for the rehabilitation efforts and credits of Tracks II and II clients.

(2) *Track II.* This track provides individual, group, or family counseling on a nonresidential or out-patient basis. In addition to a more intensified counseling effort, the education sessions of Track I are available, as necessary. Enrollment in this track will be for a minimum of 30 days and will not exceed 360 days. There is no set time in Track II other than the minimum 30 days. Track II does not require a medical evaluation, however, one may be requested at any time during the rehabilitation process. The client may be transferred to Track III or referred to another agency or resource for additional counseling or treatment services if required.

(3) *Track III.* Provides an intensive residential rehabilitation treatment program of 6 to 8 weeks duration with mandatory nonresidential followup period for a total treatment program of 1 year. Initial treatment in Track III is provided under direct medical supervision in a residential, medical treatment facility setting. This track is designed for individuals who cannot respond favorably to out-patient treatment or have such a long standing history of abuse that they have become dependent upon alcohol or other drugs. The decision to enter a client into Track III is made by a physician in consultation with the other rehabilitation team members. The residential phase of treatment is the direct responsibility of the MEDDAC/MEDCEN commander; however, Track III remains an integral part of the ADAPCP and operates in accordance with the provisions of this regulation and applicable medical regulations. All client accountability and reporting is done by the servicing ADAPCP of the client. Servicing ADAPCP staff members are required

to remain in contact with and monitor progress of clients that are referred from their ADAPCP to a RTF. When a client is referred directly to an RTF (without responsible ADAPCP's knowledge), it is the responsibility of the gaining RTF to insure that the client's servicing ADAPCP has been notified and that all administrative information is provided for the client's enrollment in the ADAPCP. Normally all referrals to the RTF will be made through the installation ADAPCP clinical director. A medical evaluation is required prior to placement in Track III and again before release from the residential phase of Track III.

**4-6. Residential treatment.** *a. Policy.* RTFs for alcohol and other drug abuse patients will be established as an integral part of both the health care delivery system and the ADAPCP. Non-medical treatment facilities, "Half-way Houses" or other nonmedical treatment residential facilities programs outside MEDDAC operational supervision are not authorized and will not be provided ADAPCP resources. RTFs will be operated by the respective medical commander, ordinarily as a separate and independent clinical service under the supervision of the MEDDAC/MEDCEN Chief of Professional Services, and in coordination with the other aspects of the ADAPCP as provided by the provisions of this regulation. RTFs will not be colocated with psychiatric wards. All RTFs will provide for female as well as male patients.

*b. Responsibilities.*

(1) TSG will establish health care standards and guidance for residential treatment; TSG and Commanding General, HSC have approving authority for requests to establish RTFs.

(2) OCONUS MACOMs having MEDDAC/MEDCEN as subordinate command elements will recommend approval or disapproval for requests arising within their commands. When requests for RTFs are approved by TSG and HSC, in coordination with ODCSPER, MACOMs will revise the mission statement of the supervisory MEDDAC/MEDCEN to reflect the added requirement to operate the RTF.

(3) MEDDAC/MEDCEN commanders will

determine requirements for an RTF. If a valid requirement exists, a request to establish a residential treatment program will be forwarded concurrently through command channels to HQDA (DASG-PS), WASH DC 20310, and Commanding General, HSC, Fort Sam Houston, TX 78234. The request will include a description of the proposed facility and staffing plan as well as identify the sources of the proposed RTF resources. When appropriate, comments from installation and major unit commanders whose personnel would be eligible to participate in the proposed program should be obtained and forwarded with the request. Commanders in the forwarding chain will recommend approval or disapproval.

*c. Staffing.* ODCSPER, HQDA and designated MACOMs will develop and publish staffing guides for an RTF.

*d. Eligibility for admissions and charges for care.* AR 40-3 describes eligibility and priorities for admissions to Army medical treatment facilities (MTF) and states policy governing charges for care. Rates of charges for care in Army MTFs are contained in AR 40-330.

*e. Admission and discharge of patients.* The admission and discharge of patients to and from RTFs will be coordinated with the ADAPCP clinical director that services the client's unit or geographical area. As a part of admission to an RTF, the client will be enrolled in the servicing ADAPCP, be referred by his commander, the clinical director, and a physician. Additionally, an agreement should be sought with family members to accompany and participate in a part of the rehabilitation process, when appropriate. All administrative and legal matters should be resolved prior to admission, when possible. Upon admission, the RTF staff will maintain and report client data as required to the ADAPCP. The client will return to duty with his referring (former) unit and to the servicing ADAPCP for followup services or administrative action, as required.

*f. Treatment.* Each RTF will follow the multidisciplinary treatment approach. Group therapy will be the primary treatment modality for patients and family members. Pharmacother-

apy, Alcoholics Anonymous (AA), Alanon family groups, individual counseling, education, physical training, recreational therapy and other modalities may be employed if necessary. Generally, there will be a 2 week initial evaluation period during which patients will be screened and discharged if the evaluation indicates that the patient will not benefit from residential treatment. RTFs will be operated in a strictly military environment. The length of treatment will be 6 to 8 weeks. Treatment may be extended for some patients with advanced alcoholism or other drug dependency or conversely may be terminated earlier for patients who would not respond to further treatment. Followup services will be coordinated by the RTF with the patient's commander and servicing ADAPCP, subsequent to patient's return to duty.

**4-7. Transfer of clients to RTFs.** *a.* The orderly administrative transfer of ADAPCP clients from nonresidential rehabilitation (Track I or Track II) to residential treatment in Track III is essential. Coordination between the physician, local ADAPCP and the RTF admitting physician and RTF staff is necessary to insure that initial and followup treatment is effective. The local ADAPCP will—

(1) Provide any treatment summaries requested by the RTF that may be helpful to the residential treatment staff.

(2) Provide followup care for each client released from an RTF and insure that all previous records on the client are in order.

*b.* The RTF will—

(1) Provide recommendations for followup care and an assessment of progress during residential treatment to the local ADAPCP by the most expeditious means possible.

(2) Provide all information necessary to the local ADAPCP for completion of Client Progress Reports (CPRs) that become due during residential treatment. Client Intake Records (CIRs) and CFRs will be maintained at and by the local ADAPCP on each Track III client in the client's ADAPCP case file.

**4-8. Rehabilitation progress.** *a.* With the exception of the 6-8 weeks, plus followup of Track

III clients, the length of time a service member is enrolled in the ADAPCP will be determined by the commander in consultation with the rehabilitation team. The commander, as a member of the rehabilitation team, is responsible for determining progress by evaluating the following:

(1) Duty performance and conduct (i.e., work efficiency, relationships with co-workers).

(2) Nonduty performance and conduct (i.e., unit and personal responsibilities).

(3) Abstinence from alcohol and/or other drug abuse.

(4) Personal motivation to overcome alcohol or other drug abuse problems and to be rehabilitated.

*b.* Discussion of this criteria will provide the commander with an overall impression of the client's progress in the ADAPCP. When the commander determines that duty performance and progress is unsatisfactory and cannot justify further rehabilitation efforts in a military environment, discharge from military service will be effected. ADAPCP services will continue to be provided until the client is separated.

**4-9. Type and frequency of counseling.** The type and frequency of counseling used in rehabilitation will vary depending upon the individual case and will be determined by the rehabilitation team.

*a.* If relapse occurs during rehabilitation, the rehabilitation team will determine what course of action should be taken on a case-by-case basis and will adjust the frequency of appointments for counseling as required.

*b.* ADAPCP services will be available for all eligible former ADAPCP clients. Re-enrollment will occur on a case by case basis after the meeting of the rehabilitation team. Re-enrollment in the ADAPCP requires the submission of a new CIR and will be treated as a new case for administrative reporting.

**4-10. Appointments.** Appointments for counseling will be scheduled for clients so as not to interfere with the client's job or duty requirements, in so far as possible. Counselors may

schedule appointments during duty and non-duty hours, as required. In the event that counselors have clients engaged in field exercises or training, they will consult with the commander and arrange to provide counseling sessions at the duty site, when appropriate.

**4-11. Return to the unit.** One of the most critical and difficult aspects of the rehabilitation process is the reinvolvement of the service member in his or her role and responsibilities in the unit. Human attitudes toward the alcohol or other drug abuser undergoing rehabilitation will range from compassionate understanding to open hostility. If rehabilitation is to succeed, the service member must be afforded a realistic opportunity to demonstrate that he or she is motivated to remain alcohol or drug free and can once more function effectively.

*a.* The immediate unit commander and other key unit personnel must insure that the service member is—

(1) Assigned duties commensurate with his abilities, experience, and MOS.

(2) Required to comply with the same standards of performance and behavior that are expected of other members of the unit of equal grade and length of service.

(3) Provided positive support and not subjected to embarrassment or ridicule (e.g., derogatory reference to his prior alcohol or other drug abuse or his participation in the ADAPCP) by other members of his unit.

(4) Encouraged to participate fully in followup, as prescribed.

*b.* Frequent consultation between the immediate unit commander and the ADAPCP staff is critical during this phase of the rehabilitation process.

**4-12. Rehabilitation modalities.** No single rehabilitation modality will prove effective for all individuals. Installation rehabilitation programs must offer a wide variety of rehabilitation modalities structured to meet both individual needs and the requirements for effective duty performance. Rehabilitation modalities used by the ADAPCP staff will be structured within the

scope of the Army's rehabilitation objective of individualized, short term treatment with rapid restoration to full effective duty. The ADCO, in coordination with the clinical director, will insure that—

*a.* Professional counselors are fully qualified and trained in the rehabilitation/treatment modalities which they employ.

*b.* Paraprofessional counselors are experienced and trained in the alcohol and drug abuse rehabilitation field.

*c.* Adequate professional supervision and consultation is available for professional and paraprofessional counselors.

**4-13. Alcoholics Anonymous (AA).** AA is a bona fide treatment modality as well as an organization. It will be used extensively in Track III and as an adjunct to Tracks I and II. Installations will facilitate formation of AA, Alanon and Alateen chapters and activities on-post and provide assistance to these groups to the greatest extent possible. AA, Alanon, and Alateen do not fall into the category of "outside organizations" and under no circumstances will chapters be required to provide the names of members. Commanders and ADAPCP staff members should become familiar with AA, Alanon, and Alateen as referral sources.

**4-14. Referral to Veteran's Administration (VA) medical facilities.** *a.* Alcohol or drug dependent military personnel may be transferred to the VA only under the following conditions:

(1) When within 30 days of separation.

(2) On the service member's written request for transfer and additional treatment.

*b.* The request will specify the length of treatment to which the service member agrees. No active duty service member will be transferred to the VA through medical channels without completing separation processing. (See app F and AR 634-200.)

**4-15. Unacceptable rehabilitation modalities.** Certain rehabilitation modalities are not adaptable to the Army's rehabilitation model and will not be used in Army alcohol/drug rehabilitation programs. Some of these are—

*a. Methadone maintenance.* This modality will not be used in Army rehabilitation programs, except as described in paragraph 4-20. The policy is intended to assist the individual in overcoming drug dependency, not to substitute one drug for another. Military personnel will not be entered into civilian methadone maintenance programs. The ADCO and the clinical consultant should establish liaison with representatives of local civilian programs using methadone maintenance and inform them of the Army policy regarding the use of the drug in treatment.

*b. Mandatory disulfiram (Antabuse) programs.* While the use of Antabuse is medically recognized as being of chemotherapeutic value in the treatment of alcoholism, it will not be a mandatory requirement of any Army rehabilitation program. It will not be used to the exclusion of other accepted rehabilitation/treatment modalities. This policy is not to discourage the use of Antabuse when appropriate and prescribed by a physician. The intent of this policy is to insure that rehabilitation program personnel consider Antabuse on an individual case basis rather than as a therapeutic requisite.

## Section II. DETOXIFICATION

**4-16. General.** Detoxification involves withdrawing alcohol or other drugs from an individual, treating the physical symptoms resulting from that withdrawal, and initiating rehabilitation. Not every alcohol or other drug abuser need be hospitalized during detoxification. The decision as to whether hospitalization is required is a medical one and will be made only by a physician. Requirements to submit to medical care will be in accordance with the provisions of section IV of AR 600-20, and AR 40-3.

**4-17. Methods of referral for detoxification.** An individual will normally be admitted for detoxification to a MTF by one of the following methods—

*a.* Referral by the individual's commander or the ADAPCP staff to a physician for evaluation.

*b.* Referral from the emergency room, outpatient clinic, or other hospital wards or clinics by a physician who suspects an individual may need evaluation or detoxification. The ADCO and the individual's unit commander will be notified by the MTF if the referral is independent of or without the knowledge of the commander and the ADAPCP staff.

*c.* Civilian employees in CONUS will be referred to civilian community hospitals. Civilian employees in oversea areas will be referred to the MTF if eligible for Army medical services.

**4-18. Responsibilities.** *a.* The MEDCEN/MED-DAC commander will—

(1) Provide adequate personnel and facilities to evaluate and manage patients admitted or referred for detoxification.

(2) Notify the ADCO and the appropriate unit commander of all individuals referred for alcohol and other drug abuse or related conditions. (Examples would be alcohol or other drug-related diseases or injuries, or emergency treatment of overdose cases.)

(3) Insure coordination with the ADAPCP so that a structured rehabilitation regimen for individuals undergoing detoxification can be implemented when discharged from the MTF and referred to the ADAPCP.

*b.* The unit commander will maintain contact with the individual undergoing detoxification and will participate, when appropriate, in the detoxification effort.

**4-19. Medical processing.** *a.* The attending physician will determine the time necessary for detoxification. Usually 3 to 7 days of inpatient care will be sufficient for most alcohol or other drug dependent individuals; however, longer periods may be necessary.

*b.* No patient will be medically evacuated who has not been completely detoxified, except under very unusual circumstances.

**4-20. Use of methadone.** Methadone may be used only to ease extreme and otherwise uncontrollable discomfort of rapid withdrawal from

opiate dependency. Methadone will not be used for maintenance therapy. (See para 4-15a.)

4-21. **Line of duty determination.** During detoxification a line of duty determination is not required. An exception to this would be if an individual is determined by a physician to be totally and physically incapacitated for a period of more than 24 consecutive hours. In such cases, the determination will be "Not in Line of Duty; Due to Own Misconduct" only for the

period of actual incapacitation. (See AR 600-33.)

4-22. **Action after detoxification.** The commander may enroll the individual in the ADAPCP before, during, or after detoxification. After the detoxification has been completed, the enrolled individual will continue in the track of rehabilitation deemed appropriate by the rehabilitation team in coordination with the attending physician.

#### Section IV. PERSONNEL ACTIONS DURING REHABILITATION

4-23. **Effect of enrollment.** Enrollment in the ADAPCP need not interfere with normal command administrative actions. (See chap. 5 for civilian personnel.)

a. The granting of leave during the rehabilitation period will be determined by the commander in consultation with the rehabilitation team. This is necessary to permit the coordination of counseling activities.

b. **Temporary personnel actions:** The commander may temporarily relieve the service member from duties requiring special mental or physical alertness. For temporary personnel actions relating to civilian employees see chapter 5 of this regulation. The commander may also temporarily deny a service member's access to classified information. Ordinarily, security clearances will not be revoked until, in the judgment of the commander and the CCF—

(1) The service member has failed to rehabilitation treatment.

(2) The service member is determined to be otherwise unreliable or untrustworthy to the extent that access to classified information or special duty requirements would not be consistent with national security.

c. During rehabilitation, the individual facts of the client's situation must be reviewed to decide upon appropriate personnel actions. The ADAPCP staff should not interfere with any pending, favorable actions.

4-24. **Disposition of personnel.** a. Personnel identified as alcohol or other drug abusers during leave, TDY, or PCS status who require detoxification, will be admitted to the nearest military MTF. Upon completion of detoxification, the service member will be returned to his or her unit for rehabilitation.

b. In all cases of identification as an abuser, the immediate commander of the individual's unit will be notified of the circumstances that led to the curtailment of the service member's leave or other status. This includes compassionate leave, or temporary assignment or TDY.

c. Personnel enrolled in the ADAPCP are not eligible for PCS until at least 30 days rehabilitation have been completed.

4-25. **Separation actions.** The ADAPCP is a manpower conservation program, designed to assist commanders in retaining soldiers with potential for continued military service. However, when a commander, in consultation with the ADAPCP staff, determines that further rehabilitative measures are not practical and that separation will be based upon alcohol or other drug abuse, the following procedures are suggested:

a. Review chapter 6, this regulation, for legal restrictions.

b. For officer separation, see AR 635-100.

c. For enlisted personnel, see AR 635-200 and review case-by-case circumstances.

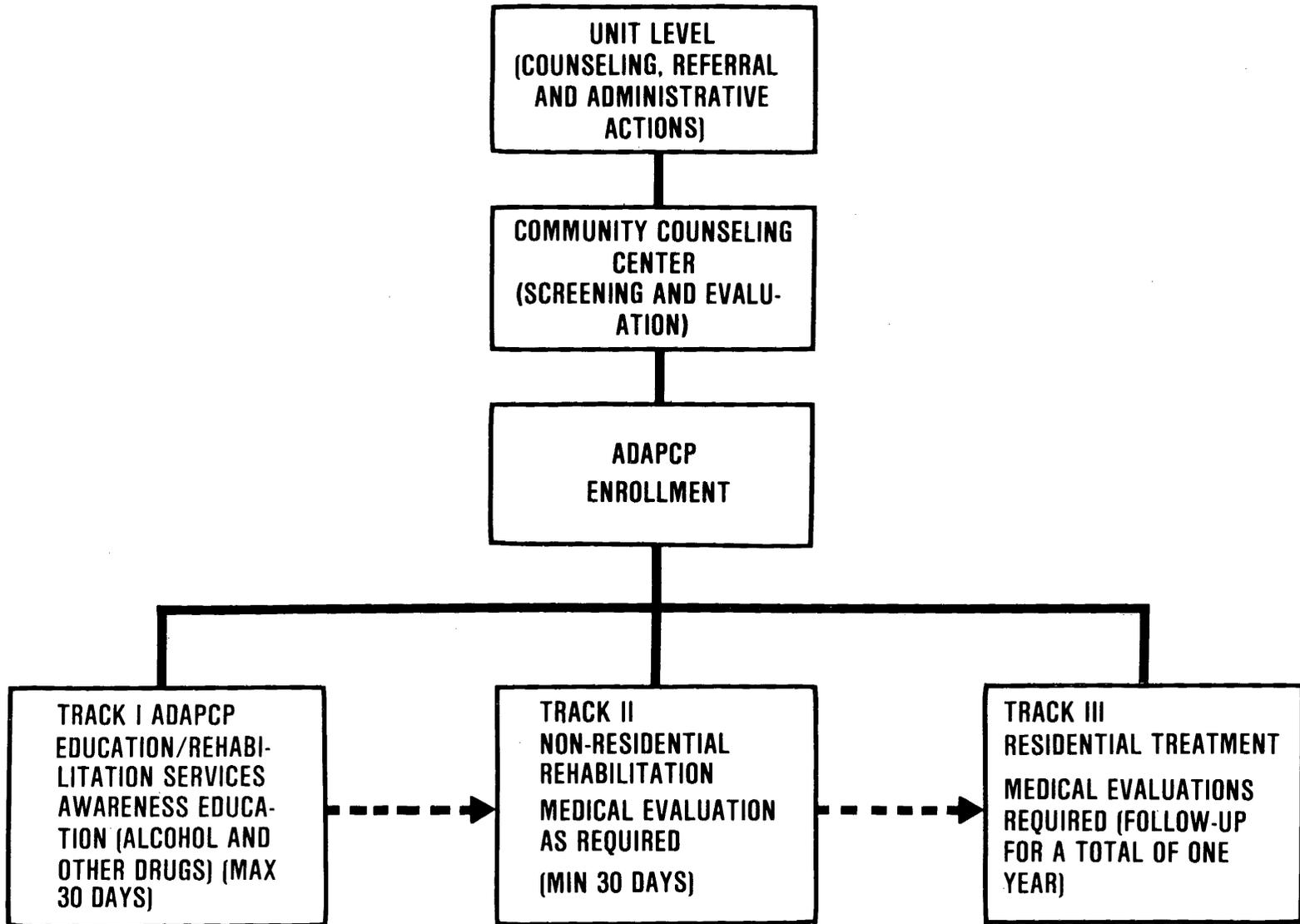
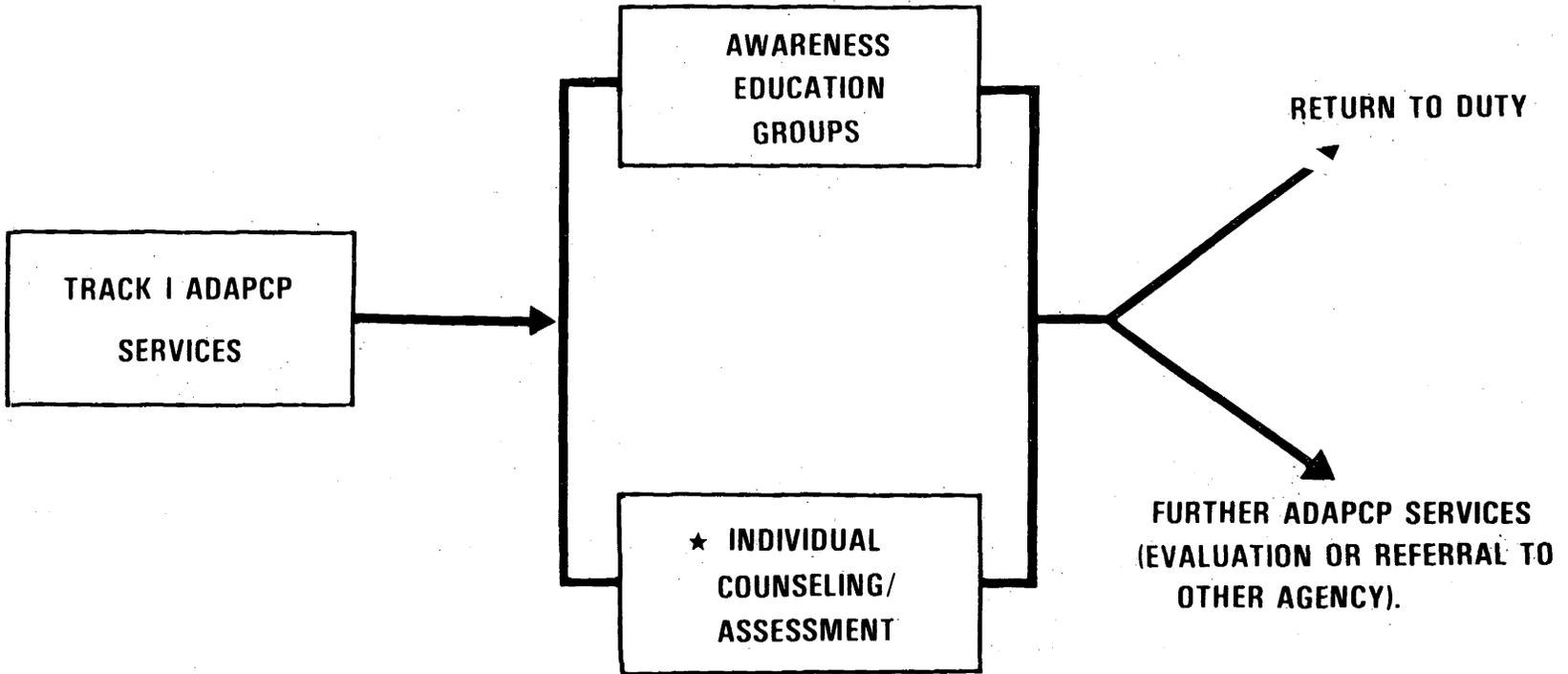


Figure 4-1. ADAPCP rehabilitation and treatment process.



★ AS REQUIRED

Figure 4-2. Track I, ADAPCP education/rehabilitation services.

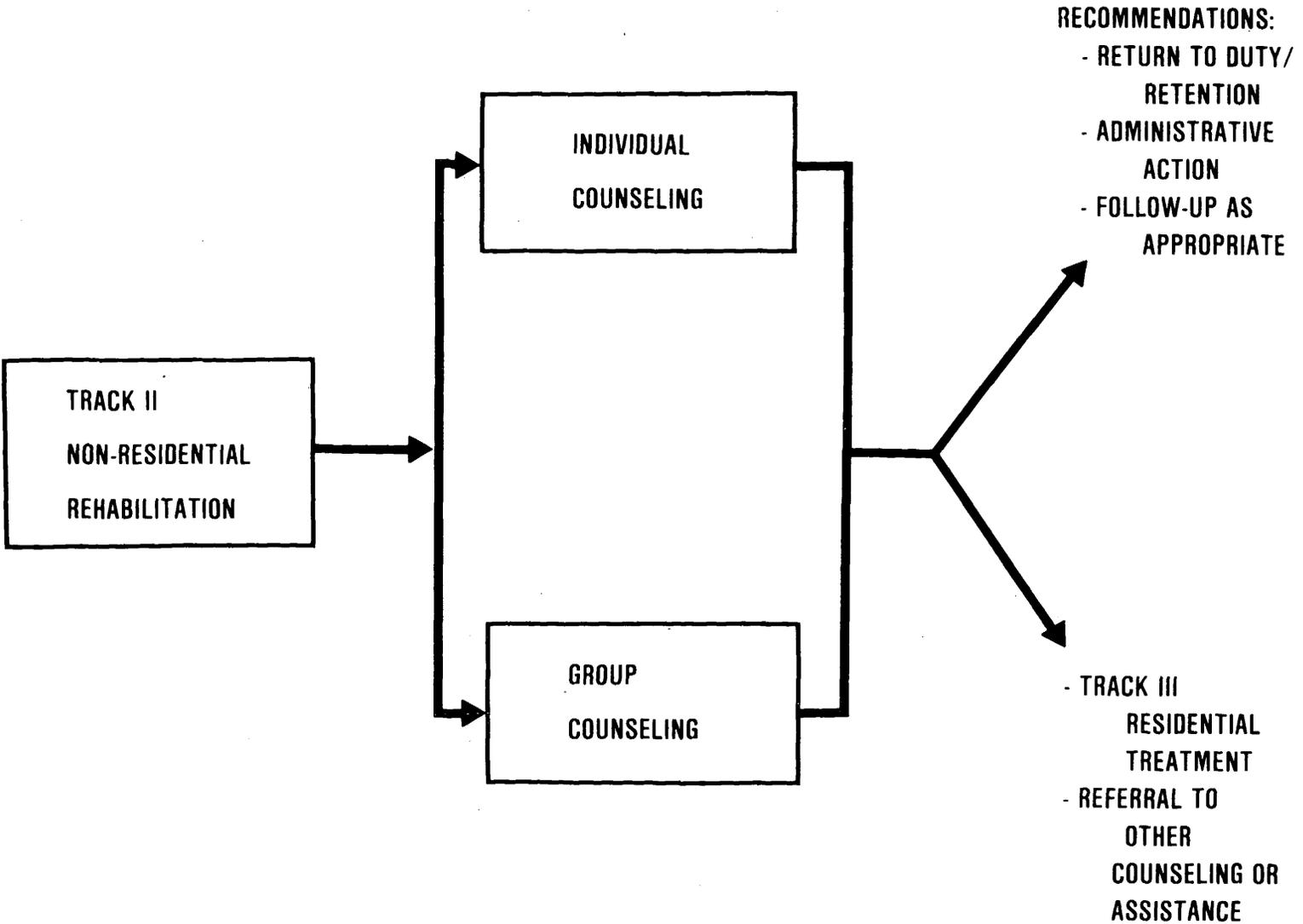
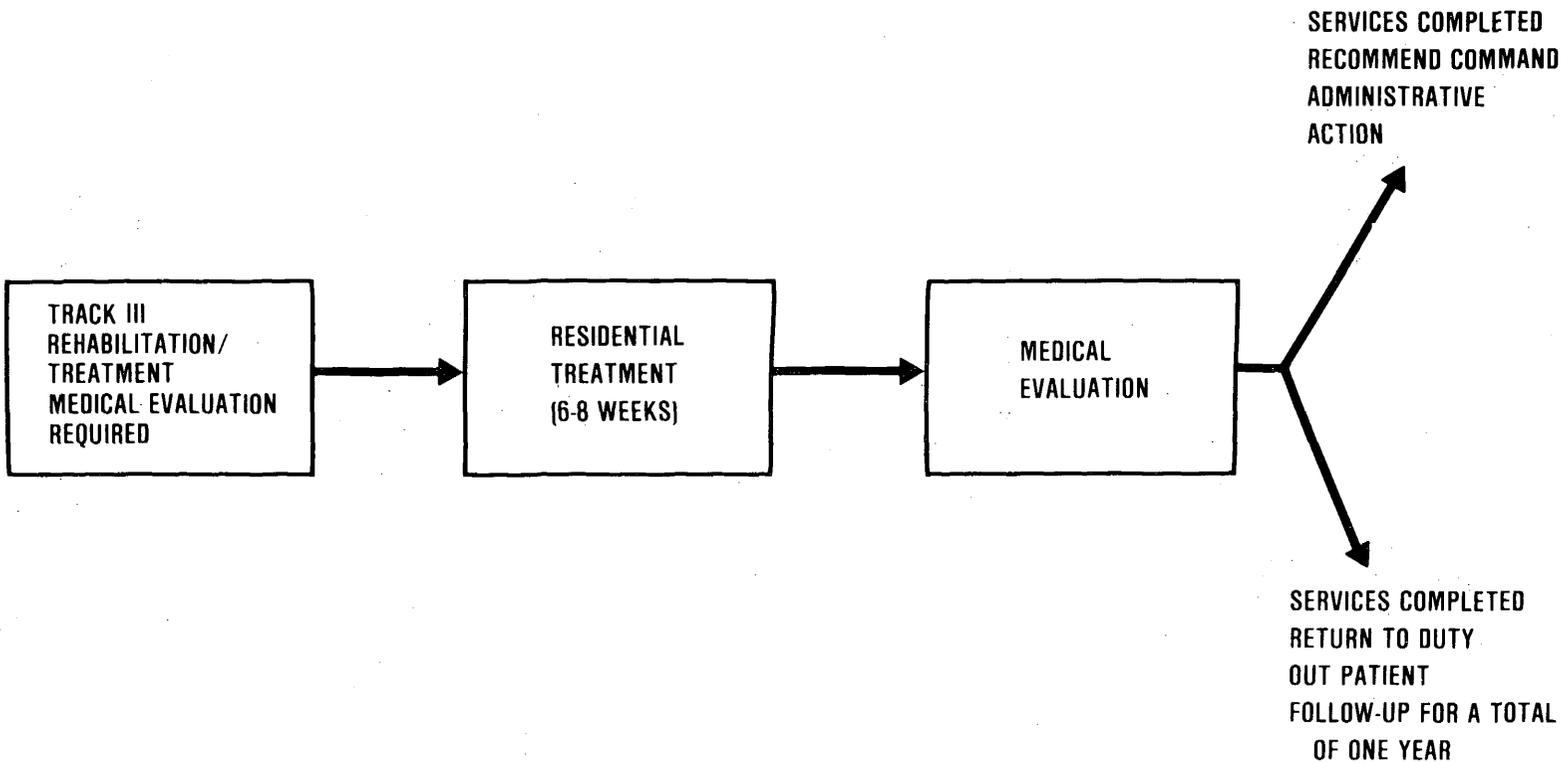
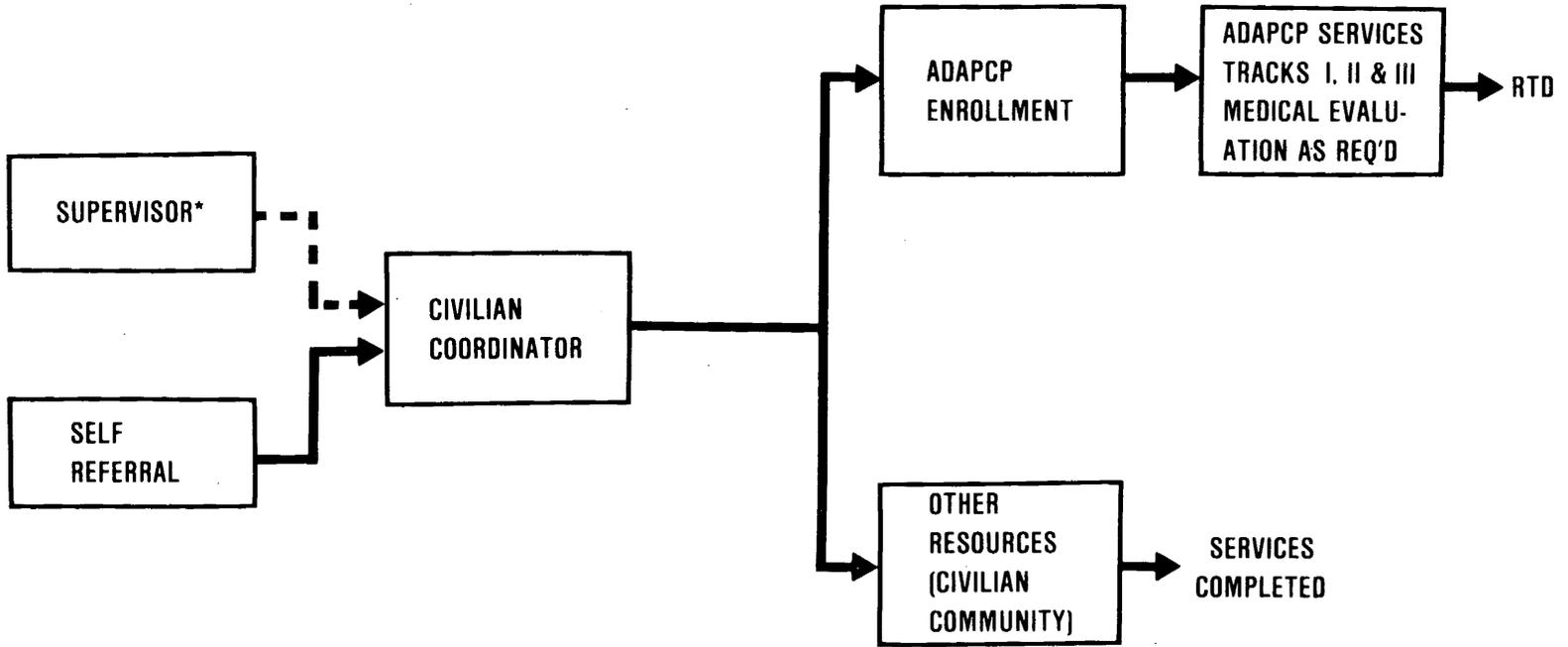


Figure 4-3. Track II nonresidential rehabilitation.



*Figure 4-4. Track III residential rehabilitation/treatment.*



\*WRITTEN PERMISSION FROM CLIENT REQUIRED FOR SUPERVISOR INVOLVEMENT.

Figure 4-5. Civilian rehabilitation model (voluntary).

## CHAPTER 5

### ADAPCP CIVILIAN COUNSELING SERVICES

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**5-1. General.** This chapter addresses various aspects of ADAPCP policies and special administrative procedures for civilians and family members which differ from those for military service members. In the private sector there are a variety of titles applied to counseling services for employees, including "Employee Assistance Program and Employee Counseling Service Program." In DA, ADAPCP services for civilian employees and military and civilian family members will be called Civilian Counseling Services (CCS) and will be identified as a part of the ADAPCP and not as a separate program.

*a.* In 1973, the DA merged the Civilian Personnel Office (CPO) sponsored alcoholism program with the previously established military ADAPCP. As a result, the Army has one ADAPCP, with the Deputy Chief of Staff for Personnel (DCSPER) having overall proponentcy. The OPM has issued Federal Personnel Manual (FPM) chapter 792, subchapter 5, "Alcoholism and Drug Abuse Programs" and subchapter 6, "Employee Counseling Service Program" (dated 31 Dec 80) and FPM Supplement 792-2, Alcohol and Drug Abuse Programs (dated 29 Feb 80) as general guidance for all Federal agencies in implementing programs to assist civilian employees with alcohol and drug abuse and other problems. The Army program follows the mandates of Public Laws 91-616 and 92-285 and "utilizes existing services and facilities insofar as possible" for civilian as well as military personnel and their family members. The FPM guidance has been incorporated into the Army program insofar as organizational structure, funding, and manpower constraints permit. However, there remains a very clear and distinct delineation between ADAPCP counseling and assistance and Management Employee Relations (MER) functions of the Civilian

Personnel Office and other agencies which assist civilians in various ways.

*b.* The ADAPCP is responsible for implementing only the alcohol and drug counseling program aspects of the Employee Counseling Service Program as described in FPM chapter 792. The CPC is assigned to the ADAPCP to insure that the special needs of civilian employees with alcohol and other drug problems are met. The CPC also acts as a liaison between the ADAPCP and the CPO. There are specific considerations involving civilian clients (e.g., confidentiality, separate case record files, and applicable civilian personnel regulations) that are quite different from the military. In compliance with the intent of FPM chapter 792, provisions are made for civilian client's alcohol and drug problems within the ADAPCP. These are designed to augment CPO responsibilities for counseling and assistance in other employee problem areas. Under no circumstances will the CCS of the ADAPCP be identified as a separate counseling service or employee assistance program. Under no circumstances will civilian employee alcohol and other drug problem management be placed under the CPO, regardless of the name applied to the services provided. The Army structure is quite different from other federal agencies and other military service's structures within DOD. The civilian aspects of the ADAPCP, as outlined in this regulation, not only meet OPM guidance but meet the letter and intent of all the Public Laws pertaining to alcohol and other drug abuse and have been reviewed by the Government Accounting Office (GAO).

*c.* It is recognized that the philosophy of FPM chapter 792, subchapter 6 (Employee Counseling Services Program (ECSP)) may encourage early identification and referral of

alcohol and drug abuse problems and eliminate the need for supervisors to determine the nature of an employee's problem before making a referral. Therefore, the ECSP described in FPM chapter 792 may be integrated into the ADAPCP with the following provisions:

(1) The name will remain ADAPCP CCS.

(2) The CCS should function as a screening service for all employees whose job performance appears to be affected by a personal problem. If the personal problem involved has as its basis alcohol or other drug abuse, the ADAPCP will provide counseling or referral services designed to resolve the problem and restore the employee to effective job performance. If the personal problem is unrelated to alcohol or other drug abuse, the employee will be referred to the appropriate installation or community resource and ADAPCP involvement with that client will end. If the employee has signed a Civilian Employee Consent Statement, the supervisor will be notified of the referral and advised that ADAPCP involvement has ended.

(3) Policy statements will make it clear that the CCS exists to enhance earlier identification of alcohol and other drug abuse and that it functions only as a screening and referral service for other problems.

(4) Integration of the ECSP into the CCS will not take priority over ADAPCP functions such as the extension of services to family members.

(5) Proposals to integrate the ECSP into the ADAPCP must have the concurrence of the servicing Civilian Personnel Office.

(6) Employees referred to other resources who are not enrolled in the ADAPCP will be entered in the ADAPCP log.

*d.* In accordance with paragraph 1-2*c* of this regulation, all military family members and US citizen employees and family members, to include NAF employees, under the jurisdiction of the Secretary of the Army are eligible for ADAPCP Civilian Counseling Services. It should be noted that temporary hire employees or civilian employees in their probationary period are not eligible for ADAPCP services. Other DOD employees who are entitled to care in an Army medical treatment facility may also

be offered ADAPCP services. In special instances, foreign national employees are provided Army medical services through special treaty arrangements and are eligible for ADAPCP services on a space available basis.

**5-2. Objectives.** *a.* The CCS for civilian employees will be implemented as a counseling service that is responsive only to alcohol and drug abuse problems and serves as a screening and referral service for other civilian employee problems. The civilian aspects of the ADAPCP are based upon the assumption that alcohol and other drug abuse and related problems have an adverse effect on the job performance and retainability of any Army civilian. It is extremely important to treat the "whole person." Therefore, the ADAPCP will establish good working relationships with MER and other Army and civilian agencies designed to assist in "troubled employee" problems. Accordingly, the objectives of the ADAPCP for civilian employees are to—

(1) Increase the efficiency, productivity and effectiveness of the civilian workforce.

(2) Reduce absenteeism and the abuse of sick leave by the civilian work force through early intervention and prevention of alcohol or other drug abuse. Refer related emotional/behavioral disorders to appropriate Army or civilian agencies.

(3) Provide information or referral services to employees with personal problems.

(4) Provide assistance or rehabilitation to identified alcohol or other drug abusers among the civilian work force.

(5) Provide a management tool and resource for managers and supervisors who—

(*a.*) Identify employee's deteriorating job performance.

(*b.*) Wish to use the ADAPCP concurrently with performance counseling for problems of alcohol and other drug abuse.

*b.* For family members of military and civilian personnel the objectives are based upon the assumption that alcohol and drug abuse within the family can seriously impact upon service member or employee job performance. Therefore, the objectives are the following:

(1) Extend ADAPCP services to family members of military and civilian personnel in accordance with public law.

(2) Prevent alcohol/drug abuse and its impact upon the service members or employee's family.

(3) Reduce the number of alcohol/drug related incidents among family members.

(4) Educate young adults through ADAPCP prevention activities for youth (formerly Teen Involvement Program (TIP)). (See chap. 2.)

**5-3. Responsibility for ADAPCP Civilian Counseling Service efforts.** Successful achievement of the objectives of the ADAPCP are vested in installation commanders. Major installation, activity, or organizational commanders will insure that all management and staff officials and supervisors support the civilian aspects of the ADAPCP and that the officials named in paragraph 5-4 below carry out their duties effectively. The local ADAPCP policy will be given adequate publicity to insure that eligible civilians and family members are aware of the commander's support and of the availability of information, referral, and treatment services by the ADAPCP.

**5-4. Responsibilities.** *a.* Overall monitoring of ADAPCP Civilian Counseling Services are the responsibility of the MACOM CPA. The CPA is assigned full-time at MACOM level and will function under the direct operational control of the MACOM ADCO. The CPA will—

(1) Advise the MACOM ADCO on all matters pertaining to the CCS.

(2) Develop MACOM guidelines for delivery and monitoring of ADAPCP services for civilian employees and military and civilian family members.

(3) Provide staff and technical guidance to CPCs at installations/communities or activities and insure quality control of services.

(4) Serve as staff liaison between the CPCs and HQDA on matters of manpower, budget and the overall administration of the civilian aspects of the ADAPCP.

(5) Collect and maintain data pertaining to the status of civilian employee and family member participation in the ADAPCP.

(6) Evaluate on-going progress made within the command, activity, or organization.

(7) Provide reports as required to HQDA.

*b.* The installation CPC will function under the direct operational control of the ADCO in all instances, and will—

(1) Serve as the liaison between the ADAPCP and the CPO.

(2) Assess, plan, and provide comprehensive ADAPCP services for eligible civilian employees and military and civilian family members within the military community.

(3) Establish local procedures for providing ADAPCP services to civilian employees and family members.

(4) Develop prevention campaigns. Provide education and assistance for supervisor and employee education. Publicize the services available for civilian employees through the ADAPCP.

(5) Establish and maintain appropriate liaison with MER personnel.

(6) Establish liaison with other resources to include—

(*a*) MEDCEN/MEDAAC, civilian employee Occupational Health Services.

(*b*) Mental hygiene clinics.

(*c*) Financial and all types of family counseling services (military and civilian) available locally.

(7) Assist the EDCO in providing education and prevention programs for various civilian groups.

(8) Interview employees with possible problems to determine the nature of the problem, motivate them to seek assistance and refer them to the appropriate resource. The CPC will also advise civilians who utilize the ADAPCP of the procedures and policies of the program.

(9) Advise supervisors of employee progress if the employee has signed a Civilian Employee Consent Statement.

(10) Evaluate, develop, and implement adequate procedures for exchange of program/treatment information among local community

programs, and assist the ADAPCP clinical director in approving community referral sources.

(11) Provide consultation and information to management, union representatives, law enforcement, and civilian agencies utilized by the ADAPCP.

c. CPO: The CPO will provide appropriate advice and assistance to ADAPCP CPAs and CPCs. The CPO will—

(1) Provide information during supervisory training regarding alcohol and other drug abuse, the availability of ADAPCP consultation for supervisors, and the ADAPCP services available for civilian employees.

(2) Assist in providing information required for the annual OPM Report (NARS 0058-OPM-AN) to the CPA or CPC.

(3) Explore with supervisors all proposed adverse/disciplinary actions to determine whether alcohol or other drug use may be involved and refer appropriate cases to the ADAPCP.

(4) Develop procedures which enable civilian employees to seek confidential assistance and to use appropriate leave to attend counseling sessions during duty hours.

(5) Provide liaison in all dealings with unions that may be required for the ADAPCP.

(6) Support the CPA/CPC in establishing and conducting an orientation program for new DA civilian employees (para 2-12 f (4)(b)1) and a continuing education program for supervisors (para 2-12 f (4)(b)2).

d. Role of supervisors of civilian employees: The supervisor is responsible for supporting both the ADAPCP and the employee through careful and consistent attention to the evaluation of the employee's job performance. Particular attention will be paid to proper documentation of poor performance, conduct or attendance, which could indicate a pattern for alcohol or other drug abuse. After discussion with the MER and when usual corrective supervisory methods do not result in improvement in performance or conduct, and there is reason to suspect alcohol or other drug abuse, the supervisor will offer information on available ADAPCP services. The supervisor *will not* attempt

to diagnose the employee's problem. The objective of ADAPCP services is to upgrade performance or prevent continued deterioration through education and rehabilitation. The supervisor will be involved in ADAPCP counseling activities *only* with the client's consent. Responsibilities of the supervisor are to—

(1) Be alert, through continuing observation, to changes in the work and/or behavior of assigned employees. It is DA policy to intervene as soon as possible when alcohol or drug abuse is adversely affecting an employee's job performance. Therefore, supervisors should follow procedures described below as soon as there is reason to believe an employee's performance problems may be related to alcohol or other drug abuse.

(2) Document specific instances in which an employee's work performance, behavior, or attendance fail to meet minimum standards, or instances in which the employee's pattern of performance appears to be deteriorating.

(3) Consult with CPC and MER regarding questionable behavior which may indicate an alcohol or other drug problem.

(4) Conduct an interview with the employee, focusing on deteriorating work performance and informing the employee of available counseling services. This and subsequent interviews will be documented. Supervisors will not attempt to diagnose personal or health problems of an employee. (See *b* below.)

(5) Request that the employee seek appropriate counseling or medical assistance.

(6) Conduct a subsequent interview, in followup to (4) above if job performance does not improve. Provide the employee with a choice of either accepting assistance through counseling or professional diagnosis of problems, or accepting consequences for continuing unsatisfactory job performance or conduct.

(7) Offer to temporarily suspend initiation of disciplinary/adverse action if the employee agrees to seek assistance. (See para 5-5a.) If the employee enrolls in the ADAPCP, such action will be suspended and subsequently cancelled if the employee successfully participates in the program, and performance and conduct

is satisfactory at the end of 90 days. Supervisors must coordinate these procedures closely with MER specialists in CPO. Supervisors are only required to offer to suspend disciplinary/adverse action once. Therefore, supervisors should document all offers of assistance and should continue to monitor and document employee performance and conduct in case there is a necessity to propose adverse action or other action based on unacceptable performance or conduct.

(8) Direct personnel actions to be taken (e.g., disciplinary or separate actions) in accordance with current civilian personnel regulations, when counseling and rehabilitation efforts have not been successful and the overall job performance or conduct of the employee warrants such actions.

*e.* Civilian employee supervisors should not confront an employee with the possibility of alcohol or other drug involvement.

(1) If the employee appears to be under the influence of alcohol or other drugs on the job the supervisor has a number of options and should act only after consultation with MER specialists. Supervisors should insure that action taken in such cases will demonstrate to the employee that such behavior is not acceptable in the workplace. As with all incidents in which job performance appears to be impaired as a result of alcohol or other drug use, supervisors must insure that such incidents are properly documented.

(2) If the employee is involved in illegal activities related to alcohol or other drugs, the following measures are appropriate and consistent with DA and OPM policy:

(a) If an employee has engaged in criminal conduct directed exclusively toward himself, the supervisor should be careful not to elicit or entertain from the employee any specificity or detail as to the nature of any illegal activity or conduct involved.

(b) When the supervisor has good reason to believe an employee is involved in criminal conduct directed toward or potentially harmful to the person or property of others (such as selling drugs or stealing to support a drug habit), the supervisor has an obligation

first to the persons or properties in jeopardy and then to the employee. The supervisor will report the known facts to law enforcement authorities. Reports should be made through a management level at which the exercise of discretion is normally expected and through which reports of other types of criminal activity are generally made.

**5-5. Relationship with disciplinary and/or adverse actions.** *a.* The ADAPCP provides non-disciplinary procedures by which an employee with alcohol or other drug-related problems is offered rehabilitation assistance. Initiation of adverse actions for absenteeism, misconduct, and marginal or unsatisfactory job performance related to alcohol or other drug abuse will be postponed for 90 consecutive days for employees who are enrolled in and satisfactorily progressing in the ADAPCP, unless retention in a duty status might result in damage to Government property or personal injury to the employee or others. In the latter instance, consideration should be given to approving official leave for the employee for all or a portion of the rehabilitation period, if appropriate. Information pertaining to the employee's enrollment and progress in the ADAPCP can be obtained only with the employee's consent. If the employee refuses rehabilitation assistance or, upon completion of the 90 day period fails to achieve satisfactory job performance and conduct, appropriate adverse action may be initiated. Adverse action must be based on unacceptable conduct or performance and may not be initiated based upon failure to participate in or complete the rehabilitation program. Previously initiated adverse actions in which the final decision letter has not been issued will be cancelled upon the employee's enrollment in the ADAPCP, provided the employee has not previously refused rehabilitation assistance. Actions may be initiated anew if, at the end of the 90 consecutive days active rehabilitation, job performance or conduct is unsatisfactory or if, at any time during the active rehabilitation phase, the employee refuses such assistance. Once an adverse action has been initiated against an employee who previously refused rehabilitation assistance or did not successfully complete rehabilitation, the proposed

adverse action need not be delayed as a result of the employee's subsequent request for rehabilitation.

b. Civilian employees may be re-enrolled in the ADAPCP at any time. However, suspension of adverse or disciplinary action during re-enrollment is not required and may be determined by the supervisor on a case-by-case basis.

c. There will be a clear delineation between the ADAPCP staff, whose function is to deal as effectively as possible with the employee's alcohol or other drug abuse problems, and the supervisor and MER specialists who deal with employee's job performance. The supervisor may be involved in ADAPCP counseling and support activities with the consent of the client.

d. The civilian aspect of the ADAPCP supplements but does not replace existing procedures and services for dealing with employees whose job performance or conduct is not acceptable. The ADAPCP is a method for improving job performance when there is reason to suspect deteriorating job performance or conduct related to alcohol or other drug abuse. The CPC and ADAPCP staff will not become involved in disciplinary actions. However, the CPC will be knowledgeable of OPM and CPO procedures and regulations, and provide appropriate coordination with the MER specialist, as necessary.

**5-6. Identification, referral, and enrollment (fig. 3-1).** a. DA civilians may be identified and referred for screening by—

(1) Volunteering for ADAPCP services.

(2) Being referred by his or her supervisor, the CPC, MER or other outside source of referral.

(3) Referral to the ADAPCP by a physician as the result of a fitness-for-duty examination, or routine medical or emergency treatment.

b. Once referred to the ADAPCP, civilian employees will be screened by the CPC who will —

(1) Determine the nature of the problem.

(2) Attempt to motivate the employee to seek assistance.

(3) Advise employees of ADAPCP procedures and policies.

(4) Refer the employee to appropriate assistance within the ADAPCP or in the community.

(5) Complete the DA Form 4465 and request that the employee sign the Civilian Employee Consent Statement if the employee chooses to enroll in the ADAPCP.

c. If enrolled, all civilian employees will be requested to sign the Civilian Employee Consent Statement (DA Form 5017-R) prior to entering the ADAPCP. (See app B.) If the employee refuses to sign the consent form, the ADAPCP record will be so annotated and appropriate precautions will be taken against release of information to supervisors or interested others. Signing of the consent form or revoking prior consent is strictly voluntary. If signed, however, the consent enables the CPC, acting for the ADCO, to report specific information to the supervisor named on the consent form, and enables two-way communication regarding clinical progress and performance during rehabilitation for the purpose of the supervisor's providing support in the work environment. Suspension of adverse/disciplinary action for 90 days will only apply to employees who have signed a consent form and have an active consent from currently on file.

d. If an employee decides to withdraw from the ADAPCP prior to completion of a prescribed rehabilitation plan, the CPC will notify the supervisor if the Civilian Employee Consent Statement has been signed. If adverse action was suspended by the supervisor, it may be reinstated upon the client's withdrawal, if the supervisor so desires.

**5-7. Medical evaluation.** Medical evaluations conducted for civilian employees will be provided at no charge by the designated military or civilian medical officer, or Occupational Health physician. Costs incurred in medical evaluations not directed by Army Management performed by physicians in the civilian community will be the responsibility of the employee.

**5-8. Employee records and procedures.** Policy for maintaining civilian ADAPCP records is as follows:

*a.* Client records which deal with the identity, diagnosis, prognosis, treatment, or rehabilitation of a civilian enrolled in any alcohol or other drug abuse program will not be disclosed, except as permitted by Sec. 408, PL 92-255 and Sec. 333 of PL 91-616 as amended by Sec. 122, PL 93-282. Such records are confidential client records protected by the Privacy Act (5 USC 552a), and will remain in the ADAPCP under appropriate security at all times. Client records will not be made part of the employee's official personnel record. However, ADAPCP client folders may include information concerning efforts to rehabilitate the employee that is related to subsequent disciplinary or separation action. Civilian records must be maintained in a separate locked file and may not be filed with military ADAPCP records.

*b.* A DA Form 4465 is required for civilian personnel participating in the ADAPCP, to include those participating in approved civilian community programs. ADAPCP records for civilians are maintained by appropriate ADAPCP staff in the same manner as for other clients with the above restrictions.

*c.* Civilian case notes will be maintained on SF 600 (Health Record—Chronological Record of Medical Care) and will be subject to confidentiality and the Privacy Act provisions for such records. Clients will be made aware of recording procedures and have access to records upon request. Civilian case records in the ADAPCP will be maintained in accordance with chapter 7 of this regulation.

**5-9. Eligibility for retirement.** Eligibility requirements for disability retirement and procedures for applying for retirement are contained in FPM Chapter 831 and FPM Supplement 831-1. Participation in the ADAPCP does not in itself jeopardize the employee's right to disability retirement. Either the employee or the activity may initiate an application.

**5-10. Relationship with labor organizations.** The active support of labor organizations will

contribute to the success of the ADAPCP. Union stewards can be influential in developing and maintaining employee confidence in the ADAPCP. It is important that labor organizations understand and support the efforts of management to assist the employee with alcohol or other drug-related problems. Therefore, management should insure appropriate coordination, through the CPO, with labor organization representatives.

**5-11. Client costs.** *a.* There will be no charge for—

(1) Medical evaluations by the Army Federal Civilian Employees Health Services Program, or by the ADAPCP physician or designee.

(2) All other out-patient ADAPCP services.

*b.* There will be charges associated with residential care or subsistence charges for meals when clients are not eligible for residential care in AMEDD facilities. All costs associated with the in-patient care will be the obligation of the client (or their insurance carriers), and will include necessary costs for families involved in family counseling.

*c.* In oversea areas, civilians will be provided residential care at no charge, on the same basis as any other illness, when eligible for Army medical services in a foreign country.

**5-12. Client management.** Services provided for civilian employees will comply with ADAPCP policy and procedures prescribed by this regulation.

*a.* Civilians may participate in any aspect of the ADAPCP. Clients requiring residential care will be provided diagnostic services and referral to military or civilian community residential programs. Civilians may be referred to residential programs less than 6 weeks long if approved by the CPC or clinical director. The CPC or clinical director may also approve the use of free standing (nonmedical) facilities. Such facilities should be carefully reviewed to determine if they are covered by employee health insurance.

b. Length and type of treatment will be determined by the employee, the CPC, the supervisor (if a civilian consent form has been signed), the clinical director (if referred to ADAPCP treatment resources) or counselor from a community resource if used.

c. Referral will not be made by ADAPCP staff to civilian community resources until the programs have been visited and approved by the clinical director or CPC. To approve a community resource, a satisfactory agreement of client confidentiality and no exchange of specific information for progress reporting must be negotiated by the CPC, if ADAPCP services are to be involved in monitoring, assisting, or followup.

d. Civilian employees will be granted leave to obtain treatment and rehabilitation in accordance with existing civilian personnel regulations.

e. Throughout rehabilitation, the CPC will remain in contact with all civilian employee clients in the ADAPCP, including those participating in approved civilian community programs.

**5-13. Procedures for family members.** a. Family members may participate in all aspects of the ADAPCP within the capabilities of existing resources. If ADAPCP resources are not sufficient, every effort should be made to serve this population through Civilian Health and Medical Program of the Uniformed Services (CHAMP-US) referral to community or to other installation resources.

b. Military or civilian family members may be referred to the ADAPCP by—

(1) Volunteering for ADAPCP services.

(2) Being encouraged to seek assistance through the employee/service member's supervisor.

(3) Being encouraged to seek assistance through installation resources (e.g., chaplain, Community Mental Health Activity, Child Protective Case Management Team, Army Community Services, schools) or other family members.

c. Once referred, family members should be screened by the CPC or an ADAPCP clinician skilled in working with family members to determine the nature of the problem and make an appropriate referral to the ADAPCP (if resources are available) or to a community resource.

(1) The originals of DA Form 4465 (ADAPCP Client Intake Record (CIR)) and DA Form 4466 (ADAPCP Client Progress Report CPR)) will be forwarded to Patient Administration Systems and Biostatistics Agency, Fort Sam Houston, TX 78234 for enrollment and treatment in accordance with chapter 7 of this regulation.

(2) Minor family members may participate in the ADAPCP and will be encouraged to involve their parents in counseling. However, minors will not be enrolled without written parental consent.

d. Occasionally family members may seek assistance for the employee/service member's (spouse) alcohol or drug related problem. In such cases—

(1) Family members will be screened by the CPC or ADAPCP clinician skilled in working with families of alcohol or drug abusers.

(2) Such family members may be enrolled in the ADAPCP (only one member should be enrolled) for the purpose of intervening to encourage the employee/service member to seek treatment.

(3) Maximum use of community resources, particularly Alanon and Alateen, is encouraged when working with such cases.

## CHAPTER 6

### LEGAL ASPECTS OF THE ADAPCP

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#### Section I. GENERAL

**6-1. General.** *a.* Legal requirements and guidelines for the ADAPCP must be consistent with the provisions of public law, civil court determinations, DOD directives, and other Army regulations. (See AR 340-21; 5 USC 552a (Privacy Act); part 2, chapter 1, Title 42, Code of Federal Regulations (CFR); and AR 40-66 concerning Medical Confidentiality). It is essential that the legal issues of the ADAPCP be clearly understood by all levels of command and supervision and that legal procedures and protections be understood by all potential clients. The intent of applicable laws and regulations is to protect the privacy and personal confidences of the ADAPCP client. These laws and regulations do not conflict with the Army mission or standards of discipline when applied properly. Program effectiveness, as well as quality of client care, will depend upon the manner in which the ADAPCP is executed. These restrictions apply to individual client personal information and should not impair exchange of general information between staff agencies.

*b.* Confidentiality of military client ADAPCP information. The release and/or discussion of information *within* the Armed Forces concerning a service member's abuse of alcohol and other drugs is governed by the restrictions contained in the 5 USC 552a, AR 40-66, and AR 340-21. Such information will be made known to those individuals within the Armed Forces who have an official need to know. The restrictions on release of information *outside* the Armed Forces concerning service members and on *all* releases of information concerning civilian clients are prescribed by the CFR cited above.

*c.* Exemption does not grant immunity for *present* or *future* use or *illegal* possession of

drugs or for other illegal acts, past, present or future. (See para 6-2.) For example, *information* that the client presently possesses illegal drugs or that the client assaulted a person while under the influence of drugs is *not* exempt under this policy. (See sec II and table 6-1.)

*d.* Exemption does not prevent a counselor from revealing, to the appropriate authority knowledge of illegal acts. These would be acts which may have an adverse impact on mission, national security, or the health and welfare of others. The reporting in such an instance is from counselor, to clinical director, to ADCO, to the client's commander. The commander will report the information to the appropriate authority.

(1) ADAPCP records are medical records and are protected by AR 40-66. All ADAPCP records will be maintained and stored for a period of 12 months after closing the case by the ADAPCP per AR 340-18-9.

(2) The ADAPCP clinical director will periodically review ADAPCP client files. He or she will insure that counselors maintain high ethical standards in recording only relevant ADAPCP clinical information.

(3) Commanders seeking information from an individual's ADAPCP record must specify their need to know specific information. Their request must be made to the responsible MEDCEN/MEDDAC commander for proper release of information. Commanders do not have unlimited access to review a client's ADAPCP clinical notes or records.

(4) For clients in certain sensitive positions or with the PRP, counselors or other medical personnel will immediately advise the commander if any information is provided by the

client which would serve to disqualify the person for continuation in any sensitive duty position. If the need to release the information is in doubt, it should be released to the commander based on that requirement to protect the interest of the United States Government. The decision in such cases will be made by the commander.

(5) The ADAPCP is a command program. The rehabilitation process involves the client, his unit commander and intermediate supervisors, and the ADAPCP staff. Normally, there is no reason for anyone other than these individuals to learn of a service member's alcohol or other drug problem. While commanders above the unit level may on rare occasions have an official need to know the specific identity of an abuser within their commands, their knowledge of the number of abusers enrolled in the

ADAPCP is usually sufficient information. No lists of individuals from the unit who are enrolled in the ADAPCP will be maintained.

(6) Anyone seeking assistance through the ADAPCP prior to official enrollment is protected by the confidentiality requirements of the program. Information given to such inquiries will include a description of the local program including an explanation of exemption, confidentiality, and enrollment procedures. Military personnel must be officially enrolled by their commander regardless of the source of referral. The ADAPCP will not provide rehabilitation counseling for anyone who is not enrolled in one of the three program tracks. Nor will services be provided to anyone for whom accountability has not been established through the ADAPCP client reporting system.

## Section II. EXEMPTION POLICY

**6-2. Objective.** The objective of exemption is to facilitate effective identification, treatment, and rehabilitation. This is done by eliminating the barriers to successful communications between alcohol or other drug abusers and ADAPCP counselors or physicians.

**6-3. Definition of exemption.** Exemption is—

*a.* An immunity from disciplinary action under the UCMJ or from administrative separation with less than an honorable discharge as a result of certain occurrences of alcohol abuse or drug misuse or possession of drugs incidental to personal use.

*b.* An immunity from use of information obtained directly or indirectly from the member having been involved in the ADAPCP as described in paragraphs 6-4 and 6-5 and in table 6-1.

**6-4. Exemption policy.** *a.* Subject to the exceptions listed in paragraphs 6-4*b* and *c* below, table 6-1 describes the DA exemption policy. This policy will be strictly adhered to in all instances and cannot be modified by subordinate commands.

*b.* The exemption policy (except for the evidentiary aspect described in column D, table 6-

1) does not apply to those offenses of alcohol abuse, nor to drug use or drug possession, incidental to personal drug use, that occurred before a service member acquired exemption if, at the effective time of exemption, the member

(1) Is the subject of an alcohol or drug abuse investigation concerning that offense.

(2) Has been apprehended for the offense.

(3) Has been officially warned that he or she is suspected of the offense.

(4) Has been charged under the UCMJ with the offense or has been offered Article 15 punishment for the offense.

(5) Receives emergency medical treatment for an actual or suspected alcohol or other drug overdose and such treatment resulted from apprehension by law enforcement officials, civilian or military.

*c.* Those offenses described in *b* above and offenses other than offenses of alcohol abuse or illegal personal drug use or possession thereto are not affected by the exemption policy. Such offenses are not affected even though such offenses may be motivated by alcohol or other drug abuse or committed concurrently with alcohol abuse or illegal drug use or possession

incident thereto. Thus, appropriate disciplinary action may be initiated against a service member committing such offenses if warranted under the circumstances. The member may be administratively discharged with other than an honorable discharge, if appropriate. But, no use may be made of evidence obtained directly or indirectly from the member having been involved in the ADAPCP. However, the discharge will be with an honorable discharge if the decision to initiate discharge action against a service member is motivated—

(1) By the member's having been identified as an alcohol abuser.

(2) By the member's exempt use or incidental possession of drugs.

(3) By the member's having been involved in the ADAPCP. (See para 6-5d).

*d.* Exemption is automatic. It is not granted and it cannot be vacated or withdrawn.

*e.* An order from competent authority to submit to urinalysis is a lawful order. Failure to obey such an order may be the subject of appropriate disciplinary action under the UCMJ.

**6-5. Implementation.** *a.* As a part of enrollment in the ADAPCP, the service member's unit commander will—

(1) Advise the servicemember of his or her rights under Article 31, UCMJ, before any discussions take place between the commander and the service member concerning the service member's alcohol and drug involvement.

(2) Explain the scope and limitations of the exemption policy to the member. The member will not be required to sign any type of contract or agreement. The commander will inform the ADAPCP staff of the briefing and the effective date of exemption for entry on client records.

(3) Collect any illegal drugs or drug paraphernalia from the service member and turn them over to the local provost marshal according to AR 190-22.

(4) Refer the service member to the local ADAPCP for medical evaluation if he or she deems necessary or the client so requests.

(5) Encourage the service member to pro-

vide information on drug sources. (However, such disclosure is voluntary and will not be made a requirement for treatment or rehabilitation.)

*b.* When a service member receives emergency treatment from a military medical facility for an actual or possible alcohol or other drug overdose, his or her commander is notified of the event as a routine matter. When a service member receives such emergency treatment from a civilian medical facility, however, there is no routine procedure to notify the service member's commander. Further, physicians at any federally supported civilian alcohol or other drug treatment facility are prohibited by statute from releasing such information without written consent of the patient. Hence, in cases where information of the emergency treatment does not otherwise come to the attention of the service member's unit commander, the following requirements must be met before the exemption policy becomes effective—

(1) The service member must inform his or her commander of the facts and circumstances concerning the actual or possible overdose. This must be done as soon after receiving emergency treatment as is reasonably possible.

(2) The service member must give written consent to the treating civilian physician or facility for release of information verifying that emergency treatment was rendered.

(3) If the civilian physician verifies emergency treatment, exemption is effective as of the time the treatment was rendered.

(4) If the civilian physician refuses to release the information in spite of the service member's written consent, the commander will interpret the member's actions described in (1) above as an act of volunteering for treatment in the ADAPCP. The exemption policy will be effective as of the time the treatment was rendered.

*c.* One or more military associates of an actual or possible alcohol or other drug overdose victim might be reluctant to assist the victim in obtaining emergency treatment from a medical treatment facility because they themselves are alcohol or other drug abusers. Such a person

may, therefore, fear possible adverse consequences from becoming involved. Although exemption is not automatically extended to such a person, the availability of the following options to that service member and his or her commander should reduce reluctance to assist the victim.

(1) The service member may seek help for his or her own alcohol or drug problem from—

(a) His or her commander.

(b) The physician at the military medical treatment facility.

(c) Any other agency or individual described in paragraph 3-3.

(2) If the commander, because of a service member's assistance to an actual or possible alcohol or other drug overdose victim, suspects that member of alcohol or other drug abuse, the commander will—

(a) Inform the member of these suspicions.

(b) Insure that the member is aware of the treatment and rehabilitation services available.

(c) Give the member an opportunity to volunteer for help.

(3) If the member admits to alcohol or other drug abuse and volunteers for help, exemption becomes effective as of the time the member asks for help.

*d.* A service member protected by the exemption policy may be recommended for administrative discharge on the basis of evidence other than information obtained directly or indirectly from the member's involvement in the ADA-PCP. Such a member may receive a discharge characterized as honorable, general, or under other than honorable conditions. (See AR 635-100, AR 635-200, and other regulations authorizing separation with less than an honorable dis-

charge certificate.) The member will receive an honorable discharge certificate, regardless of his overall performance of duty, if discharge is based on a proceeding where the Government initially introduces evidence prohibited above. The Government includes the following:

(1) The commander (in his or her recommendation for discharge or in documents forwarded with his or her recommendation).

(2) Any member of the board of officers adjudicating the service member's case before the board.

(3) The investigating officer or recorder presenting the case before the board.

*e.* Alternatively, if the prohibited evidence is introduced by the Government before the board convenes, the elimination proceedings may be reinitiated, excluding all references to exempt information. If the prohibited evidence is introduced by the government after the board convenes, only a general courts-martial convening authority who is a general officer may set aside the board proceedings and refer the case to a new board for rehearing. The normal rules governing rehearings and permissible actions thereafter will apply in accordance with AR 635-100 or AR 635-200, as appropriate.

*f.* On the other hand, if the service member (respondent) or his counsel initially introduces such evidence, the type of discharge certificate issued is not restricted to an honorable discharge certificate. This would be because of the presence of that evidence (or rebuttal thereto) in the discharge action record.

*g.* All situations which could possibly arise in applying the exemption policy in the field cannot be foreseen. As in other instances in which the commander applies regulatory guidance in an actual case, he or she should seek advice from the supporting judge advocate.

Table 6-1. Exemption Policy

<i>RULE</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
	If the member is identified as an alcohol or drug abuser by—	the member acquires exemption as to drug use/possession for personal use or alcohol abuse occurring prior to— <sup>1</sup>	and the member will not be subject to disciplinary action under the UCMJ or to administrative separation with less than an honorable discharge based in whole or in part on an occurrence of drug/alcohol abuse or drug possession, incidental to personal use, which is revealed to a physician or ADAPCP counselor at a scheduled interview/evaluation or is revealed by a positive urinalysis administered during any rehabilitation track. This exemption is effective at the time such occurrences are revealed or the urine test is laboratory confirmed as positive.	and information (or evidence developed by or as a direct or indirect result of such information) that is revealed to a physician or ADAPCP counselor at a scheduled interview/evaluation or that is revealed by a positive urinalysis administered either to identify drug abusers for entry into ADAPCP or to monitor progress during any rehabilitation track of the ADAPCP, will not be used in any disciplinary action under the UCMJ or in any administrative separation proceeding in which the service member is subject to less than an honorable discharge. (See para 6-5d.)
1	Volunteering for help with alcohol/drug problem (para 3-3)	time of volunteering		
2	Receiving emergency medical care for actual/possible drug/alcohol overdose (para 3-6)	time of treatment (See para 6-5b when treated by civilian medical facility)		
3	Urinalysis (para 3-5)	time urine test is confirmed as positive by laboratory		
4	Medical referral to ADAPCP (para 3-6)	time of diagnosis		
5	Command referral to ADAPCP (para 3-4)	time of initial ADAPCP interview		
6	Apprehension for alcohol/drug offense (para 3-7)			
7	Discovery of use/possession of drugs/drug paraphernalia in routine inspections (para 3-4)			

<sup>1</sup> Exemption is subject to the exceptions outlined in paragraph 6-4.

### Section III. RELEASE OF PERSONAL CLIENT INFORMATION

**6-6. References.** *a.* Section 408 of Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972 (21 USC 1175), as amended by section 303 of Public Law 93-282 (88 Stat. 137).

*b.* Section 333 of Public Law 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 USC 4582), as amended by section 122(a) of Public Law 93-28 (88 Stat. 131).

*c.* Chapter 1, Title 42, Code of Federal Regulations (CFR).

**6-7. Scope.** *a.* This section prescribes policy and provides guidance on the release of information on abusers of alcohol or other drugs who are or have been enrolled in the ADAPCP. The primary intent of the references in paragraph 6-6 and of the policies in this section is to remove any fear of public disclosure of past or present abuse. It is also intended to encourage participation in a treatment and rehabilitation program.

*b.* The restrictions on disclosure prescribed in this section are allowed by the Freedom of Information Act (5 USC 552) or the Privacy Act (5 USC 552a).

**6-8. Applicability.** The provisions of this section apply both to individuals responsible for any client record and to individuals who have knowledge of the information contained in client records. Such records would be those maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research. The criminal penalties for unauthorized disclosure of information prohibited by the Federal statutes and regulations listed are a fine of not more than \$500 in the case of the first offense and not more than \$5000 in the case of each subsequent offense.

**6-9. Policy.** No person subject to the jurisdiction or control of the Secretary of the Army shall divulge any information or record of identity, diagnosis, prognosis, or treatment of any client. This includes any information which is maintained in connection with alcohol or other

drug abuse education, training, treatment, rehabilitation, or research, except as specifically authorized in *a* through *c* below.

*a.* Subject to the provisions of section IV of this chapter disclosure of information on military clients is authorized within the Armed Forces, if the individual seeking the information has an official need to know. This includes those components of the VA furnishing health care to veterans. The provisions of section IV and of this section apply to further disclosure within the Armed Forces; the provisions of the references listed in paragraph 6-6 apply to further disclosures by the VA.

*b.* *With the written consent of the client* (para 6-10*i*) and subject to other applicable restrictions of this section, disclosure to the following is authorized:

(1) To medical personnel or to treatment or rehabilitation programs where such disclosure is needed to furnish better services to the client (para 6-10*b*).

(2) To the client's family or to any person with whom the client has a personal relationship (para 6-10*c*).

(3) To the client's attorney, when a bona fide attorney-client relationship exists (para 6-10*d*).

(4) To the following designees of the client for the purpose of benefiting the client (para 6-10*c*):

(*a*) To the President of the United States or to members of the US Congress when they are acting in response to an inquiry or complaint from the client (para 6-10*e*(8)).

(*b*) To civilian criminal justice system officials where the client's participation in the ADAPCP is made a condition of—

1. The individual's release from confinement.

2. The disposition or status of any criminal proceedings against the individual.

3. The execution or suspension of any sentence imposed on the individual (para 6-10*e*).

(c) To employers or employment agencies (para 6-10e).

(d) To other designees for the purpose of benefiting the client (para 6-10e).

*c. Without the written consent of the client, but subject to other applicable restrictions of this section, disclosure of information is authorized—*

(1) To medical personnel, to the extent necessary to meet a bona fide medical emergency to include family violence (spouse/child abuse) of a potentially life-threatening nature (para 6-10b(1)).

(2) To qualified personnel conducting scientific research, management or financial audits, or program evaluation (para 6-10f).

(3) To any person designated by a court to receive such information, upon issuance by that court of an order under the provisions of 21 USC 1175(b)(2)(C) or 42 USC 4582(b)(2)(C). (See para 6-10h.)

#### 6-10. Implementation. *a. General.*

(1) Responding to an inquiry that concerns an abuser or former abuser of alcohol or other drugs is a complicated and sensitive matter. Requests for information may originate from a variety of sources and take a variety of forms. They may be direct (e.g., from a parent) or through an intermediary (e.g., a member of Congress inquiring for a parent). They may be received by written correspondence, by telephone, or during face-to-face conversation. Further, alcohol or other drug involvement may not surface until after an investigation has been initiated to provide information upon which to base a reply. The guidance contained in this section is intended to assist commanders or other officials receiving requests for information in preparing replies and complying with the policy contained in paragraph 6-9.

(2) In all cases where disclosure is prohibited or is authorized only with the client's written consent, every effort should be made to avoid inadvertent disclosure. Even citing a referenced statute, the CFR, or this regulation as the authority for withholding information would identify the client as an abuser. Accordingly, replies to such inquiries should state that

disclosure of the information needed to fully respond to the inquiry is prohibited by regulations and statutes. As appropriate, the reply may suggest that the inquirer contact the client directly. Where disclosure is permitted with the client's written consent, an interim reply may state that an attempt will be made to obtain the client's written consent.

(3) The disclosure that an individual is not or has not been a client in the ADAPCP is fully as much subject to the prohibitions and conditions of the statutes, the CFR, and this regulation as a disclosure that such a person is or has been a client. Any improper or unauthorized request for disclosure of records or information subject to the provisions of this section must be met by a non-committal response.

*b. Disclosure to medical personnel or to treatment or rehabilitation programs.*

(1) Disclosure to medical personnel, either private or governmental, to the extent necessary to meet a bona fide medical emergency, is authorized without the consent of the client. This includes emergency situations such as family violence where there is spouse/child abuse of a potentially life threatening nature. If an oral disclosure is made under the authority of this paragraph, the ADCO will make a written memorandum for the record. This memorandum will be filed in the same manner as a written consent. (See para *i* below.) It will show the following:

- (a) The client's name.
- (b) The reason for the disclosure.
- (c) The date and time the disclosure was made.
- (d) The information disclosed.
- (e) The name of the individual to whom it was disclosed.

(2) In other than emergency situations the written consent of the client is required (*i* below). Such disclosure may be made to medical personnel or to nonmedical counseling and other treatment and rehabilitative services to enable such individuals or activities to furnish services to the client.

*c. Disclosure to a family member or to any*

*person with whom the client has a personal relationship.*

(1) Written consent of the client is required (*i* below).

(2) Written approval of a program physician or the clinical director that disclosure will not be harmful to the client is required. (See *i*(4) and (5) below).

(3) The only information that is releasable is an evaluation of the client's current or past status in the ADAPCP.

*d. Disclosure to the client's attorney.*

(1) Written consent of the client is required (*i* below).

(2) A bona fide attorney-client relationship must exist between an attorney and the ADAPCP client.

(3) The attorney must endorse the consent form.

(4) Subject to the limitations stated by the client in his or her written consent form, any information from the client's ADAPCP records may be disclosed.

(5) Information so disclosed may not be further disclosed by the attorney, even if the client waives the protection of the attorney-client relationship. The attorney's attention will be directed to section 2.35 chapter 1, 42 CFR.

*e. Disclosure to client's designee for the benefit of the client.*

(1) This paragraph provides guidance for handling the general class of inquiries from individuals who are not members of the Armed Forces and whose actions may be beneficial to the client.

(2) Disclosures under the provisions of this paragraph require the written consent of the client (*i* below).

(3) For the purpose of this section, the circumstances under which disclosure may be deemed for the benefit of a client include, but are not limited to, those in which the disclosure may assist the client in connection with any public or private—

(a) Claim.

(b) Right.

(c) Privilege.

(d) Gratuity.

(e) Grant.

(f) Or, other interest accruing to, or for the benefit of, the client or the client's immediate family.

(4) Examples of the foregoing include—

(a) Welfare.

(b) Medicare.

(c) Unemployment.

(d) Workmen's compensation.

(e) Accident or medical insurance.

(f) Public or private pension or other retirement benefits.

(g) Any claim or defense asserted or which is an issue in any civil, criminal, administrative, or other proceeding in which the client is party or is affected.

(5) The criteria for approval of disclosure are the following.

(a) The statutes and implementing regulation, chapter I, Title 42, CFR, provide specific criteria for disclosure in two of the circumstances under which such disclosure may be deemed for the benefit of the client. These criteria are contained in (5) and (6) below.

(b) In any other benefit situation (such as those listed in (3) above), disclosure is authorized with the written consent of the client only if the ADCO determines that all of the following criteria are met:

1. There is no suggestion in the written consent or the circumstances surrounding it, as known to the ADCO, that the consent was not given freely, voluntarily, and without coercion.

2. Granting the request for disclosure will not cause substantial harm to the relationship between the client and the ADAPCP. Nor will it cause harm to the ADAPCP's capacity to provide services in general. This determination is to be made with the advice of the clinical director.

3. Granting the request for disclosure will not be harmful to the client. This determination is to be made with the advice of either the program physician or the program clinical director.

(6) Disclosure to employers, employment services, or agencies.

(a) Written consent of the client is required (*i* below).

(b) Ordinarily, disclosures pursuant to this paragraph should be limited to a verification of the client's status in treatment or a general evaluation of progress in treatment. More specific information may be furnished where there is a bona fide need for such information. This would be information needed to evaluate hazards which the employment may pose to the client or others or where such information is otherwise directly relevant to the employment situation.

(c) Subject to the provisions of (a) and (b) above, disclosure is authorized if the ADCO determines that the following criteria are met:

1. There is reason to believe, on the basis of past experience or other credible information (which may in appropriate cases consist of a written statement by the employer), that such information will be used for the purpose of assisting in the rehabilitation of the client. Such information must not be disclosed for the purpose of identifying the individual as a client in order to deny him employment or advancement because of his history or drug or alcohol abuse.

2. The information sought appears to be reasonably necessary, in view of the type of employment involved.

(7) Disclosures in conjunction with Civilian Criminal Justice System Referrals (para 6-9b(4)(b)).

(a) Written consent of the client is required (*i* below).

(b) Disclosure may be made—

1. To a court granting probation, or other post-trial or pretrial conditional release.

2. To a parole board or other authority granting parole.

3. To probation or parole officers responsible for the client's supervision.

(c) The client may consent to unrestricted communication between the ADAPCP and the individuals or agencies listed in (b) above.

(d) Such consent shall expire 60 days after it is given or when there is a substantial change in the client's criminal justice system status, whichever is later. For the purposes of this paragraph, a substantial change occurs in the criminal justice system status of a client who, at the time such consent is given, has been sentenced, or when the sentence has been fully executed. Examples of substantial changes are the following:

1. Arrested, when such client is formally charged or unconditionally released from arrest.

2. Formally charged, when the charges have been dismissed with prejudice, or the trial of such client has been commenced.

3. Brought to a trial which has commenced, when such client has been acquitted or sentenced.

(e) A client's release from confinement, probation, or parole may be conditioned upon his or her participation in the ADAPCP. Such a client may not revoke his or her consent until there has been a formal and effective termination or revocation of such release from confinement, probation, or parole.

(f) Any information directly or indirectly received by an individual or agency may be used only in connection with their official duties concerning the particular client. Such recipients may not make such information available for general investigative purposes. Nor may such information be used in unrelated proceedings or made available for unrelated purposes. The recipient's attention will be directed to section 2.38, chapter 1, Title 42, CFR.

(8) Disclosures to the President of the United States or to members of the US Congress acting in response to an inquiry or complaint from the client.

(a) Written consent of the client is required (*i* below).

(b) Any information not otherwise prohibited from release by other regulations or directives may be disclosed. This is subject to the limitations stated by the client in his or her written consent form.

(c) This authority for disclosure from a client's record does not extend to situations where the President or a member of Congress is acting as an intermediary for a third party (such as the client's parents or spouse). However, most correspondence concerning Army personnel that is addressed to the President is forwarded to the Army for direct reply to the inquirer. Such correspondence addressed to the President may, therefore, be treated as inquiries directed initially to the Army.

(d) The limitation in (c) above should not be interpreted as a restriction on complete and accurate responses to inquiries on behalf of third parties concerning—

1. The nature and extent of the drug and alcohol problem in a unit, installation, or command.

2. A description of the ADAPCP, program facilities, techniques, or the like.

*f. Disclosure for research, audits, and evaluations.* Subject to (1) through (3) below, paragraph 6-8 of this regulation, AR 340-1, and AR 340-17, a disclosure to qualified personnel for the purpose of scientific research, management or financial audit, or program evaluation is authorized whether or not the client gives consent.

(1) The term qualified personnel means persons whose training and experience are appropriate to the nature and level of work in which they are engaged. These are persons who, when working as part of an organization, are performing such work with adequate administrative safeguards against unauthorized disclosures.

(2) The personnel to whom disclosure is made may not identify, directly or indirectly, any individual client in any report of such research, audit, or evaluation. They may not otherwise disclose client identities in any manner. Personnel to whom disclosure is made will be reminded that sections 2.52 through 2.56, chapter I, Title 42, CFR apply.

(3) In cases of scientific research, the restrictions contained in AR 340-1 apply.

*g. Disclosure in connection with an investigation.* Release of information to conduct an

investigation against a civilian client or to conduct an investigation outside the Armed Forces against a military client is prohibited; the only exception is by order of a court of competent jurisdiction (*h* below). An investigation conducted by governmental personnel in connection with a benefit to which the client may be entitled (e.g., a security investigation by an FBI agent in conjunction with the client's application for Government employment) is not considered to be an investigation against the client. Hence, with the written consent of the client, the required information may be disclosed under the provisions of *e* above.

*h. Disclosure upon court orders.* Under the provisions of 21 USC 1175(b)(2)(c), 42 USC 4582(b)(2)(c), and subpart E, chapter 1, Title 42, CFR, a court may grant relief from the duty of nondisclosure of records covered by 21 USC 1175 and 42 USC 4582 and direct appropriate disclosure.

(1) Such relief is applicable only to records as defined in the glossary. Such relief is not applicable to secondary records generated by disclosure of primary records to researchers, auditors, or evaluators in accordance with paragraph *f* above.

(2) Such relief is limited to only that objective data such as facts or dates or enrollment, discharge, attendance, and medication that are necessary to fulfill the purpose of the court order. And, in no event, may such relief extend to communications by a client to ADAPCP personnel.

(3) Such relief may be granted only after strict compliance with the procedures, and in accordance with the limitation, of subpart E, chapter 1, Title 42, CFR. This is whether the court order deals with an investigation of a client, an investigation of the ADAPCP, undercover agents, informants, or other matters.

*i. Written consent requirement.*

(1) Where disclosure of otherwise prohibited information is authorized with the consent of the client, such consent must be in writing and signed by the client, except as provided in (10) and (11) below.

(2) The client will be fully informed of the nature and source of the inquiry. And, he

or she will be informed that his or her voluntary written consent is required to release information upon which to base a reply.

(3) If the client consents to the release of all or part of the requested information, he or she will confirm that fact by signing the ADAPCP Client's Consent Statement for Release of Treatment Information (DA Form 5018-R) (see fig. 6-1). DA Form 5018-R will be reproduced locally on 8½" x 11" paper.

**(Fig. 6-1 (DA Form 5018-R) is on a fold-in page and is located at the end of the regular-size pages.)**

(4) As indicated in *c* above, the only information releasable to the client's family or to a person with whom the client has a personal relationship is information evaluating the client's present or past status in a treatment or rehabilitation program. Release of such an evaluation requires not only the consent of the client, but also the approval of the MEDCEN/MEDDAC commander. The commander must signify that in his or her judgment the disclosure of such information would not be harmful to the client. This approval authority may be delegated to the program physician or the program clinical director. The form of consent in such cases will include an additional statement by the MEDCEN/MEDDAC commander or his designated representative (program physician or clinical director only) as shown in figure 6-1.

(5) In the judgment of the MEDCEN/MEDDAC commander or the designated physician or clinical director, release of information may be considered to be harmful to the client although the client has already signed the consent form. In this event, the inquirer will be informed that statutes and regulations prohibit the release of certain personal information.

(6) The consent will be prepared in an original only—reproduction is not authorized. For a client actively participating in the program, it will be filed in the client's ADAPCP records. When these records are destroyed or when the client leaves an installation program for any reason, the form will be transferred to

the client's health records. For a service member or civilian no longer in the ADAPCP at the time written consent is given, the form will be filed in the individual's health records.

(7) The consent is not a continuing document. Its retention is to justify the specific disclosure described thereon and to maintain a record of that justification. Any future disclosure of information must be supported by a new consent form. Exception: Duration of consent for disclosures in conjunction with civilian criminal justice referrals is prescribed in *e(7)(d)* above.

(8) Where the client's unit commander provides information for a higher headquarters' reply to an inquiry, the forwarding correspondence will specifically verify that the consent—

(a) Has been signed by the client and, where applicable, signed by the appropriate MEDCEN/MEDDAC commander, program physician, or clinical director.

(b) Has been, or will be, filed in the client's ADAPCP records.

(9) If the client does not consent to the release of the request information or if the client limits the scope of releasable information to the extent that an adequate reply is impossible—

(a) He or she will be encouraged to correspond directly with the originator of the inquiry.

(b) He or she will be informed that the reply to the inquiry will state that if no consent is given statutes and regulations prohibit the release of personal information and will state that he or she has been requested to correspond directly with the inquirer. Of, if the client authorizes only the release of limited information, he or she will be informed that the reply will state this, and will state that he or she has been requested to correspond directly with the inquirer.

(c) Where the client's unit commander provides information for a higher headquarters' reply to an inquiry, forwarding correspondence will include a statement that—

1. The client refused to sign a form

of consent or authorized the release of only limited information.

2. The client has been encouraged to correspond directly with the inquirer.

(10) When disclosure is authorized with the consent of the client, such consent may be given by a guardian or other person authorized under State law to act in the client's behalf; this would only be in the case of a client who has been adjudged as lacking the capacity to manage his or her own affairs. Such consent may also be given by an executor, administrator, or other personal representative, in the case of a deceased client.

(11) When any individual suffering from a serious medical condition resulting from alcohol or other drug abuse is receiving treatment at a military medical facility, the treating physician may, at his discretion, give notification of such condition to a member of the individual's family. Or, notification may be given to any other person with whom the individual is known to have a responsible personal relationship. Such notification may not be made without such individual's consent at any time he or she is capable of rational communication.

*j. Inquiry made by telephone.*

(1) Without violating the requirements of this section or other policies on the release of personal information, every effort should be made to provide the requested information.

(2) If the caller specifically requests information on a client's abuse of alcohol or other drugs, the following actions will be taken: (Such actions will also be taken if the answer to a more general question, such as health and welfare, would require the divulgence of information prohibited under the provisions of this section.)

(a) Inform the caller that statutes and regulations prohibit the disclosure of such information.

(b) Request that the caller submit a written request stating the specific type of information desired. Included must be the purpose and need for such information.

*k. Inquiries made in face-to-face conversation.* The policy and implementing guidance of

this section make no exceptions for face-to-face inquiries. Commanders, supervisors, and staff officers should anticipate and be prepared to respond to such inquiries without compromising the client's personal privacy. The guidance on telephone inquiries (*j* above) should be utilized for the disclosure.

*l. Limitations on information.* Any disclosure made under this section, with or without the client's consent, shall be limited to information necessary in light of the need or purpose for the disclosure.

*m. Written statements.* All disclosures shall be accompanied by a written statement substantially as follows: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose." An oral disclosure, as well, should be accompanied or followed by such a notice.

*n. Regulations governing release of information.*

(1) To the extent that the contents of this section are in conflict with any other regulatory directives, the contents of this section will prevail.

(2) Disclosures authorized by this section are subject to further restrictions imposed by other regulatory directives pertaining to the release of information that are not in conflict with this section.

(3) This section does not prohibit release of information concerning the abuse of alcohol or other drugs from records other than those specified in paragraph 6-9. For example, a record of trial is not a record maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research. If, in the judgment of the commander, disclosure of information not otherwise prohibited by this section would assist in providing an appropriate reply to an inquiry, the information may be released.

**Section IV. RELEASE OF ADAPCP INFORMATION TO THE MEDIA**

**6-11. Scope.** This section provides guidance for the release to the news media of program information that does not identify any individual, directly or indirectly, as either an abuser or nonabuser of alcohol or other drugs. This includes information concerning a former abuser of alcohol or other drugs. (See sec II and III.)

**6-12. Objectives.** The objectives of this section are the following:

*a.* To provide the public with appropriate information about the Army's ADAPCP in accordance with AR 360-5.

*b.* To insure that all military personnel have accurate and complete knowledge of the program. (See AR 360-81.)

**6-13. Concept.** Release of information pertaining to DOD activities remains the responsibility of the Office of the Assistant Secretary of Defense (Public Affairs). The office of the Chief of Public Affairs (OCPA) HQDA, is responsible for coordinating, planning, and monitoring the execution of appropriate Army information activities.

**6-14. Implementation.** *a.* Guidelines for release of information are as follows:

(1) Unclassified factual information on the following may be provided to the news media in response to queries.

(*a*) The Army's alcohol or other drug problems.

(*b*) The Army's prevention and control program as described in this regulation.

(2) Tours of facilities and discussions with ADAPCP staff personnel must have the prior approval of the installation command and, if appropriate, the MEDCEN/MEDDAC commander. Such tours or discussions will not be conducted at a time or location that could result in the identification of a client as an alcohol or other drug abuser.

(3) Information on quantitative results of the urine testing program will not be given unless or until it has been released by ODSPER, HQDA. Overall ADAPCP statistics will be cleared with the HQDA Alcohol and Drug Policy Office prior to release in any form.

*b.* MACOMs will insure that command information materials receive wide distribution and will respond to queries as provided in (*a*)(1) above.

**6-15. Administration.** *a.* Public Affairs Officers may communicate directly with Public Affairs Office (PAO), HQDA.

*b.* Requests for authority to release additional information will be directed to OCPA, HQDA (SAPA-PI).

## CHAPTER 7

### MANAGEMENT INFORMATION SYSTEM

#### Section I. RECORDS AND REPORTS

**7-1. General.** A system of reports will be used to provide essential management information on the ADAPCP at each level of command. The data generated by the reports will provide—

*a.* A measure of the magnitude of alcohol and other drug abuse.

*b.* A measure of the progress made in the ADAPCP preventive education effort.

*c.* A measure of the progress made in the rehabilitative and medical treatment aspects of the ADAPCP.

*d.* Statistical trends to support requisite policy and procedural changes.

*e.* Information to support and justify funding and manpower requirements for the ADAPCP.

*f.* Statistical information required to reply to public, media, Congressional, or other Government agency inquiries.

**7-2. Client categories.** A thorough understanding of client categories is critical to the efficient administrative and clinical processing of individuals participating in the ADAPCP. For administrative reporting requirements, ADAPCP clients and potential clients will be placed in the following three categories:

*a.* Army service member—Active duty or active duty for training Army personnel.

*b.* Civilian employee—US citizen civilian employees of the Army. This includes the DA civilian employees and NAF civilian employees.

*c.* Other clients—This includes retired military, dependents of active duty and retired military, members of other military services, DOD civilian employees who are not DA or NAF civilian employees, dependents of US citizen civilian employees, and where care is authorized them, certain foreign nationals. USAR and

ARNG personnel, whom on active duty for training for less than 30 days and participating in the ADAPCP, will be reported as “other clients”.

**7-3. Alcohol and Drug Abuse Prevention and Control Program Summary (RCS CSGPA 1291-R3)(DA Form 3711-R).** *a.* DA Form 3711-R (ADAPCP Summary) provides management information on many aspects of the local program. These include compliance with policy, effectiveness of procedures, workload, and adequacy of resources. The summary also provides most of the data required of HQDA by the Office of the Secretary of Defense and other federal agencies. DA Form 3711-R will be reproduced locally (head to foot) on 8½ by 11-inch paper. See appendix G.

(DA Form 3711-R is on four fold-in pages located at the end of the regular-size pages.)

*b.* Responsibilities for preparation, transmission, and review of the ADAPCP Summary are as follows:

(1) The DCSPER will—

(*a.*) Use data provided in the ADAPCP Summary for overall program management.

(*b.*) Periodically disseminate data based on consolidated reports to major Army commands.

(2) TSG will—

(*a.*) Review incoming reports for completeness and statistical accuracy.

(*b.*) Provide consolidated ADAPCP Summary reports to ODCSPER, HQDA (DAPE-HRA), WASH DC 20310, for evaluation.

(*c.*) Prepare and forward to ODCSPER,

HQDA (DAPE-HRA) appropriate reports required by the Office of the Secretary of Defense.

(3) MACOM commanders will monitor the submission of ADAPCP Summaries by subordinate elements and prepare consolidated reports for overseas areas indicated in appendix G.

(4) MEDCEN/MEDDAC commanders will provide the ADCO with information required to complete appropriate parts of the report.

(5) Installation and overseas area ADCO will—

(a) Prepare the ADAPCP Summary (DA Form 3711-R) each month for those installations and overseas areas listed in appendix G.

(b) Submit ADAPCP Summary by letter (para 7-4) through command channels to the MACOM commander concerned.

**7-4. Procedures for completing ADAPCP Summary.** *a.* The ADAPCP Summary, DA Form 3711-R, will be submitted by letter through command channels to the MACOM commander concerned. To assist in meeting deadlines imposed on HQDA, a copy of both the summary and the letter from each CONUS installation and overseas area will be mailed directly to Commander, US Army Patient Administration Systems and Biostatistics Activity (PASBA), ATTN: HSHI-QPD, Fort Sam Houston, TX 78234, for statistical review and processing. Direct communication is authorized between Commander, PASBA and ADCOs of CONUS installations and overseas areas. If, in this direct communication, a corrected summary is required, copies of the revised summary will be submitted directly to PASBA and through command channels to the MACOM commander concerned.

*b.* A letter of transmittal signed by the appropriate commander will accompany the sum-

mary. The letter should include any information necessary to interpret data appearing in the program summary. Commanders providing support to off-installation military and civilian activities will list these activities. They will indicate the hours provided and the resources utilized. If no medical treatment facility is located on the installation, the letter will indicate the name of the facility that provides medical evaluation, detoxification, and related medical care.

*c.* The report period will begin on the 26th day of one month and will end on the 25th day of the next. Completed summaries will be dispatched as follows:

(1) CONUS installations will submit summaries to arrive at PASBA (HSHI-QPD) not later than 12 calendar days after the end of the report period.

(2) Overseas areas will submit a consolidated summary to arrive at PASBA (HSHI-QPD) not later than 17 calendar days after the end of the report period.

*d.* Parts of the summary require separate accounting for individuals with "alcohol" problems and for those involved with "other drugs." Individuals abusing both alcohol and other drugs (polydrug abuse) will be accounted for under either the first listed diagnosis of abuse or the specific type of abuse an ADAPCP counselor has determined as the basis for enrollment. This is entered on the DA Form 4465. Throughout the summary, negative entries will be indicated by leaving spaces blank (zeros will not be entered). The summary will be completed in accordance with the instructions in appendix G and authenticated by the ADCO.

*e.* Data concerning individuals from other military services participating in the ADAPCP will be reported as part of the data compiled for other clients in the report.

## Section II. CLIENT ORIENTED DRUG ABUSE REPORTING SYSTEM (CODARS)

**7-5. ADAPCP Military Client Referral and Screening Record.** The ADAPCP Military Client Referral and Screening Record, DA Form 2496, (fig. B-1) will be completed in triplicate by the commander. This will be done for all

Army service members referred to the ADAPCP for an initial screening interview. The completed record will be maintained in the ADAPCP client case file.

**7-6. Civilian Employee Consent Statement (DA**

**Form 5017-R).** The Civilian Employee Consent Statement (fig. B-2) will be completed for each civilian employee upon enrollment in the ADAPCP for rehabilitation. The completed consent statement will be maintained in the ADAPCP client case file.

**7-7. ADAPCP Client Intake Record (CIR) (RCS CSGPA-1400-1R)(DA Form 4465).** *a.* The CIR (fig. B-3) will be completed for each client who is to receive a medical evaluation or who is enrolled in *any* track of the ADAPCP. The ADAPCP staff will prepare the CIR prior to medical evaluation or upon enrollment. The ADAPCP staff will insure proper internal distribution of the form when medical evaluation or enrollment in the ADAPCP is completed.

*b.* The CIR will be completed in triplicate for all Army service members and in duplicate for civilian employees and other clients. Upon completion of the CIR for enrollment, the ADCO will authenticate the form. The ADAPCP staff will insure proper distribution.

*c.* Distribution of completed CIRs.

(1) The original CIR for all clients enrolled in the ADAPCP will be forwarded to the Commander, PASBA, ATTN: HSHI-QPD, Fort Sam Houston, Texas 78234. Any record or report forwarded to PASBA (HSHI-QPD) with incomplete or incorrect data will be returned to the ADCO for completion or correction. Under no circumstances will the original contain the client's name or duty unit/office.

(2) The original CIR plus all copies and the DA Form 2496 for Army service members who are medically evaluated and not enrolled will be placed in the inactive section of the ADAPCP client files. The CIRs for civilian employees and other clients medically evaluated and not enrolled will be placed in this same inactive file.

(3) A copy of the CIR will be placed in each enrolled individual's ADAPCP client case file.

(4) A copy of the CIR will be filed in the Army service member's health record that is maintained by the MTF which provides the primary health care. (See AR 40-66.)

(5) Any additional copies not necessary

for the above described distribution will be destroyed.

(6) Additional reproduction and distribution of completed CIRs is prohibited.

(7) ADAPCP services will be available for all former ADAPCP clients. Re-enrollment in the ADAPCP requires the submission of a new CIR and will be treated as a new case for administrative reporting.

**7-8. ADAPCP Client Progress Report (CPR) (RCS CSGPA-1400-R1) (DA Form 4466).** *a.* The CPR (fig. B-4) will be used for all clients enrolled in the ADAPCP with a CIR. For clients enrolled in Track I, a CPR will be completed at the end of Track I. For Track II and III clients, CPRs will be completed at the termination of rehabilitation or at 90, 180, 270, or 360 day anniversary dates of enrollment in the ADAPCP. Any client moving from Track I to another track or from Track II to Track III must have a CPR completed at the time of transfer indicating the new track. Clients will not be transferred from Track III to Track II or I. Clients will not be transferred from Track II to Track I. Transfers between tracks will be explained in the remarks section of the CPR. CPRs of clients administratively released from the program should be clearly marked as released from the program or as 4th CPR and program completed. No reporting is required beyond 360 days unless the client is re-enrolled by submission of a new CIR. If re-enrolled, CPRs are required at times and intervals previously described. A CPR is also required for all Active Army service members who are either a PCS loss or gain to an installation or activity (para 7-9).

*b.* The CPR for Army service members will be prepared by the ADAPCP counselor in consultation with the unit commander. The unit commander will provide an evaluation of duty performance and conduct as a part of each CPR. On the termination CPR, the unit commander will authenticate the individual's status and progress in rehabilitation. The ADAPCP counselor may request information pertinent to the client from other ADAPCP staff members, military law enforcement officials, medical personnel, and other military or civilian personnel

within DOD as required. Inquiries to non-DOD personnel or agencies are not authorized without the service member's consent. The ADA-PCP counselor will obtain all information for completion of the CPR from the service member's unit commander. The use of written reports or telephone contacts is discouraged when it is possible to obtain the information through personal contact with the commander. Termination CPRs will be signed personally by the service member's unit commander.

c. The CPR for civilian employees in the program will be prepared jointly by the employee's ADAPCP counselor and the CPC. The CPC will provide an opinion of the employee's progress as of the report date. The CPC's input will be based upon input from the civilian employee's supervisor *provided the civilian employee gives consent for contact with the supervisor and the statement has been signed or consent has not been withdrawn*. ADAPCP personnel are not authorized to request information directly from the civilian employee's supervisor, *except* through the CPC who may, if appropriate, arrange ADAPCP consultation with the supervisor named on the client consent form.

d. The CPR for other personnel participating in the program will be prepared jointly by the individual's ADAPCP counselor and the clinical director. Input for the CPR, in these cases, will be limited to information gathered during the clinical treatment of the individual.

e. Distribution of the completed CPR is identical to that for CIRs (para 7-7c). Exceptions are Army service members who are either a PCS loss or gain to an installation ADAPCP. For PCS loss or gain CPRs see paragraph 7-9 of this regulation. Under no circumstances will the original CPR contain the client's name or duty unit/office.

f. Additional reproduction and distribution of completed CPRs is prohibited.

**7-9. Reassignment while enrolled in the ADA-PCP (PCS loss or gain).** a. A commander may suspend PCS movement for up to 30 days to enable an Army service member to obtain necessary rehabilitation services. The ADCO will monitor Army service members departing the

rehabilitation program until they are officially enrolled in the ADAPCP at the gain installation. Normally, individual Army service members receiving Track III residential treatment will not be transferred prior to completion of the residential treatment phase of the program.

b. Upon the Army service member's departure for the new assignment, the ADAPCP counselor will prepare DA Form 4466. This will serve as a PCS loss report. It will be prepared for all Army service members who require further rehabilitation.

c. Distribution of the completed PCS loss report will be made as follows:

(1) The original PCS loss report will be forwarded to PASBA (HSHI-QPD) per paragraph 7-12. Under no circumstances will the original contain the Army service member's name or duty unit/office.

(2) A copy of the PCS loss report will be placed in the Army service member's health record.

(3) A second copy of the PCS loss report will be forwarded by first class mail to the gaining installation ADCO. Included will be information outlined in figure B-6 (Request for Confirmation of Reassignment and Enrollment of ADAPCP Client). For mailing addresses see table B-3.

d. Upon receipt of the PCS loss report and the client information, the gaining installation ADCO will contact the local in-processing facility or the commander of the Army service member's new unit. This is to insure continuation in the ADAPCP at the new installation.

e. When service members are received by the gaining ADAPCP, the gaining ADCO will prepare a PCS gain report using DA Form 4466. Distribution will be as follows:

(1) The original PCS gain record will be forwarded to PASBA, (HSHI-QPD) per paragraph 7-12.

(2) A copy will be placed in the individual Army service member's health record.

(3) Another copy will be forwarded by first class mail to the losing installation ADCO. Included will be a request for the Army service member's complete ADAPCP client case file (fig. B-9).

f. Upon receipt of the request, the losing ADCO will forward the service member's complete ADAPCP client case file to the gaining ADCO.

g. When the losing installation ADCO cannot determine the specific overseas ADAPCP in which a PCS client will be enrolled, the following procedures will apply:

(1) For personnel whose overseas assignment instructions include only a duty unit mail address, the losing ADCO will forward only the required information in figure B-7 to the Army service member's new commander.

(2) For service members whose overseas assignment instructions fail to list a specific duty unit and indicates assignment to a replacement activity, the losing installation ADCO will forward information to the replacement activity commander specified in the individual's orders (fig. B-8).

h. No information that would identify the Army service member as an ADAPCP client will appear on the mailing envelope. The return address will not indicate ADAPCP or CCC. Correspondence to the commander of the replacement activity will include a request that the information pertaining to the Army service member be immediately forwarded to the commander of the Army service member's new unit of assignment.

i. Normally, client information on participation in the ADAPCP is forwarded from ADCO to ADCO. In no instance will the client's case file be forwarded to anyone other than the gaining ADAPCP.

j. Upon receipt of the information forwarded by the losing ADCO, the commander's enrollment of the Army service member in the ADAPCP will be automatic, if rehabilitation has not been completed. The new commander will then be advised of the client's rehabilitation plan.

**7-10. Procedures for special situations.** a. TDY Army service members who are absent from their permanent duty station for 31 days or more will be processed according to the PCS transfer procedures.

b. Clients admitted to an installation MTF or to a local (short-term) military or civilian confinement facility will be continued in the

local program. ADAPCP counselors will go to the client's location. CPRs will be submitted as usual.

c. Clients admitted to an RTF will be continued in the local ADAPCP for reporting purposes. CPRs will be submitted as usual.

d. For Army service members transferred from the local ADAPCP to a correctional facility, the PCS transfer procedure applies. Exceptions are for individuals who are being separated/discharged from the Army and require a program termination CPR to PASBA (HSHI-QPD).

e. Former (Army service members) clients returned to military control from deserter status will be treated as new clients. Item 18, CIR, will be checked "Army". Such clients will be required to restart and complete the rehabilitation program.

f. Submission of termination CPR to PASBA (HSHI-QPD) by overseas ADCO is required for clients returned to CONUS for separation.

**7-11. Deletion of erroneously identified clients from the ADAPCP.** If a client's entry into the ADAPCP is discovered to have been in error, the ADCO will cease submission of CPRs. The ADCO will terminate the case by forwarding a written request to PASBA (HSHI-QPD) to delete the record from the data files. Requests will contain only the client ID code, initial MTF code and the reason for termination. Deletion request will be signed by the requesting ADCO. It will be forwarded with the monthly transmittal of records.

**7-12. ADAPCP record transmission.** a. The ADCO is responsible for the scheduled transmission of authenticated CIRs (DA Form 4465) and CPRs (DA Form 4466) to the PASBA. The original CIRs and CPRs will be compiled and forwarded monthly. They will cover the period from the 26th day of one month until the 25th day of the next month. Each package will contain a letter of transmittal. (See fig. B-5 for a sample letter of transmittal.)

b. CONUS installation ADCOs will submit reports to arrive at PASBA (HSHI-QPD) not later than 12 calendar days after the end of the report period.

c. Oversea ADCOs will submit reports to arrive at PASBA (HSHI-QPD) not later than 17 calendar days after the end of the report period.

*Note.* The required report period for CIRs and CPRs is the same as for the monthly ADAPCP Summary. Data submitted on the monthly ADAPCP Summary for program gains and losses, change of tracks, case finding method, etc., will be substantiated by concurrent submission of CIRs and CPRs.

**7-13. Management information feedback reports.** a. Direct communication between Commander, PASBA and ADCOs is authorized. A file of aggregate ADAPCP data will be maintained as a source of information essential for program management, evaluation, and research. This data will be based on the monthly submission of CIR, CPR, PCS loss or gain records, and the monthly ADAPCP Summary.

b. In addition to receiving quarterly management reports, each ADCO will receive periodic feedback reports directly from PASBA. This is for the purpose of maintaining an accurate data base. Included will be an indication of the number of clients contained on the data base. The reports will show current reporting status, including overdue progress reports and incomplete PCS loss and gain transactions.

**7-14. Other management information reports.** Other reports, particularly those required for budget or resource actions, may be required from time to time. Requests for all reports and surveys will be coordinated with MACOMs and submitted through the MACOMs with 30-45 days advance notice wherever possible.

### Section III. INTERNAL ADMINISTRATION

**7-15. General.** Unless otherwise specified, the term "client" used in terms of procedures, refers to Army service members, civilian employees and other participants enrolled in the ADAPCP.

**7-16. Responsibilities.** a. The ADCO will—

(1) Insure that an ADAPCP referral and screening record is received for all Army service members who are referred to the ADAPCP by their commander, or who self refer.

(2) Insure that the Civilian Employee Consent Statement (DA Form 5017-R) (fig. B-2) is signed by the employee *before* information is released to the named supervisor through the CPC.

(3) Insure that a CIR is prepared for each client that receives a medical evaluation or is enrolled in any track of the ADAPCP.

(4) Insure that a CPR is prepared when required for all clients enrolled in any track of the ADAPCP.

(5) Authenticate and insure proper distribution of individual CIRs and CPRs for all clients participating in the ADAPCP.

(6) Notify the gaining installation ADCO of a service member's projected PCS.

(7) Forward individual service member

case files to the gaining installation ADCO, and insure that they have been received.

(8) Have administrative responsibility for maintaining ADAPCP client case files. This includes proper recording, security, confidentiality, and destruction per this regulation and AR 340-18-9, AR 40-66 and professional and ethical standards.

(9) Insure that the ADAPCP staff urinalyses are carried out according to current DOD requirements. Insure that all civilians employed in the ADAPCP are aware of this requirement and have a signed condition of employment statement on file in their ADAPCP personnel file as well as with the CPO.

(10) Insure that a formalized ADAPCP log is maintained by the ADAPCP staff. This log will contain a record of all clients referred by others or referred by themselves (walk-in) for any services. The information solicited from the potential client to enter in the log is covered by the Privacy Act. A Privacy Act statement for the ADAPCP log is shown in figure B-10. The reason for soliciting information will be explained to each potential client. Each potential client will be given the opportunity to read the provisions of the Privacy Act statement in figure B-10. The ADAPCP

log is for the purpose of documenting workload accurately. It will be an internal record of the number of contacts and man hours expended in the initial screening process. The ADAPCP log will be treated as though it were a client case file and therefore will be maintained in a secure area when not in use. The ADAPCP client log will record by date and source of referral only the following information on clients or potential clients:

(a) For Army service members referred or self-referred list the following:

1. Name.
2. Rank.
3. Social security number (SSN).
4. Service provided, i.e., screening.
5. Disposition of the referral, i.e., enrollment, unit counseling, USP, no ADAPCP services required or other disposition.

(b) For Army and NAF civilian employees referred or self-referred (listed separately from Army service members) list the following:

1. Name.
2. Date of birth and first three numbers of SSN.
3. Reason for referral (e.g., alcohol problems, family problems, children's drug use).
4. Service provided, i.e., screening or information services.
5. Disposition of the referral, i.e., enrollment for counseling (specify whether for alcohol abuse, drug abuse or other emotional disorder associated with alcohol or other drug abuse), no ADAPCP services required, or referral to another agency.

(c) For other clients (listed separately from Army service members and Army and NAF civilian employees) list the following:

1. Name.
2. Date of birth.
3. Reason for referral, i.e., alcohol problems in the family, children's drug use, etc.
4. Service provided, i.e., screening, information or intervention.
5. Disposition of the referral, i.e., enrollment, no ADAPCP services required, or referral to another agency.

b. The Clinical Director will—

(1) Review all CPRs for clinical and administrative accuracy before submission to the ADCO.

(2) Provide technical guidance and training to subordinate counselors for recording individual and group counseling sessions in client case files.

(3) Insure that personal client information entered in case records is appropriate and necessary.

c. The MEDCEN/MEDDAC commander will—

(1) Insure that the health records of newly assigned service members are screened for possible evidence of untreated alcohol or other drug abuse (or a diagnosis thereof) within the previous 360 days.

(2) Insure that ADAPCP client case files are maintained and disposed of as medical records per AR 340-18-9.

(3) Be responsible for the release of information from ADAPCP client case files.

(4) Insure that periodic assistance and coordination is provided to the ADAPCP staff through the local MEDCEN/MEDDAC Patient Administration Division (PAD).

**7-17. ADAPCP client case files.** ADAPCP client case files are medical records and will consist of official ADAPCP forms and case notes recorded on Standard Form 600 (Chronological Record of Medical Care). *For legal reasons, no other official forms will be created without MACOM and DA approval.* Any exceptions to policy will be approved by the ODCSPER (HQDA (DAPE-HRA) WASH, DC 20310). Clinical correspondence and reports from outside agencies will be maintained in client case files. Every document contained in an ADAPCP client case file will comply with the requirements of the Privacy Act of 1974.

**7-18. ADAPCP client case filing procedures.** ADAPCP client case files will be maintained in two sections—

a. Active client case files. This section will include clients being seen on a regular scheduled basis. Clients in residential facilities will be

included in this active case file during residential treatment and until the end of all counseling activities.

b. Inactive client case files. Inactive clients and clients pending transfer of record (PCS) will be maintained in this section. Inactive clients include former enrollees or those who were screened and returned to units with no further action indicated. Former participants of Tracks I, II, or III are filed in this section when not receiving followup, supportive counseling services.

c. Access to individual ADAPCP client files will be restricted to the following:

(1) ADCO.

(2) Rehabilitation staff members.

(3) AMEDD personnel concerned with treatment of individual client cases and evaluators who will be charged with determining the extent of compliance with this regulation. Specifically, these are DA and MACOM AMEDD personnel, detailed Inspectors General, and

appropriate AMEDD personnel participating as members of official inspection teams.

d. MEDCEN/MEDDAC commanders may authorize research personnel, on a project-by-project basis, to extract information from client case files. This is allowed only if there is compliance with restrictions imposed by AR 40-66 and this regulation.

**7-19. Federal Employees Occupational Health, Alcoholism and Drug Abuse Programs Annual Report (NARS 0058-OPM-AN).** CPCs will prepare the OPM Alcoholism and Drug Abuse Annual Report. Installation reports will be submitted by letter through command channels to the MACOM normally during the month of December following the close of the fiscal year. MACOMs will submit a consolidated report, together with the individual installation or activity reports, to HQDA (DAPE-HRA), WASH DC 20310. Suspense dates and guidance for submission of the report will be announced each year by the ODCSPER, HQDA.

## CHAPTER 8 EVALUATION

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**8-1. General.** Operation of the ADAPCP must include a comprehensive program of evaluation. The following guidelines address minimum evaluation standards. Evaluation will—

- a.* Stress the impact of the program on the recipients.
- b.* Be primarily objective rather than subjective.
- c.* Attempt to compare the relative effectiveness of the various approaches to prevention and rehabilitation.
- d.* Consider guidance contained in FPM Supplement 792-2, appendix B, concerning civilian aspects of the ADAPCP.
- e.* Ascertain the relative effectiveness of various approaches with different target groups.

**8-2. Objectives.** Program evaluation will—

- a.* Insure integration of all facets of the ADAPCP at every level of command.
- b.* Permit priority setting among program efforts and alternatives.
- c.* Provide feedback as a basis for program improvement and allocation of scarce dollar and staff resources for economy and efficiency.
- d.* Identify areas for possible research by HQDA.

**8-3. Concept.** *a.* Evaluation is an integral part of program planning, decision-making, and management. It is intended to help administrators and managers at all levels of the Army make informed decisions by communicating to them what program alternatives are available to them and which alternatives are most applicable for their particular circumstances. Evaluation will—

- (1) Determine if program objectives are being met and provide the flexibility for change as goals are met.

- (2) Determine program effectiveness and efficiency, including client perceptions.

- (3) Obtain data for development of policies and procedures and resource requests or allocations.

- (4) Determine problem areas and needs for technical assistance at specific installations or commands.

- (5) Determine compliance with pertinent directives.

- (6) Determine what effect the program has or what difference it makes.

*b.* Evaluation cannot be based solely on the compilation of statistical data. Records and reports are only one facet in the index of program progress. To be effective, evaluation must be joined with planning and programming. Program indicators are prevalent at all command levels for both subjective and analytical information.

**8-4. Responsibilities.** *a.* The ODCSPER, HQDA (DAPE-HRA) will maintain a continuous objective evaluation based on reports submitted. Staff assistance visits will be made by USADATA when on-site evaluation of installation ADAPCPs are desired by ODCSPER, HQDA. Staff assistance visits by USADATA will be coordinated through the MACOM alcohol and drug control office.

*b.* Each MACOM commander will maintain a continuous assessment of the ADAPCP through reports, staff visits, and drug and alcohol assistance teams. DA Form 3711-R (ADAPCP Summary) and Inspector General reports should be used to assist in programming and structuring staff and team visits. Additionally, development of a Program Evaluation Worksheet is recommended for use as the basis for continuing local program evaluation. Accurate and current information

should allow ADAPCP personnel to correct program deficiencies and to improve overall program effectiveness. If automated data processing is used in program evaluation, methods must be formulated to preclude identification of individuals and to preserve confidentiality.

8-5. **USADATA.** *a.* Representatives of USADATA will visit installations and activities upon the request of the commander. This will be done with a view to providing technical support and assistance as determined by the installation commander. (See AR 10-78.)

*b.* USADATA visits will normally be made after the annual MACOM assistance team's visit and will be coordinated with the MACOM alcohol and drug control office.

8-6. **MACOM assistance teams.** *a. General.* Each MACOM commander will establish an assistance team to visit selected subordinate installations and activities on a regular basis. The team will—

- (1) Determine if program objectives are being met.
- (2) Explain program policy.
- (3) Respond to queries.
- (4) Collect and disseminate information.
- (5) Make recommendations on local program operation and organization.

*b. Procedures.*

- (1) Assistance teams will visit each sub-

ordinate installation or activity within the MACOM area of responsibility a minimum of once each fiscal year. Additional visits may be scheduled as required.

(2) Representatives of HSC will participate in assistance team visits to installations having an HSC MEDCEN/MEDDAC, insofar as possible, and will observe program activities listed in (3) (d) below.

(3) Assistance team visits to installations will include, as a minimum, observations of the following:

(a) *Total program effectiveness.* This includes command support to all levels, administration, organization, management, personnel, and funding.

(b) *Prevention.* This includes law enforcement activities, community action, and preventive education and training efforts.

(c) *Identification and referral procedures.*

(d) *Rehabilitation.* This includes medical support, reports, and records (including intake and followup records).

(e) All aspects of service for civilian employees.

(4) Following visits, written reports of significant findings and observations, including recommendations for local program improvement, will be provided to subordinate elements directly or through command channels, depending on local policy.

## CHAPTER 9

### ARMY NATIONAL GUARD AND ARMY RESERVE

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**9-1. General.** This chapter prescribes procedures for the implementation and management of the ADAPCP for the ARNG and the USAR.

**9-2. Applicability.** *a.* The provisions of this chapter are applicable to members of the ARNG and USAR when not on active duty or active duty for training. Chapter 5 of this regulation applies to those personnel that are members of the ARNG and USAR who are also DA civilian employees.

*b.* The other chapters of this regulation will be applicable to ARNG and USAR members when on active duty or active duty for training, other than annual training.

**9-3. Background and policy.** *a.* Alcohol and other drug abuse has been documented as a serious problem in the active services and in civilian society in general. It is reasonable to conclude that such problems have an impact on members of the ARNG and USAR.

*b.* The focus of this program centers on the impact that alcohol and other drug abuse may have on the performance of Reserve Component (RC) members. Alcohol and other drug abuse may affect the performance of an individual member, but the actual use or abuse of the substance may never be witnessed by the commander. This is especially true in the normal RC setting of infrequent personal contact, limited principally to periods of inactive duty training.

*c.* It is important that commanders be alert to *potential* failure in performance due to alcohol and other drug abuse and that they take timely and appropriate action when problems are identified. The emphasis of the program is that alcohol and other drug abuse are treatable and preventable. Successful rehabilitation is encouraged and supported. However, if rehabil-

itation fails, separation action may be taken, if appropriate. (See AR 135-178).

*d.* The detrimental effect that alcohol and other drug abuse can have on individual performance and on unit readiness is strong reason for an effective ADAPCP in the ARNG and USAR. This is especially so in light of increased mobilization demands placed on the RC by the Total Force Policy.

**9-4. Responsibilities.** To assure unit readiness for mobilization, in accordance with the Total Force Policy, the Chief, National Guard Bureau (CNGB), is responsible for development and implementation of an effective ADAPCP in the ARNG. The CG, US Army Forces Command (FORSCOM), is responsible for development and implementation of an effective ADAPCP in the USAR.

**9-5. Implementation.** The basics of the RC ADAPCP will include prevention, identification, referral, and followup.

*a. Resources.*

(1) *ARNG.* Each State Adjutant General will appoint a State ADAPCP coordinator, on a collateral duty basis, to coordinate the program for the state.

(2) *USAR.* Each Army commander will appoint a ADAPCP coordinator, on an additional duty basis, to coordinate the program for the command. ADAPCP coordinators should be mature, stable personnel. They should have had previous education or experience in the areas of alcohol and other drug abuse prevention, control, rehabilitation counseling, or related fields.

*b. Prevention.*

(1) Commanders, staff members, and other members of the chain of command must be aware of the contributory factors which lead

to alcohol and other drug abuse. This awareness must be developed through preventive education and improved communication.

(2) The primary means of disseminating education information on the ADAPCP will be through the Command Information Program. The National Guard Bureau (NGB) and Office of the Chief, Army Reserve (OCAR, will provide command information material to support the ADAPCP. This will include learning objectives and instructional guidance, and information regarding training resources. In addition, maximum use will be made of support materials available through Active Army channels. All information and materials utilized will have the approval of the DOD Media Committee.

(3) The RC ADAPCP coordinators will be provided training to administer the program through special RC ADAPCP training courses. These will be developed jointly by ODCSPER (DAPE-HRA), NGB, and OCAR.

*c. Identification.* The key to identification of alcohol and other drug abusers will be their duty performance.

(1) *Voluntary identification.* Commanders should strive to maintain an atmosphere which encourages alcohol or other drug abusers to identify themselves and ask for assistance.

(2) *Involuntary identification.* Commanders should be alert to the following:

- (a) Deteriorating duty performance.
- (b) Errors in judgment.
- (c) Periods of being unfit for duty.
- (d) Increasing incidence of disciplinary, health and personal problems.

(3) *Assistance.* When it is believed that the above circumstances are caused by alcohol or other drug abuse, commanders should seek assistance from the ADAPCP coordinator. They should advise the individual to seek help from an appropriate community program for professional assistance.

*d. Referral.*

(1) The RC ADAPCP coordinator will develop a list of local resources available in the civilian community from which RC members may voluntarily seek professional assistance. ADAPCP coordinators should take advantage of existing Government contacts in developing

referral lists. This may include Active Army or other Service installations with ADAPCP resources, Air National Guard (ANG), Drug and Alcohol Social Actions offices of ANG flying units, and alcohol and drug offices (agencies) in State and local government. Information or availability of local resources may also be obtained by writing the National Institute for Alcoholism and Alcohol Abuse (NIAAA), and the National Institute for Drug Abuse (NIDA), both located in Rockville, Maryland 20857.

(2) Emphasis in the referral program will be on positive encouragement of the individual to change and positively influence his job performance. Performance will be the major criteria for judging improvement or success in this program.

*e. Followup.*

(1) In cases where individuals are successfully rehabilitated and duty performance is improved to a satisfactory level, the individual should continue normal duty in the unit. He or she should be provided appropriate encouragement, assistance, and support.

(2) In cases where successful performance is not achieved after attempts at local rehabilitation or in cases where an individual refuses rehabilitation assistance, elimination action under appropriate USAR or ARNG regulations shall be considered.

*f. Annual training.* ARNG and USAR personnel on AT status may seek assistance from the ADAPCP at the training installation. The local ADAPCP will provide whatever resources are available to assist RC personnel on AT status within the scheduled AT period. The ADAPCP will coordinate with the appropriate RC commanders to facilitate necessary referral or followup action that takes place after the AT period.

*g. Full-time military tours.* ARNG personnel on full-time military tours (Title 32 USC or Title 10 USC) and USAR personnel on full-time military tours (Title 10 USC) are eligible for assistance from local ADAPCP resources on a full-time basis.

*h. Applicants for RC membership.* Chronic

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alcoholism, alcohol dependency, and other drug dependency are causes for enlistment rejections, in accordance with AR 40-501 and NGR

40-501. Such cause for rejection will not apply to individuals with demonstrated, successful recovery.

## APPENDIX A REFERENCES

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### Section I. REQUIRED PUBLICATIONS

1. DOD Instruction 1010.1 (DOD Drug Abuse Testing Program). Cited in paragraphs 1-4*b* and D-2.
2. DA Pam 570-4 (Manpower Procedures Pamphlet). Cited in paragraphs 1-19 and 1-21*b*.
3. DA Pam 570-551 (Staffing Guide for US Army Garrisons). Cited in paragraphs 1-19 and 1-21*b*.
4. DA Pam 570-553 (Staffing Guide for Headquarters Continental US Armies). Cited in paragraph 1-19.
5. DA Pam 570-557 (Staffing Guide for US Army, Medical Department Activities). Cited in paragraph 1-19.
6. DA Pam 570-566 (Staffing Guide for US Army Depots). Cited in paragraph 1-19.
7. AR 1-35 (Basic Policies and Principles for Interservice, Interdepartmental and Interagency Support). Cited in paragraph 1-2*e*.
8. AR 40-2 (Army Medical Treatment Facilities General Administration). Cited in paragraph 2-1*b*.
9. AR 40-3 (Medical, Dental, and Veterinary Care). Cited in paragraphs 4-6*d* and 4-16.
10. AR 40-61 (Medical Logistics Policies and Procedures). Cite in paragraph 2-15*a*.
11. AR 40-66 (Medical Record and Quality Assurance Administration). Cited in paragraphs 6-1, 7-7, 7-16, and 7-18.
12. AR 40-330 (Rates for Army Medical Department Activities for Fiscal Year 1980). Cited in paragraph 4-6*b*.
13. AR 40-501 (Standards of Medical Fitness). Cited in paragraph 1-14.
14. AR 50-5 (Nuclear Surety). Cited in paragraphs 1-10*b*, 1-15, and 3-14*d*.
15. AR 50-6 (Chemical Surety Program). Cited in paragraphs 1-10*b* and 1-15.
16. AR 190-5 (Motor Vehicle Traffic Supervision). Cited in paragraphs 2-15*c* and G-2.

17. AR 190-22 (Search, Seizure and Disposition of Property). Cited in paragraphs 2-15 and 6-5a.
18. AR 190-50 (Physical Security for Storage of Controlled Medical Substances and Other Medically Sensitive Items). Cited in paragraph 2-15d.
19. AR 195-5 (Evidence Procedures). Cited in paragraph 2-15.
20. AR 210-65 (Alcoholic Beverages). Cited in paragraph 2-5c.
21. AR 310-10 (Military Orders). Cited in paragraphs F-4c and F-5b.
22. AR 310-49 (The Army Authorization Document System (TAADS)). Cited in paragraph 1-21b.
23. AR 340-1 (Records Management Program). Cited in paragraph 6-10f.
24. AR 340-17 (Release of Information and Records From Army Files). Cited in paragraph 6-10f.
25. AR 340-18-9 (Maintenance and Disposition of Medical Functional Files). Cited in paragraphs 6-1d and 7-16.
26. AR 340-21 (The Army Privacy Program). Cited in paragraph 6-1b.
27. AR 360-5 (Public Information). Cited in paragraph 6-12a.
28. AR 570-4 (Manpower and Management). Cited in paragraphs 1-19 and 1-21b.
29. AR 600-20 (Army Command Policy and Procedures). Cited in paragraphs 4-16.
30. AR 600-107 (Medical Restriction/Suspension from Flight Duty, Non-medical Suspensions, Flying Evaluation Boards, and Flight Status Review System). Cited in paragraph 1-14.
31. AR 604-5 (Clearance of Personnel for Access to Classified Defense Information and Material). Cited in paragraph 1-13.
32. AR 635-10 (Processing Personnel for Separation). Cited in paragraphs F-4c and F-5b.
33. AR 635-100 (Officer Personnel). Cited in paragraphs 4-25b, 6-5e, and G-2.
34. AR 635-200 (Enlisted Personnel). Cited in paragraphs 4-25c, 6-5e, D-2, and G-2.
35. AR 690-1 (Civilian Applicant and Employee Security Program). Cited in paragraph 1-13.
36. TB Med 290 (Drug Abuse). Cited in paragraph 3-12.
37. TB Med 291 (Guidance for Inventory, Control and Accountability of Drugs and Injection Devices of Potential Abuse at Medical Treatment Facilities Worldwide). Cited in paragraph 2-15a.

**Section II. RELATED REFERENCES<sup>1</sup>**

1. DOD Directive 1010.4 (Alcohol and Drug Abuse by DOD Personnel).
2. DOD Directive 1332.14 (Enlisted Administrative Separations).
3. DOD Directive 5210.42 (Nuclear Personnel Reliability Program).
4. DOD Instruction 1010.3 (Drug and Alcohol Abuse Reports).
5. DOD Instruction 1010.5 (Education and Training in Alcohol and Drug Abuse Prevention).
6. DOD Instruction 1010.6 (Rehabilitation and Referral Services for Alcohol and Drug Abusers).
7. DSM-III (Diagnostic and Statistical Manual of Mental Disorders (Third Edition)).
8. AR 10-78 (Organization and Functions United States Army Drug and Alcohol Technical Activity).
9. AR 40-501 (Standards of Medical Fitness).
10. AR 135-178 (Separation of Enlisted Personnel).
11. AR 190-30 (Military Police Investigations).
12. AR 190-41 (Customs Law Enforcement).
13. AR 195-2 (Criminal Investigation Activities).
14. AR 340-21 (The Army Privacy Program).
15. AR 360-5 (Public Information).
16. AR 360-81 (Command Information Program: Objectives and Policies: Newspapers, Radio and Television).
17. AR 623-105 (Officer Evaluation Reporting System).
18. AR 623-205 (Enlisted Evaluation Reporting System).
19. AR 635-5 (Separation Documents).
20. AR 680-1 (Unit Strength Accounting and Reporting).
21. AR 690-1 (Civilian Applicant and Employee Security Program).
22. Civilian Personnel Regulation 302.2.
23. Combined Federal Regulations (CFR).
24. NGR 40-501 (Standards of Medical Fitness).

**Section III. FORMS<sup>2</sup>****Prescribed**

1. DA Form 3711-R (Alcohol and Drug Abuse Prevention and Control Program Summary).

<sup>1</sup> A related publication serves merely as a source of additional information. By reading it the user may better understand a subject discussed in this regulation, but the user does not have to read it to understand or comply with this regulation.

<sup>2</sup> Forms are separated into two distinct groups (prescribed and referenced) on the basis of their relevance with regard to this regulation.

2. DA Form 4465 (ADAPCP Client Intake Record (CIR)).
3. DA Form 4466 (ADAPCP Client Progress Report (CPR)).
4. DA Form 5017-R (Civilian Employee Consent Statement).
5. DA Form 5018-R (ADAPCP Client's Consent Statement for Release of Treatment Information).
6. DA Form 5019-R (Condition of Employment for Certain Civilian Employee Positions in Support of the Alcohol and Drug Abuse Prevention and Control Program).

#### Referenced

7. DA Form 3997 (Military Police Desk Blotter).
8. SF Form 513 (Medical Record—Consultation Sheet).
9. SF Form 600 (Chronological Record of Medical Care).
10. DD Form 1892 (Drug Screening Urinalysis Record).
11. DD Form 1155 (Order for Supplies for Services/Request for Quotations).
12. DD Form 1384 (Transportation Control and Movement Document).
13. DD Form 214 (Certificate of Release or Discharge from Active Duty).
14. DD Form 214WS (Worksheet for Certificate of Release or Discharge from Active Duty).
15. OVR-2 (Reemployment Rights and Employment Data).
16. DD Form 1407 (Dependent Medical Care and DD Form 1173 Statement).
17. DD Form 664 (Service Member's Statement Concerning Application for Compensation from the Veterans Administration (VA Form 21-526E)).

## APPENDIX B

### CLIENT MANAGEMENT RECORDS AND REPORTS

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**B-1.** DA Form 2496 (ADAPCP Military Client Referral and Screening Record) :

*a.* DA Form 2496, shown in figure B-1, will be used in the referral and screening of Army service members.

*b.* Instructions for completing the ADAPCP Military Client Referral and Screening Record, DA Form 2496 (overprinted), are contained in table B-1.

**B-2.** DA Form 5017-R (Civilian Employee Consent Statement) : DA Form 5017-R, shown in figure B-2, will be used as the civilian employee consent statement.

**B-3.** DA Form 4465 (ADAPCP Client Intake Record (CIR)) :

*a.* A sample DA Form 4465 is shown in figure B-3. Data required by the Privacy Act of 1974 is on the reverse side of this form.

*b.* Instructions for completing the DA Form 4465 are contained in table B-2.

*c.* MTF and ADAPCP service area codes for use with DA Forms 4465 and 4466 are contained in table B-3.

*d.* Diagnostic concepts and terminology for use with DA Form 4465 and 4466 are contained in table B-4.

*e.* Civilian employee classifications codes for use with DA Form 4465 are contained in table B-5.

*f.* Length of service codes for use with DA Form 4465 are contained in table B-6.

**B-4.** DA Form 4466 (ADAPCP Client Progress Report (CPR)) :

*a.* A sample DA Form 4466 is shown in figure B-4. Data required by the Privacy Act of 1974 is on the reverse side of this form.

*b.* Instructions for completing the DA Form 4466 are contained in table B-7.

**B-5.** A sample letter of transmittal forwarding client management records and reports from an installation Alcohol and Drug Control Office to the US Army Patient Administration Systems and Biostatistics Activity is shown in figure B-5.

**B-6.** A sample request for confirmation of reassignment and enrollment of an Army ADAPCP client is shown in figure B-6 (from ADCO to ADCO).

**B-7.** A sample request for confirmation of reassignment and enrollment of an Army service member is shown at figure B-7 (from ADCO to unit commanders).

**B-8.** A sample request for confirmation of reassignment and enrollment of an Army service member is shown at figure B-8 (from ADCO to replacement activity commander).

**B-9.** A sample request for an ADAPCP client case file is shown at figure B-9 (from ADCO to ADCO).

**B-10.** A sample privacy act statement is shown at figure B-10 for use with the ADAPCP log.

<b>DISPOSITION FORM</b>												
For use of this form, see AR 340-15; the proponent agency is TAGO.												
REFERENCE OR OFFICE SYMBOL	SUBJECT											
AFUF-JFO	ADAPCP Military Client Referral and Screening Record											
TO Ft Stewart Counseling Center	FROM HHC, USA Gar	DATE 20 Mar 81	CMT 1 CPT Lancaster/mt/228-8201									
<p>1. Effective this date <u>PFC JOHN C. Doe</u> is referred for CCC screening.</p> <p>2. Reason for referral <u>PFC Doe was apprehended by Military Police while driving under the influence of alcohol on 19 MARCH 81.</u></p> <p>3. Request medical evaluation    <input checked="" type="checkbox"/> Yes    <input type="checkbox"/> No</p> <div style="text-align: right; margin-right: 100px;"> <p><i>John T Lancaster</i> JOHN T. LANCASTER CPT, INF Commanding</p> </div>												
DPCA-ADCO-CCC												
TO CDR, HHC, USA Gar	FROM Ft Stewart Counseling Center	DATE 21 Mar 81	CMT 2 Mrs. Sperling/al/228-8309									
<p>1. The above individual has been screened and the following is recommended:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">a. Enrollment (1) <input type="checkbox"/> Track I</td> <td style="width: 25%;">b. <input checked="" type="checkbox"/> Unit counseling by the Commander or designated representative</td> <td style="width: 25%;">d. <input type="checkbox"/> Other (specify) _____</td> </tr> <tr> <td>(2) <input checked="" type="checkbox"/> Track II</td> <td>c. <input type="checkbox"/> Urine Surveillance Program (USP)</td> <td>e. <input type="checkbox"/> No ADAPCP services required at the present time.</td> </tr> <tr> <td>(3) <input type="checkbox"/> Track III ,</td> <td></td> <td></td> </tr> </table> <p>2. Rehabilitation team meeting is scheduled for the following date <u>21 March 81</u> to discuss results of initial screening interview and recommendation(s).</p> <div style="text-align: right; margin-right: 100px;"> <p><i>Jane T Sperling</i> JANE T. SPERLING Clinical Director CCC</p> </div>				a. Enrollment (1) <input type="checkbox"/> Track I	b. <input checked="" type="checkbox"/> Unit counseling by the Commander or designated representative	d. <input type="checkbox"/> Other (specify) _____	(2) <input checked="" type="checkbox"/> Track II	c. <input type="checkbox"/> Urine Surveillance Program (USP)	e. <input type="checkbox"/> No ADAPCP services required at the present time.	(3) <input type="checkbox"/> Track III ,		
a. Enrollment (1) <input type="checkbox"/> Track I	b. <input checked="" type="checkbox"/> Unit counseling by the Commander or designated representative	d. <input type="checkbox"/> Other (specify) _____										
(2) <input checked="" type="checkbox"/> Track II	c. <input type="checkbox"/> Urine Surveillance Program (USP)	e. <input type="checkbox"/> No ADAPCP services required at the present time.										
(3) <input type="checkbox"/> Track III ,												
AFUF-JFO												
TO Ft Stewart Counseling Center	FROM HHC USA Gar	DATE 22 Mar 81	CMT 3 CPT Lancaster/mt/228-8201									
<p><input checked="" type="checkbox"/> Approve    <input type="checkbox"/> Disapprove recommendation</p> <div style="text-align: right; margin-right: 100px;"> <p><i>John T Lancaster</i> JOHN T. LANCASTER CPT, INF Commanding</p> </div>												

**Table B-1. Instructions for Completing DA Form 2496 (ADAPCP  
Military Client Referral and Screening Record) (Overprinted).**

PRINCIPAL PURPOSE:	The ADAPCP Military Client Referral and Screening Record is forwarded from the commander to the CCC to enable the CCC staff to evaluate the Army service member for possible alcohol or other drug abuse problems. The original and one copy are forwarded to the CCC and placed on file. The ADAPCP Referral and Screening Record will be hand carried from the unit to the CCC or placed in a properly addressed and sealed envelope and mailed to the attention of the servicing CCC. Under no circumstances <i>will the ADAPCP Referral and Screening Record be forwarded in any other manner than those described above.</i>	
CMT 1	Paragraph 1	Enter the rank and full name of the Army service member being referred.
	Paragraph 2	Enter the reason for referral, i.e., one of the following: <ul style="list-style-type: none"> <li>(a) Laboratory positive test following commander directed or other biochemical urine testing.</li> <li>(b) Self referral.</li> <li>(c) Commander referral.</li> <li>(d) Investigation/apprehension referral (includes DWI arrest and court ordered referral).</li> <li>(e) Medical referral.</li> </ul>
	Paragraph 3	Check whether a medical evaluation is requested as a part of the screening process. The commander may request a medical evaluation for any Army service member referred to the CCC. <i>Note: A laboratory positive biochemical urine test requires a medical evaluation of the positive result. Therefore, always check yes for medical evaluation when the reason for referral is a laboratory positive urine test.</i>
CMT 2	Paragraph 1	Check the box which corresponds to the recommendation. <i>Note: In some instances more than one box may be checked, e.g., enrollment in Track I and unit counseling by the commander.</i>
	Paragraph 2	Indicate the mutually agreed upon time for the rehabilitation team meeting to further discuss the case and the rehabilitation plan for the Army service member.
CMT 3		Indicate approval or disapproval of the recommendation(s) for the Army service member after the scheduled meeting.

<b>CIVILIAN EMPLOYEE CONSENT STATEMENT</b> <small>For use of this form, see AR 600-85; the proponent agency is DCSPER.</small>		
<p><i>NOTE: Prepare this form in the original only and file in the ADAPCP client case file folder. Reproduction and distribution of this form are prohibited.</i></p>		
<b>JUSTIFICATION</b>		
<p>Purpose of this statement is to request and enlist the cooperation and assistance of your immediate supervisor in your behalf. His/her involvement in your treatment plan will greatly assist us in providing ADAPCP services. For this purpose, however, it is necessary to obtain your consent, pursuant to S 1401.21 of the Public Law cited as follows: Section 408, Public Law 92-255, The Drug Abuse Office and Treatment Act of 1972 (21 USC 1175), as amended in 1974 by Section 303, Public Law 93-282.</p>		
<b>UNDERSTANDING</b>		
<p>I understand that I must give my consent before any involvement or participation by my supervisor can take place concerning my treatment plan. (By "supervisor", it is intended the person who initiates and/or rates all personnel actions concerning myself.) I further understand that my supervisor will only receive information on progress and attendance. No personal information of any kind will be disclosed without my specific consent each time information is either required or given. I also understand that, with or without consent for release of information to my supervisor, ADAPCP services will be equally available to me. I understand that my consent to provide my supervisor with pertinent information is necessary to avert or suspend any adverse personnel action relating to my performance and/or conduct during the period of rehabilitation.</p>		
<b>CONSENT</b>		
<p>Having understood the basis for consent, I _____  <small>(name of client)</small></p> <p>agree/do not agree with the Civilian Program Coordinator on the involvement of my supervisor,          _____  <small>(name of supervisor)</small> in my treatment plan. I understand that I may withdraw this consent at any time.</p>		
<b>REMARKS</b>          		
<b>SIGNATURE OF CLIENT</b>  	<b>DATE</b>  	
<b>NAME AND TITLE OF WITNESS (Type or print)</b>  	<b>SIGNATURE</b>  	<b>DATE</b>  
<b>WITHDRAWAL OF CONSENT</b> <small>(Sign below if and when you decide to withdraw your consent.)</small>		
<b>SIGNATURE OF CLIENT</b>  	<b>DATE</b>  	

**FOR LOCAL USE ONLY**

CLIENT'S NAME: John D. Doe UNIT/OFFICE: HQ Company 24<sup>th</sup> Inf Div

**ADAPCP CLIENT INTAKE RECORD (CIR)** REQUIREMENT CONTROL SYMBOL: CSGPA-1400(R1)

For use of this form, see AR 600-85; the proponent agency is DCSPER.

**SEE REVERSE SIDE FOR PRIVACY ACT STATEMENT**

1. DATE OF ENROLLMENT: a. 81/11/24 (Yr. Mo. Day) b. [ ] (Julian Date)

2. SERVICE AREA CODE: a. 1371 (Initial MTF) b. F22 (Current Area)

3. CLIENT'S ID CODE: 021552495

4. SVC MEMBER GRADE: a. PFC (Rank) b. E3 (Grade Code)

5. CIV EMPLOYEE GRADE: [ ]

6. DIAGNOSTIC CODES: [ ]

7. CLIENT'S STATUS (Check one box only):  
 a.  Army AD/ADT b.  Other Mil Svc (Specify) \_\_\_\_\_  
 c.  ARNG d.  USAR e.  DA/NAF Civ Empl  
 f.  Other DOD Civ Empl g.  Dep AD Mil  
 h.  Dep Ret/Dec Mil i.  Dep DA/NAF Civ Empl  
 j.  Dep DOD Civ Empl k.  Ret Military l.  Foreign National

8. PHYSICIAN DIAGNOSIS/BASIS FOR ENROLLMENT: a. alcohol abuse, episodic

9. NAME OF MED TREATMENT FACILITY (MTF) (Type or print): US Army Health Clinic Fort Stewart, GA 31313

10a. NAME AND GRADE OF PHYSICIAN (Type or print): ROBERT T. EVANS MAJ. MC

10b. SIGNATURE OF PHYSICIAN: Robert T. Evans

10c. DATE: 23 Nov 81

11. CLIENT'S YEAR OF BIRTH (YOBY): 60

12. RACE:  Cau  Negro  Other

13. SEX:  Male  Female

14. EDUCATION: a.  College Graduate b.  Some College c.  HS Graduate/GED d.  Some High School e.  1-8 Grade

15. MARITAL STATUS: a.  Never Married b.  Now Married c.  Divorced d.  Separated e.  Widowed

16. LENGTH OF SERVICE: a. 14 (Years) b. E1 (LOS Data Code) c. D3 (LOS Present Unit)

17. PMOS OF SVC MEMBER: a. 11B10 b. Performing in PMOS:  Yes  No

18. PREVIOUS ALCOHOL OR DRUG COUNSELING/REHABILITATION: a.  Army b.  None c.  Other (Specify) \_\_\_\_\_

19. CONSENT OF CIV EML TO RELEASE INFO TO SUPERVISOR:  Yes  No

20. CLIENT'S DISCIPLINARY RECORD (Alcohol or Drug Related):

Civilian	No.	Military	No.	Total Number of AWOL Episodes:
a. Arrests	<u>1</u>	c. Articles 15	<u>1</u>	<u>0</u>
b. Convictions	<u>1</u>	d. Courts Martial	<u>0</u>	

21. SVC MEMBER'S RECORD OF AWOL: Total Number of AWOL Episodes: 0

22. SVC MEMBER'S ETS DATE: a. (Yr. Mo. Day): 83/9/15 b. Julian Date: [ ]

23. CLIENT'S PRESENT RESIDENCE: a.  Army Barrack b.  BEQ c.  BOQ d.  On-Post Housing e.  Off-Post Housing w/Dep f.  Off-Post Housing w/o Dep

24. CASE FINDING METHOD: a.  Cdr Dir b.  Phys Dir c.  Rehab Staff d.  Other local testing e.  Self Ref f.  Cdr Ref g.  Supv Ref h.  Inves/App i.  Med Ref

25. IMMEDIATE DISPOSITION: a.  Track I b.  Track II c.  Track III d.  Holding for Track \_\_\_\_\_  
 e. Inpatient Detoxification:  Necessary  Unnecessary  Completed  
 f. Utilization of Treatment/Rehabilitation Facilities:  Yes  No

26. DRUG/ALCOHOL USAGE PROFILE (Items a through k below must be accounted for by circling appropriate blocks)

	Never Used	LAST TIME USED						HOW OFTEN USED						HOW TAKEN		USE EPTS		CURRENT PROBLEM	
		Within 48 Hrs	2-7 Days Ago	1-4 Weeks Ago	1-6 Months Ago	Over 6 Months Ago	Daily	2-6 Times/Week	Once/Week	2-3 Times/Month	Once/Month	Less than Once/Month	By Needle	Not By Needle	Yes	No	Yes	No	
a. Alcohol	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
b. Amphetamines	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
c. Barbiturates	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
d. Cannabis Product	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
e. Cocaine	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
f. Hallucinogens	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
g. Methaqualone	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
h. Opiates	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
i. Other Tranquilizer	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
j. Phencyclidine	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	
k. Other (Specify):	1	2	3	4	5	6	1	2	3	4	5	6	1	2	Y	N	Y	N	

27. TYPED NAME OF COUNSELOR: GAYLE SMITH

28. SIGNATURE OF COUNSELOR: Mrs. Gayle Smith

29. MILITARY MAILING ADDRESS OF ADCO: 24<sup>th</sup> INF DIV, FORT STEWART, ATTN: AFZ-PAP-AP (CCC), FORT STEWART GA, 31313

30. TYPED NAME OF ADCO: JOHN T. MURPHY, MAJ, AG

31. SIGNATURE OF ADCO: John T. Murphy

DA FORM 4465 NOV 81

EDITION OF NOV 75 IS OBSOLETE.

**Table B-2. Instructions for Completing DA Form 4465  
(Client Intake Record (CIR))<sup>1</sup>**

<i>Item</i>	<i>Title</i>	<i>Completed by</i>	<i>Remarks</i>
	Client's Name. Client's unit/office.	ADAPCP staff.	For local use only. Include only on health record and ADAPCP client record copies. Information not to be forwarded to PASBA (HSHI-QPD). Enter office where civilian employee works.
1	Date of enrollment.		
1a	Year, month, day.	ADAPCP staff.	For Army service members, enter calendar date of CMT 3 on the ADAPCP Military Client Referral and Screening Record. For civilian employees and other clients enter the date the client was enrolled by the ADAPCP staff.
1b	Julian date.	PASBA (HSHI-QPD).	This item will be completed by PASBA.
2	Service area code.		
2a	Initial MTF code. <sup>2</sup>	ADAPCP staff.	See table B-3.
2b	Current ADAPCP service area code.	ADAPCP staff.	See table B-3.
3	Client's ID code. <sup>3</sup>		
	Active duty/ADT military client.	ADAPCP staff.	Enter SSN for all military service members.
	Nonmilitary client code.	ADAPCP staff.	Enter the first three digits of the client's SSN plus date of birth by year, month, day, e.g., 253450215 (15 Feb 45). For foreign nationals and other clients who do not have a SSN enter 000 plus date of birth by year, month, day, e.g., 000450215 (15 Feb 45).
4	Service member grade.		
4a	Rank.	ADAPCP staff.	For all service members: Enter service member's rank, e.g., SSG, CPT.
4b	Grade code.	ADAPCP staff.	For all service members: Enter pay grade designation, e.g., E6, O3.
5	Civilian employee grade.	ADAPCP staff.	For the first two digits-alpha character indicating GS, WG, etc. See table E-5. For the second two digits enter the pay grade level. For

**Table B-2. Instructions for Completing DA Form 4465  
(Client Intake Record (CIR))<sup>1</sup>—Continued**

<i>Item</i>	<i>Title</i>	<i>Completed by</i>	<i>Remarks</i>
			Foreign Nationals leave blank.
6	Diagnostic code(s).	PASBA (HSHI-QPD).	This item will be completed by PASBA.
7	Client's status.	ADAPCP staff.	Check one box only. Retired military or family members currently working in Federal service will be reported as a Federal Service Employee.
8	Physician diagnosis/basis for enrollment.	Physician/ADAPCP staff.	See table B-4. ADCO will insure that physicians performing medical evaluations have access to information in table B-4.
9	Name of MTF.	Physician.	Enter name of MTE.
10a	Name and grade of physician.	Physician.	Complete items 10 a, b, and c only when item 8 (Physician's diagnosis/basis for enrollment) is completed by a physician. Enter typed or printed name and grade of physician. Items 10 a, b, and c will not be completed unless a specific diagnosis or no diagnosis apparent is rendered during medical evaluation by a physician.
10b	Signature of physician.	Physician.	Signed by physician.
10c	Date.	Physician.	Self-explanatory.
11	Client's year of birth.	ADAPCP staff.	Enter the last two digits of the client's year of birth.
12	Race.	ADAPCP staff.	Check appropriate box.
13	Sex.	ADAPCP staff.	Check appropriate box.
14	Education.	ADAPCP staff.	Check appropriate box.
15	Marital status.	ADAPCP staff.	Check appropriate box.
16	Length of service.		
16a	Years.	ADAPCP staff.	Enter length of service for all military service members and civilian employees in accordance with paragraph 1, table B-6.
16b	Length of service (LOS) data code.	ADAPCP staff.	For LOS data code see paragraph 2, table B-6. Enter length of service for all military service members and civilian employees.

**Table B-2. Instructions for Completing DA Form 4465  
(Client Intake Record (CIR))—Continued**

<i>Item</i>	<i>Title</i>	<i>Completed by</i>	<i>Remarks</i>
16c	Length of service present unit.	ADAPCP staff.	For LOS data code, see paragraph 3, table B-6. Enter length of service in present unit for all military service members.
17	Primary Military Occupational Speciality (PMOS) of service member.		
17a	PMOS Code.	ADAPCP staff.	Enter Army service member's PMOS code. Leave blank for members of other services.
17b	Performing in PMOS.	ADAPCP staff.	Check appropriate box.
18	Previous alcohol or drug client.	ADAPCP staff.	Check appropriate box. "Other" rehabilitation programs include rehabilitation programs of other Services, civilian program, Alcoholics Anonymous and any other counseling that was alcohol or other drug related.
19	Consent of civilian employee to release information to supervisor.	ADAPCP staff.	Check yes if civilian employee consented to release of rehabilitation information to supervisor. Otherwise, check no.
20a,b,c,d	Client's disciplinary record (Alcohol or Drug Related).	ADAPCP staff.	Enter numbers appropriate to specific disciplinary record items for all clients. For any entry that exceeds "9" enter "9." <i>Enter information for all clients in items a and b. Enter numbers for military service members in items c and d.</i>
21	Service member's record of AWOL.	ADAPCP staff.	Enter total number of AWOL episodes for all military service members. For any entry that exceeds "9" enter "9."
22	Service member's expiration term of service (ETS) date.		
22a	Year, month, day.	ADAPCP staff.	Enter calendar date of all military service member's ETS date, i.e., 850516 (16

**Table B-2. Instructions for Completing DA Form 4465  
(Client Intake Record (CIR))<sup>1</sup>—Continued**

<i>Item</i>	<i>Title</i>	<i>Completed by</i>	<i>Remarks</i>
			May 1985. Enter "INDEF" for all military service members who do not have an ETS date.
22b	Julian date.	PASBA (HSHI-QPD)	This item will be completed by PASBA.
23	Client's present residence.	ADAPCP staff.	Check appropriate box.
24	Case finding method.	ADAPCP staff.	Check appropriate box which indicates the reason for referral by the commander on the ADAPCP Military Client Referral and Screening Record. For civilian employees and other clients, check the box which best reflects how the client's problem was initially discovered.
			<i>NOTE.</i> For court ordered referral report the case finding method as investigation/apprehension.
25	Immediate disposition.	ADAPCP staff.	Check appropriate box(es) for disposition of client at time of program entry. Also indicate if inpatient detoxification or civilian rehabilitation facilities are to be/were used. For clients who are awaiting availability of Track III inpatient services, check item 25 and complete "Holding for Track III."
26	Drug/alcohol usage profile.	ADAPCP staff.	Show history of client's drug/alcohol usage by circling appropriate response. A response is required for each drug listed. An appropriate entry must be made for each frequency-of-use category.

*Notes:*

1. "Use EPTS" means: Did the client use this drug prior to military or Federal service? Leave blank for clients who do not have Federal or military service.

**Table B-2. Instructions for Completing DA Form 4465  
(Client Intake Record (CIR))<sup>1</sup>—Continued**

<i>Item</i>	<i>Title</i>	<i>Completed by</i>	<i>Remarks</i>
			2. "Current Problem" show a yes answer for the drug(s) for which the client was enrolled. If the client is not medically evaluated by a physician and is entered into Track I or Track II, the ADAPCP counselor will provide an opinion of the client's current problem by marking alcohol or drug(s) for which the client was enrolled.
27	Typed name of counselor.	ADAPCP staff.	Self-explanatory.
28	Signature of counselor.	ADAPCP Counselor.	Must be signed by counselor. Unsigned forms will be returned.
29	Military mailing address of ADCO.	ADAPCP staff.	Enter the complete mailing address of ADCO and organization to which assigned.
30	Typed name of ADCO.	ADCO.	Self-explanatory.
31	Signature of ADCO.	ADCO.	Must be authenticated by ADCO. Unsigned forms will be returned.

<sup>1</sup> Incomplete records will be returned to the submitting ADAPCP for completion.

<sup>2</sup> To assist in the compilation of accurate data and to insure the matching of the ADAPCP Client Intake Records (CIR) (DA Form 4465) with subsequent ADAPCP Client Progress Reports (CPR) (DA Form 4466), it is important that entries in items 3 and 2a of the CIR be identical to items 3 and 2a on all subsequent CPRs submitted on the same client. Once a CIR has been submitted to PASBA (HSHI-QPD), the codes in items 3 or 2a of the CIR and items 3 and 2a of CPRs must not be changed unless specifically requested by PASBA (HSHI-QPD). Any errors discovered after submission of a CIR or CPR will be immediately reported by the ADCO to PASBA (HSHI-QPD) for correction of the record.

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes**

This table lists Medical Treatment Facility codes and ADAPCP service area codes required for completion of items 2a and 2b of DA Form 4465, and items 2a, 2b of DA Form 4466. *Mailing address corrections for ADAPCP's listed will be sent directly to:*

Commander  
US Army Patient Administration Systems  
and Biostatistics Activity (HSHI-QPD)  
Fort Sam Houston, TX 78234

**Part I. OVERSEA AREAS**

*Section 1. Alaska, Panama and Puerto Rico*

Commander  
US Army Forces Command  
ATTN: AFPR-HR  
Fort McPherson, GA 30330

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Commander 172d Infantry Bde (Alaska) ATTN: CCC Fort Richardson, AK 99505	0141	A02
2. Commander 193d Infantry Bde (Panama) ATTN: AFZU-PA-HAD-CCC APO Miami 34004	0121	C01
3. Commander US Army Garrison (Puerto Rico) ATTN: AFZK-B-PA-PA (CCC) Fort Buchanan, Puerto Rico 00934	1301	F10

*Section 2. Europe*

Commander in Chief  
US Army Europe & 7th Army  
ATTN: AEAGA-HRD  
APO New York 09403

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Community Commander Amberg Military Community ATTN: Amberg CCC, Pond Bks APO New York 09452	0361	E01
2. Community Commander Ansbach Military Community ATTN: Ansbach CCC Hindenberg Kaserne APO New York 09326	0361	E02
3. Community Commander Aschaffenburg Military Community ATTN: Aschaffenburg CCC Ready Bks APO New York 09162	0391	E03

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
4. Community Commander Augsburg Military Community ATTN: Augsburg CCC Sheridan Kaserne APO New York 09178	0391	E04
5. Community Commander Camp King Military Community (Oberursel) ATTN: Camp King CCC APO New York 09451	0331	E65
6. Commander Fulda Military Community ATTN: Bad Hersfeld CCC McPheeters Bks APO New York 09141	0331	E05
7. Community Commander Bad Kissingen Military Community ATTN: Bad Kissingen CCC APO New York 09252	0381	E06
8. Community Commander Bad Kreuznach Military Community ATTN: Bad Kreuznach CCC Rose Bks APO New York 09111	0351	E07
9. Community Commander Bad Toelz Military Community ATTN: Bad Toelz CCC APO New York 09050	0391	E88
10. Community Commander Darmstadt Military Community ATTN: Babenhausen CCC Babenhausen Kaserne APO New York 09175	0331	E08
11. Community Commander Bamberg Military Community ATTN: Bamberg CCC Kaserne Bks APO New York 09139	0361	E09
12. Community Commander Baumholder Military Community ATTN: Baumholder CCC APO New York 09034	0351	E10
13. Community Commander Berlin Military Community ATTN: Berlin CCC, McNair Bks APO New York 09742	0311	E11
14. Community Commander Bindlach Military Sub-Community ATTN: Bindlach CCC Christensen Bks APO New York 09411	0361	E12

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
15. Community Commander Boeblingen Military Sub-Community (Stuttgart) ATTN: Boeblingen CCC APO New York 09046	0371	E13
16. Community Commander Bremerhaven Military Community ATTN: Bremerhaven CCC APO New York 09069	0321	E14
17. Community Commander Hanau Military Community ATTN: Buedingen CCC Armstrong Bks APO New York 09079	0331	E15
18. Community Commander Ansbach Military Community ATTN: Crailsheim CCC, McKee Bks APO New York 09751	0371	E17
19. Community Commander Darmstadt Military Community ATTN: Cambrai-Fritsch CCC Cambrai-Fritsch Kaserne APO New York 09175	0331	E18
20. Community Commander Bad Kreuznach Military Community ATTN: Dexheim CCC Anderson Bks APO New York 09111	0331	E19
21. Community Commander Erlangen Military Sub-Community (Nuernberg) ATTN: Erlangen CCC, Ferris Bks APO New York 09066	0361	E20
22. Community Commander Hanau Military Community ATTN: Fliergerhorst CCC APO New York 09165	0331	E22
23. Community Commander Frankfurt Military Community ATTN: Betts CCC, Betts Kaserne APO New York 09757	0331	E23
24. Community Commander Frankfurt Military Community ATTN: Eschborn CCC, Eshborn Kaserne APO New York 09757	0331	E24
25. Community Commander Frankfurt Military Community ATTN: Frankfurt North CCC Edwards Kaserne APO New York 09039	0331	E25

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
26. Community Commander Giessen Military Community ATTN: Friedberg CCC, Ray Bks APO New York 09074	0331	E26
27. Community Commander Fuerth Military Community ATTN: Fuerth CCC, Montietth Bks APO New York 09068	0361	E27
28. Community Commander Fulda Military Community ATTN: Downs Barracks CCC Downs Kaserne APO New York 09146	0331	E28
29. Community Commander Garlstadt Military Community (Bremerhaven) ATTN: Garlstadt CCC APO New York 090262	0321	E89
30. Community Commander Hanau Military Community ATTN: Gelnhausen CCC Coleman Kaserne APO New York 09165	0331	E29
31. Community Commander Karlsruhe Military Community ATTN: Germersheim CCC Germersheim Army Depot APO New York 09095	0341	E30
32. Community Commander Giessen Military Community ATTN: Giessen North CCC Giessen Army Depot APO New York 09169	0331	E31
33. Community Commander Wuerzburg Military Community ATTN: Gibelstadt CCC APO New York 09036	0381	E32
34. Community Commander Goeppingen Military Community ATTN: Goeppingen CCC APO New York 09137	0371	E33
35. Community Commander Grafenwoehr Military Community (7th ATC) ATTN: Grafenwoehr CCC APO New York 09114	0361	E34
36. Community Commander Hanau Military Community ATTN: Hanau North CCC Francois Kaserne APO New York 09165	0331	E35

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes --Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
37. Community Commander Hanau Military Community ATTN: Hanau South CCC Pioneer Kaserne APO New York 09165	0331	E35
38. Community Commander Heidelberg Military Community ATTN: Patton Bks CCC Patton Bks APO New York 09102	0341	E37
39. Community Commander Heidelberg Military Community Tompkins Bks CCC Tompkins Bks APO New York 09102	0341	E38
40. Community Commander Heilbronn Military Community ATTN: Heilbronn CCC Wharton Bks APO New York 09176	0371	E39
41. Community Commander Herzo Base Military Community ATTN: Herzo Base CCC APO New York 09352	0361	E40
42. Community Commander Frankfurt Military Community ATTN: Hoechst CCC McNair Bks APO New York 09403	0331	E41
43. Community Commander Hohenfels Military Community ATTN: Hohenfels CCC Hohenfels Tng Area APO New York 09173	0361	E42
44. Community Commander Baumholder Military Community ATTN: Idar Oberstein CCC APO New York 09034	0351	E43
45. Community Commander Ansbach Military Community ATTN: Illesheim CCC, Stork Bks APO New York 09140	0361	E44
46. Community Commander Kaiserlautern Military Community ATTN: Daenner CCC, McNair Bks Daenner Kaserne APO New York 09227	0351	E45

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
47. Community Commander Vogelweh Military Community (Kaiserlautern) ATTN: Vogelweh CCC Rhine Ordnance Bks APO New York 09227	0351	E46
48. Community Commander Karlsruhe Military Community ATTN: Gerzewski CCC Gerzewski Bks APO New York 09360	0341	E47
49. Community Commander Kirchgoens Military Community ATTN: Kirchgoens CCC Ayers Kaserne APO New York 09045	0331	E49
50. Community Commander Kirchgoens Military Community ATTN: Butzbach CCC APO New York 09045	0331	E16
51. Community Commander Kitzingen Military Community ATTN: Harvey Bks CCC Harvey Bks APO New York 09031	0381	E50
52. Community Commander Kitzingen Military Community ATTN: Larson Bks CCC Larson Bks APO New York 09701	0381	E51
53. Community Commander Kaiserslautern Military Community ATTN: Landstuhl CCC c/o Daenner Kaserne CCC APO New York 09227	0351	E52
54. Community Commander Stuttgart Military Community ATTN: Ludwigsburg CCC Ludendorf Kaserne APO New York 09154	0371	E53
55. Community Commander Mainz Military Community ATTN: Mainz CCC, Lee Bks APO New York 09185	0331	E54
56. Community Commander Frankfurt Military Community ATTN: McCully Bks CCC McCully Bks APO New York 09185	0331	E90

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
57. Community Commander Mannheim Military Community ATTN: Coleman CCC, Coleman Bks APO New York 09086	0341	E55
58. Community Commander Mannheim Military Community ATTN: Sullivan CCC Sullivan Bks APO New York 09086	0351	E56
59. Community Commander Zweibrucken Military Community ATTN: Miesau CCC, Miesau APO New York 09052	0351	E28
60. Community Commander Munich Military Community ATTN: Munich CCC McGraw Kaserne APO New York 09407	0391	E59
61. Community Commander Neu Ulm Military Community ATTN: Neu Ulm CCC Nelson Bks APO New York 09035	0391	E60
62. Community Commander Stuttgart Military Community Nellingen CCC Nellingen Bks APO New York 09160	0371	E61
63. Community Commander Worms Military Community ATTN: Weirhof CCC APO New York 09058	0351	E62
64. Community Commander Neurnberg Military Community ATTN: Merrel Bks CCC APO New York 09093	0361	E63
65. Community Commander Nuernberg Military Community ATTN: Wm O'Darby Kaserne CCC APO New York 09696	0361	E64
66. Community Commander Pirmasens Military Community ATTN: Pirmasens CCC Huesterhoeh Kaserne APO New York 09189	0351	E66
67. Community Commander Hoenfels Military Sub-Community (7ATC) ATTN: Regensburg CCC, Hienfels APO New York 09173	0361	E67

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
68. Community Commander Schwabach Military Community ATTN: Schwabach CCC, O'Brien Bks APO New York 09142	0361	E68
69. Community Commander Goeppingen Military Community ATTN: Schwaebisch Gmuend CCC Bismarch Kaserne APO New York 09281	0371	E69
70. Community Commander Heilbronn Military Community ATTN: Schwaebisch Hall CCC Dolan Bks APO New York 09025	0371	E70
71. Community Commander Schweinfurt Military Community ATTN: Conn Bks CCC, Conn Bks APO New York 09038	0381	E71
72. Community Commander Schweinfurt Military Community ATTN: Ledward Bks CCC, Ledward Bks APO New York 09033	0381	E72
73. Community Commander Camp Darby Military Community (SETAF) ATTN: Camp Darby CCC Livorno, Italy APO New York 09109	0411	E73
74. Community Commander Caserna Ederle Military Community (SETAF) ATTN: Caserna Ederle CCC Vincenza, Italy APO New York 09221	4211	E74
75. Community Commander SHAPE, Belgium ATTN: SHAPE Belgium CCC APO New York 09088	0211	E75
76. Community Commander Wackernheim Military Community ATTN: Wackernheim CCC APO New York 09047	0381	E80
77. Community Commander Wuerzburg Military Community ATTN: Wertheim CCC APO New York 09047	0381	E81
78. Community Commander Wildflecken Military Community ATTN: Wildflecken CCC APO New York 09026	0381	E83

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
79. Community Commander Worms Military Community ATTN: Worms CCC APO New York 09058	0381	E85
80. Community Commander Wuerzburg Military Community ATTN: Wuerzburg CCC Leighton Bks APO New York 09801	0331	E86
81. Community Commander Weisbaden Military Community ATTN: Weisbaden CCC Weisbaden Air Force Base APO New York 09457	0351	E91
82. Community Commander Zwiebruecken Military Community ATTN: Zweibruecken CCC Grenadier Kaserne APO New York 09052	0351	E87
83. Community Commander Camp Pieri Military Community ATTN: Camp Pieri CCC APO New York 09457	0331	E82

*Section 3. Hawaii*

Commander  
US Army Western Command  
ATTN: AOZV-PAH  
Fort Shafter, HI 96857

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
Commander HQUSASCH ATTN: CCC Schofield Barracks, HI 96857	0101	W01

*Section 4. Japan and Okinawa*

Commander  
US Army Japan  
ATTN: AJGA-HG  
APO San Francisco 96343

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Commander USAG-HONSKY (Japan) ATTN: CCC APO San Francisco 96343	0711	J01
2. Commander USARBCO (Okinawa) ATTN: BCOA CCC APO San Francisco 96331	0681	R01

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

*Section 5. Korea*

Commander  
Eighth US Army (Korea)  
ATTN: AJ-HAB-D  
APO San Francisco 96301

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Camp Humphrey CCC 19th Spt Bde APO San Francisco 96271	0611	K01
2. Camp Casey CCC 2d Inf Div APO San Francisco 96224	0611	K02
3. Camp Howze CCC Co C, 2d Med Bn APO San Francisco 96224	0611	K04
4. Camp Page CCC 4th MSL CMD APO San Francisco 96208	0611	K03
5. Camp Red Cloud CCC I Corps APO San Francisco 96358	0611	K05
6. Camp Stanley CCC 2d Inf Div APO San Francisco 96224	0611	K06
7. Yongsan CCC USAGY APO San Francisco 96301	0661	K07
8. Pusan CCC 2d Trans Grp APO San Francisco 96259	0611	K08
9. Taegu CCC 19th Spt Grp APO San Francisco 96212	0611	K09

**Part II. CONUS**

*Section 1. US Army Materiel Development and Readiness Command (DARCOM)*

Commander  
US Army Materiel Development and  
Readiness Command (DARCOM)  
ATTN: DRCPT-H  
5001 Eisenhower Avenue  
Alexandria, VA 22333

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Commander Aberdeen Proving Ground ATTN: ADAPCP Aberdeen Proving Ground, MD 21005	10Y1	G02

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
2. Commander Anniston Army Depot ATTN: ADAPCP Anniston, AL 36201	1361	G03
3. Commander Army Materials & Mechanics Research Center ATTN: ADAPCP Watertown, MA 02171	1041	G04
4. Commander Dugway Proving Ground ATTN: ADAPCP Dugway, UT 84022	1201	G13
5. Commander Jefferson Proving Ground ATTN: ADAPCP Madison, IN 47250	12Z1	G19
6. Commander Letterkenny Army Depot ATTN: ADAPCP Chambersburg, PA 17201	10X1	G23
7. Commander Lexington-Blue Grass Army Activity ATTN: ADAPCP Lexington, KY 40507	1071	G24
8. Commander McAlester Army Ammo Plant ATTN: ADAPCP McAlester, OK 74501	1481	G69
9. Commander US Army Communications & Electronics Material Command ATTN: ADAPCP Fort Monmouth, NJ 07703	1111	G30
10. Commander US Army Natick Research and Development Command ATTN: ADAPCP Kansas Street Natick, MA 01760	1041	G31
11. Commander New Cumberland Army Depot ATTN: ADAPCP New Cumberland, PA 17070	10X1	G33
12. Commander Armament Research and Development Command ATTN: ADAPCP Dover, NJ 07801	1111	G35

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location :</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
13. Commander Pine Bluff Arsenal ATTN: ADAPCP Pine Bluff, AR 71601	1431	G36
14. Commander Pueblo Army Depot Activity ATTN: ADAPCP Pueblo, CO 81001	1211	G37
15. Commander Red River Army Depot ATTN: ADAPCP Texarkana, TX 75501	1411	G39
16. Commander US Army Missile Material Readiness Command ATTN: ADAPCP Redstone Arsenal, AL 35809	1351	G40
17. Commander Rock Island Arsenal ATTN: ADAPCP Rock Island, IL 61201	1251	G43
18. Commander Rocky Mountain Arsenal ATTN: ADAPCP Denver, CO 80240	1201	G44
19. Commander Sacramento Army Depot ATTN: ADAPCP Sacramento, CA 95813	1601	G45
20. Commander Savanna Army Depot ATTN: ADAPCP Savanna, IL 61074	1251	G48
21. Commander Seneca Army Depot ATTN: ADAPCP Romulus, NY 14541	1041	G50
22. Commander Sharpe Army Depot ATTN: ADAPCP Lathrop, CA 95330	1601	G51
23. Commander Sierra Army Depot ATTN: ADAPCP Herlong, CA 96113	1601	G52
24. Commander Tobyhanna Army Depot ATTN: ADAPCP Tobyhanna, PA 18466	10X1	G55

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
25. Commander Tooele Army Depot ATTN: ADAPCP Tooele, UT 84074	1201	G56
26. Commander Umatilla Army Depot ATTN: ADAPCP Hermiston, OR 97838	1701	G58
27. Commander Watervliet Arsenal ATTN: ADAPCP Watervliet, NY 12189	1041	G60
28. Commander White Sands Missile Range ATTN: ADAPCP White Sands Missile Range, NW 88002	1501	G61
29. Commander Yuma Proving Ground ATTN: ADAPCP Yuma, AZ 85364	1511	G63
30. Commander US Army Materiel Development and Readiness Command ATTN: ADAPCP Alexandria, VA 22333	1011	G65
31. Commander US Army Troop Support and Aviation Materiel Readiness Command ATTN: ADAPCP St. Louis, MO 63120	1231	G67
32. Commander US Army Tank-Automotive Material Readiness Command ATTN: ADAPCP Warren, MI 48090	1251	G11
33. Commander Corpus Christi Army Depot ATTN: ADAPCP Corpus Christi, TX 78419	1401	G68
34. Commander Harry Diamond Laboratories ATTN: ADAPCP 2800 Power Mill Road Adelphi, MD 20783	1001	G12
<i>Section 2. Office of the Deputy Chief of Staff for Personnel (ODCSPER)</i>		
Commander United States Military Academy ATTN: Chief PSD (MAPS-G) West Point, NY 10996	1121	D01

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

*Section 3. Defense Mapping Agency (DMA)*

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
Commander Army Topographic Station ATTN: ADAPCP 6500 Brooks Lane Washington, DC 20315	1001	P01

*Section 4. Defense Supply Agency (DSA)*

1. Commander Defense Construction Supply Center ATTN: ADAPCP Columbus, OH 43215	1071	L01
2. Commander Defense General Supply Center ATTN: ADAPCP Richmond, VA 23219	1081	L02
3. Commander Defense Personnel Support Center ATTN: ADAPCP 2800 S. 20th Street Philadelphia, PA 19101	1051	L03
4. Commander Memphis Defense Depot ATTN: ADAPCP Airways Blvd. Memphis, TN 38115	1321	L04
5. Commander Ogden Defense Depot ATTN: ADAPCP Ogden, UT 84402	1201	L05

*Section 5. US Army Forces Command (FORSCOM)*

Commander  
US Army Forces Command  
ATTN: AFPR-HR  
Fort McPherson, GA 30330

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Commander XVIII Airborne Corps & Fort Bragg ATTN: AFZA-MD-DA (CCC) Fort Bragg, NC 28307	1031	F03
2. Commander 101st Airborne Div (Air Assault) and Fort Campbell ATTN: AFZB-PA-AD (CCC) Fort Campbell, KY 42223	1321	F04
3. Commander 4th Inf Div (Mech) & Fort Carson ATTN: AFZB-PA-PA (CCC) Fort Carson, CO 80913	1211	F05

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
4. Commander Fort Devens ATTN: AFZD-PAH-AD (CCC) Fort Devens, MA 01433	1041	F07
5. Commander Fort Drum ATTN: AFZS-PA-A (CCC) Fort Drum, NY 13602	1041	F08
6. Commander III Corps & Fort Hood ATTN: AFZF-HRD-AD-A (CCC) Fort Hood, TX 76544	1411	F11
7. Commander Fort Indiantown Gap ATTN: AFQZ-PA-PS (CCC) Annville, PA 17003	10X1	F13
8. Commander Fort Irwin ATTN: Fort Irwin CCC Fort Irwin, CA 92311	1631	F28
9. Commander 9th Inf Div & Fort Lewis ATTN: AFZH-AD (CCC) Fort Lewis, WA 98433	1701	F14
10. Commander Fort McCoy ATTN: AFZR-PAS-MSA (CCC) Sparta, WI 54656	1251	F16
11. Commander Fort McPherson ATTN: AFZK-PA-PD (CCC) Fort McPherson, GA 30330	13Z1	F17
12. Commander Fort Meade ATTN: AFZI-PA-AD (CCC) Fort Meade, MD 20755	1091	F18
13. Commander 7th Inf Div & Fort Ord ATTN: AFZX-PA-GH (CCC) Fort Ord, CA 93941	1611	F26
14. Commander 5th Inf Div (Mech) & Fort Polk ATTN: AFZX-PA-GH (CCC) Fort Polk, LA 71459	1421	F27
15. Commander Presidio of San Francisco ATTN: AFZM-PA-HRDD (CCC) Presidio of San Francisco, CA 94129	1601	F20

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
16. Commander 1st Inf Div & Fort Riley ATTN: AFZN-PA-HDA (CCC) Fort Riley, KS 66442	1241	F19
17. Commander Fort Sam Houston ATTN: AFZG-PA-HDA (CCC) Fort Sam Houston, TX 78234	1401	F12
18. Commander Fort Sheridan ATTN: AFZP-PA-HD (CCC) Fort Sheridan, IL 60037	1251	F21
19. Commander 24th Inf Div & Fort Stewart ATTN: AFZ-PAP-AP (CCC) Fort Stewart, GA 31313	1371	F22

**Section 6. Military Defense of Washington (MDW)**

Commander  
US Military District of Washington  
ATTN: ANPE-AD  
Fort Myer, VA 22211

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
Commander Fort Myer ATTN: CCC Fort Myer, VA 22211	1001	M08

**Section 7. Military Traffic Management Command (MTMC)**

Commander  
Military Traffic Management Command  
ATTN: NT-PE  
5611 Columbia Pike  
Falls Church, VA 22041

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Commander Bayonne Military Ocean Terminal ATTN: CCC Bayonne, NJ 07002	1111	X01
2. Commander Oakland Army Base ATTN: CCC Oakland, CA 96262	1601	X02
3. Commander Sunny Point Military Ocean Terminal ATTN: CCC Southport, NC 28461	1031	X03

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
4. Commander Military Traffic Management Command ATTN: CCC 5611 Columbia Pike Falls Church, VA 22041	1001	X04
<i>Section 8. US Army Communications Command (USACC)</i>		
Commander US Army Communications Command ATTN: CC-PA-HA Fort Huachuca, AZ 85613		
<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Commander Fort Huachuca ATTN: Fort Huachuca CCC Fort Huachuca, AZ 35613	1511	Z01
2. Commander Fort Ritchie ATTN: Fort Ritchie CCC Fort Ritchie, MD 21719	1091	Z02
<i>Section 9. US Army Training and Doctrine Command (TRADOC)</i>		
1. Commander Fort Belvoir ATTN: CCC Fort Belvoir, VA 22060	1021	B01
2. Commander Fort Benning ATTN: CCC Fort Benning, GA 31905	1311	B02
3. Commander Fort Bliss ATTN: CCC Fort Bliss, TX 79916	1501	B03
4. Commander Carlisle Barracks ATTN: CCC Carlisle Barracks, PA 17013	10X1	B04
5. Commander Fort Dix ATTN: CCC Fort Dix, NJ 08640	1051	B05
6. Commander Fort Eustis ATTN: CCC Fort Eustis, VA 23604	1061	B06
7. Commander Fort Gordon ATTN: CCC Fort Gordon, GA 30905	1301	B07

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
8. Commander Fort Benjamin Harrison ATTN: CCC Fort Benjamin Harrison, IN 46216	12Z1	B08
9. Commander Fort Jackson ATTN: CCC Fort Jackson, SC 29207	1331	B11
10. Commander Fort Knox ATTN: CCC Fort Knox, KY 40121	1071	B12
11. Commander Fort Leavenworth ATTN: CCC Fort Leavenworth, KS 66027	1221	B13
12. Commander Fort Lee ATTN: CCC Fort Lee, VA 23801	1081	B14
13. Commander Fort McClellan ATTN: CCC Fort McClellan, AL 36205	1341	B15
14. Commander Fort Monroe ATTN: CCC Fort Monroe, VA 23651	1081	B16
15. Commander Presidio of Monterey ATTN: CCC Presidio of Monterey, TC 93940	1611	B17
16. Commander Fort Rucker ATTN: CCC Fort Rucker, AL 36362	1361	B21
17. Commander Fort Sill ATTN: CCC Fort Sill, NJ 73503	1431	B22
18. Commander Fort Leonard Wood ATTN: CCC Fort Leonard Wood, MO 65473	1231	B24
19. Commander Fort Hamilton ATTN: CCC Fort Hamilton, NY 11252	1111	B25

**Table B-3. Medical Treatment Facility (MTF) and ADAPCP  
Service Area Codes—Continued**

*Section 10. US Army Intelligence and Security Command (INSCOM)*

Commander  
US Army Intelligence and Security Command  
ATTN: IAPER-M  
Arlington Hall Station  
Arlington, VA 22212

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Commander Arlington Hall Station ATTN: CCC Arlington, VA 22212	1001	U01
2. Commander Vint Hill Farms Station ATTN: CCC Warrenton, VA 22186	1021	U02

*Section 11. US Army Health Services Command (HSC)*

Commander  
US Army Health Services Command  
ATTN: HSPE-HA  
Fort Sam Houston, TX 78234

<i>Organization/Location</i>	<i>MTF Code</i>	<i>ADAPCP Service Area Code</i>
1. Commander Fort Dietrick ATTN: Fort Dietrick CCC Frederick, MD 21701	1001	H01
2. Commander Fitzsimmons Army Medical Center ATTN: Fitzsimmons CCC Denver, CO 80240	1201	H02
3. Commander Walter Reed Army Medical Center ATTN: Walter Reed CCC 6925 16th Street, NW Washington, DC 20012	1001	H03

Table B-4. Diagnostic Concepts and Terminology

**1. General.** Individuals referred for medical evaluation will be diagnostically assessed utilizing terms, concepts and criteria consistent with the Diagnostic and Statistical Manual-3rd edition (DSM-III), American Psychiatric Association, 1980. It is to be emphasized that some individuals will use alcohol or other drug(s) in ways that do not meet the criteria required for specific DSM-III diagnosis of substance use disorder. Nevertheless, there may be evidence of problematical alcohol or other drug use that results in relatively ineffective psychological, social, or occupational functioning. In these instances, though a diagnosis of alcohol or other drug use disorder may not be rendered, awareness education or other rehabilitation or other rehabilitative services may be warranted in order to interrupt the pattern of misuse at the earliest possible time.

**2. Criteria. a. Alcohol or other drug abuse.** This general category includes diagnoses that are essentially equivalent to "psychological dependence." Three criteria must be met in order to diagnose alcohol or other drug abuse:

(1) There must be a pattern of pathological use. This may be manifested by the following:

(a) Intoxication throughout the day.

(b) Inability to decrease or stop use.

(c) Repeated efforts to control use through periods of temporary abstinence or restriction of use to certain times of the day.

(d) Continuation of use despite knowledge of the presence of a serious physical disorder aggravated by use of the substance.

(e) Need for daily use for adequate functioning.

(f) Episodes of complications of substance intoxication (e.g., alcoholic blackouts, opioid overdose).

(2) There must be impairment in social or occupational functioning caused by the pattern of pathological use, e.g., fights, loss of friends, absence from work, loss of job, legal difficulties, arguments with family or friends.

(3) There must be a minimal duration of disturbance of at least 1 month. Signs of the disturbance need not be continuously present throughout the month, but should be frequent enough for a *pattern* of pathological use causing interference with social or occupational functioning to be apparent.

*b. Alcohol or other drug dependence.* The only requirement is that there be evidence of *tolerance* or *withdrawal*, except for alcohol or cannabis, which, in addition, require that criteria *a*(1) and/or *a*(2) above also be met. Tolerance means that markedly increased amounts of the substance are required to achieve the desired effect or that there is a markedly diminished effect with regular use of the same dose. Withdrawal means that a substance-specific syndrome or symptom pattern follows cessation or reduction in the intake of the substance previously regularly used by the individual to induce a state of intoxication.

**3. Recording specific diagnoses. a.** In recording a specific diagnosis on the DA Form 4465 or 4466, the physician will record the *name of the specific substance(s) rather than the entire class of substance*. The name of the substance should be entered in item 8a-e of the DA Form 4465 or item 20 of the DA Form 4466. For example, the clinician should write—

(1) Amphetamine abuse, in remission (rather than amphetamine or sympathomimetic use disorder).

(2) Valium dependence, continuous (rather than barbiturate or similarly acting sedative or hypnotic use disorder with dependence).

(3) Compazine abuse, continuous (rather than other, mixed, or unspecified substance use disorder).

*b.* In addition to writing the specific substance, the clinician must indicate the specific course of the diagnosis rendered. The physician will complete each diagnosis of abuse or dependence using the following terms.

(1) *Continuous*. This is more or less regular maladaptive use for over 6 months.

(2) *Episodic*. This is a fairly circum-

scribed period of maladaptive use with one or more similar periods in the past.

(3) *In remission.* This is previous maladaptive use, but the client is not using the substance at present.

(4) *Unspecified.* This is a course of unknown nature or the first signs of illness with the course uncertain.

**4. Specific diagnoses.<sup>1,2</sup>** The physician will enter the following diagnoses in item 8 of DA Form 4465 or item 20 of DA Form 4466. (The physician will also enter the course description, for example, alcohol dependence, continuous.)

a. Alcohol abuse.

b. Alcohol dependence.

c. Barbiturate or similarly acting sedative or hypnotic abuse.

d. Barbiturate or similarly acting sedative or hypnotic dependence.

e. Opioid abuse.

f. Opioid dependence.

g. Cocaine abuse.

h. Amphetamine or similarly acting sympathomimetic abuse.

i. Amphetamine or similarly acting sympathomimetic with dependence.

j. Phencyclidine (PCP) or similarly acting arycyclohexylamine abuse.

k. Hallucinogen abuse.

l. Cannabis abuse.

m. Cannabis dependence.

n. Other or mixed substance abuse.<sup>3</sup>

o. Other or mixed specified substance dependence.<sup>3</sup>

<sup>1</sup> Each specific diagnosis should be completed with the course of abuse or dependence.

<sup>2</sup> A diagnosis code is not to be used by physicians when conducting medical evaluations. Record only the written diagnosis on the DA Form 4465 or 4466. Coding of each diagnosis will be completed at PASBA (HSHI-QPD), Fort Sam Houston, TX 78234.

<sup>3</sup> When multiple substances are involved, the clinician should record the substances from left to right in decreasing order of clinical importance, e.g., alcohol, valium and barbiturate dependence, continuous.

p. Dependence on a combination of opioid and other nonalcoholic substances.<sup>3</sup>

q. Dependence on a combination of substances, excluding opioids and alcohol.<sup>3</sup>

**5. No Diagnosis Apparent.** a. If during the diagnostic interview, sufficient information suggests illegal, improper or wrongful use of alcohol or other drugs which does not fully meet criteria for a formal diagnosis, the physician will enter "No Diagnosis Apparent" in item 8 of the DA Form 4465 or item 20 of the DA Form 4466. The physician will specify the substance involved as shown below:

(1) No diagnosis apparent, improper use of alcohol.

(2) No diagnosis apparent, improper use of amphetamines.

(3) No diagnosis apparent, improper use of barbiturates.

(4) No diagnosis apparent, improper use of cannabis.

(5) No diagnosis apparent, improper use of cocaine.

(6) No diagnosis apparent, improper use of hallucinogens.

(7) No diagnosis apparent, improper use of methaqualone.

(8) No diagnosis apparent, improper use of opioids.

(9) No diagnosis apparent, improper use of other tranquilizers (specify drug).

(10) No diagnosis apparent, improper use of phencyclidine.

(11) No diagnosis apparent, improper use of (specify drug).

b. The category "no diagnosis apparent" without an additional identifier of alcohol or other drugs will be used only when the physician cannot substantiate illegal, improper or wrongful use. In these cases the physician will confer with the rehabilitation team for proper disposition of the referral.

**6. Enrollment in Track I or II without medical evaluation or no diagnosis apparent.** For those clients that are enrolled in either Track I or II without medical evaluation or no diagnosis

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apparent, the ADAPCP counselor will indicate in item 8, DA Form 4465, the specific drug(s) in decreasing order of importance for which the client was enrolled for rehabilitation services, as follows:

- a. Alcohol.
- b. Amphetamines.
- c. Barbiturates.
- d. Cannabis.
- e. Cocaine.

f. Hallucinogens. (Specify specific drug rather than "hallucinogens.")

g. Methaqualone.

h. Opioids.

i. Tranquilizers. (Specify specific drug rather than "tranquilizer.")

j. Phencyclidine.

k. Other. (Specify specific drug rather than "other.")

**Table B-5. Federal Civilian Employee Categories and Pay Grades**

<i>Employee Categories</i>	<i>Codes and Pay Grades</i>
General Service	GS 01-18
Wage Grade	WG 01-15
Wage Leaders	WL 01-15
Wage Supervisors	WS 01-19
Non-Supervisory Production Schedulers	WD 01-11
Supervisory Production Schedulers	WN 01-09
General Merit (eff 1 Oct 81)	GM 13-15
Senior Executive Service	ES 16-18
Local Craft Workers	NA 01-15
Local Craft Leaders	NL 01-15
Local Craft Supervisors	NS 01-19
Administrative Services	AS 01-18
Universal Annual	UA 01-18
Personal Services	OS 01-07
Contract Workers	CW

**Table B-6. Length of Service Codes**

1. For item 16a of DA Form 4465, length of service will be indicated as follows:
  - a. For less than two years, list service in months.
  - b. More than two years, list service in years. Round down, e.g., 2 years 11 months will be coded as 02.
2. For item 16b length of service data code, one of the following will be used for coding information in block 16a.

<i>Length of service</i>	<i>Data codes</i>
One week or less .....	A1
Over one week to one month .....	A2
One month, less than two .....	A3
Two months, less than three .....	A4
Three months, less than four .....	B1
Four months, less than five .....	B2
Five months, less than six .....	B3
Six months, less than seven .....	C1
Seven months, less than eight .....	C2
Eight months, less than nine .....	C3
Nine months, less than 10 .....	D1
10 months, less than 11 .....	D2
11 months, less than 12 .....	D3
12 months, less than 16 .....	E1
16 months, less than 19 .....	F1
19 months, less than 22 .....	G1
22 months, less than 24 .....	H1
Two years, three years, etc. ....	02, 03, etc.

3. For item 16c, length of service present unit, enter one of the following appropriate data codes for service members:
  - a. For service members oversea, enter the appropriate data code for months or years assigned to the theatre.
  - b. For service members in CONUS, enter the appropriate data code for months or years assigned to the installation or activity.

FOR LOCAL USE ONLY			
CLIENT'S NAME <i>John D. Doe</i>		UNIT/OFFICE <i>HQ COMPANY, 24th Inf Div</i>	
<b>ADAPCP CLIENT PROGRESS REPORT (CPR)</b>		REQUIREMENT CONTROL SYMBOL	
For use of this form, see AR 600-85; the proponent agency is DCSPER.		CSGPA - 1400(R1)	
SEE REVERSE SIDE FOR PRIVACY ACT STATEMENT			
1. DATE REPORT IS DUE	2. SERVICE AREA CODE	3. CLIENT'S ID CODE	
a. <i>82/2/24</i> <small>(Yr - Mo - Day)</small>	b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>(Julian Date)</small>	a. <i>1371</i> <small>(Initial MTF Code)</small>	b. <i>F22</i> <small>(Current Area)</small>
4. ADD DIAGNOSTIC CODES	5. REASON FOR REPORT (Check appropriate box) (For 1st, 2d and 3d CPR, complete Sec A and blocks 20 thru 22c only.)		
a. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> c. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> d. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	a. <input type="checkbox"/> Released from Program    b. <input checked="" type="checkbox"/> 1st CPR    c. <input type="checkbox"/> 2d CPR    d. <input type="checkbox"/> 3d CPR e. <input type="checkbox"/> 4th CPR (Reporting completed) f. <input type="checkbox"/> PCS Loss Report    g. <input type="checkbox"/> PCS Gain Report h. <input type="checkbox"/> Change of Track (See Instructions for CPR)		
SECTION A - CLIENT'S PROGRESS REPORTING			
6. REHABILITATION METHODS USED SINCE INITIAL CIR OR LAST CPR (Check as many boxes as appropriate)			
a. <input checked="" type="checkbox"/> Awareness Education	b. <input checked="" type="checkbox"/> Individual Counseling	c. <input checked="" type="checkbox"/> Group Counseling	
d. <input type="checkbox"/> Antabuse	e. <input type="checkbox"/> Other Prescribed Medication	f. <input type="checkbox"/> Alcoholics Anonymous	
g. <input type="checkbox"/> Family Treatment	h. <input type="checkbox"/> Other (Specify) _____		
7. CLIENT'S STATUS AS OF REPORT DATE (Check as many boxes as appropriate)			
a. <input type="checkbox"/> Track I	b. <input checked="" type="checkbox"/> Track II	c. <input type="checkbox"/> Track III	
d. <input type="checkbox"/> Holding for Track _____	e. <input type="checkbox"/> In Confinement (Military or Civilian)	f. <input type="checkbox"/> AWOL 30 Days or Less (Service Member)	
g. <input type="checkbox"/> Other Hospitalization	h. <input type="checkbox"/> Other (Specify) _____		
8. REHABILITATION FACILITIES USED SINCE INITIAL CIR OR LAST CPR (Check as many boxes as appropriate)			
a. <input type="checkbox"/> Military Inpatient Detoxification	b. <input type="checkbox"/> Military Residential Treatment (RTF Code: <input type="text"/> <input type="text"/> )		
c. <input checked="" type="checkbox"/> ADAPCP Facility	d. <input type="checkbox"/> Other Civilian Facility		
COMPLETE BLOCK 9 BELOW ONLY IF CLIENT IS RELEASED FROM PROGRAM			
9. REASON FOR PROGRAM RELEASE (Check as many boxes as appropriate)			
AD/ADT Army Service Member			
a. <input type="checkbox"/> Program Completed	b. <input type="checkbox"/> Expiration Term of Service		
c. <input type="checkbox"/> Other Honorable Discharge	d. <input type="checkbox"/> Administrative Discharge (Alcohol or drug related)		
e. <input type="checkbox"/> Less than Honorable Discharge	f. <input type="checkbox"/> AWOL 31 Days or More (DFR)		
g. <input type="checkbox"/> Retired	h. <input type="checkbox"/> Death	i. <input type="checkbox"/> USAR/ARNG ADT Completed	j. <input type="checkbox"/> Transferred to VA
Civilian Employee or Other Client			
k. <input type="checkbox"/> Program Completed	l. <input type="checkbox"/> Leaving Federal Service		
m. <input type="checkbox"/> Terminated from Federal Service (Alcohol or drug related)	n. <input type="checkbox"/> Transferring to Another Federal Agency		
o. <input type="checkbox"/> Refuses Further ADAPCP Services	p. <input type="checkbox"/> Leaving ADAPCP Service Area		
q. <input type="checkbox"/> Retired	r. <input type="checkbox"/> Death	s. <input type="checkbox"/> Other (Specify) _____	
10. COUNSELOR'S ASSESSMENT OF PROGRESS DURING REHABILITATION		11. COMMANDER'S APPRAISAL OF PROGRESS AND MILITARY EFFECTIVENESS	
a. <input checked="" type="checkbox"/> Progressing	b. <input type="checkbox"/> Not Progressing	a. Efficiency: <input checked="" type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory	b. Conduct: <input checked="" type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory
12. ADAPCP RECOMMENDATION TO COMMANDER		13. TYPED NAME OF CLINICAL DIRECTOR/ COUNSELOR'S SUPERVISOR	
a. <input checked="" type="checkbox"/> Retention on Active Duty	b. <input type="checkbox"/> Separation	<i>Jane T. Spurling</i>	13c. DATE <i>25 Feb 82</i>
JANE T. SPURLING			
SECTION B - MILITARY CLIENT'S DISPOSITION			
14. COMMANDER'S ACTION:			
15a. TYPED NAME OF COMMANDER	15b. SIGNATURE	15c. DATE	
SECTION C - PCS LOSS OR GAIN REPORT			
16. DATE OF PCS LOSS	17. LOSING AREA CODE	18. DATE OF PCS GAIN	19. GAINING AREA CODE
a. _____ <small>(Yr - Mo - Day)</small>	b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>(Julian Date)</small>	a. _____ <small>(Yr - Mo - Day)</small>	b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>(Julian Date)</small>
20. REMARKS			
21a. TYPED NAME OF COUNSELOR		21b. SIGNATURE	
GAYLE SMITH		<i>Mrs Gayle Smith</i>	
22a. MILITARY MAILING ADDRESS OF ADCO <i>24th Inf Div Fort Stewart ATTN: AF2-PAP-AP(CCC) Fort Stewart GA, 31313</i>	22b. TYPED NAME OF ADCO	22c. SIGNATURE	
	JOHN T. MURPHY, MAJ, AG	<i>John T. Murphy</i>	

Figure B-4. DA Form 4466 (Client Progress Report) sample.

**Table B-7. Instruction for Completing DA Form 4466  
(Client Progress Report (CPR))<sup>1</sup>**

<i>Item</i>	<i>Title</i>	<i>Completed by</i>	<i>Remarks</i>
	Client's name.	ADAPCP staff.	For local use only. Include only on health record and ADAPCP client record copies. Information not to be forwarded to PASBA (HSHI-QPD). Enter office where civilian employee works.
	Client's unit/office.		
1	Date report is due.		
1a	Year, month, day.	ADAPCP staff.	Enter the date on which the CPR is actually due for the 1st, 2d, 3d, or 4th CPR reports. Program release reports will reflect the actual date the client is released from the program. PCS loss or gain reports will reflect the actual date a Army service member is a PCS loss or gain to an installation.
1b	Julian date.	PASBA (HSHI-QPD).	
2	Service area code.		
2a	Initial MTF code. <sup>2</sup>	ADAPCP staff.	Enter as <i>previously reported</i> in item 4a on the initial CIR.
2b	Current ADAPCP service area code.	ADAPCP staff.	Enter current ADAPCP area code of assignment from table B-3.
3	Client's ID code. <sup>2</sup>		
	Active duty/ADT military client.	ADAPCP staff.	Enter SSN for all military personnel as reported in item 3 of the initial CIR.
	Nonmilitary client code.	ADAPCP staff.	Enter the same client code as reported in item 3 of the initial CIR.
4	Additional diagnostic code(s).	PASBA (HSHI-QPD).	
5	Reason for report.	ADAPCP staff.	Check the entry which reflects the reason for report. A final program CPR will be submitted immediately when a client is released from the ADAPCP or when the client reaches the 360th day of a rehabilitation program. A CPR is required for each of the 90, 180, 270, or 360th day anniversary dates of enrollment in the ADAPCP. Clients that are entered into track I will receive a release from Pro-

**Table B-7. Instruction for Completing DA Form 4466  
(Client Progress Report (CPR))<sup>1</sup>—Continued**

<i>Item</i>	<i>Title</i>	<i>Completed by</i>	<i>Remarks</i>
			gram CPR at the end of track I services. Clients needing more intense services after Track I service may be transferred to track II or III through immediate submission of a completed CPR. Item 5h of the CPR will be completed and item 7 will show the client's new status. Item 20 will be completed showing the client's old track and new track and the reason for the client's change of track. A CPR is required when a Army service member is a PCS loss or PCS gain to an installation ADAPCP. Changes of program status other than change of tracks will be recorded on the next anniversary date submission of the CPR. Each client that is entered into the ADAPCP through the submission of a CIR, must be released from the ADAPCP through the submission of a CPR. The CPR for PCS loss must be completed in its entirety. The PCS gain record will only contain the information requested in items 1, 2, 3, and 5, and items 17, 18, 19, 20, and 22a, b, and c of section C.
6	Rehabilitation methods used since initial CIR or last CPR.	ADAPCP staff.	1st CPR: Check all entries applicable to client since entry into the ADAPCP through submission of the CIR.  Subsequent CPRs: Check only those methods used in rehabilitation since submission of the last CPR.
7	Client's status as of report date.	ADAPCP staff.	Check the client's status in the program as of the date of submission of the CPR. If the client is awaiting Track III services, check item 7d and complete the item.
8	Rehabilitation facilities used since initial CIR or last CPR.	ADAPCP staff.	1st CPR: Check all entries applicable to client since the client entered the ADAPCP through submission of a CIR. RTF code. <sup>3</sup>

**Table B-7. Instruction for Completing DA Form 4466  
(Client Progress Report (CPR))<sup>1</sup>—Continued**

<i>Item</i>	<i>Title</i>	<i>Completed by</i>	<i>Remarks</i>
			Subsequent CPRs: Check only those facilities used in rehabilitation since submission for the last CPR.
9	Reason for program release.	ADAPCP staff.	Check appropriate box(es) a-j for Army AD/ADT service members, and box(es) k-s for civilian employees and other clients being released from the program.
10	Counselor's assessment of progress during rehabilitation.	ADAPCP staff.	Check appropriate box.
11	Commander's appraisal of progress and military effectiveness.	ADAPCP staff.	The ADAPCP staff will complete the efficiency and conduct rating after consulting with the commander on the Army service member's efficiency and conduct during rehabilitation. Item 11 will be completed on each CPR submitted for Army service members.
12	ADAPCP recommendation to commander.	ADAPCP staff.	The ADAPCP staff will complete item 12 for each Army service member released from the program.
13a	Typed name of clinical director/counselor's supervisor.	Clinical director/ counselor supervisor.	Self-explanatory.
13b	Clinical director/counselor supervisor signature.	Clinical director/ counselor supervisor.	The clinical director or counselor supervisor will review each CPR for clinical and administrative accuracy before submission to the ADCO. Review will be indicated by signature in item 13b.
13c	Date.	Clinical director/ counselor supervisor.	Self-explanatory.
14	Commander's action.	Commander.	Commander will check appropriate box based upon planned action in each Army service member's case upon release from the ADAPCP. <i>Item 14 will be completed only when a Army service member is being released from the program.</i>

**Table B-7. Instruction for Completing DA Form 4466  
(Client Progress Report (CPR))<sup>1</sup>—Continued**

<i>Item</i>	<i>Title</i>	<i>Completed by</i>	<i>Remarks</i>
15a	Typed name of commander.	Commander.	Self-explanatory.
15b	Signature of commander.	Commander.	The commander will authenticate the planned action for each Army service member upon <i>release</i> of the service member from the program. The commander will authenticate the planned action by signing item 15b.
15c	Date.	Commander.	Self-explanatory.
16a	Date of PCS loss.	ADAPCP staff.	In addition to items 1 through 3 and item 5, the losing ADAPCP staff will complete section A and items 16, 17, 19, 20, 21, and 22 upon PCS of an Army service member.
16b	Julian date.	PASBA (HSHI-QPD).	
17	Losing area code.	ADAPCP staff.	
18a	Date of PCS gain.	ADAPCP staff.	
18b	Julian date.	PASBA (HSHI-QPD).	
19	Gaining area code.	ADAPCP staff.	In addition to items 1 through 3 and item 5, the gaining ADAPCP staff will complete section C, items 17, 18, 19, 20, 21, and 22 upon enrollment of the Army service member at the new duty station.
20	Remarks.	ADAPCP staff physician ADCO.	Complete if additional remarks will help to clarify the report. Physicians will enter additional diagnosis in accordance with table B-4.
21a	Typed name of counselor.	ADAPCP staff.	Self-explanatory.
21b	Signature of counselor.	ADAPCP counselor.	Must be signed by counselor. Unsigned forms will be returned.
22a	Military mailing address of ADCO.	ADAPCP staff.	Enter the complete mailing address of the ADCO and the organization to which assigned.
22b	Typed name of ADCO.	ADCO.	Self-explanatory.
22c	Signature of ADCO.	ADCO.	Must be signed by ADCO. Unsigned forms will be returned.

<sup>1</sup> Incomplete records will be returned to the submitting ADAPCP staff for completion.

<sup>2</sup> Items 3 and 2a on the CPR must be identical to items 3 and 2a on the CIR submitted for the same client. These items will not be changed for any client unless specifically requested by PASMA (HSHI-QPD).

<sup>3</sup> RTF Code, leave blank. For future use.

1 December 1981

ATZM-PA-AD

1 November 1981

SUBJECT: Letter of transmittal.

Commander  
US Army Patient Administration Systems  
and Biostatistics Activity  
ATTN: HSHI-QPD  
Fort Sam Houston, TX 78234

In accordance with AR 600-85, chapter 7, paragraph 7-12, the inclosed ADAPCP Client Intake Records (5), Client Progress Reports (11) and PCS loss (2) and gain reports (1) are submitted for the period 26 September through 25 October 1980.

FOR THE COMMANDER:

19 Incl  
as

LAWRENCE P. SMITH  
Major, IN  
Alcohol and Drug Control  
Officer

*Figure B-5. Letter of transmittal.*

1 December 1981

AR 600-85

ATZM-PA-AD

7 November 1980

SUBJECT: Request for confirmation of reassignment and enrollment of ADAPCP client.

Commander  
24th Inf Div & Fort Stewart  
ATTN: ATZ-PAP-AP (CCC)  
Fort Stewart, GA 31313

1. Request confirmation of assignment and enrollment in the ADAPCP of the following named individual. Upon notification of enrollment in your program the client's ADAPCP record will be forwarded per AR 600-85.
    - a. Name/rank/SSN: John D. Doe, PFC, 021-55-2495.
    - b. Status in program: Track II, nonresidential rehabilitation.
    - c. Program entry date: 29 September 1980.
    - d. Rehabilitation progress: Progressing.
    - e. Date of PCS loss report to PASBA (HSHI-QPD): 30 October 1980.
    - f. Physician diagnosis/basis for enrollment: Alcohol abuse, episodic.
    - g. Assignment instructions/reporting date: Headquarters Company, 24th Infantry Division, Fort Stewart, GA 31313. Reporting date, 10 November 1980.
    - h. Counselor's name/telephone number: Mrs. Gayle Smith, AV 687-2804
  2. The above information has been released to you from official ADAPCP rehabilitation records whose confidentiality is protected by Federal law and Army regulation.
- FOR THE COMMANDER:

LAWRENCE P. SMITH  
Major, IN  
Alcohol and Drug Control  
Officer

*Figure B-6. Sample request from ADCO to ADCO.*

1 December 1981

ATZM-PA-AD

7 November 1980

SUBJECT: Request for confirmation of reassignment and enrollment of ADAPCP client.

Commander of:  
PFC John D. Doe, 021-55-2495  
Company C, 793 Medical Company  
APO San Francisco 96334

1. The above named individual has been enrolled in the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) since 29 September 1980. Request that PFC John Doe be referred to your local Community Counseling Center (CCC) for further rehabilitative counseling services per AR 600-85.

2. In order for counseling service to continue, the following information is provided for your local CCC staff.

- a. Name/rank/SSN: John D. Doe, PFC, 021-55-2495.
- b. Status in program: Track II, nonresidential rehabilitation.
- c. Program entry date: 29 September 1980.
- d. Rehabilitation progress: Progressing.
- e. Date of PCS loss report to PASBA (HSHI-QPD): 30 October 1980.
- f. Physician diagnosis/basis for enrollment: Alcohol abuse, episodic.
- g. Assignment instructions/reporting date: Company C, 793 Medical Company, APO SF 96334. Reporting date, 10 November 1980.
- h. Counselor's name/telephone number: Mrs. Gayle Smith, AV 687-2804

2. The information in paragraph 2 of this correspondence has been released to you from official ADAPCP rehabilitation records whose confidentiality is protected by Federal Law and Army regulation. It is requested that this correspondence be forwarded to the servicing CCC staff at the time of referral of the individual for enrollment.

FOR THE COMMANDER:

LAWRENCE P. SMITH  
Major, IN  
Alcohol and Drug Control  
Officer

*Figure B-7. Sample request from ADCO to unit commander.*

1 December 1981

AR 600-85

ATZM-PA-AD

7 November 1980

SUBJECT: Request for confirmation of reassignment and enrollment of ADAPCP client.

THRU: Commander  
21st (AG) Replacement Battalion  
APO New York 09057

TO: Commander  
PFC John D. Doe, 021-55-2495

1. In accordance with AR 600-85, request this correspondence be immediately forwarded to the unit commander of PFC John D. Doe, 021-55-2495 for immediate action.
2. The above named individual has been enrolled in the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) since 29 September 1980. Request that PFC John Doe be referred to your local Community Counseling Center (CCC) for further rehabilitative counseling services.
3. In order for counseling service to continue, the following information is provided for your local CCC staff.
  - a. Name/rank/SSN: John D. Doe, PFC, 021-55-2495.
  - b. Status in program: Track II, Nonresidential rehabilitation.
  - c. Program entry date: 29 September 1980.
  - d. Rehabilitation progress: Progressing.
  - e. Date of PCS loss report to PASBA (HSHI-QPD): 30 October 1980.
  - f. Physician diagnosis/basis for enrollment: Alcohol abuse, episodic.
  - g. Assignment instructions/reporting date: 21st (AG Replacement Battalion, APO New York 09057. Reporting date, 10 November 1980.
  - h. Counselor's name/telephone number: Mrs. Gayle Smith, AV 687-2804.
4. The information in paragraph 3 of this correspondence has been released to you from official ADAPCP rehabilitation records whose confidentiality is protected by Federal Law and Army Regulation. It is requested that this

*Figure B-8. Sample request from ADCO to replacement activity commander.*

ATZM-PA-AD

7 November 1980

SUBJECT: Request for confirmation of reassignment and enrollment of ADAPCP client.

correspondence be forwarded to the servicing CCC staff at the time of referral of the individual for enrollment.

FOR THE COMMANDER:

LAWRENCE P. SMITH  
Major, IN  
Alcohol and Drug Control  
Officer

1 December 1981

AR 600-85

AFUF-JFO-CCC

20 November 1980

SUBJECT: Request for ADAPCP client case file

Commander  
24th Inf Div & Fort Stewart  
ATTN: ATZ-PAP-AP (CCC)  
Fort Stewart, GA 31313

1. In accordance with AR 600-85, request that the following named Army service member's complete ADAPCP client case file be forwarded to this location for continuation in rehabilitation counseling. The following information is provided for confirmation of enrollment:

- a. Name/rank/SSN: John D. Doe, PFC, 021-55-2495.
- b. Date of enrollment at new assignment: 20 November 1980.
- c. Date of PCS gain report to PASBA (HSHI-QPD): 20 November 1980.
- d. Mailing address for gaining ADAPCP: Community Commander  
Hanau Military Community  
ATTN: Hanau North CCC  
Francois Kaserne  
APO New York 09165

FOR THE COMMANDER:

FRANK T. DOBBS  
MAJ, AR  
Alcohol and Drug Control Officer

*Figure B-9. Sample request for ADAPCP client case file.*

**AUTHORITY.**

Title V, Public Law 92-129 Section 413, Public Law 92, 255

**PRINCIPAL PURPOSES.**

- a. To provide statistical information for program evaluation.
- b. To document ADAPCP initial screening interview workload.
- c. To provide a ready reference for the ADAPCP staff of clients and potential clients who received an initial interview and the disposition of each client.

**ROUTINE USES.**

a. *Active Army service members.* Release of any information from the ADAPCP is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137; 42 USC 4582 as amended by 88 Stat 131; and Chapter 1, Title 42, Code of Federal Regulations. Under these statutes and regulations, disclosure is authorized within the Armed Forces or to those components of the Veterans Administration furnishing health care to veterans. AR 600-85 further limits disclosure within the Armed Forces to those individuals having an official need to know (for example, the physician or the client's unit commander). All other disclosures require the written consent of the client except disclosures (1) to medical personnel outside the Armed Forces to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial audits or program evaluation; or, (3) upon the order of a court of competent jurisdiction.

b. *Civilian employees and other personnel.* Release of any information from the ADAPCP Log is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137, 42 USC 4582 as amended by 88 Stat 131, and Chapter 1, Title 42, Code of Federal Regulations. All disclosures require the written consent of the client except disclosures (1) to medical personnel to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial audits or program evaluation; or, (3) upon the order of a court of competent jurisdiction.

c. *Studies.* Information contained in the ADAPCP Log is an internal record of contacts. The log is maintained in the ADAPCP facility and is maintained in the same manner as an ADAPCP client case file.

**MANDATORY/VOLUNTARY DISCLOSURE AND EFFECT ON AN INDIVIDUAL NOT PROVIDING INFORMATION**

a. Disclosure is mandatory for Active Army service members. Failure to obey an order from competent authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.

b. Disclosure is voluntary for civilian employees and other personnel. Failure to disclose the information will result in a reduced capability of the program to provide proper treatment and services.

*Figure B-10. Data required by the Privacy Act of 1974.*

**APPENDIX C**  
**CONDITION OF EMPLOYMENT**  
**FOR CERTAIN CIVILIAN EMPLOYEE POSITIONS IN**  
**SUPPORT OF THE ADAPCP**

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C-1. Civilian employees are not subject to commander-directed urinalysis for purposes of initial identification as an alcohol or other drug abuser. Civilian employees working within the ADAPCP must remain drug free and, therefore, will be tested as a condition of this employment.

C-2. DA Form 5019-R (Condition of Employment for Certain Civilian Employee Positions in Support of the Alcohol and Drug Abuse Prevention and Control Program), shown in figure C-1, will be used as the condition of employment, and continuing employment, agreement which is applicable to appropriate members of the ADAPCP staff (para 3-16b(5)). Since working arrangements within the program change from time to time, this requirement should be explained to all civilian employees within the ADAPCP (para 1-25d). For exceptions to staff testing requirement, see paragraph 3-16b(5).

(Fig. C-1 (DA Form 5019-R) is on a fold-in page and is located at the end of the regular-size pages.)

## APPENDIX D

### TRAINING AND EDUCATION STANDARDS AND GUIDELINES

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**D-1. General.** This appendix contains the following:

- a. Minimum standards for Track I, alcohol and other drug awareness education.
- b. Guidelines for ADAPCP education and training.

**D-2. Minimum standards for Track I, alcohol and other drug awareness education.** a. Track I alcohol and other drug awareness education will be instituted at all Army installations and military communities where a formal ADAPCP exists. The ADCO is responsible to the commander for instituting and evaluating the program in his or her installation or community. The EDCO is responsible for design and coordination of the program and, where qualified, will assist in instruction. The clinical director and the rehabilitation staff will assist the EDCO by providing instructors for technical and clinical instruction and any clinical assessment of a client that may be required. Other resources within the community include the safety officer, provost marshal, Staff Judge Advocate, chaplain, ACS, Organizational Effectiveness Staff officer, and qualified volunteers. Such personnel may be called upon to assist in the development, conduct, and evaluation of awareness education.

b. The goals of Track I awareness education include the following areas:

- (1) Alcohol and other drug awareness. Emphasis is upon the entire spectrum of drinking and drug taking behavior, not solely on alcoholism and drug dependency.
- (2) Participant self evaluation of personal drinking habits and patterns, attitudes toward use and abuse of other drugs.
- (3) Impact of alcohol and other drug abuse upon career, health, family, and other social relationships.

(4) Resources available within the community/command for support in any decision to change abusive drinking or other drug taking behavior.

(5) Strategies, opportunity, and support for those who wish to change drinking and drug taking behavior.

c. Track I awareness education is an educational approach to behavior change and is not designed to be treatment for alcoholism or drug dependency. Nor is it designed for individual or group counseling. Individuals who are found to be or who discover themselves to be in a serious situation with regard to abuse or dependency of alcohol or other drugs must be referred to other tracks.

d. The minimum standards for Track I awareness education are as follows:

(1) Awareness education will consist of at least 12 hours, but may be longer. Any brief individual or group counseling of a client or assessment will not be counted as part of the minimum 12 hours.

(2) Size of the group should not exceed 15 persons so that group participation can be maximized.

(3) Family participation is encouraged, but not required.

(4) Timing and sequencing is not prescribed here. However, the following subject areas will be covered for either alcohol, other drugs, or both as the design dictates:

(a) Self-measurement, self-evaluation instruments that measure knowledge and attitudes about alcohol or other drugs and that impact on the awareness of individual drinking or drug taking behavior.

(b) Appropriate and applicable command policies, Army regulations, and state laws governing the use of illegal drugs, driving while intoxicated (DWI) and other violations com-

monly committed under the influence of alcohol or other drugs.

(c) Applicable provisions of Army regulations such as AR 600-85, AR 635-200, and AR 50-5.

(d) Information on definitions and the nature of alcohol and/or other drugs. This includes how they affect the human body, mind, and overall health.

(e) Information about the impact of alcohol and/or other drugs on career, family, and other social relationships.

(f) Causes and conditions which lead to the abuse of alcohol and/or other drugs to include stress, peer pressure, alienation and loneliness.

(g) Resources available for support and assistance in overcoming problems with alcohol and other drugs.

(h) Support systems available within the community and family and means to obtain that support.

(i) Development of goals, strategies, and individual "action plans" for each participant wishing to change drinking or drug taking behavior.

### D-3. Guidelines for ADAPCP education and training.

a. All films and videotapes must conform to guidelines established by the Education and Training Subcommittee of the DOD Drug and Alcohol Advisory Committee before purchase or use by an Army program. To obtain review of any film or videotape by the DOD Education and Training Subcommittee contact, through channels, the Alcohol and Drug Policy Office, HQDA(DAPE-HRA), WASH DC 20310.

b. Films and videotapes intended for use only with professional and paraprofessional audiences do not require review by the DOD Education and Training Subcommittee. Such audiences include physicians, chaplains, counselors, law enforcement personnel, alcohol and drug abuse program staff.

c. All alcohol and other drug abuse education materials which do not comply with the guidelines in this chapter will be modified or removed from circulation as soon as possible.

d. The following guidelines will govern all

prevention education and training conducted for DA audiences:

(1) The kinds of instructional techniques and strategies listed below generally have proven to be either ineffective or counter-productive. Thus, education employing the following techniques will not be used:

(a) Exaggerating risks and making fear the main deterrent to future use.

(b) Relying on "preaching" or "sermonizing" to convince the audience not to abuse alcohol or other drugs.

(c) Using stereotypes for characters and settings, such as only minorities are abusers and pushers, drug abusers are hippies, the alcoholic is a skid row bum, only young people abuse drugs, or only illegal drugs are abused.

(d) Demonstrating the use of illegal drugs.

(2) As with other manifestations of human behavior, alcohol and other drug abuse have a variety of causes. Educational solutions for prevention require a variety of approaches taking into consideration all aspects of the problem from the obvious indicators to the more obscure variations. Instruction which presents the following concepts is encouraged:

(a) The nature of chemicals, medicines, alcohol and other drugs and their psychological, sociological, and pharmacological effects.

(b) The harmful effects of the abuse of alcohol and other drugs upon one's physical and mental well-being, interpersonal relations, and short and long range personal goals.

(c) The legal implications and consequences of the use and abuse of alcohol and other drugs.

(d) How alcohol and other drug abuse is related to accidents, absenteeism, degradation of work effectiveness, and family problems.

(e) Conditions that help to solve the problem of abuse of alcohol and other drugs are—

(1) Better communications.

(2) People who have a feeling of control over their own lives and a purpose in living.

(3) Value structures which emphasize long range personal goal setting.

(4) A better understanding of leadership, decisionmaking, attitudes and values.

## APPENDIX E

### AREA RESPONSIBILITIES OF SUPPORTING LABORATORIES

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#### CONUS

<i>Laboratory</i>	<i>Area Supported</i>
<p>Drug Testing Laboratory Department of Pathology (WI AMC) Ft Meade, MD 20755 AUTOVON: 923-4076/6075</p>	<p>Connecticut, Delaware, Indiana, Kentucky, Maine, Maryland, Massachusetts, Military, District of Washington, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, West Virginia</p>
<p>Epidemiology Division Drug Detection Branch School of Aerospace Medicine Brooks AFB, TX 78253 AUTOVON: 240-2604/3188/3165</p>	<p>Arizona, Arkansas, Colorado, Idaho, Illinois, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Utah, Wisconsin, Wyoming</p>
<p>Drug Screening Laboratory Naval Regional Medical Center Jacksonville, FL 32214 AUTOVON: 942-2497</p>	<p>Alabama, Florida, Georgia, South Carolina</p>
<p>Drug Screening Laboratory Naval Regional Medical Center Oakland, CA 94627 AUTOVON: 855-2123/2244</p>	<p>California, Nevada, Oregon, Washington</p>

#### OVERSEA (OCONUS)

<p>Drug Screening Laboratory Naval Regional Medical Center Jacksonville, FL 32214 AUTOVON: 942-2497</p>	<p>Panama Canal Zone, Puerto Rico</p>
<p>Drug Testing Laboratory Wiesbaden Air Base APO NY 09457 AUTOVON: Weisbaden Military 5721/5185</p>	<p>European Command</p>
<p>Drug Testing Laboratory USA Tripler Medical Center Schofield Barracks HI 96857 AUTOVON: 655-9253/9133</p>	<p>Hawaii, Korea, Japan, Okinawa, Taiwan, Philippines, Guam</p>
<p>Drug Screening Laboratory Naval Regional Medical Center Oakland, CA 94627 AUTOVON: 855-2123/2244</p>	<p>Alaska</p>

## APPENDIX F

### PROCEDURES FOR MEDICAL EVACUATION FOR TRANSFER TO THE VETERANS ADMINISTRATION

**F-1. Purpose.** The purpose of this appendix is to provide guidance on the separation processing for those alcohol or other drug dependent AD or ADT members being transferred via medical evacuation to a Veterans Administration (VA) medical facility prior to separation.

**F-2. Objectives.** The objectives of these procedures are—

*a.* To insure completion of separation processing for those members being transferred to the VA.

*b.* To process those members for separation who do not desire transfer to a VA medical facility, in the normal manner.

**F-3. Concept.** For those members being transferred to the VA, discharge from the Army will occur subsequent to the member's arrival at the VA medical facility. This will require the completion of some steps of separation processing before the members depart for the VA. Additional steps will be completed after the member's arrival at the VA. The expeditious processing of members being transferred to the VA will reduce opportunities for further alcohol or other drug involvement. It will facilitate continuity of the rehabilitation effort and result in the efficient transfer to civilian life.

**F-4. Procedures for members assigned to CONUS units.** *a.* The commander of a member designated for transfer to a VA medical facility prior to discharge from the Army will, in the order below:

(1) Initiate and complete administrative discharge proceedings. This will include asking a member in writing if he or she desires to be transferred to a VA medical facility.

(2) Request that the supporting MEDCEN/MEDDAC obtain a VA bed designation from the Armed Services Medical Regulating Office (ASMRO).

(3) Request the Military Personnel Office (MILPO) publish orders reassigning the member to the separation transfer point (STP) listed in the ASMRO message. This request will be deferred until notification that a VA bed designation has been received and administrative discharge proceedings, including medical examination, have been completed.

(4) Furnish copies of the ASMRO message designating a VA bed to the MILPO and the STP listed in the ASMRO message.

*b.* Upon notification by the member's commander, the losing MILPO will issue discharge orders (Format 501, app A, AR 310-10).

(1) The MILPO will prepare and distribute the orders as follows:

(*a.*) Assign the member to the US Army separation transfer point shown in the ASMRO message.

(*b.*) Enter a reporting date that coincides with the date that the member will physically complete separation processing.

(*c.*) Enter a date of discharge that is exactly 15 days from the expected arrival date of the member at the VA medical facility.

(2) The additional instructions portion of the order will include the authority for the member and family members (by name and relationship) to receive the same benefits and entitlements as authorized by their identification cards. This will be valid for a period of 30 days from the date the order is issued. Example: You and your family members are authorized medical care, exchange privileges, and admission to military theaters until 31 May 1980. (Mary S., wife; Samuel U., son).

(3) The additional instructions portion of the order will also include the statement, "You will be admitted to the (enter MEDCEN/MEDDAC shown in the ASMRO message) for medical evaluation direct to (enter VA medical facility shown in the ASMRO message)."

(4) Distribution will include one copy of the VA medical facility to which the member will be evacuated, addressed to the attention Chief, Medical Administration Service #136, and one copy for the CONUS MEDCEN/MEDDAC shown in the ASMRO message.

c. Prior to being medically evacuated to the VA, the member will physically report to and complete separation processing at the STP. The responsible STP commander or chief will accomplish separation processing actions as outlined in AR 635-10, paragraph 3-7, except for final pay and the departure ceremony. These actions will include:

(1) Collecting identification cards of the member and of any family members.

(2) Preparing DD Form 214 (Certificate of Release or Discharge from Active Duty) under AR 635-5.

(3) Obtaining from the member the address to which the final pay check, copies 1 and 4 of DD Form 214, and discharge certificate will be mailed.

d. The MEDCEN/MEDDAC which obtains the VA bed designation will insure that the clinical and health record accompanies the member to the VA.

e. For strength accountability purposes at the STP, the member will be carried as present for duty (PDY) until the effective date of discharge. (See AR 680-1.)

f. If, after evacuation of the VA, the member is not returned to military control and is not reported by the VA as either AWOL or deceased, the responsible finance and accounting officer (FAO) and STP commander or chief will—

(1) Distribute DD Form 214 under AR 635-5.

(2) Mail the final pay check, copies 1 and 4 of DD Form 214, and discharge certificate to the member on the next duty day following the effective date of discharge.

(3) Dispose of the Military Personnel Records Jacket (MPRJ) and accompanying documents under AR 635-10, appendix E.

(4) Submit the Standard Installation/Division Personnel System (SIDPERS) separation transaction on the next duty day following the effective date of discharge.

**F-5. Procedures for members assigned to OCONUS units.** a. The commander of a member designated for transfer to a VA medical facility prior to discharge from the Army will, in the order below:

(1) Initiate and complete administrative discharge proceedings. This will include asking a member in writing if he desires to be transferred to a VA medical facility.

(2) Request that supporting OCONUS MEDCEN/MEDDAC obtain a VA bed designation from the ASMRO.

(3) Request that the MILPO publish orders assigning the member to the STP listed in ASMRO message and start separation processing. This will be done after notification that a VA bed designation has been received and administrative discharge proceedings (including medical examination) have been completed.

(4) Furnish a copy of the ASMRO message designating a VA bed to the MILPO.

b. Upon notification by the member's commander the MILPO having custody of the member's MPRJ will accomplish separation processing actions listed below. (This will not include final pay, preparation of DD Form 214, and discharge certificate which will be accomplished by the CONUS STP. (See para d.)

(1) Issue discharge orders (Format 501, app A, AR 310-10). Prepare and distribute orders as follows:

(a) Assign the member to the US Army STP shown in the ASMRO message. (This will be for records processing only.)

(b) Enter a reporting date that is exactly 15 days after the expected arrival date of the member at the VA.

(c) Enter a date of discharge that is exactly 15 days after the expected arrival date of the member at the VA.

(2) The additional instructions portion of

the order will include the authority for the member and family members (by name and relationship) to receive the same benefits and entitlements as authorized by their identification cards. This will be valid for a period of 30 days from the date of the order is issued. Example: You and your dependents are authorized medical care, exchange privileges, and admission to military theaters until 31 May 1980. (Mary S., wife; Samuel U., son).

(3) The additional instructions portion of the order will also include the statement, "You will be admitted to the (enter MEDCEN/MEDDAC shown in the ASMRO message) for medical evacuation direct to (enter VA medical facility shown in the ASMRO message)."

(4) Distribution will include one copy of the VA medical facility to which the member will be evacuated, addressed to the attention Chief, Medical Administration Service #136, and one copy for the OCONUS MEDCEN/MEDDAC shown in the ASMRO message.

(5) Prepare DD Form 214WS (Worksheet for Certificate of Release or Discharge from Active Duty) and insert it in the member's MPRJ.

(6) Conduct the separation orientation (AR 635-10).

(7) Collect the identification cards of the member and of any family members.

(8) Obtain from the member the address to which the member desires the final paycheck, copies 1 and 4 of DD Form 214, and discharge certificate to be mailed by the CONUS STP.

(9) Have the member complete a OVR-2 (Reemployment Rights and Employment Data), DD Form 1407 (Dependent Medical Care and DD Form 1173 Statement), and DA Form 664 (Service member's statement concerning application for compensation from the Veterans Administration (VA Form 21-526E)). Include these forms in the MPRJ.

(10) Forward to the CONUS STP named in the discharge orders (para (1)), on the day of the member's medical evacuation, the following: (This in most cases will require expeditious telephonic communication with the OCONUS MEDCEN/MEDDAC.)

(a) The member's MPRJ, to include sufficient copies of discharge orders, an original copy of approved administrative discharge proceedings, and a copy of the separation medical examination.

(b) The member's Personal Financial Record (PFR).

(c) One copy of the ASMRO message.

(d) Notification that the health record has accompanied the member to the VA.

c. Upon transfer, the OCONUS MEDCEN/MEDDAC will—

(1) Insure that the inpatient treatment record and health record accompanies the member to the VA.

(2) Transport the member to the VA medical facility only after the unit commander advises that—

(a) The original copy of the approved administrative discharge proceedings and a copy of separation medical examination is in MPRJ.

(b) The original separation medical examination is in health records.

d. The CONUS FAO and STP commander or chief, upon receipt of the member's MPRJ, PFR, discharge orders, and ASMRO message will—

(1) Contact the VA medical facility listed in the discharge orders (and also listed in the ASMRO message) to determine the date of the member's arrival at the VA. (OCONUS members will not physically report to the CONUS STP.)

(2) Indorse the discharge order to show the correct effective date of discharge if the member arrived at the VA more than 15 days before the scheduled date of discharge shown in the order.

(3) Rescind the unexecuted portion (Format 705, app A, AR 310-10) of the discharge order and issue Format 500, appendix A, AR 310-10, if the member arrived at the VA before the scheduled date of discharge, but less than 15 days before the scheduled date of discharge shown in the order.

(4) Indorse the discharge order to show the actual effective date of discharge if the member reports to VA and his or her discharge

from the Army is delayed due to lack of documentation. Example: No approved administrative discharge proceedings, no separation medical examination, or discharge orders not received at CONUS FAO/STP.

(5) Prepare DD Form 214 under AR 635-5.

(6) Compute the member's final pay.

(7) Distribute DD Form 214 under AR 635-5.

(8) Mail final pay check, copies 1 and 4 of DD Form 214, and discharge certificate to the

member at the address furnished by the member (para F-5b(5)) on the next duty day following the effective date of discharge. (This will not be done if the member was returned to military control by the VA, or was reported as either AWOL or deceased by the VA prior to the effective date of discharge.)

(9) Dispose of the MPRJ and accompanying documents under AR 635-10, appendix E.

(10) Submit the SIDPERS separation transaction on the next duty day following the effective date of discharge.

## APPENDIX G

### MANAGEMENT INFORMATION REPORTS

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G-1. ADAPCP Summaries (DA Form 3711-R) are required each month from the following CONUS installations and oversea areas:

a. *FORSCOM.*

- (1) Ft Bragg, NC
- (2) Ft Campbell, KY
- (3) Ft Carson, CO
- (4) Ft Devens, MA
- (5) Ft Drum, NY
- (6) Ft Hood, TX
- (7) Ft Indiantown Gap, PA
- (8) Ft Irwin, CA
- (9) Ft Lewis, WA
- (10) Ft McPherson, GA
- (11) Ft Meade, MD
- (12) Ft Ord, CA
- (13) Ft Polk, LA
- (14) Presidio of San Francisco, CA
- (15) Ft Riley, KA
- (16) Ft Sam Houston, TX
- (17) Ft Sheridan, IL
- (18) Ft Stewart, GA

b. *TRADOC.*

- (1) Ft Belvoir, VA (Vint Hill Farms, VA)
- (2) Ft Benjamin Harrison, IN
- (3) Ft Benning, GA
- (4) Ft Bliss, TX
- (5) Carlisle Barracks, PA
- (6) Ft Dix, NJ
- (7) Ft Eustis, VA
- (8) Ft Gordon, GA
- (9) Ft Hamilton, NY
- (10) Ft Jackson, SC
- (11) Ft Knox, KY
- (12) Ft Leavenworth, KS
- (13) Ft Lee, VA
- (14) Ft Leonard Wood, MO
- (15) Ft McCellan, AL
- (16) Ft Monroe, VA
- (17) Ft Rucker, AL
- (18) Ft Sill, OK

c. *DARCOM*. DARCOM installations and activities not listed will submit data to the next higher command or servicing installation, which will submit a consolidated report.

- (1) HQ DARCOM, Alex, VA
- (2) HQ ARMCOM, Rock Island, IL
- (3) HQ TSARCOM, St. Louis, MO
- (4) HQ ECOM, Ft Monmouth, NJ
- (5) HQ MICOM, Redstone Arsenal, AL
- (6) HQ TACOM APG, MD
- (7) HQ TECOM, APG, MD
- (8) Anniston Army Depot, Anniston, AL
- (9) Corpus Christi Army Depot, Corpus Christi, TX
- (10) Letterkenny Army Depot, Chambersburg, PA
- (11) Lexington-Bluegrass Army Depot, Lexington, KY
- (12) New Cumberland Army Depot, New Cumberland, PA
- (13) Red River Army Depot, Texarkana, TX
- (14) Sacramento Army Depot, Sacramento, CA
- (15) Seneca Army Depot, Romulus, NY
- (16) Sharpe Army Depot, Lathrop, CA
- (17) Sierra Army Depot, Herlong, CA
- (18) Tobyhanna Army Depot, Tobyhanna, PA
- (19) Tooele Army Depot, Tooele, UT

d. *Other*. CONUS installations/activities.

- |   |              |
|---|--------------|
| (1) Ft Detrick, MD                      | (HSC)        |
| (2) Fitzsimons Army Medical Center, CO  | (HSC)        |
| (3) Walter Reed Army Medical Center, DC | (HSC)        |
| (4) Ft Huachuca, AZ                     | (USACC)      |
| (5) Ft Ritchie, MD                      | (USACC)      |
| (6) Military District of Washington     | (MDW)        |
| (7) USMA West Point, NY                 | (DCSPER, DA) |
| (8) MTMC, Eastern Area, Bayonne, NJ     | (MTMC)       |
| (9) MTMC, Western Area, Oakland, CA     | (MTMC)       |

e. *Oversea areas*.

- | <i>Area</i>      | <i>Responsible command</i> |
|------------------|----------------------------|
| (1) Europe       | USAREUR                    |
| (2) Berlin       | USAREUR                    |
| (3) SETAF        | USAREUR                    |
| (4) Alaska       | FORSCOM                    |
| (5) Panama       | FORSCOM                    |
| (6) Hawaii       | WESCOM                     |
| (7) Korea        | EUSA                       |
| (8) Japan        | USARJ                      |
| (9) Okinawa      | USARJ                      |
| (10) Puerto Rico | FORSCOM                    |

G-2. Instructions for completing DA Form 3711-R (Alcohol and Drug Abuse Prevention and Control Program Summary) (fig. G-1, fold-ins) are as follows:

*Section A—Installation/MACOM Identifying Data.**Line*

- 1 Enter the full mailing address including the "ATTN:" line.
- 2 Enter the acronym for the MACOM which operates the installation, e.g., FORSCOM, USACC, TRADOC.
- 3 Enter the ADAPCP area code from table B-3 on each page of report.
- 4 Enter the report period, e.g., 26 Dec 80 to 25 Jan 81.
- 5 Enter the name, title, and the AUTOVON telephone number of the person preparing the report.
- 6 Enter the name, grade, title, and signature of the person who is the authenticator for the report.
- 7 Signature of authenticator of the report.

*Section B—ADAPCP Rehabilitation Facilities and Staff.*

*Note.* For sections B through G, negative (zero) entries for any cell will be indicated by leaving cells blank.

*Line*

- 8 and 9 Enter the number of nonresidential CCC facilities and RTFs operated on the installation. Do not count the number of buildings being used for CCC facility. Count only the formal organization. Include satellite CCC facilities that are under the supervision of a clinical director. If the installation MEDDAC operates a RTF include that RTF. Do not report a RTF operated on another installation even though those facilities service your clients. Classify and report CCC and RTF facilities by the type of clients treated, i.e., alcohol only, drug only, or a combination of alcohol and drug.
- 10-14 Report all staff working within the ADAPCP (both garrison and medical TDA). Report the number of authorized spaces on appropriate TRAs in columns b, d, and h. Report special duty personnel (includes troop diversions) or other personnel assigned elsewhere but working in the ADAPCP in columns j and k. Report military personnel with a 91G MOS on the line which describes their assignment against an authorized TDA space, not where they may be working. Count personnel only once even though they may be responsible for other functions.
- 10 Administration—Report the number of personnel authorized and assigned to administration to include the ADCO, Civilian Program Coordinator, clerical staff, and personnel responsible for urine collection.
- 11 Counseling services—Report the number of personnel authorized and assigned to counseling services. Include supervisory counselors but not the clinical director.
- 12 Clinical directors—Report the authorization and assignment of the clinical director. Do not report supervisory counselors even though there is not a clinical director assigned to the CCC facility. Report a clinical director only once even though the clinical director may supervise several CCC facilities.
- 13 Prevention Education/Training—Report the authorization and assignment of personnel assigned to the education and training function. This will include the EDCO and other personnel whose activity is primarily education and training.
- 14 Total—Sum of each column.

*Note.* Twice each calendar year, on the February and August reports, report the number of personnel included in section B that are authorized and assigned against a medical TDA. This report will be presented in the remarks section following section D in the following format:

*Medical TDA Staff Personnel*

<i>Officer</i>	<i>Enlisted</i>	<i>Civilian</i>
Authorized/assigned	Authorized/assigned	Authorized/assigned
Administrative		
Counseling services		
Clinical director		
Education/training		

*Section C—ADAPCP Functions, Activities, and Services—Man-hours and Workload.*

This section describes the personnel effort (man-hours and workload) required to accomplish the ADAPCP mission. Where man-hours are required, report only whole hours even though the data are collected in less than 1 hour increments.

<i>Column</i>	<i>Description</i>
<i>b</i>	Man-hours—Man-hours reported will be those expended by the ADAPCP staff in the reported activity, including preparation time. If the total time expended exceeds or is less than the working time available during the report month explain the difference in remarks.
<i>c</i>	Number of courses—Enter the number of courses that were conducted by ADAPCP staff members. Where a course consisted of several sessions spread over one or more days, report only one course. Data will include those courses provided to units, schools, community centers, or other locations outside the ADAPCP facilities.
<i>d</i>	Number of students—Enter the total number of students attending each course (lines 17-22) during the report period.
<i>e</i>	Number of Visits—Enter the actual number of visits during the report period. The key to reporting a visit is the documentation of the event in appropriate records such as the client case file or the ADAPCP log of contacts for screening. <p>(a) A visit may be counted each time a client or potential client is seen by a counselor or other care provider for screening, rehabilitation counseling, consultation or medical advice. This is a visit for which a signed and dated entry is made in a client case file, other record or log of such treatment or contact.</p> <p>(b) Other examples of client or potential client contacts are—</p> <ol style="list-style-type: none"> <li>(1) Each time a potential client is screened even though the individual is referred to another agency for counseling.</li> <li>(2) Each time a previous client is seen for crisis intervention or other rehabilitation services.</li> <li>(3) Each time medical advice or consultation, e.g., crisis intervention, is provided by telephone, <i>if properly</i> documented in an appropriate record or log.</li> </ol> <p>(c) For group counseling sessions count each patient attending as one visit without regard to the length of the session or the number of counselors involved as long as the requirements for documentation are satisfied.</p>

*Line*

15	Man-hours Spent in Administrative Support—Enter the total number of man-hours spent in the administrative aspects of the ADAPCP during the report month. This will include, but not be limited to, the following functions: personnel, supply, reports preparation, administrative control of the urinalysis testing program, writing of case notes.
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*Line*

- 16 Man-hours Spent in Planning and Evaluation—Enter the total number of man-hours spent in the functions of planning and evaluating ADAPCP activities.
- 17 Man-hours Spent in Command Consultation—Enter the total number of man-hours spent in the function of command consultation including documented telephonic contacts.
- 18 Man-hours Spent in Other ADAPCP Related Functions—Enter the total number of man-hours spent in support of the ADAPCP that are not classified elsewhere in this section.  
Prevention, Education, and Training Activities (see chapter 2, for requirements).
- 19 Commander and Staff Education—Enter the required data relating to the training of commanders and commander's staff.
- 20 Unit Education—Enter the required data relating to the training provided to military and civilian work force. This need not be provided to basic unit elements and can include commanders and staff in the student body.
- 21 Dependent Youth Education (family members)—Enter the required data related to education provided to youth groups, directors of youth activities, etc.
- 22 Civilian Employee Supervisor Education—Enter the required data related to the education of civilian or military supervisors of civilian employees.
- 23 ADAPCP Staff Education/Training—Enter the required data for ADAPCP staff training. USADATT and USADART and other Army sponsored training will be included on this line.
- 24 Other Education and Training—Enter the required data for outreach programs, e.g., education to schools, PTA's, and other interested groups.  
Screening, Rehabilitation and Treatment Services.
- 25 Screening Interviews—Indicate the total number of man-hours expended in conducting screening interviews. Enter the total number of visits of potential clients for screening interviews.
- 26 Alcohol/Drug Awareness Education—Enter the required data for personnel participating in alcohol/drug awareness education. This will include personnel in the alcohol and other drug awareness programs of Track I.
- 27 Individual Counseling—Enter the number of man-hours and visits for individual counseling sessions. These may include other counseling contacts outside of the normal office visit.
- 28 Group Counseling—Enter the number of man-hours and visits for group counseling sessions. Count the number of clients involved in each session as a visit.
- 29 Other Rehabilitation Services—Enter the number of man-hours and visits for alcohol or drug related crisis intervention or other rehabilitation services provided to previous ADAPCP clients.

*Section D—Case Finding Method and Disposition for All Referrals.*

Section D presents the case finding method and disposition of persons who were referred as potential clients of the ADAPCP during the report period. Data for AD/ADT Army service members DA/NAP civilian employees (DAC), and other clients are presented in three separate columns and are not a subtotal of any other data set. Section D also presents the primary substance abused or basis for enrollment for all clients; see DA Form 4465 block 8. *Note: Do not report clients or potential clients on line 30 (screening interviews) until the complete ADAPCP evaluation process is completed and disposition of the referral is made by the ADAPCP counselor. After this initial screening process is completed. Report the initial interview and the disposition of the case on lines 30 through 48 by case finding method.*

*Column*

- b* Biochemical testing of urine is the case finding method that applies to uniformed members of the Armed Forces and those civilian employees who are employed in the ADAPCP and by the terms of their employment are subject to biochemical testing of urine samples. All persons reported as lab positives (line 89) in section G, columns *b, c, d, e, h,* and *i* of this report will be reported under this column when an initial screening interview is required. Exceptions will be noted in the remarks section following section D.
- c* Self Referral (Volunteer) includes those persons who upon their own initiative request help for an alcohol or other drug problem from their unit commander, supervisor, ADAPCP, medical treatment facility, other military or civil agencies, chaplain, or other commissioned or noncommissioned officer in their chain of command. Identifications resulting from the person seeking emergency medical treatment for an actual or possible alcohol or drug overdose will be reported under Self Referral category. *Note: Individuals who agree to treatment/rehabilitation as a result of their knowledge of impending detection by other means will not be reported under the Self Referral (Volunteer) category. When in doubt of the self referral status check with the unit commander.*
- d* Commander/Supervisor includes those individuals who are referred for screening at the direction of a commander or supervisor for suspected alcohol or other drug abuse. *Note: An individual sent to the ADAPCP by a commander or supervisor subsequent to investigation or apprehension by law enforcement authorities, e.g., DWI arrest or civil court order, will be reported in column e, Investigation/Apprehension referral.*
- e* Investigation/Apprehension includes those who are referred by civilian court order or as the result of law enforcement activities, e.g., individuals referred to the ADAPCP under provisions of AR 190-5 or who were apprehended for a drug or alcohol offense by civilian or military law enforcement officials. *Note: These figures will include those individuals referred by a commander or supervisor after notification of an entry on the MP blotter report. These personnel will not be reported under Commander/Supervisor referral.*
- f* Medical Referral includes those individuals evaluated during annual or other routine medical examination or during observation or treatment, either as an inpatient or outpatient including emergency room care, for a condition which was recognized by a physician as related to alcohol or other drug abuse. *Note: Those individuals who voluntarily seek help from medical activities for alcohol or other drug problems are reported in column c, Self Referral.*
- g* Total—each line will be the sum of entries of columns *b* through column *f*. *Note: The total number enrolled by track will equal lines 50 c, d, e, g, h, i and 69 c, d, e, g, h, i of sections E and F.*

*Line*

- 30 Screening Interviews—Specify on line 30 by case finding method the number of AD/ADT Army personnel, DA/NAF Civilian Employees, and all other persons with whom screening interviews were performed during the report period.
- 31 Referred for Medical Evaluation—Specify on line 31 by case finding method the number of AD/ADT Army personnel, DA/NAF civilian employees and all other persons that were referred for medical evaluation during the report period.

*Line*

- 32 Referred to Other Resources—Specify on line 32 by case finding method the number of AD/ADT Army personnel, DA/NAF civilian employees, and all other persons who were not enrolled in the ADAPCP, but were referred to other resources during the report period.
- 33 No ADAPCP Services Required—Specify on line 33 by case finding method the number of AD/ADT Army personnel, DA/NAF civilian employees, and all other persons who were not enrolled in the ADAPCP or referred to other resources during the report period and for whom ADAPCP rehabilitation services were not provided.
- 34 Enrolled in Track I—Specify on line 34 by case finding method the number of AD/ADT Army personnel, DA/NAF civilian employees, and all other clients enrolled in Track I during the report period.
- 35 Enrolled in Track II—Specify on line 35 by case finding method the number of AD/ADT Army personnel, DA/NAF civilian employees, and all other clients enrolled in Track II during the report period.
- 36 Enrolled in Track III—Specify on line 36 by case finding method the number of AD/ADT Army personnel, DA/NAF civilian employees, and all other clients enrolled in Track III during the report period.
- 37 Total Enrollment—Specify on line 37 by case finding method the number of AD/ADT Army personnel, DA/NAF civilian employees, and all other clients enrolled in the ADAPCP during the report period. *Note: For each column line 37 will equal the sum of lines 34, 35, and 36 as well as the sum of lines 38 through 48.*
- 38-48 Enrollment by Drug—On lines 38 through 48 distribute the data recorded in each column and subcolumn on line 37 by the primary drug of abuse or basis for enrollment. (See DA Form 4465, block 8.) *Note: Polydrug abusers will not be reported on line 48 but will be reported according to the primary drug of abuse. On line 48 report the number of drug abusers whose primary drug of abuse is not listed on lines 38-48 and specify their primary drug of abuse in the remarks section.*

*Note.* The drugs listed in section D as in other sections of this report are the general term for a family of products, e.g., amphetamine includes methamphetamine, amphetamine sulfate, amphetamine hydrochloride, dextroamphetamine. The opiates family will include codeine, morphine, etc.

*Sections E and F—Caseload and Disposition of ADAPCP Clients.*

These sections provide a summary of monthly activity within different modes of rehabilitation and treatment relative to the ADAPCP client population during the report month. Section E shows data for AD/ADT Army personnel only. Section F shows data for DA/NAF Civilian employees and other clients.

*Column*

- c through e Alcohol—All clients whose primary diagnosis/basis for enrollment is alcohol abuse will be reported in columns c thru e.
- g through i Other Drugs—All clients whose primary diagnosis/basis for enrollment is drug abuse other than alcohol will be reported in columns g through i. *Note: Do not change clients from drug to alcohol or alcohol to drug portions of the report.*
- b, f Inpatient Detoxification—Is a count of ADAPCP clients who underwent medically supervised detoxification during the report period. Clients counted in these columns must be either enrolled in a track of the program when they entered detoxification or enrolled while going through detoxification. If a person participating in Inpatient Detoxification is not enrolled in a

*Column*

track they *will not* be reported. Do not show clients as moving from a specific track into detoxification or from detoxification back to a specific track. These data have been accounted for under Tracks III, II, and I of the report. *Note: Count only clients who entered the program from detoxification or were hospitalized for detoxification and are participating in a track of the program. Columns b and f are not sub-totals for any other columns in section E and F.*

- c, g* Track III—Clients who are medically evaluated and diagnosed as dependent on alcohol or other drugs or in need of residential treatment and are enrolled in Track III rehabilitation will be reported in columns *c* or *g*.
- d, h* Track II—Clients who are enrolled in the ADAPCP for Track II services in nonresidential rehabilitation will be reported in columns *d* or *h*.
- e, i* Track I—Clients who are enrolled in the ADAPCP for the purpose of receiving Track I services will be reported in columns *e* or *i*.

*Line*

- 49, 68 Start of Month Caseload—Enter the number of individuals participating in each track of the rehabilitation program on the first day of the report month. These numbers shall be identical to those reported on end of month caseload line 66 and 83, sections E or F of the previous month report. *Note: Any discrepancies between End of Month (last month) and Start of Month (this month) figures will be explained in the remarks section.*
- 50, 69 New Program Gains—Enter the number of new clients who were enrolled by track in the ADAPCP during the report period. For new clients who were enrolled in a track while in Inpatient Detoxification report the client in two columns: once in column *b* or *f*, as appropriate, and once in the column which represents the specific track in which the new client was enrolled. These data will include previously enrolled clients who were terminated from the program and have been re-enrolled. Do not include PCS/transfer clients who come from other programs. The number of personnel reported on this line will be substantiated by the concurrent completion and submission of the CIR, DA Form 4465.
- 51, 70 PSC/Transfer Gains—Enter the number of clients who are received from another ADAPCP rehabilitation program. These clients normally will be involved in a PCS or transfer move. The number of AD/ADT Army personnel reported on line 51 will be substantiated by the concurrent completion and submission of the PCS gain portion of the CPR.
- 52, 71 Intra-Program Change of Track-Out—Enter the number of clients who have moved from one specific track to another track of the rehabilitation program during the report period. *Note: Track III clients can not be Intra-Program change to Track II, or I. Track II clients cannot be Intra-Program changed to Track I. Clients already in a program track that are found to be in need of Inpatient Detoxification will remain in a previously recorded track. Show these clients as entering detoxification on line 53 or 72 as appropriate. (See instructions below.)*
- 53-72 Intra-Program Change of Track-In—Enter the number of clients who have moved from one track to another track of the rehabilitation program during the report period. (See note above for line 52, 69.) Record in column *b* or *f* as appropriate the number of clients who entered Inpatient Detoxification from a specific track but do not remove the client from the specific track previously recorded.

*Notes.* Together these two sets of lines (52, 53) and (71, 72) must balance. The numbers show movement of clients between tracks of the rehabilitation program. The formula for checking the balance between these sets of two lines are—

*Line*

$52c + 52d + 52e = 53c + 53d = 52e$ , and

$52g + 52h + 52i = 53g + 52h + 52i$ .

$71c + 71d + 71e = 72c + 72d + 72e$ , and

$71g + 71h + 71i = 72g + 72h + 72i$

Do not transfer clients between the Alcohol and Drug parts of sections E or F. Do not report permanent losses to the local ADAPCP on lines 52 or 71. For permanent losses to the local ADAPCP use lines 54 or 73.

54, 73 Program Losses—Enter the total of all permanent program losses from the local ADAPCP by columns on these lines.

*Note.* The data reported on lines 54 through 65 and 73 through 82 will be substantiated by the data on a completed and submitted PCS loss report CPR, 4th CPR, or a released from program CPR.

55, 74 Program Completed—Enter the number of clients who have completed the ADAPCP program.

56 Expiration Term of Service—Enter the number of AD/ADT Army clients who were discharged from service by reason of having reached their normal ETS date. (Section E only.)

57 Other Honorable Discharge—Enter the number of AD/ADT Army clients who were discharged from service with an other honorable discharge. (Section E only.)

58 Administrative Discharge-Alcohol or Drug Related—Enter the number of AD/ADT Army clients who were discharged from service under the provisions of AR 635-100 or AR 635-200, chapter 9. Do not include those who should be counted on lines 56 or 57 above. (Section E only.)

59 Less than Honorable Discharge—Enter the number of AD/ADT Army clients who were discharged from service with a less than honorable discharge. (Section E only.)

60 AWOL 31 days or more (DFR)—Enter the number of AD/ADT Army clients who have been dropped from the rolls of the US Army for being AWOL 31 days or more. (Section E only.)

61, 80 Retired—Enter the number of AD/ADT Army clients who retired from the US Army on line 61, section E. Enter the number of DA/NAF civilian employees who retired from Federal Civil Service on line 80, section F.

62, 81 Deaths—Enter the number of clients who died while in the ADAPCP rehabilitation program. Enter in the remarks section the following information on each death recorded on these lines: branch of service or client category (AD Navy, AD Army, DAC, family member of AD-AF, etc.), date of death, location, installation, probable cause of death, and whether the death was related or not related to alcohol or drug abuse.

63 USAR/ARNG ADT Completed—Enter the number of USAR/ARNG clients who have been released from the ADAPCP by reason that their term of Active Duty for Training has expired. (Section E only.) *Note: These personnel are USAR/ARNG who were on ADT for more than 30 days.*

- Line*
- 64 PCS Loss—Enter the number of AD/ADT Army clients who PCS'd and were transferred to another rehabilitation program. The number of AD/ADT Army clients reported on these lines will be substantiated by the concurrent completion and submission of the PCS loss portion of the CPR, DA Form 4466. *In the remarks section, report the number of clients who have been previously reported as PCS losses and have not yet been picked up by their gaining ADCO. (Section E only.)*
- 65, 82 Other—Enter the number of clients who are leaving the ADAPCP for reasons not classified above. *Note: The number on these lines must be explained in the remarks section.*
- 66, 83 End of Month Caseload—Enter the number of clients by column (c through e and g through i) who are remaining in the ADAPCP at the end of the report month. For each column and section this number will be the sum of lines:
- For section E:*
- $$49 + 50 + 51 + 53 - 52 - 54 = 66.$$
- For section F:*
- $$68 + 69 + 70 + 72 - 71 - 73 = 83.$$
- 67, 84 Total—Enter the total client caseload as follows:
- $$66c + 66d + 66e = 67e.$$
- $$66g + 66h + 66i = 67i.$$
- $$83c + 83d + 83e = 84e.$$
- $$83g + 83h + 83i = 84i.$$
- 75 Leaving Federal Service—Enter the number of AD/NAF civilian employee clients who are voluntarily leaving Federal service. Do not include clients who are retiring, transferring to another Federal agency, or are being involuntarily terminated from Federal service. (Section F only.)
- 76 Terminated from Federal Service—Enter the number of AD/NAF civilian employee clients who are being involuntarily terminated from Federal service. (Section F only.)
- 77 Transferring to another Federal Agency—Enter the number of DA/NAF civilian employee clients who are moving to another agency whether or not they are being transferred to another ADAPCP. (Section F only.)
- 78 Refuses further ADAPCP Services—Enter the number of DA/NAF civilian employee clients and other clients who have refused to continue in the program or have consistently missed appointments or have exhibited other evidence of a desire not to participate. (Applies to section F.) *Note: For DA/NAF civilian employees always attempt to determine if a classification of program loss can be made on lines 75, 76, 77, or 80 before entering them on this line.*
- 79 Leaving ADAPCP Service Area—Enter the number of DA/NAF civilian employee clients and other clients who are terminating their participation by reason of moving away from the ADAPCP area. Use line 79 for military clients of other rservices who are PCS moves to another assignment. (Section F only.)

*Section G—Biochemical Testing of Urine specimens for Drug Abuse.*

This section describes the workload and results of the testing of urine specimens for drug abuse by the types of testing programs used by the Army.

*Column*

- b* Commander Directed Testing—Individual—The testing of an individual soldier upon the lawful order of his commander to produce a urine sample for analysis. Laboratory results of such testing will not be purged of multiple samples for the same individual.
- c* Commander Directed Testing—Unit (Sweep)—The testing of an entire unit (however defined) upon the lawful order of the commander of that unit. Laboratory results of such testing will not be purged of multiple samples for the same individual.
- d* Commander Directed Testing—Urine Surveillance Program (USP)—Normally the testing of an individual soldier for a series of eight specimens in 30 calendar days after his commander has ordered his participation in USP. Normally, the test results will not be reported until all eight tests results have been received and compiled. On occasion the USP series of eight specimens (tests) for an individual service member is shortened because of an early enrollment by the commander, a real inability of the service member to continue the series, or other cause which shortens the series. In these cases the series will consist of all specimens submitted. The data for a USP series will be purged (i.e., compiled) into a single figure which describes the results of the series. If all eight test results are negative, then the series (as a single figure) will be (1) negative. An example of purging is the following: CPL Doe is ordered by his commander on 15 Jan 81 to participate in the USP. CPL Doe completes the series of eight tests (specimens) on 13 Feb 81. Also on 13 Feb 81 the first test result is received by the ADAPCP. The last test result is received on 20 Mar 81. The first three test results in the series are all negative; the fourth and fifth test results are positive for PCP; the sixth and seventh tests results are negative but the eighth test result is positive for amphetamine and cocaine. On the ADAPCP Summary, section G, under USP for the period 26 Feb 81 to 25 Mar 81, CPL Doe is reported as a 1 Laboratory positive and is shown as polydrug abuser of PCP, cocaine, and amphetamines, thus all laboratory positives are accounted for in the series. If the fourth and fifth test results were the only positives then CPL Doe would have been reported as an abuser of PCP only. If all test results were negative CPL Doe would be reported as a 1 laboratory negative.

Physician Director Testing—The testing of an individual soldier upon the direction of a physician. Physicians may at any time direct that an Army service member patient be tested when drug abuse is suspected. Laboratory results of such testing will not be purged of multiple samples for the same individual.

Rehabilitation (Client Testing)—The testing of clients while in the rehabilitation process. The test results *must be purged* for multiple test results for the same individual in the same month. A single positive in a series will be the basis for reporting a laboratory positive for that individual for that report month. The results returned for an individual client during a report month will be considered a series for that month no matter when the test samples were taken.

## Column

- g* EAD—Not to be completed.
- h* Treatment/Rehabilitation Staff—Testing of treatment/rehabilitation staff on a regular basis. The results of testing *must be purged* of multiple test results for the same individual using the rule that a single positive result will make the entire series positive for the report month. The results returned for a staff member during a report month will be considered a series for that month.
- i* Detoxification Testing—Testing of clients (inpatients) while undergoing medical detoxification. Laboratory results of such testing *must be purged* of multiple test results for the same individual in the same report month. The results returned for a patient during a report month will be considered a series for that month.

## Line

- 85 Total Tests (Specimens)—Enter the total number of tests taken (specimens collected and shipped to testing laboratories) during the report period. This should equal the number of lines completed on DD Forms 1892 (Drug Screening Urinalysis Record) that were forwarded to the testing laboratory during the report month. *Note: On line 86 through 107 DO NOT report the positive or negative results of Armed Forces Institute of Pathology quality control samples (specimens) that are submitted by your local installation.*
- 86 Total Positive (Specimens) Enter total number of positive tests (specimens) received from laboratory during report period. *Total positives* will not be purged of multiple specimens for the same individual. *Note: For the purposes of this line each laboratory positive is to be counted, i.e., all laboratory positive tests are to be accounted for.*
- Note. Do not report on lines 86 through 110 data that pertains to test results returned from the testing laboratory marked Quantity Not Sufficient (QNS) for testing. These tests will be considered void and should be rescheduled.*
- 87 Total Persons Tested—Enter the number of personnel for whom test results have been received (laboratory positive and laboratory negative) and the entire screening, medical evaluation, and disposition of the case has been completed for positive results during the report month. *Note: Carefully read and follow the rules for purging test results under columns d, f, h, and i as described above. Line 87 will include all individuals with lab positive test results for whom completion of screening interview and medical evaluation are no longer possible, i.e., PCS, ETS. These individuals will be reported on line 106. Line 87 will equal the sum of lines 88 + 89 + 106.*
- 88 Laboratory Negative—Enter the number of personnel reported on line 87 whose test or series or tests were reported as negative.
- 89 Laboratory Positive—Enter the number of personnel reported on line 87 whose tests or series of tests were reported as positive AND who have been through the complete evaluating process (screening interview, medical evaluation, and disposition of the case) during the report period. *Line 89 = 90 + 99 + 105 + 107.*

- Line*
- 90 Diagnosed Abuse—Enter the total number of personnel reported on line 89 who were diagnosed by a physician as being abusers of drugs or enrolled for improper use of drugs by the ADAPCP staff that were detected by urinalysis. Line 90 equals the sums of lines 91 through 98.
- 91-98 Enter all personnel reported on line 90 according to the type of drug abuse/improper use. For single drugs not properly classified on line 91-96 report them on line 97, other. In the remarks section following section G specify for all entries on line 97 the type of drug being abused/used. Report all polydrug abuse on line 98 and specify in the remarks section following section G the combinations being used.
- 99 Authorized Use—Enter the total number of personnel reported on line 89 who had a legal prescription for the drug(s) reported as positive. Line 99 equals the sum of lines 100 through 104.
- 100-104 Enter all personnel reported on line 99 according to the type of drug(s) authorized. For single drugs not properly classified on lines 100-102 report them on line 103, other. Specify in the remarks section following section G for all entries on line 103 the type of drugs being used. Report all polydrugs used on line 104 and specify in the remarks section following section G the combinations being used.
- 103 Administrative Error—Enter the number of personnel reported on line 89 who as a result of screening and medical evaluation and coordination between the unit commander and the ADAPCP staff have been declared by the unit commander to be free of drug abuse by reason that an administrative error occurred during the urine testing process.
- 106 Incomplete Evaluation—Enter all personnel reported on line 89 for whom completion of the evaluation process is impossible because of PCS, ETS, death, etc. Entries on this line should be infrequent and are to be explained in the remarks section following section G.
- 107 Unconfirmed Abuse—Enter the total number of personnel who were reported on line 89 who following screening and medical evaluation could not be classified as either diagnosed abuse/improper use, authorized use or administrative error. These persons will be reported on lines 108-110. *Note: Most of these people will be those who receive medical evaluation and are enrolled with no diagnosed abuse or improper use finding by a physician.*
- 108 To Urine Surveillance (Program)—Enter all personnel reported on line 107 who have been assigned to the Urine Surveillance Program by their unit commander following a screening interview and medical evaluation and coordination between the unit commander and the ADAPCP Staff.
- 109 Enrolled in ADAPCP—Enter those personnel reported on line 107 that were enrolled in the ADAPCP at the direction of the commander in coordination with the ADAPCP Staff, after medical evaluation could not substantiate diagnosed abuse or improper use of drug(s).
- 110 No Further Action—Enter the number of personnel reported on line 107 for whom no further action was required of the ADAPCP after medical evaluation and consultation with the commander.

## GLOSSARY

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The following terms are intended solely for administration of the ADAPCP. They are not intended to modify or influence definitions applicable to statutory provisions; the administration of military justice under the UCMJ; or regulations which are related to determinations of misconduct and line of duty, disability benefits, and criminal or civil responsibility for a person's acts or omissions.

**Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).** A manpower conservation program that includes prevention, identification, education, and rehabilitation services. The program includes nonresidential and residential treatment. The ADAPCP is responsive to the chain of command and supports the morale, safety, and combat readiness of the Army.

**Alcohol abuse.**<sup>1</sup> Any irresponsible use of an alcoholic beverage which leads to misconduct, unacceptable social behavior, or impairment of an individual's performance of duty, physical or mental health, financial responsibility, or personal relationships.

**Alcoholism.**<sup>1</sup> A treatable, progressive condition or illness, characterized by excessive consumption of alcohol to the extent that the individual's physical and mental health, personal relationships, social conduct, or job performance are impaired.

**Alcohol and drug abuse residential treatment facility (RTF).** A facility which provides intensive full-time residential care and treatment for eligible personnel.

**Alcohol and drug control officer (ADCO).** The person having staff responsibility for imple-

menting, operating, and monitoring the ADAPCP at MACOM, installation, or major tenant unit level.

**Armed Forces.** As used in the statutes upon which this regulation is based, refers to active members of the Army, Navy, Air Force, Marines, and Coast Guard. This includes former members of these components for any period in which they were on active duty. It does not include their dependents or civilian employees of the Armed Forces.

**Awareness education.** Education which aims at increasing knowledge of the effects and consequences of alcohol or other drugs on both an organizational and personal level.

**Civilian client.** Any US citizen DA employee, including NAF employees, enrolled in an ADAPCP or referred by the ADAPCP to an approved civilian rehabilitation program.

**Civilian program coordinator (CPC).** The individual who is responsible to the ADCO for the civilian aspects of the ADAPCP. (At MACOM, designated as Civilian Program Administrator.)

**Clinical consultant.** The military physician who is responsible for providing, coordinating and supervising consultative and medical support to the ADAPCP for the MEDCEN/MEDDAC commander.

**Clinical director.** The behavioral science professional who is responsible to the ADCO for implementing and monitoring the medical rehabilitation aspects of the ADAPCP. This includes supervision and training of the counselors.

**Command consultation.** The coordination process through which members of the ADAPCP staff and/or the MEDCEN/MEDDAC staff meet with an immediate commander to discuss or recommend a course of action concerning a service member. (See rehabilitation team.)

**Community Counseling Center (CCC).** The facility where local ADAPCP counseling services are provided. The Alcohol and Drug Control Office may or may not be co-located with the CCC.

**Confidential information.** Personal information revealed by a client to a counselor which will be used only for counseling or official ADAPCP purposes in accordance with Federal regulations.

**Drug abuse.**<sup>1</sup> The illegal, wrongful, or improper use of any narcotic substance or its derivative, cannabis or its derivative, other controlled substances or dangerous drugs. This includes the improper use of drugs prescribed by a physician.

**Drug dependence.**<sup>1</sup> The need for a drug which results from the continuous or periodic use of the drug. Dependence can be either physical or psychological. Physical dependence is characterized by a changing or accustoming of the body's physical system to the drug so as to cause withdrawal symptoms when the drug taking stops. Psychological dependence refers to the mental changes in the user that causes the user to believe that he or she must have the drug to function or feel normal. Either type of dependence interferes with the social, behavioral, and physical functioning of the individual.

**Education coordinator (EDCO).** The individual who is responsible to the ADCO for administering an alcohol and other drug abuse prevention education and training program.

**Enrollment.** The formal action taken by a commander to enter a service member into the ADAPCP. Or the formal admission or direc-

tion to the ADAPCP of all other categories of clients by the CCC staff, physicians, or appropriate law enforcement personnel.

**Exception.** Protection from the use of certain information, determined to be confidential by Federal regulation, to support disciplinary action under the UCMJ or administrative separation with a less than honorable discharge.

**Family member.** Spouse and minor children of a service member or a DA civilian. Use of the term in this regulation is intended to include only those persons eligible for ADAPCP services by law or regulation.

**Medical evaluation.** Examination of an individual by a physician to determine whether there is evidence of alcohol or other drug abuse or dependency.

**Military client.** Any active duty member or active duty for training member (30 days or more) of the Armed Forces who is enrolled in the ADAPCP.

**Other client.** Any retired member of the Armed Forces who became enrolled in an ADAPCP after retirement from active duty. Any family member (spouses, children) of active and retired military or of US citizen civilian employee (to include, where authorized, certain foreign nationals) who are enrolled in an ADAPCP. ARNG and USAR personnel when on active duty for training for less than 30 days and participating in the ADAPCP.

**Prevention procedures.** Those actions designed to increase the likelihood that individuals will make responsible decisions regarding the use of alcohol or other drugs. Those actions taken to eliminate to the extent possible, abuse or misuse of alcohol or other drugs.

**ADAPCP Record.** Forms, records, or other documents required by this regulation. This includes any information, whether recorded or not, which relates to a client and which is received or acquired in connection with any

function of the ADAPCP, including evaluation for possible enrollment in the ADAPCP. The creation or maintenance of alcohol or other drug abuse records that would identify an individual as a client of the ADAPCP, other than as required by this regulation, are prohibited.

**Recovering client.** A person who no longer abuses alcohol or other drugs.

**Rehabilitation services.** Preventive education, referral and clinical services provided to clients by the ADAPCP. These services are intended to reverse an individual's drug or alcohol related impairment and restore satisfactory job performance.

**Rehabilitation team.** An informal coordinating group consisting of the client's unit commander or his designee, immediate supervisor, and counselor plus other appropriate person-

nel as required (i.e., clinical director, chaplain, physician). The group reviews all pertinent information about the client and recommends to the commander when rehabilitation is required. It selects the appropriate rehabilitation track and assists the commander in setting standards of behavior and goals for evaluation of the client's progress in rehabilitation.

**Sensitive position.** Any position within the DA in which the occupant could cause, by virtue of the nature of his or her position, a material adverse effect on the national security. (See para 6, section I, AR 690-1).

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The definitions of these terms are generic. Such definitions are not to be confused with the wording found in the Diagnostic and Statistical Manual—3rd edition (DSM-III), American Psychiatric Association, 1980. (See table B-4.) DSM-III wording is for the use of the physician's diagnosis and requires adherence to criteria not necessarily met in the above definitions which are directed to the layman.

The proponent agency of this regulation is the Office of the Deputy Chief of Staff for Personnel. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) direct to HQDA(DAPE-HRA) WASH DC 20310.

By Order of the Secretary of the Army:

E .C. MEYER  
*General, United States Army*  
*Chief of Staff*

Official:

ROBERT M. JOYCE  
*Brigadier General, United States Army*  
*The Adjutant General*

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**ADAPCP CLIENT'S CONSENT STATEMENT FOR RELEASE OF TREATMENT INFORMATION**

For use of this form, see AR 600-85, the proponent agency is DCSPER

**SECTION A – CONSENT**

I, \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ 19 \_\_\_\_\_,

*(client's full name)*

do hereby voluntarily consent to the release of the following information by \_\_\_\_\_

*(name of installation ADAPCP)*

pertaining to my identity, diagnosis, prognosis, or treatment from any Army record maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research to \_\_\_\_\_

\_\_\_\_\_ for the purpose of \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ namely,

\_\_\_\_\_ *(extent or nature of information to be disclosed)*

\_\_\_\_\_

**SECTION B – EXPIRATION/REVOCAION**

*(Check applicable paragraph)*

1.  I understand that this consent automatically expires when the above disclosure action has been taken in reliance thereon and that, except to the extent that such action has been taken, I can revoke this consent at any time.

— Or —

*(For disclosure to civilian criminal justice officials under the provisions of paragraphs 6-9b(4)(b) and 6-10e(3), AR 600-85)*

2.  I understand that this consent automatically expires 60 days from today's date or when my present criminal justice system status changes to \_\_\_\_\_

Further, I understand that if my release from confinement, probation, or parole is conditioned upon my participation in the ADAPCP, I cannot revoke this consent until there has been a formal and effective termination or revocation of my release from such confinement, probation, or parole.

SIGNATURE OF CLIENT		DATE
NAME OF WITNESS <i>(Type or print)</i>	SIGNATURE	DATE

**SECTION C – APPROVAL AUTHORITY FOR RELEASE OF INFORMATION**

*NOTE. Other than the MEDCEN/MEDDAC Commander, approval authority for release of information may be delegated to the Program Physician or the Clinical Director.*

In my judgment, the release of an evaluation of the present or past status of \_\_\_\_\_

*(client's name)*

in the alcohol or other drug treatment and rehabilitation program will not be harmful to him/her.

NAME OF MEDCEN/MEDDAC COMMANDER OR DESIGNATED REPRESENTATIVE <i>(Type or print)</i>		DATE
SIGNATURE		

**CONDITION OF EMPLOYMENT FOR CERTAIN CIVILIAN EMPLOYEE POSITIONS  
IN SUPPORT OF  
THE ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM**

For use of this form, see AR 600-85, the proponent agency is DCSPER.

**SECTION A - BACKGROUND**

The written policy and agreement below will be read and signed by all prospective and current employees as a condition of employment and continuing employment for certain identified positions that are in support of the Army's Alcohol and Drug Abuse Prevention and Control Program (ADAPCP). Failure to sign this agreement will be a basis for rejection for initial employment and reassignment or for separation of current employees, in accordance with applicable regulations. You are entitled to any additional, reasonable information or clarification you desire prior to signing the agreement. A copy of the signed agreement will be given to you and your supervisor. The original will be placed in your official personnel folder.

**SECTION B - POLICY**

One of the essential requirements for the success of the Army's program to prevent and control alcohol and other drug abuse is the maintenance of a drug-free environment for alcohol and other drug abuse clients. Additionally, Department of the Army policy requires the command ADAPCP to provide a combined program for the treatment of both alcohol and drug clients. Treatment, counseling, and other support personnel (*e.g., typists, records clerks, receptionists, detoxification and laboratory personnel, CPC, ADAPCP physicians, personnel collecting urine specimens, etc.*) who come regularly in direct contact with clients (*at least weekly*) must remain drug free to maintain credibility with commanders and drug abuse clients. The duties that you are to perform will expose you with frequent regularity to direct contacts with clients who are either alcohol or drug abusers. To verify that you are drug free, you will be required, as a condition of your continued employment in the ADAPCP, to submit a urine sample for testing purposes at least twice a month, on an unannounced basis, during duty hours. To assure the validity of these tests, a para-medical staff member of the same sex will observe you while you are providing the urine sample. Detection of drug usage (*excluding medically prescribed drugs authorized by a physician and confirmed by appropriate evidence*) through positive urinalysis test results (*the results of urinalysis will be utilized for clinical and necessary administrative purposes only*) that are supported by clinical confirmation (*by a physician*) may be cause for a determination that you have failed to meet the conditions necessary for your continued employment in the position. The same administrative personnel action will be applied if and when alcohol abuse or alcoholism is determined. In either case, however, that is, whether involvement is with drugs or alcohol, you will be given the opportunity to be rehabilitated by being referred to an approved rehabilitation program. During the rehabilitation period, however, it may be necessary to detail you to another position or place you on leave. If rehabilitation efforts fail, you will be given appropriate consideration for reassignment to a position for which you are qualified. Should both rehabilitation and/or reassignment efforts fail, action may be taken to terminate your employment.

A current list of all positions in the ADAPCP which require personnel to be tested, as a condition of continuing employment, will be posted on the ADAPCP staff bulletin board at all times.

**SECTION C - AGREEMENT**

This is to certify that I understand the contents of the policy described above and the reasons therefor and that I agree to adhere to the terms of this policy as a continuing condition of my employment in positions to which this agreement applies.

SIGNATURE OF EMPLOYEE

DATE SIGNED



SECTION D - CASE FINDING METHOD AND DISPOSITION FOR ALL REFERRALS												ADAPCP AREA CODE								
L I N E	ITEMS  a	BIOCHEMICAL  b			SELF REFERRAL  c			COMMANDER/ SUPERVISOR  d			NON-BIOCHEMICAL INVESTIGATION/ APPREHENSION  e			MEDICAL REFERRAL  f			TOTAL  g			
		AD/ADT	OTHER	DAC	AD/ADT	OTHER	DAC	AD/ADT	OTHER	DAC	AD/ADT	OTHER	DAC	AD/ADT	OTHER	DAC	AD/ADT	OTHER	DAC	
30	Screening Interviews																			
31	Referred for Medical Evaluation																			
32	Referred to Other Resources																			
33	No ADAPCP Service Required																			
34	Enrolled in Track I																			
35	Enrolled in Track II																			
36	Enrolled in Track III																			
37	<b>TOTAL ENROLLMENT</b>																			
38	Alcohol																			
39	Amphetamines																			
40	Barbiturates																			
41	Cannabis Products																			
42	Cocaine																			
43	Hallucinogens																			
44	Methaqualone																			
45	Opiates																			
46	Other Tranquilizers																			
47	Phencyclidine (PCP)																			
48	Other (Specify in remarks)																			
REMARKS																				

NOTE: If separated and/or misplaced, forward this page to Commander, US Army PASBA (HSI-QPD), Fort Sam Houston, TX 78234

Figure G-1. ADAPCP Summary (DA Form 3711-R)—Page 2 of 4.

SECTION E - CASELOAD AND DISPOSITION OF AD/ADT ARMY CLIENTS										
L I N E	ITEMS a	ALCOHOL			ADAPCP AREA CODE			TRACK I e	TRACK II d	TRACK I i
		INPATIENT DETOXIFICATION b	TRACK III c	TRACK II d	INPATIENT DETOXIFICATION f	TRACK III g	TRACK II h			
49	Start of Month Caseload									
50	New Program Gains									
51	PCS Gains									
52	Intrrogram Change of Track (Out)									
53	Intrrogram Change of Track (In)									
54	Program Losses									
55	Program Completed									
56	ETS									
57	Other Honorable Discharge									
58	Admin Discharge - Alcohol or Drug Related									
59	Less than Honorable Discharge									
60	AWOL 31 days or more (DFR)									
61	Retired									
62	Deaths (Explain in remarks)									
63	USAR/ARNG ADT Completed									
64	PCS Loss									
65	Other (Specify in remarks)									
66	End of Month Caseload									
67	<b>TOTAL (c+d+e) (g+h+i)</b>									

SECTION F - CASELOAD AND DISPOSITION OF DA/NAF CIVILIAN EMPLOYEES AND ALL OTHER CLIENTS										
L I N E	ITEMS a	ALCOHOL			ADAPCP AREA CODE			TRACK I e	TRACK II d	TRACK I i
		INPATIENT DETOXIFICATION b	TRACK III c	TRACK II d	INPATIENT DETOXIFICATION f	TRACK III g	TRACK II h			
68	Start of Month Caseload									
69	New Program Gains									
70	Transfer Gains									
71	Intrrogram Change of Track (Out)									
72	Intrrogram Change of Track (In)									
73	Program Losses									
74	Program Completed									
75	Leaving Federal Service									
76	Terminating Federal Service-Alcohol or Drug Related									
77	Transfer to another Federal Agency									
78	Refuses further ADAPCP Services									
79	Leaving ADAPCP Service Area									
80	Retired									
81	Deaths (Explain in remarks)									
82	Other (Specify in remarks)									
83	End of Month Caseload									
84	<b>TOTAL (c+d+e) (g+h+i)</b>									

NOTE: If separated and/or misplaced, forward this page to Commander, US Army PASBA(HSHI-QPD), Fort Sam Houston, TX 78234

Figure G-1. ADAPCP Summary (DA Form 3711-R)—Page 3 of 4.

LINE	SECTION G - BIOCHEMICAL TESTING OF URINE SPECIMENS FOR DRUG ABUSE							ADAPCP AREA CODE		
	ITEMS a	COMMANDER DIRECTED			PHYSICIAN DIRECTED e	REHABILITATION f	ENTRY ON ACTIVE DUTY g	TREATMENT REHABILITATION STAFF h	DETOXIFICATION i	
		INDIVIDUAL b	UNIT c	URINE SURVL PROGRAM d						
85	TOTAL TESTS (Specimens)									
86	TOTAL POSITIVE									
87	TOTAL PERSONS TESTED									
88	Lab Negative									
89	Lab Positive									
90	Diagnosed Abuse									
91	Amphetamines									
92	Barbiturates									
93	Cocaine									
94	Methaqualone									
95	Opiates									
96	Phencyclidine (PCP)									
97	Other (Specify in remarks)									
98	Polydrug (Specify in remarks)									
99	Authorized Use									
100	Amphetamines									
101	Barbiturates									
102	Opiates									
103	Other (Specify in remarks)									
104	Polydrug (Specify in remarks)									
105	Administrative Error									
106	Incomplete Evaluation (Specify in remarks)									
107	Unconfirmed Abuse									
108	To Urine Surveillance									
109	Enrolled in ADAPCP									
110	No Further Action									
REMARKS										
COMMAND/INSTALLATION MAILING ADDRESS										
									DATE (month and year)	



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