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PERSONNEL-GENERAL

Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) Education and Training in Alcohol and Drug Abuse Prevention

This interim change implements DOD Instruction 1010.5, Education and Training in Alcohol and Drug Abuse Prevention, and modifies policy and procedures which have an immediate and direct impact on the individual servicemember; expires one year from date of publication and will be destroyed at that time unless sooner superseded by a formal printed change; is being distributed by 1st class mail through the publications pinpoint distribution system to all holders of AR 600-85; and is, as an interim measure, issued in other than page for page format.

Change paragraphs 2-6 and 2-7 to read as follows:

2-6. Policy.

a. Commanders at all levels will provide education and training concerning Department of the Army Alcohol and Drug Abuse Prevention policy and effective measures to alleviate problems associated with alcohol and drug abuse.

Education and training will be event and target group specific and will include references to both the military and civilian aspects of the program.

b. The alcohol and drug control officer (ADCQ), the ADAPCP education coordinator (EDCO) and the Alcohol and Drug Coordinator (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.

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 healthy alternatives to alcohol and other drug abuse will be presented as well as the disciplinary, career, and health consequences of abuse. Recruits will also be made aware of counseling and treatment resources and procedures, and 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.

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(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, to 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) Lieutenants, Warrant Officers (W-1), and junior non-commissioned officers (E-4/5). Education will emphasize the responsibilities of junior leaders in the alcohol and drug abuse prevention program with particular emphasis on deterrence and detection methods, enforcement, counseling, and motivational skills.

(4) Captains, Chief Warrant Officers, and middle grade non-commissioned officers (E-6/7). In addition to (3) above, education will emphasize intervention and instructional skills, and methods of monitoring the progress of identified abusers in the unit.

(5) Lieutenant Colonels, majors and senior non-commissioned officers (E-8/9). Education will emphasize the role and responsibilities of senior leaders in the function of the alcohol and drug abuse prevention and control program. Areas of particular focus will be the influence of the senior leader's attitude about alcohol and drug abuse on subordinates, the reasons for and benefits derived from ADAPCP, and the problem of stigma and strategies for diminishing it.

(6) Colonels. Education will emphasize the need for vigorous command support for the alcohol and drug abuse prevention and control program, the law enforcement, prevention and performance aspects of the problem, the federal response and intervention techniques for senior and executive level personnel.

2-7. Responsibilities.

a. Deputy Chief of Staff for Personnel (DCSPER), 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. Commander TRADOC. In addition to responsibilities contained in para 6 and in e., f. and g. below, the Commander, TRADOC will:

(1) Develop nonmedical aspects of alcohol and other drug training and education doctrine for Army-wide use.

(2) Ensure that alcohol and other drug training and education modules are developed, updated and incorporated in appropriate service school and training center instruction.

(3) Develop alcohol and other drug training and education modules for use at organizational and unit level.

d. Commander, Health Services Command (HSC). In addition to responsibilities contained in para 6 and in e., f. and g. below, the commander 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 ADAPCP.

(3) AMEDD Officers. During initial orientation courses, training will be conducted in the diagnosis, counseling, treatment and referral of alcohol and other drug abusers and in Army policy regarding alcohol and other drug abuse and their roles in the ADAPCP, as appropriate.

(4) Behavioral Science Specialists (MOS, 91G). Behavioral science specialists whose initial assignment is as an ADAPCP counselor will be provided the four week US Army Drug and Alcohol Rehabilitation Training (USADART) enroute to or within 180 days after assignment.

(5) Continuing AMEDD education: Continuing education and training will be provided for 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) Ensure 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 and that they comply with HQDA goals, objectives, and guidelines.

f. Commanders at all levels. Commanders at all levels will conduct alcohol and other drug prevention education and training for military personnel on a regular basis with the focus on the command - unique elements of the ADAPCP and local prevention and treatment resources. In addition, commanders will conduct the following education and training:

(1) At permanent change of station (PCS).

(a) Servicemembers (E-1 through E-4). Education will be conducted within 60 days after each PCS and will emphasize the legal consequences of abuse under both the uniform code of military justice and the local laws, the availability of an ADAPCP at the installation to include location, referral procedures, and types of treatment available and the alternatives to abuse available at the local installation and neighboring communities.

(b) Leaders (E-5 through E-9 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, local military and civilian resources, the availability of an ADAPCP to include location, leaders' responsibilities in the identification and referral process opportunities for continuing education and training, and their responsibilities for the maintenance of military discipline and the enforcement of the uniform code of military justice.

(2) Department of the Army civilian employees.

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

(b) 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, the symptoms of abuse, especially as they relate to job performance, intervention and referral techniques, and the post-treatment responsibilities of the supervisor. Continuing education will also 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.

(3) 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.

(4) Family members of military and civilian personnel.

(a) Family members OCONUS. Education will be provided on a voluntary basis and will emphasize the local alcohol and drug abuse situation, local alcohol and drug abuse laws, counseling, treatment, rehabilitation opportunities and procedures, and alternatives to abuse available at the local installation and neighboring community.

(b) Family members in US locations. Education will be offered on a voluntary basis to the extent feasible.

25 June 1981

I01, AR 600-85

(DAPE-HRA)

By Order of the Secretary of the Army

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ARMY REGULATION }
NO. 600-85

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 1 May 1976

PERSONNEL—GENERAL

ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM

Effective 1 September 1976

This is a complete revision of DA Circular 600-85 and incorporates AR 600-53, AR 600-84, and AR 600-300. This regulation establishes the objectives of the Army's Alcohol and Drug Abuse Prevention and Control Program, defines Army policy on alcohol and other drug abuse, and defines responsibilities for implementation of the program. Chapter 9 applies solely to National Guard and Army Reserve Forces. Supplementation of this regulation is required by major commands and may be supplemented by other commands. One copy of major command supplements will be furnished HQDA (7/APE-HRL-A), WASH DC 20310 within 60 days following the effective date of this regulation.

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1 May 1976

AR 600-85

This regulation supersedes the following publications:

1. Army regulations:

- a. AR 600-53, 25 July 1974, including all changes.
- b. AR 600-84, 15 November 1973, including all changes.
- c. AR 600-300, 24 January 1972.
- d. AR 600-51, 16 June 1967.

2. DA Circular 600-85, 30 June 1972.

3. DA messages:

- a. DASG 131854Z Sep 71 (U), subject: Drug Abuse Counter-Offensive, Medical Guidance.
- b. DAPE-CPE 152120Z Dec 71 (U), subject: Condition of Employment for Certain Civilians in Support of Army Drug Abuse Prevention and Control Program.
- c. DAPE-DDD 132023Z Jun 72 (U), subject: Suspension of Access and Revocation of Security Clearances for Drug and Alcohol Dependent Personnel.
- d. DAPE-DDD 151912Z Jun 72 (U), subject: Line of Duty Status of Members Being Treated Under the ADAPCP.
- e. DAPE-DDD 201145Z Jun 72 (U), subject: Pacific Drug Screening Program.
- f. DAPE-DDD 232007Z Jun 72 (U), subject: Drug Testing Program.
- g. DAPE-DDD 281856Z Jun 72 (U), subject: Drug Testing Program.
- ✓ h. DAPE-HRA 051936Z Dec 72 (U), subject: Interim Change to DA Cir 600-85, Scope of Exemption.
- i. DAPE-HRA 151310Z Dec 72 (U), subject: Urinary Surveillance Program — Reports and Records.
- j. DAPE-HRA 051340Z Mar 73 (U), subject: Forensic Use of Drug Testing Laboratories.
- k. DAPE-HRA 052050Z Mar 73 (U), subject: Random Testing Frequency for Taiwan.
- l. DAPE-HRA 152036Z Mar 73 (U), subject: Alcohol and Drug Abuse Prevention and Control Program Summary — RCS Med 289.
- ✓ m. DAPE-HRA 301405Z Mar 73 (U), subject: Interim Change to DA Cir 600-85.
- n. DAPE-HRA 291230Z Jun 73 (U), subject: Alcohol and Drug Abuse Prevention and Control Program — Records and Reports.
- o. DAPE-HRA 121826Z Jul 73 (U), subject: Change in Urine Testing Laboratory Support of Drug Abuse Testing Program.
- p. DAPE-HRA 121827Z Jul 73 (U), subject: Change in Urine Testing Laboratory Support of Drug Abuse Testing Program.
- ✓ q. DASG-HCA 191633Z Jul 73 (U), subject: Identification of Drug Dependent Personnel in Transit.
- r. DAPE-HRA 272124Z Jul 73 (U), subject: Change in Urine Testing Laboratory Support of Drug Abuse Testing Program.
- ✓ s. DAPE-HRA 011140Z Aug 73 (U), subject: Changes in DA Cir 600-84 and DA Cir 600-85.
- ✓ t. DAPE-HRA 201616Z Sep 73 (U), subject: Use of Methadone.
- u. DAPE-HRA 121300Z Oct 73 (U), subject: Change in Laboratory Support for Drug Abuse Urine Testing Program.

- v. DAPE-HRA 171937Z Oct 73 (U), subject: Change in Laboratory Support for Drug Abuse Testing Program in the State of California.
- ✓w. DAPE-HRA 261900Z Oct 73 (U), subject: Extension of DA Cir 600-84 and DA Cir 600-85.
- x. DAPE-HRA 301640Z Oct 73 (U), subject: Alcohol and Drug Abuse Prevention and Control Program — Records and Reports.
- y. DAPE-HRA 261951Z Feb 74 (U), subject: Interim Change to DA Cir 600-85—Release of Information.
- z. DAPE-HRA 221904Z Mar 74 (U), subject: Change 1 to AR 600-84 (Drug Abuse Testing Program).
- aa. DAPE-HRA 111945Z Apr 74 (U), subject: Condition of Employment for Certain Civilians in Support of Army Drug Abuse Prevention and Control Program.
- ✓ab. DAPE-HRA 021430Z May 74 (U), subject: Alcohol and Drug Abuse Prevention and Control Program.
- ac. DAPE-HRA 222010Z May 74 (U), subject: Interim Change to AR 600-300 (change 1).
- ad. DAPE-HRA 281715Z Jun 74 (U), subject: Interim Change to AR 600-84, Drug Abuse Testing Program (change 2).
- ae. DAPE-HRA 282013Z Jun 74 (U), subject: Policy Clarification Regarding Urinalysis Testing of Civilian Staff Personnel in Specialized Alcohol Programs.
- af. DACH-PPE, 201230Z Sep 74 (U), subject: Drug and Alcohol Abuse Reports.
- ag. DAPE-HRA 132214Z Jan 75 (U), subject: Urine Testing in Support of the Alcohol and Drug Abuse Prevention and Control Program.
- ✓ah. DAPE-HRA 142345Z Feb 75 (U), subject: Alcohol and Drug Program Exemption Policy.
- ✓ai. DAPE-HRA 201700Z Feb 75 (U), subject: Alcohol and Drug Program Exemption Policy.
- aj. DAPE-HRA 051335Z Mar 75 (U), subject: Change 2, AR 600-53, 25 Jul 74.
- ak. DAPE-HRL-A 161835Z Sep 75 (U), subject: Compliance with Policy for ADAPCP Staff Participation in Random Urinalysis.
- ✓al. DAPE-HRL-A 262200Z Sep 75 (U), subject: Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)—Exemption Policy.
- am. DAPE-HRL-A 012356Z Oct 75 (U), subject: Contractual Support for Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) Reports Control Symbol GSGPA(OT) 1380.
- ✓an. DAPE-HRL-A 301839Z Oct 75 (U), subject: Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)—Exemption Policy.
- ✓ao. DAPE-HRL-A 302135Z Jan 76 (U), subject: Separation Procedures for Alcohol and Other Drug Abusers.

CHAPTER 1

GENERAL

Section I. INTRODUCTION

1-1. Purpose and scope. This regulation prescribes policies and procedures for implementing, operating, and evaluating the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP). Except for chapter 9, this regulation applies to all Active Army personnel, including members of the Army National Guard (ARNG) and the US Army Reserve (USAR) serving on active duty (AD), initial active duty training (IADT), special tours of active duty training (special ADT), or 45 days' involuntary active duty training (45 days' ADT). The provisions of chapter 9 apply to members of the ARNG and USAR when not on AD or any type of ADT. The services of the ADAPCP are available to US citizen civilian employees of the Army, and to certain other Federal civilian employees who, on a case-by-case basis, may be deemed eligible. The ADAPCP is available to retired personnel and to dependents as specified in paragraph 1-5d. Chapter 7 details the aspects of ADAPCP policies and functions particularly applicable to eligible civilian employees. Policies and guidance described in other than chapters 7 and 9 should be interpreted as applicable to all civilian clients, including retired personnel.

1-2. Background. a. On 28 September 1971, Public Law 92-129 mandated that a program be initiated 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 servicemembers dependent on drugs. In response to this guidance and to the escalating use of drugs by Army personnel, the US Army initiated a determined effort to prevent and control the abuse of alcohol and other drugs. The civilian aspects of the ADAPCP are mandated

by Public Laws 91-616 and 92-255. These statutes require that all Federal agencies provide alcohol and other drug abuse services to their employees, utilizing existing facilities and services insofar as possible.

b. Worldwide implementation of the Army alcohol and drug program was based on three policy decisions which continue to provide the basis for the ADAPCP. These were: the program would be a command program; the program would be decentralized; and alcohol and other drugs would be addressed in one program.

1-3. Objectives. The objectives of the ADAPCP are to—

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 processing from Government service.

d. Provide for program evaluation and research.

1-4. Explanation of terms. See appendix A.

1-5. Policy. a. Department of the Army will make a sustained effort to prevent alcohol abuse, alcoholism, and abuse of and dependency on other drugs; attempt to restore to effective and reliable duty all individuals who are failing to function properly in a military environment because of problems attributable to abuse of alcohol and/or other drugs; and process for discharge or termination those who cannot be effectively restored to duty within a reasonable period of time.

b. 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.

c. ADAPCP rehabilitative efforts for both alcohol and other drug abusers will be short term, will utilize the same ADAPCP staff and treatment facilities for both alcohol and other drug abusers, and will be conducted in the military environment where the abuse occurred. Participation in the ADAPCP is mandatory for all servicemembers clinically confirmed by a physician as an alcohol or other drug abuser. (See chap. 7 for guidance for civilian employee participation.)

d. In addition to active duty military personnel, ADAPCP services are extended to dependents of active duty personnel, retired military personnel and their dependents, US citizen civilian employees of the Army (para 1-1) who are provided medical service under the Army Federal Civilian Employee's Health Service Program (and their dependents who are authorized military medical services), and certain foreign nationals when Army medical services are provided to them through special treaty arrangements.

e. Close command supervision is required over those aspects of military life that tend to encourage the abuse of alcohol. The drinking of alcoholic beverages will not be made a compulsory part of any ceremony, celebration, or social function. Toasting, if any, will be done in moderation and under circumstances which do not draw special attention to those who prefer not to drink alcoholic beverages. Nonalcoholic beverages will be made available at all functions where alcoholic beverages are served.

f. Commanders are prohibited from taking certain administrative and disciplinary actions against servicemembers who are voluntarily or involuntarily referred to the ADAPCP. (See sec V, chap. 3.)

g. Except under specified conditions, commanders are prohibited from releasing information that an individual is, or has been, an abuser of alcohol or other drugs (sec IV and V).

h. Development of an in-house capability is essential to accomplish all required prevention (education, training, law enforcement, and community action) objectives, to deliver necessary treatment and rehabilitation services, and to conduct local program associated studies and evaluations. Although progress toward that goal and the broad objectives of the ADAPCP are being achieved, continued emphasis and support by the chain of command to the lowest level are

necessary. On occasion, local situations may dictate use of outside civilian contractual services; however, such contracts will be minimal and oriented toward development of essential in-house capabilities. Civilian contractors will not be utilized for such services when appropriate DOD and other Federal resources are available and feasible.

i. The Department of the Army seeks and encourages the support and active participation of recognized labor organizations in policy formulation of the civilian employee aspects of the ADAPCP.

1-6. Concept. a. The ADAPCP is a manpower conservation program comprised of the following functional areas: prevention; identification; detoxification; rehabilitation; program evaluation; and research.

b. This regulation implements DOD Alcohol and Drug Program directives. Other service personnel under the administrative jurisdiction of an Army installation commander are subject to the DOD directives as implemented by this regulation. When Army servicemembers are under the administrative jurisdiction of another service, they will comply with the alcohol and drug program of that service, but will be reported through Army channels. In those cases where elements of the Army and another service are so located that cost effectiveness, efficiency, and combat readiness can be achieved by combining facilities, the service to receive the support will be responsible for initiating a local interservice agreement to receive that support (AR 1-35).

1-7. Responsibilities. a. Deputy Chief of Staff for Personnel (DCSPER), Headquarters, Department of the Army (HQDA), has General Staff responsibility for plans, policies, programs, budget formulation, and behavioral research pertaining to alcohol and other drug abuse in the Army.

b. The Surgeon General (TSG), HQDA, supports the ADAPCP with resources, statistical data, technical assistance, and medical research.

c. Inspectors general will inquire into the operation of the ADAPCP during general inspections in accordance with AR 20-3.

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

e. The responsibilities of major commanders are

as follows:

(1) Major commanders who operate installations will—

(a) Exercise program management of the ADAPCP.

(b) Establish, operate, and support the ADAPCP at all installations, organizations, agencies, and activities under their jurisdiction.

(c) Establish monitoring and evaluation procedures at all levels of command to insure that major elements of the ADAPCP (prevention, identification, detoxification, and rehabilitation) are coordinated and managed effectively.

(d) Appoint a civilian program administrator.

(2) Major commanders who do not operate installations will—

(a) Exercise program management of the ADAPCP.

(b) Coordinate provision of ADAPCP services for their personnel, wherever assigned.

(c) Establish monitoring and evaluation procedures at all levels of command to insure that major elements of the ADAPCP (prevention, identification, detoxification, and rehabilitation) are coordinated and managed effectively.

(d) Appoint a civilian program administrator.

f. Commanders of CONUS installations, commanders of equivalent oversea geographic/organizational areas/units, and heads of agencies and activities will—

(1) Operate an ADAPCP or insure that such services are available for eligible personnel at each installation, organization, agency, and activity under their jurisdiction.

(2) Insure that the procedures prescribed in

this regulation are complied with or request waiver from HQDA (DAPE-HRL-A) through command channels.

(3) Insure that requests for funds and manpower are based on sound management practices and appropriate regulations.

(4) Appoint a civilian program coordinator.

g. The MEDCEN/MEDDAC commander will—

(1) Provide medical support to the ADAPCP, to include authorized service for civilian employees.

(2) Designate physicians to perform clinical evaluations.

(3) Provide for detoxification.

(4) Insure that client records are maintained and disposed of in accordance with appropriate regulations.

(5) Establish procedures for the control of abusable prescription drugs.

(6) Provide personnel to the ADAPCP based on manpower authorization documents.

(7) Appoint a military officer (i.e., physician, psychologist, or social worker) to serve as the clinical consultant. The clinical consultant will—

(a) Provide technical supervision of professional medical aspects of rehabilitation.

(b) Insure that professional development and in-service training are provided for the ADAPCP rehabilitation and counseling staff.

(c) Insure that clinical evaluations are performed.

h. Responsibilities of other staff agencies contributing to the ADAPCP efforts are discussed in chapter 2. Civilian personnel officer's (CPO) responsibilities are provided in chapter 7.

1-8. **References.** Appendix B provides a list of references applicable to the ADAPCP.

Section II. ADAPCP STAFF ORGANIZATION AND MANAGEMENT

1-9. **General.** This section prescribes policies, procedures, and responsibilities for military and civilian personnel serving on the installation ADAPCP staff. Program personnel must be selected and used in positions commensurate with their knowledge, skill, and abilities. Standards of conduct and dress for all ADAPCP personnel (military and civilian employees) will conform to local regulations.

1-10. **Policy.** a. Each Army installation will implement and operate an ADAPCP in accordance with the provisions of this regulation.

b. The actual number of individuals assigned to the installation ADAPCP staff must be justified in appropriate manpower authorization documents. This regulation may be cited when justifying Tables of Distribution and Allowances (TDA) positions discussed below (para 1-12). When full-time personnel spaces are not provided, ADAPCP functions (para 1-12) will be performed on an additional duty basis from within existing resources.

c. The alcohol and drug control officer (ADCO) will exercise operational control of the installation ADAPCP and will have supervisory responsibility

for all members of the ADAPCP staff and the facilities necessary to accommodate this staff.

1-11. Organization and procedures. *a. Staff supervision of the ADCO is normally exercised by the DPCA/G1, or personally by the commander or his chief of staff. The ADCO will not be placed under the staff supervision of any other general or special staff officer, or the civilian personnel officer.*

b. The organization of a typical installation ADAPCP is shown in figure 1-1.

1-12. Responsibilities. *a. Alcohol and drug control officer. The ADCO, as the installation ADAPCP manager, following command guidance and instructions from higher authority, will—*

(1) Coordinate the command, staff, and medical aspects of the ADAPCP.

(2) Exercise supervision or operational control of ADAPCP personnel, facilities, and funds.

(3) Develop, coordinate, and recommend ADAPCP policy for implementation.

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

(5) Serve on the Alcohol and Drug Dependency Intervention Council (ADDIC) or similar council.

(6) Provide periodic program evaluation to the commander.

(7) Be responsible for the administrative maintenance of records and reports in accordance with applicable regulations. (Responsibility regarding client records is provided in paragraphs 6-3 and 7-19.)

(8) Authenticate all ADAPCP reports furnished to higher headquarters.

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

b. Administrative officer. The administrative officer will—

(1) Manage the ADAPCP administrative functions and provide for logistical support of the halfway house, if applicable.

(2) Coordinate operational functions among designated ADAPCP staff personnel.

(3) Prepare data for budget and manpower resource transactions.

(4) Provide consolidated staff input to the ADCO for ongoing program evaluation.

(5) Supervise the administrative staff.

c. Civilian program coordinator (CPC). The CPC (chap. 7) will—

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

(2) Maintain close working relationship with the civilian personnel office and appropriate health program personnel.

(3) 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.

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

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

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

(7) Arrange for appropriate medical diagnostic consultation with a physician, insuring compliance with the confidentiality requirements.

d. Education coordinator (EDCO). The EDCO will—

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

(2) Maintain liaison with schools serving dependents of military personnel, civic organizations, civilian agencies, and military organizations in order to integrate the efforts of all community preventive education resources (paras 2-5d and 2-7f(4)(5)).

(3) Coordinate allocations for military and civilian training courses (para 1-5h).

(4) Periodically provide the ADCO with an evaluation of the installation's preventive education and training program.

(5) Coordinate with the CPC for education and training of civilian personnel.

(6) 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.

e. Clinical director. The clinical director, under

the technical supervision of the clinical consultant, will—

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

(2) Supervise the alcohol and drug abuse counselors assigned to the ADAPCP and, in coordination with the clinical consultant (para 1-7g), supervise the in-service training and development of the rehabilitation staff.

(3) Insure that all individual client case files are maintained in accordance with procedures prescribed in chapter 6.

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

(5) Maintain, in coordination with the CPC, liaison with civilian community rehabilitation agencies.

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

(7) Insure that social evaluations are performed as required.

f. Rehabilitation counselors. Counselors will—

(1) Conduct the ADAPCP initial interview (para 6-4) of individuals and provide results to physicians performing clinical evaluations.

(2) Conduct individual and group counseling sessions for clients in the active and follow-up phases of rehabilitation.

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

(4) Provide input for ADAPCP recommendation regarding client progress in rehabilitation.

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

(6) Prepare and maintain required client records and reports in accordance with procedures prescribed in chapters 6 and 7.

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

(8) Assist ADAPCP preventive education and training efforts.

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

(10) Participate in in-service training program.

g. Chaplain. The ADAPCP chaplain will—

(1) Be assigned duties within the ADAPCP staff consistent with his primary role as a minister

of religion.

(2) Serve as the advisor to the ADAPCP staff on spiritual and religious concerns.

(3) Participate in individual group counseling and talk sessions and, if properly trained, serve as group leader.

(4) Plan and present, in coordination with the EDCO, training and preventive education programs.

(5) Maintain liaison and coordination with the installation chaplain and assist in the education and training of chaplains and in development and presentations of programs which support the ADAPCP effort.

(6) Advise on the ethical implications of the ADAPCP plans and policies.

(7) Coordinate utilization of installation chaplains in support of rehabilitation facilities and referral agencies.

(8) Support the client and the ADAPCP staff through his right of privileged communication. (See para 3-3b.)

1-13. Selection of ADAPCP personnel. Consistent with military necessity, commanders will select ADAPCP personnel in accordance with the following guidance:

a. Officer personnel will be selected on the basis of the provisions of chapter 25, DA Pamphlet 600-3. These personnel must be of sufficient grade to coordinate necessary actions properly and to supervise the ADAPCP staff.

b. Enlisted administrative personnel should be MOS-qualified. When possible, military counselors should possess special qualification identifier (SQI) "Z", or be in the process of qualifying for its award.

c. Award of special qualification identifier.

(1) The SQI suffix character "Z" identifies enlisted personnel, regardless of MOS, who have worked successfully in the alcohol and drug abuse prevention and control program. Award of this SQI will be based on the following minimum prerequisites:

(a) Completion of US Army Drug and Alcohol Rehabilitation Training Course or military and civilian experience in counseling or similar activities in alcohol and other drug abuse or related fields.

(b) Evidence of personal maturity.

(c) Sincere motivation to work in the program.

(d) Formal recommendation and certification of qualifications by a responsible professional (physician, psychologist, social worker), who is associated with the program.

(2) Upon publication of appropriate orders, the personnel officer will annotate the servicemember's DA Form 2-1.

d. Civilian personnel must meet the qualification requirements contained in the US Civil Ser-

vice Commission's X-118 Qualification Standards manual for each position, with the exception of positions for which excepted service opportunities are authorized. Qualification standards for the latter positions are developed in accordance with FPM (and CPR) 302.2. (See app C for condition of employment.) Requirements established in AR 40-1 must be followed in hiring personnel as social workers, GS-185, or psychologists, GS-180.

Section III. TRAINING

1-14. General. Professional skills of all personnel should be maintained and progressively developed by local in-service training and attendance, when applicable, at military and civilian alcohol and other drug related courses. Training methodology, technique, and content will be consistent with the model shown in appendix D and with the guidelines provided in appendix E.

1-15. Goals. Training goals (a through d below) apply to all officers, supervisors, NCOs, members of the ADAPCP staff, and others having significant roles in the management and operation of the ADAPCP. These goals are to—

a. Develop detailed knowledge, understanding, and support of the ADAPCP.

b. Develop management skills required for program operation.

c. Promote performance counseling to assist in the early identification and referral of subordinates who have alcohol or other drug problems.

d. Provide professional staff development.

1-16. Objectives. The objectives of training are to—

a. Provide information and skills for all personnel who have a significant role in the ADAPCP, including all officers, NCO, and civilian supervisors.

b. Provide for integration of alcohol and drug instruction within service schools' curricula.

c. Provide for integration of alcohol and drug training within organizational and unit leadership programs.

1-17. Civilian contractual support. See paragraph 1-5h.

1-18. ADAPCP staff. a. *ADAPCP counseling staff.*

(1) *In-service training.* Members of the ADAPCP counseling staff will be provided a regularly scheduled in-service training and staff

development program supervised by the clinical director and coordinated with the clinical consultant. Such a program will develop the job-related knowledge and skills of the professional and paraprofessional counseling staff. The program should be in the form of structured classes and may include case presentations and discussions, literature reviews, panel presentations, lectures, or guest speakers from the military or civilian community.

(2) *Formal training.* For progressive development of individual counseling skills and overall program professionalism, the ADAPCP counseling staff should attend formal training activities, such as conferences, workshops, and seminars. Funds will normally be requested through MEDCEN/MEDDAC channels. Individuals who have attended formal training activities will report on them during ADAPCP in-service training sessions.

b. *Civilian program administrator/civilian program coordinator (CPA/CPC).* Training for full-time and part-time civilian program coordinators and administrators is mandatory and is available through DA-sponsored courses. This and other training should have prior approval of the major command. Training and education for civilian supervisors and the entire civilian work force will comply with appropriate DA policy for training and education prescribed in this regulation.

c. *Other ADAPCP staff.* Other staff members (e.g., ADCO and EDCO) should receive formal training which will enhance their professional development. This training will be paid for with funds requested through installation resources.

1-19. Leadership. ADAPCP training will be primarily oriented toward specific elements of the leadership structure according to current assignment and nature of responsibilities. ADAPCP

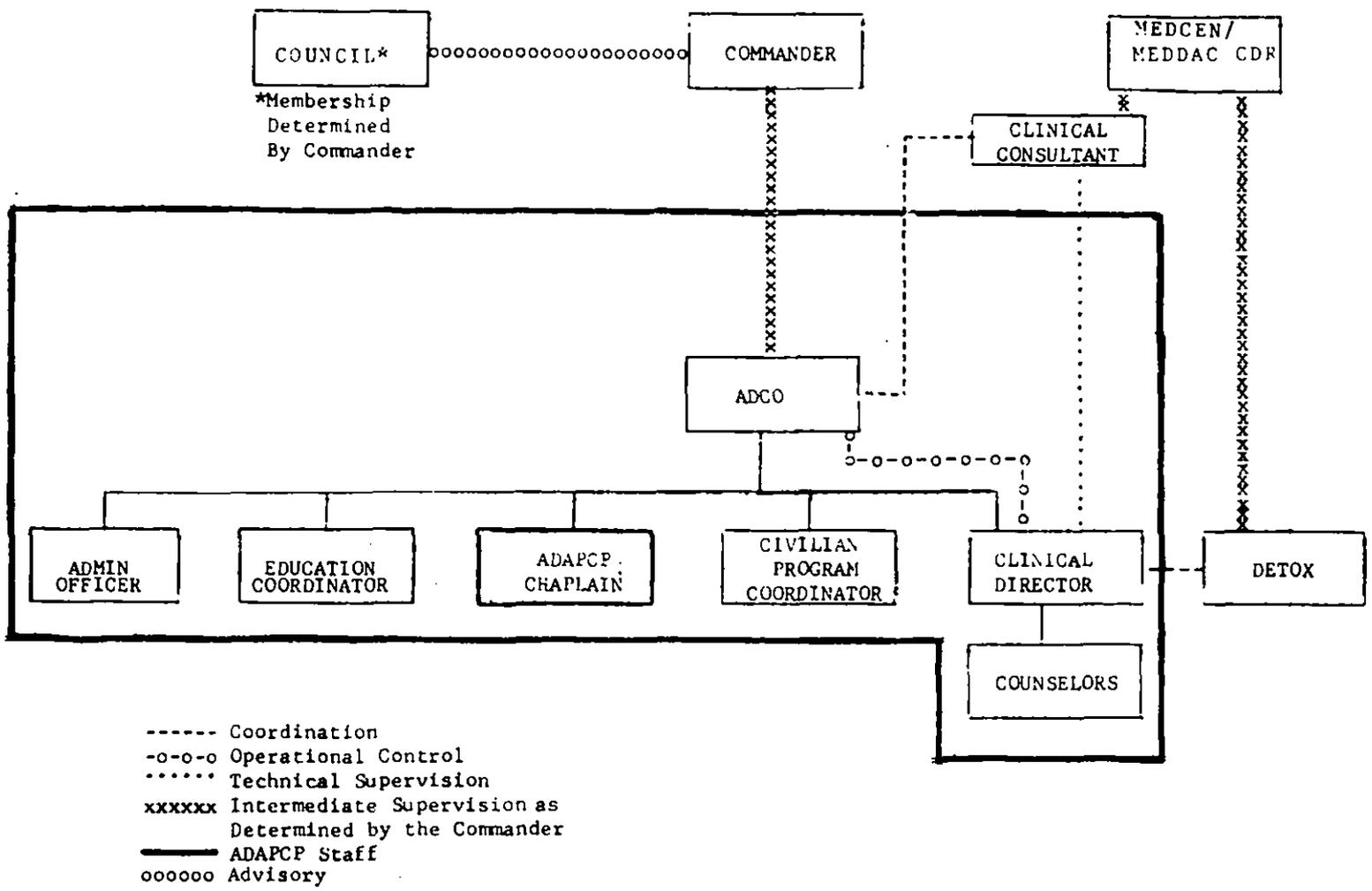


Figure 1-1. Typical installation ADAPCP organization.

training within the Army Service schools will address all elements of the ADAPCP, with emphasis on those most applicable to the expected assignment level and duties of students.

a. Training for senior commanders and their staffs at installation, brigade, and group levels, and equivalent civilian supervisors, should include—

(1) The importance of senior-level command support to program success.

(2) Information on—

(a) The background and need for a concerted effort on the part of the Army to implement the ADAPCP.

(b) The policies and concepts of the ADAPCP, including exemption.

(c) The responsibilities at all levels for implementation of the ADAPCP.

(3) An assessment of alcohol and drug abuse as it impacts on the mission and operational capabilities of the command.

(4) Detailed information on the operation of the local installation ADAPCP, local procedures for referral into the ADAPCP, and follow-up actions required.

(5) Coordination aspects of ADAPCP implementation, with emphasis on the effective use of the ADDIC or similar council.

(6) Procedures for extending the ADAPCP to the entire community.

(7) Measures for evaluating the ADAPCP implementation in subordinate commands.

b. In addition to a(2), (3), and (4) above, training for battalion level commanders and staffs and

equivalent-level civilian supervisors should include—

(1) Knowledge of post-wide assessment of alcohol and drug abuse as it impacts on the installation's mission and resources.

(2) Working knowledge of all program elements of the ADAPCP and the specific responsibilities of all military staff organizations and agencies (including the ADDIC), which support the program and its objectives.

(3) Measures to insure a thorough knowledge of the role of the commander/leader/supervisor in the rehabilitation process, with special emphasis on how to accept and treat personnel upon their return to the unit or section following a period of detoxification or live-in rehabilitation.

(4) Measures of evaluating program implementation by unit commanders, leaders, and supervisors.

c. In addition to b(1), (2), and (3) above, training for unit-level commanders, leaders, and equivalent civilian supervisors should include a clear understanding of the ADAPCP's functions and the role of the junior commander/leader/supervisor in the program, with particular emphasis on—

(1) Coordination with the installation ADAPCP staff.

(2) Recognition and documentation of deteriorating work performance.

(3) Supervisory level job performance counseling.

(4) Criteria for referral to the ADAPCP for evaluation.

Section IV. CONFIDENTIALITY OF ADAPCP MILITARY CLIENT INFORMATION

1-20. **Scope.** This section gives the restrictions on release and/or discussion of information *within* the Armed Forces concerning a servicemember's abuse of alcohol or other drugs. The restrictions on release of information *outside* the Armed Forces concerning servicemembers, and on *all* releases of information concerning civilian clients, are described in section V. Additional restrictions on the discussion of the alcohol or other drug problem of a civilian employee of the Army with his supervisor are provided in chapter 7.

1-21. **General.** a. Successful rehabilitation is enhanced if the alcohol or other drug abuser is aware that a minimum number of individuals will

become aware of his problem. Abusers are also more likely to volunteer for treatment under such conditions.

b. 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 servicemember's alcohol or other drug problem. While commanders above the unit level may have occasional 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.

1-22. Policy. A servicemember's enrollment in the ADAPCP, his alcohol or other drug involvement, and details of related problems will be made known only to those individuals within the Armed Forces who have an official need to know.

1-23. Implementation. *a.* Alcohol and other drug client rehabilitation records required by this regulation are medical records. Direct access to a client's records by nonmedical personnel (or medical personnel without a need to know) is not authorized except as noted in paragraphs 1-28c(2) and (3), 1-29f, and 6-3c.

b. Other than as authorized by this regulation, no record or report that would identify an in-

dividual as a client of the ADAPCP will be created or maintained.

c. Each ADAPCP facility will provide limited assistance to potential clients who are seeking information prior to volunteering for help. Such assistance will include a description of the local program, the exemption policy, and how to volunteer for treatment. Such assistance will be on an anonymous basis; no record of the requesting individual's identity will be made. *The ADAPCP staff will not conduct rehabilitation counseling for any individual who has not been clinically confirmed and entered into the program.*

Section V. RELEASE OF PERSONAL INFORMATION

1-24. References. *a.* Section 408 of Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 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 U.S.C. 4582), as amended by section 122(a) of Public Law 93-282 (88 Stat. 131).

c. Chapter 1, Title 42, Code of Federal Regulations (CFR).

1-25. Scope. *a.* This section prescribes policy and provides guidance concerning 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 provided in paragraph 1-24 and of the policies prescribed in this section is to remove any fear of public disclosure of past or present abuse of alcohol or other drugs in order to encourage participation in a treatment and rehabilitation program.

b. The restrictions on disclosure prescribed in this section are not limited by the Freedom of Information Act (5 U.S.C. 552) or the Privacy Act (5 U.S.C. 552a).

1-26. Applicability. The provisions of this section apply both to individuals responsible for any client record maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research, and to individuals who have knowledge of the information contained in such records.

1-27. Explanation of terms. For purposes of this

section, the following apply:

a. Armed Forces. As used in the statutes upon which this section is based, this term refers to present members of the Army, Navy, Air Force, Marines, and Coast Guard, as well as to former members of these components for any period in which they were both on active duty and enrolled in the ADAPCP. It does not include their dependents or civilian employees of the Armed Forces.

b. Client. The statutes and regulations upon which this section is based permit the exchange of information within the Armed Forces and between the Armed Forces and those components of the VA furnishing health care to veterans from records pertaining to a person who is or was subject to the UCMJ at the time the record was created. Accordingly, a distinction will be made in this section, where applicable, between military clients and civilian client ((1) and (2) below). Unless this distinction is made, the term "client" will refer to any individual who is or has been enrolled in an ADAPCP or to any individual who has been referred for evaluation for possible enrollment in an ADAPCP.

(1) *Military client.* Any active duty member of the Armed Forces who is enrolled in an ADAPCP, or any former member of the Armed Forces who was enrolled in an ADAPCP while on active duty.

(2) *Civilian client.* Any retired member of the Armed Forces who became enrolled in an ADAPCP after retirement from active duty; and any dependent of an active or retired member of the Armed Forces, any civilian employee, or any

dependent of a civilian employee who is or has been enrolled in an ADAPCP or referred (by the ADAPCP) to an approved civilian rehabilitation program.

c. 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. Paragraph 1-23b prohibits 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.

1-28. Policy. No person subject to the jurisdiction or control of the Secretary of the Army shall divulge any record of the identity, diagnosis, prognosis, or treatment of any client 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, or to those components of the VA furnishing health care to veterans, if the individual seeking the information has an official need to know. The provisions of section IV and of this section apply to further disclosure by such an individual who is a member of the Armed Forces; the provisions of the references listed in paragraph 1-24 apply to further disclosures by the VA.

b. With the written consent of the client (para 1-29*i*), and subject to other applicable restrictions of this section, disclosure of certain items of information (that are enumerated in the specific paragraphs referenced below) is authorized—

(1) To medical personnel or to treatment or rehabilitation programs where such disclosure is needed in order to better enable them to furnish services to the client (para 1-29*b*); or

(2) To the client's family, or to any person with whom the client has a personal relationship (para 1-29*c*); or

(3) To the client's attorney, when a bona fide attorney-client relationship exists (para 1-29*d*); or

(4) To certain designees of the client for the purpose of benefiting the client:

(*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 1-29*e*(4)).

(*b*) To civilian criminal justice system officials where the client's participation in the ADAPCP is made a condition of the individual's release from confinement, the disposition or status of any criminal proceedings against the individual, or the execution or suspension of any sentence imposed on the individual (para 1-29*e*(3)).

(*c*) To employers or employment agencies (para 1-29*e*(2)).

(*d*) To other designees for the purpose of benefiting the client (para 1-29*e*(1)).

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 (para 1-29*b*(1)); or

(2) To qualified personnel conducting scientific research, management or financial audits, or program evaluation (para 1-29*f*); or

(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 U.S.C. 1175(b)(2)(C) or 42 U.S.C. 4582(b)(2)(C). (See para 1-29*h*.)

1-29. 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), and may be received by written correspondence, by telephone, or during face-to-face conversation. Further, alcohol or other drug involvement may not surface as a factor to be considered 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 1-28.

(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 of alcohol or other drug involve-

ment. 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, and that identifying such regulations and statutes would, in effect, compromise the personal privacy of the client. 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) *Emergency situation.*

(a) 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.

(b) If an oral disclosure is made under the authority of (1)(a) above, the ADCO will make a written memorandum for the record showing the client's name, the reason for the disclosure, the date and time the disclosure was made, the information disclosed, and the name of the individual to whom it was disclosed. This memorandum will be filed in the same manner as a written consent form (i below).

(2) *Other than emergency situations.*

(a) The written consent of the client is required (i below).

(b) Disclosure may be made to medical personnel or to nonmedical counseling and other treatment and rehabilitative services where such disclosure is needed in order to better 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 (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-at-law 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) *General.*

(a) This paragraph provides guidance for handling the general class of inquiries from individuals who are not members of the Armed Forces whose actions may be beneficial to the client.

(b) Disclosures under the provisions of this paragraph require the written consent of the client (i below).

(c) 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 claim, right, privilege, gratuity, grant, or other interest accruing to, or for the benefit of, the client or the client's immediate family. Examples of the foregoing include welfare, medicare, unemployment, workmen's compensation, accident or medical insurance, public or private pension or other retirement benefits, and any claim of defense asserted or which is an issue in any civil, criminal, administrative, or other proceeding in which the client is a party or is affected.

(d) The criteria for approval of disclosure are:

1. The statutes and implementing regulation (chapter 1, 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 (2) and (3) below.

2. In any other benefit situation (such as those listed in (c) above), disclosure is authorized with the written consent of the client only if the ADCO determines that all of the following criteria are met:

(a) 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.

(b) Granting the request for disclosure will not cause substantial harm to the relationship between the client and the ADAPCP or to the ADAPCP's capacity to provide services in general (this determination to be made with the advice of the clinical director).

(c) Granting the request for disclosure will not be harmful to the client. (This determination to be made with the advice of either the program physician or the program clinical director.)

(2) Disclosure to employers, employment services, or agencies.

(a) Written consent to 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 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 and not for the purpose of identifying the individual as a client in

order to deny him employment or advancement because of his history of drug or alcohol abuse.

2. The information sought appears to be reasonably necessary, in view of the type of employment involved.

(3) Disclosures in conjunction with Civilian Criminal Justice System Referrals (para 1-28b(4)(b)).

(a) *Written consent.* Written consent of the client is required (i below).

(b) *Disclosure.* Disclosure may be made—

1. To the court granting probation, or other post-trial or pretrial conditional release; or

2. To the parole board or other authority granting parole; or

3. To probation or parole officers responsible for the client's supervision.

(c) *Extent of disclosure.* The client may consent to unrestricted communication between the ADAPCP and the individuals or agencies listed in (b) above.

(d) *Duration of consent.* 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—

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.

4. Sentenced, when the sentence has been fully executed.

(e) *Revocation of consent.* A client whose release from confinement, probation, or parole is conditioned upon his/her participation in the ADAPCP may not revoke a consent given by him/her in accordance with paragraph 1-28b(4)(b) of this regulation until there has been a formal and effective termination or revocation of such release from confinement, probation, or parole.

(f) *Restrictions on redisclosure.* Any information directly or indirectly received by an individual or agency listed in (b) above pursuant to paragraph 1-28b(4)(b) may be used by the recipients thereof only in connection with their of-

ficial duties concerning the particular client with respect to whom it was acquired. Such recipients may not make such information available for general investigative purposes, or otherwise use it in unrelated proceedings or make it available for unrelated purposes. The recipients' attention will be directed to section 2.38, chapter 1, Title 42, CFR.

(4) 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) Subject to the limitations stated by the client in his/her written consent form, any information not otherwise prohibited from release by other regulations or directives may be disclosed.

(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, since 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 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 the nature and extent of the drug and alcohol problem in a unit, installation, or command; 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 6-3c 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 and 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, and 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 1, Title 42, CFR apply.

(3) In cases of scientific research, the policy 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 except by order of a court of competent jurisdiction is prohibited (*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 U.S.C. 1175(b)(2)(c), 42 U.S.C. 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 U.S.C. 1175 and 42 U.S.C. 4582 and direct appropriate disclosure.

(1) Such relief is applicable only to records as defined in paragraph 1-27c, and not 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 (facts or dates of enrollment, discharge, attendance, medication, etc.) necessary to fulfill the purpose of the court order, and in no event may 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, 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) In accordance therewith, the client will be fully informed of the nature and source of the inquiry and that his 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 will confirm that fact by signing a statement as follows:

"I, (name), this day of 19 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 (name of inquirer) for the purpose of ... namely (extent or nature of information to be disclosed) ..."

Expiration/Revocation (strike out and initial inappropriate paragraph):

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 1-28b(4)(b) and 1-29e(3), AR 600-85):

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 Date Witnessed by Date

(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 signifying that in that commander's 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 follows:

"In my judgment, the release of an evaluation of (client's name's) present or past status in the alcohol or other drug abuse treatment and rehabilitation program will not be harmful to him/her.

Signature Date

(5) If, in the judgment of the MEDCEN/MEDDAC commander or the designated physician or clinical director, release of information would be harmful to the client although the client has already signed the consent form, the inquirer will be informed that statutes and regulations prohibit the release of certain personal information, if in the judgment of a physician such release would be harmful to the client.

(6) The consent will be prepared in an original only--no reproduction is 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 servicemember 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(3)(d) above.

(8) In situations where the client's unit commander is providing input information for a higher headquarter's reply to an inquiry, the forwarding correspondence will specifically verify that the consent has been signed by the client (and, where applicable, signed by the appropriate MEDCEN/MEDDAC commander, program physician, or clinical director) and has been, or will be, filed in the client's ADAPCP records.

(9) If the client does not consent to the release of the requested information, or if the client limits the scope of releasable information to the extent that an adequate reply is impossible--

(a) He will be encouraged to correspond directly with the originator of the inquiry.

(b) He will be informed that the reply to the inquiry will state that statutes and regulations required his written consent for release of personal information, that he refused to give such consent (or authorized the release of only limited information), and that he has been requested to correspond directly with the inquirer.

(c) In situations where the client's unit commander is providing input information for a higher headquarters' reply to an inquiry, forwarding correspondence will include a statement that the client refused to sign a form of consent (or authorized the release of only limited information) and that the client has been encouraged to correspond with the inquirer directly.

(10) In any case in which 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, in the case of a client who has been adjudicated as lacking the capacity to manage his/her own affairs; or 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 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 such individual is capable of rational communication.

j. Inquiry made by telephone.

(1) To the extent that such an inquiry can be answered 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, or if the answer to a more general question (e.g., health and welfare) would require the divulgence of information prohibited under the provisions of this section, the following actions will be taken:

(a) Inform the caller that statutes and regulations prohibit the disclosure of certain personal information without the written consent of the individual who is the subject of the inquiry.

(b) Request that the caller submit a written request stating the specific type of information desired and 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 where applicable.

l. Limitations on information. Any disclosure made under this section, whether 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 regulation, order, or directive, the contents of this section will govern.

(2) Disclosures authorized by this section are subject to any further restrictions imposed by other regulations or 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 1-28. 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 or other

regulations or directives, would assist in providing an appropriate reply to an inquiry, the information may be released.

1-30. Criminal penalties for unauthorized disclosure. The criminal penalties for unauthorized

disclosure of information prohibited by the Federal statutes and regulations listed in paragraph 1-24 are a fine of not more than \$500 in the case of the first offense and not more than \$5,000 in the case of each subsequent offense.

Section VI. RELEASE OF PROGRAM INFORMATION

1-31. 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, or as a former abuser of alcohol or other drugs. (See sec IV and V.)

1-32. Objectives. *a.* To provide the public with appropriate information about the Army's Alcohol and Drug Abuse Prevention and Control Program in accordance with AR 360-5.

b. To insure that all military personnel have accurate and complete knowledge of the program (AR 360-81).

1-33. Concept. Release of information pertaining to DOD activities remains the responsibility of OASD(PA). OCINFO, HQDA, is responsible for coordinating, planning, and monitoring the execution of appropriate Army information activities.

1-34. Implementation. *a.* Guidelines for release of information are as follows:

(1) Unclassified factual information concern-

ing the Army's alcohol or other drug problems, or the Army's prevention and control program as described in this regulation may be provided to the news media in response to queries.

(2) Tours of facilities and discussions with ADAPCP staff personnel must have the prior approval of the installation commander 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 HQDA.

b. Major commanders will insure that command information materials receive wide distribution and will respond to queries as provided in (a)(1) above.

1-35. Administration. *a.* Information officers may communicate directly with OCINFO, HQDA.

b. Requests for authority to release additional information will be directed to HQDA (DAIO-PI).

CHAPTER 2

PREVENTION

Section I. INTRODUCTION

2-1. General. Prevention of alcohol and other drug abuse is one of the most important elements of the ADAPCP involving the total military community, as well as the local civilian community.

2-2. Scope. This chapter prescribes policy and establishes responsibilities for the three primary methods of prevention: education; law enforcement; and community action.

Section II. PREVENTIVE EDUCATION

2-3. General. The factors leading to alcohol and other drug abuse are complex and are the result of an interaction among the individual's attitudes, values, motivation, knowledge, and environment. Educational methodology, technique, and content will be consistent with the model shown in appendix D and the guidelines provided in appendix E.

2-4. Goals. The educational goals in *a* through *f* below apply to *all* Army personnel, their dependents, and civilian employees. The goals are to—

a. Facilitate general knowledge, understanding, skills, and motivation required for making responsible decisions regarding alcohol and other drug use.

b. Foster understanding, appreciation, and use of ADAPCP opportunities and facilities.

c. Discourage the unauthorized use of controlled substances and the abuse of alcohol and other drugs.

d. Encourage self-identification and self-referral, and the identification and referral of family members, friends, and associates.

e. Facilitate abuser's rehabilitation.

f. Promote the community's acceptance of rehabilitated abusers.

2-5. Objectives. Educational objectives are to—

a. Insure that *all* military personnel, their dependents, and civilian employees receive alcohol and other drug education required to further the objectives of the ADAPCP.

b. Provide input into the individual's decision-making process through communicative means that are—

(1) Accurate, relevant, and credible.

(2) Tailored for carefully selected target groups.

(3) Presented, using appropriate learning strategies and techniques, in the best possible learning environment.

(4) Integrated into all appropriate learning experiences.

(5) Sequential, relevant, progressive, and ongoing for *all* personnel.

c. Develop and/or promote the production, purchase, distribution, and use of materials that have the potential for significantly improving alcohol and other drug education, and that comply with DA guidelines for alcohol and drug training and education (app E).

d. Include alcohol and other drug education in the curricula of dependent schools under HQDA control and cooperate with the governing bodies of other schools attended by dependents to have alcohol and other drug education included in the school curricula.

2-6. Policy. *a.* Commanders at all levels will provide accurate and relevant information concerning alcohol and other drug abuse to active duty officer and enlisted personnel and their dependents, Military Academy cadets and ROTC students, Reserve and National Guard personnel, and

civilian employees. The information provided and the techniques used will be appropriate to the target group. Program content will include specific information on the ADAPCP; i.e., functions, policies, and local procedures concerning prevention, identification, detoxification, and rehabilitation. All content and techniques will be consistent with the guidelines in appendix E. Alcohol and other drug abuse patterns change frequently; therefore, commanders must provide a continuous, aggressive, and flexible educational program in order to address changes as they occur. Priority of educational efforts will be devoted to the needs of commanders and the soldiers under their commands. The complexity of preventive education is such that only knowledgeable, well-trained, and highly motivated instructors should be used. The ADAPCP rehabilitation staff should be used to the maximum extent. Classes, seminars, and conferences should be planned well in advance and scheduled in accordance with the overall unit or installation training program.

b. To insure that entry level (the period from initial entry—enlistment, OCS/USMA, basic officer course, etc.—through first permanent duty assignment) personnel understand ADAPCP policy, the following provisions are established:

(1) A standard ADAPCP educational program, including scheduled presentations by qualified instructors, using approved lesson plans, will be provided for all entry-level personnel.

(2) By the completion of the ninth month of active duty, all personnel will have been instructed and tested in ADAPCP policy in the following areas:

(a) Exemption policy.

(b) Identification (voluntary; medical; urinalysis, random and other; commander referral; law enforcement).

(c) Detoxification and rehabilitation opportunities and procedures, including the local installation program.

(d) Legal consequences of alcohol and other drug misuse and abuse (UCMJ and local laws).

(e) Career consequences of alcohol and other drug misuse and abuse (reenlistment, promotion, qualification for MOS and special assignments, security clearance, etc.).

(3) The entry level education program should also include the following subject areas:

(a) The reasons for and consequences of misuse and abuse of substances.

(b) Alternatives to substance misuse and abuse.

(c) Decisionmaking.

(d) Valuing and values clarification.

(4) Scheduled presentations for the entry-level program *will not* include pharmacology. The topic of pharmacology will be treated in supplementary education materials.

(5) The use of audio-visual materials during entry level scheduled presentations will be limited and used only to facilitate an understanding of ADAPCP policy.

c. The alcohol and other drug educational doctrine functions developed by Headquarters, US Army Training and Doctrine Command (HQ, TRADOC) for Army-wide use will be executed in a manner that encourages and facilitates innovative and creative efforts at command level, eliminates undesirable duplication of information and educational experiences, and provides progression in the educational program for all target groups.

d. Participation in Federal, State, and local alcohol abuse control programs through conferences, workshops, and committee membership is encouraged.

e. Civilian contractual support. See paragraph 1-5h.

2-7. Responsibilities. a. *Deputy Chief of Staff for Personnel (DCSPER), 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 other drug training and educational programs as required.

(4) Provide Army membership for the DOD Media Support Committee.

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 responsibilities contained in e and f below, the CG, TRADOC will—

(1) Develop nonmedical aspects of alcohol and other drug training and education doctrine for Army-wide use.

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

(3) Develop alcohol and other drug training and education modules for use at organizational and unit level.

d. Commanding General, US Army Health Services Command. The CG, HSC, will develop medical aspects of alcohol and other drug training education doctrine.

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 and that they comply with HQDA goals, objectives, and guidelines.

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

(1) Conduct appropriate ongoing alcohol and other drug training and educational programs for all personnel and dependents under their jurisdiction, to include orientations for newly assigned personnel and for CONUS personnel prior to departure for oversea assignment.

(2) Insure that all alcohol and other drug training and educational programs are designed for and presented to carefully selected target groups and that they comply with HQDA alcohol and other drug training and educational goals, objectives, and guidelines.

(3) Insure that all alcohol and other drug training and education are presented by instructors who have received appropriate training.

(4) At installations where there are no DOD-managed schools, the local commander and/or his representative will acquaint the appropriate school personnel (e.g., school board, superintendent, principal, counselors, PTA/PTSA) with the ADAPCP educational goals and objectives and with the available educational materials and resources. Upon request, the local commander and/or his representative will make these materials and resources available to school personnel and will assist in the establishment, expansion, or improvement of a comprehensive alcohol and other drug educational program for the local schools.

(5) The Teen Involvement Program, when supported by the command and the local school system, has proven to be an effective instrument of community outreach through which the Army has countered the development and spread of alcohol and other drug abuse among the dependent population. Because of its success and acceptance, the Teen Involvement Program has become an integral part of the Army's ADAPCP. Commanders will support the Teen Involvement Program to the extent that available resources permit.

Section III. LAW ENFORCEMENT

2-8. Objectives. Law enforcement objectives are to eliminate the supply of illegal drugs; apprehend individuals who illegally possess, use, or distribute drugs; and prevent alcohol and other drug-related crimes, incidents, and traffic accidents. A secondary objective of law enforcement is to identify alcohol and other drug abusers for referral to the ADAPCP.

2-9. Responsibilities. *a.* Major commanders down to and including installation level will insure that—

(1) Procedures are developed and implemented to suppress drug trafficking and use and to reduce crimes and traffic accidents caused by or emanating from alcohol and other drug abuse.

(2) Oversea law enforcement procedures are consistent with status of forces agreements (SOFA) or treaties to prevent the importation of drugs and the movement of contraband to the United States. (DOD Directive 5030.49 and AR 190-41 contain guidance and direction concerning the inspection of individuals, mail, baggage, and household goods that are being returned to the United States.)

(3) Procedures for securing and accounting for drugs and other sensitive items are adhered to in compliance with TB MED 291.

(4) Controlled substances which are seized as evidence, or for which ownership or possession cannot be established, will be safeguarded,

processed, and disposed of in accordance with AR 195-5.

b. Commanding General, USACIDC will—

(1) Investigate all offenses involving sale and/or traffic in controlled substances (21 U.S.C 812); investigate all offenses involving controlled substances categorized as narcotic; and maintain primary investigative responsibility for all offenses involving any form of controlled substance (AR 195-2). Use and possession of non-narcotic-controlled substances will normally be investigated by military police (AR 190-30).

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

(3) 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.

c. Installation commanders will—

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

(2) Report offenses involving illegal possession, use, sale, or trafficking in drugs to the military police for investigation or referral to USACIDC.

(3) Establish countermeasure programs to minimize the contribution of alcohol and drugs as causative factors in traffic accidents. These programs should emphasize the development and coordination of appropriate countermeasures involving public information, education, enforcement, rehabilitation, and treatment.

d. The provost marshal of each installation will—

(1) Maintain liaison and coordinate alcohol and other drug abuse countermeasures with the local elements of the USACIDC; Federal, State, and local law enforcement traffic safety and customs agencies; and, when appropriate, inter-

national host-countries, to minimize the contribution of alcohol and other drugs as causative factors in traffic accidents and criminal acts (AR 190-5).

(2) Investigate offenses involving use or possession of non-narcotic-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 (AR 190-30).

(3) Consult with local SJA prior to employing search and seizure procedures, except when making apprehensions or when otherwise impractical.

(4) Provide law enforcement data, as required, to the ADCO for use in managing and evaluating the ADAPCP.

(5) Coordinate with the ADCO to establish ADAPCP services for personnel in the installation confinement facilities.

2-10. Relationship between law enforcement personnel and the ADAPCP or ADAPCP clients.

a. Army policy is to encourage voluntary entry into the alcohol and drug program. In consonance with this policy, military police, CID special agents, and other investigative personnel will not solicit information from participants in the program, unless the participant volunteers to provide information and assistance. If the participant volunteers, the information will not be obtained in local ADAPCP facilities or in such a manner as to jeopardize the safety of sources of the information or compromise the 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 program for the purpose of law enforcement activities. This restriction does not preclude the enrollment in the ADAPCP of military police, CID, or other investigative personnel who have an actual alcohol or other drug problem; however, their law enforcement status must be made known to the ADCO at the time of their enrollment.

Section IV. COMMUNITY INVOLVEMENT

2-11. General. Commanders will promote coordinated community involvement in the prevention and control of alcohol and other drug abuse. Existing military and appropriate civilian social agencies will be used to the maximum to assist the

ADAPCP as required. A high degree of involvement by both the military and civilian community will enhance the effectiveness of the ADAPCP.

2-12. Councils. a. Major commands and installation commanders will designate a formal

council to consider alcohol and other drug-related matters applicable to the command. It may be a separate ADDIC 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 and, as with a separate ADDIC, minutes concerning alcohol and other drug issues discussed will be recorded and approved by the commander.

b. The composition of the council will be determined locally and will be representative of units/activities on the installation. The chairman of the council should be a senior officer who has had recent command and/or troop experience and who has direct access to the commander. As a minimum, the following key personnel should be members: DPCA/G1, PM, staff chaplain, MEDCEN/MEDDAC commander, SJA, IO, major unit commanders, recreation services officer, post education officer, ADCO, ACS officer, dependent schools officer, CPO, and CPC. 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.

c. The council functions in an advisory capacity to the commander. The ADCO will provide the council 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.

d. The council will meet periodically. 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 command.

e. Consideration should be given to using the installation ADDIC as the nucleus for the development, coordination, and evaluation of installation alcohol and drug countermeasures programs (para 2-9c(3)).

2-13. Military Community. a. Prevention efforts should include the use of the total assets of the military and civilian community in order to create working, living, and recreational conditions

that provide readily accessible and meaningful alternatives to alcohol and other drug abuse.

b. Coordination should be established with the staffs and agencies that perform functions related to the ADAPCP (e.g., Mental Hygiene Consultation Service, recreational services, Army Community Services, American Red Cross, education activities, chaplain, IG, RREO, IO, PM, CPO, SJA, and local school administrators).

c. Lines of communication should be established with all appropriate on-post activities to encourage their suggestions and ideas for prevention of alcohol and other drug abuse. Wives clubs, dependent youth activities, NCO and officer clubs, and other groups can often contribute valuable services to the ADAPCP. If appropriate, representation from these groups should be included in the ADDIC.

2-14. Chaplain. One of the few staff officers on an installation having access to all levels of the community is the chaplain. Through his unique relationship with the commander, members of the command, and their families, the chaplain serves as a positive influence in the ADAPCP. Using the guidelines established in AR 165-20 and in FM 16-5, the installation chaplain should—

a. Serve as a member of the ADDIC or other council which addresses alcohol and other drug abuse matters.

b. Provide chaplain coverage as appropriate to the ADAPCP.

c. Insure contact and maintenance of relationship with local clergy, veterans' organizations, civic organizations, religious and professional organizations within the civilian sector.

d. Maintain contact with the ADCO to insure that chaplains assigned to the ADAPCP are being properly used as ministers of religion.

e. Facilitate the development of spiritual, social, and moral aspects of community life that provide constructive alternatives to the abuse of alcohol and other drug abuse.

f. Initiate corrective or supportive actions and recommend material resources and policy changes within the Human Self-Development Program as it relates to the ADAPCP (AR 600-30).

g. Advise the commander on the ethical and moral implications of the ADAPCP plans and policies.

2-15. Civilian community. *a.* Cooperation and coordination with the local civilian community is essential to an effective ADAPCP. Army policy in relation to the ADAPCP should be integrated in the Command Community Relations Program governed by AR 360-61.

b. The installation should actively support and participate in the local civilian community Alcohol Safety Action Project or similar programs when available.

c. Alcohol and drug councils exist within many

political boundaries (State, county, city, or town). The ADCO should seek membership on the local alcohol and drug council(s) and, if appropriate, offer reciprocal membership on related military councils.

d. The ADCO should insure that liaison is made with local civilian mental health and social service organizations, community centers, and alcohol and drug treatment centers to promote mutual understanding of alcohol and other drug abuse program procedures and policies.

CHAPTER 3

IDENTIFICATION, REFERRAL, AND EXEMPTION

Section I. GENERAL

3-1. Objective. The objective of identification is to discover alcohol or other drug abuse as early as possible and to refer the abuser to the ADAPCP for assistance.

3-2. Scope. *a.* Identification is accomplished through a variety of methods which are described in section II. One of these methods, biochemical testing, is discussed in detail in section VI.

b. The commander's responsibilities in the referral process are outlined in section III.

c. Clinical confirmation (by a physician) of alcohol or other drug abuse is a requirement for entry into the ADAPCP (sec IV).

d. An exemption policy that restricts the consequences of servicemembers' involvement in the ADAPCP is described in section V.

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 abusers to volunteer for assistance and will avoid actions that would discourage servicemembers 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 servicemember initially seeks help from an activity or individual other than his/her unit commander, the individual contacted will immediately notify the servicemember's unit commander and installation ADCO.

b. The requirement that the individual contacted must notify the servicemember's unit commander and installation ADCO is not in conflict with a chaplain's right of privileged communication. The situation in which the servicemember is seeking assistance from the ADAPCP is addressed

in *a* above, but the situation in which the member merely reveals to a chaplain that he/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/drug treatment and rehabilitation counseling is available through the ADAPCP;

(2) The Army program requires that the member's unit commander become involved in the rehabilitation process; and

(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 servicemember's seeking emergency medical treatment for an actual or possible alcohol or other drug overdose are considered to be a variation of volunteering. (See para 3-17b(5) for exception.) For reporting purposes, such cases will be classified as volunteer (self) identifications. See paragraph 3-18b for special instructions concerning applicability of the exemption policy to such cases.

d. For civilian employee volunteers, see paragraph 7-14.

3-4. Command identification. The deterioration of a servicemember's job performance, conduct, or other behavior in a manner frequently associated with alcohol or other drug abuse may signal suspicions of such abuse. In addition, a soldier may become a suspected abuser as a result of an inspection. Suspected abusers will be interviewed by their unit commander and, if appropriate, referred to the ADAPCP for initial interview and evaluation by a physician (para 3-8).

3-5. Biochemical urine testing. This method of identification is described in section VI.

Section III. REFERRAL

3-8. Responsibilities of commanders. *a.* When individuals are identified, voluntarily or involuntarily, as possible alcohol or other drug abusers, their unit commanders will interview them and personally inform them of the evidence; advise them of their rights under Article 31, UCMJ; explain the provisions of the exemption policy; and give them the opportunity to provide additional evidence if they desire. If, at the conclusion of the interview, the commander believes that there remains a reasonable possibility of abuse, the commander will refer the individual to the ADAPCP to determine if alcohol or other drug abuse has or has not occurred. *All individuals with urine positives will be referred to the ADAPCP for evaluation by a physician except as indicated in paragraph 5-8c(2).* In the case of a member who has been diagnosed as an abuser by a physician during a sick call or other routine medical examination not associated with normal ADAPCP clinical confirmation procedures, the physician will inform the member's unit commander, who will, in turn, refer the individual to the ADAPCP for entry into the program. The physician's diagnosis in such cases serves as the clinical confirmation required in paragraphs 3-9 and 3-11b.

b. Persons apprehended by the military police for driving while under the influence of alcohol or other drugs will be referred to the ADAPCP for evaluation and education in accordance with AR 190-5. If the ADAPCP staff believes that treatment and rehabilitation are required, individuals will be referred to the Medical Treatment Facility

3-6. Medical identification. A physician conducting a physical or sick-call examination or administering emergency medical treatment or treating an inpatient may determine that a member is an alcohol or other drug abuser. In such a situation, the physician will notify the servicemember's unit commander and installation ADCO of that determination.

3-7. Investigation/apprehension. A member's alcohol or other drug abuse may be discovered as a result of apprehension or investigation by military or civilian law enforcement officials (para 2-9).

(MTF) physician for clinical evaluation in accordance with the provisions of paragraph 3-9. Second and subsequent offenders will be automatically referred to the ADAPCP for initial interview and evaluation by a physician in accordance with the provisions of paragraph 3-9.

3-9. Program referrals. Clinical confirmation by a physician of abuse of alcohol or other drugs is a prerequisite to program entry. The initial interview of a servicemember referred to the program will be conducted by the ADAPCP staff. To facilitate early identification and prompt rehabilitation efforts, this initial interview will be conducted within 2 duty days after referral to the ADAPCP. The counselor will obtain a social history, prepare the ADAPCP Initial Intake Record (fig. 6-1), and consult with the servicemember's commander/supervisor. This record and the servicemember's individual health record will be made available to the MTF physician (para 6-4). The procedures for clinical evaluation and confirmation are outlined in section IV.

3-10. Other referrals. Individuals who have problems not involving alcohol or other drug abuse may make contact with the ADAPCP staff. When such persons appear for assistance and/or advice and give no history of alcohol or other drug abuse, the ADAPCP staff will provide assistance by referring them to the appropriate agency. A log of the numbers and types of these referrals should be maintained.

Section IV. CLINICAL CONFIRMATION OF ALCOHOL OR OTHER DRUG ABUSE

3-11. General. To confirm or to discount a finding of alcohol or other drug abuse, regardless of method of initial identification, a careful evaluation of the individual must be conducted. The expertise of a variety of specialists in the field of alcohol/drug abuse will be employed in performing the overall evaluation to determine if abuse has occurred. See chapter 7 for corresponding procedures regarding civilian employees.

a. Initial interview. As an aid to the physician tasked with performing the clinical evaluation, a member of the ADAPCP staff, skilled in counseling techniques, will conduct an initial interview with the individual. This will take place within 2 duty days of the individual's referral. The counselor conducting the initial interview will inform the servicemember of the applicability of the exemption policy to disclosures of information concerning past drug use, or possession of drugs incidental to personal use, or alcohol abuse. The ADAPCP Initial Interview Record (fig. 6-1) will include a current history and appropriate information based on a consultation with the servicemember's immediate commander/supervisor and a thorough screening of the member's medical and personnel records. (Information will not be collected from the civilian employee's supervisor or records.) ADAPCP Initial Interview Record will be made available to the physician prior to clinical evaluation (para 6-4).

b. Clinical evaluation. A physician will be designated to perform the clinical evaluation in accordance with the provisions of TB MED 290. This evaluation will be scheduled within 2 duty days of the initial interview and will result in one of the following actions:

(1) If the physician, after interviewing and examining the individual and reviewing all pertinent data, determines that there has been no alcohol or other drug abuse, he may dismiss the individual from further evaluation. In this event, the Initial Interview Record will be destroyed; however, a non-identifying entry in the ADAPCP log for documenting the workload will be made.

(2) If alcohol or other drug abuse is confirmed, the physician will record his diagnosis (table 6-3) on section A, DA Form 4465 (ADAPCP Military Client Intake and Follow-Up Record) and will sign and date the form. The form will be

forwarded to the ADCO, and the servicemember will be entered into the ADAPCP.

(a) If immediate medical treatment is required for alcohol or other drug dependency or abuse or related illnesses, he will immediately enter the servicemember into detoxification.

(b) If no immediate medical treatment is required, he will refer the servicemember to the ADAPCP where, in conjunction with the ADAPCP staff and the servicemember's immediate commander, a structured program for rehabilitation will be initiated.

(3) If the physician can neither confirm nor deny the existence of alcohol or other drug abuse, the servicemember must be referred for social evaluation (*c* below) and subsequent joint medical/social consultations (*d* below) prior to final determination. The time span for consultations and final determination will not exceed 5 duty days.

c. Social evaluation. A member of the ADAPCP staff experienced in the evaluation of alcohol and other drug abuse (e.g., psychologist, social worker, rehabilitation counselor) will conduct an in-depth social investigation of servicemembers referred for evaluation under the provisions of *b*(3) above. Based on the result of this investigation, the social evaluator will prepare a recommendation for use in the joint medical/social consultation. The recommendation will be based on command or supervisory comments related to conduct or to performance of duty, the servicemember's personnel record, and any other pertinent demographic or investigative data.

d. Joint medical/social consultation. The physician and social evaluator will confer regarding their separate findings on the servicemember. Based on this joint consultation, one of the following actions will be taken:

(1) If the physician can now confirm alcohol or other drug abuse, the servicemember will be entered into the ADAPCP and, in conjunction with the ADAPCP staff and the servicemember's immediate commander, a specific course of rehabilitation will be initiated.

(2) If the result of the joint consultation remains inconclusive, this finding, along with all necessary information, will be presented to the servicemember's immediate commander for action in

accordance with the provisions of *e* below.

e. Commander's action. Upon receipt of the results of an inconclusive joint medical/social consultation (*d*(2) above), the immediate commander will take one of the following actions:

(1) The servicemember will be placed in the urine surveillance program if the consultation has produced possible, but inconclusive, evidence of drug abuse (para 3-12).

(2) The servicemember will be returned to duty when there is no justification to support a possible clinical confirmation (for example, administrative error). In this event, the physician will make an entry in the servicemember's health records as follows: "Social evaluation completed, negative findings; disposition: return to duty." In addition, the initial interview form will be destroyed; however, a nonidentifying entry in the ADAPCP log for documenting workload will be made.

3-12. Urine surveillance. The Urine Surveillance Program (USP) consists of the mandatory submission by a servicemember of a minimum of eight urine specimens on days selected at random during a 1-month period of continuing evaluation. This frequency of testing at

proper intervals is sufficient to detect the abuse of identifiable drugs. If all the tests given during that month have been negative, the servicemember will be released from the surveillance program. At this time, all records pertaining to such a servicemember will be destroyed. If a test is positive during the surveillance period, the member must be reevaluated in accordance with the evaluation sequence described in paragraph 3-11.

3-13. Interview and confirmation process. Figure 3-1 depicts schematically the flow of actions for servicemembers identified as possible alcohol or other drug abusers. (For civilian employee clients, see fig. 7-2.)

3-14. Clinical confirmation of civilian personnel. Since formal program entry is based on clinical confirmation by a physician, evaluation of civilian personnel, retirees, and dependents should follow a sequence similar to that described in this section. Individuals who are clinically confirmed as alcohol or other drug abusers should be encouraged to enter the ADAPCP for rehabilitation or referral to an approved civilian rehabilitation program. For details concerning civilian employees, see chapter 7.

Section V. EXEMPTION POLICY

3-15. Objective. The objective of exemption is to facilitate effective identification, treatment, and rehabilitation by eliminating the barriers to successful communications between alcohol or other drug abusers on the one hand, and ADAPCP counselors or physicians supporting the program on the other.

3-16. Definition of exemption. Exemption is—

a. An immunity from disciplinary action under the UCMJ, or administrative separation with less than an honorable discharge, as a result of certain occurrences of alcohol abuse, or drug use or possession of drugs incidental to personal use.

b. An immunity from use of evidence obtained directly or indirectly from the member having been involved in the ADAPCP, as described in paragraphs 3-17 and 3-18 and in table 3-1.

3-17. Exemption policy. *a.* Subject to the exceptions listed in paragraphs 3-17*b* and *c* below, table 3-1 describes the Department of the Army 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 3-1) 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 servicemember acquired exemption if, at the effective time of exemption, the member—

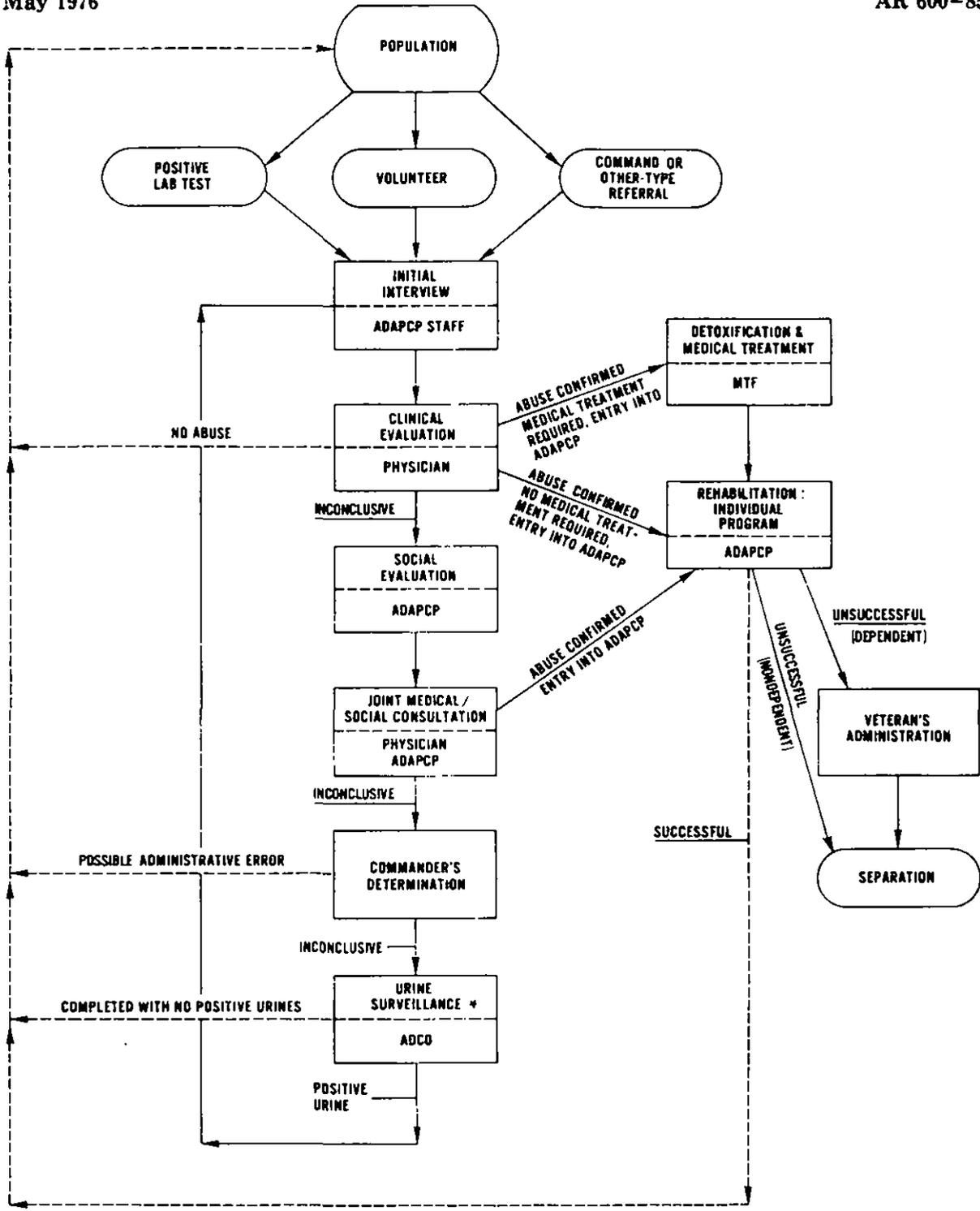
(1) Is the subject of an alcohol or drug abuse investigation concerning that offense.

(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.



INTERVIEW and CONFIRMATION PROCESS

* NA TO ALCOHOL ABUSERS

Figure 3-1.

c. Those offenses described in *b* above and offenses other than offenses of alcohol abuse or illegal drug use or possession incident thereto are not affected by the exemption policy 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 servicemember committing such offenses if warranted under the circumstances, or 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, if the decision to initiate discharge action against a servicemember is motivated by the member's having been identified as an alcohol abuser, by the member's exempt use or incidental possession of drugs, or by the member's having been involved in the ADAPCP, the discharge will be with an honorable discharge. (See para 3-18*d*.)

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.

3-18. Implementation. a. Upon the exemption policy becoming effective initially (column B, table 3-1), the servicemember's unit commander will—

(1) 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.

(2) Collect any illegal drugs or drug paraphernalia from the servicemember and turn them over to the local provost marshal in accordance with the provisions of AR 190-22.

(3) Refer the servicemember to the local ADAPCP for clinical evaluation if not already accomplished.

(4) Encourage the servicemember to provide information on drug sources (however, such disclosure is voluntary and will not be made a requirement for treatment or rehabilitation).

(5) Advise the servicemember of his/her rights under Article 31, UCMJ, before all dis-

3-6

cussions between the commander and the servicemember concerning the servicemember's alcohol and drug involvement.

b. The commander of a servicemember who receives emergency treatment from a military medical facility for an actual or possible alcohol or other drug overdose is made aware of the event as a routine matter. When a servicemember receives such emergency treatment from a civilian medical facility, however, there is no routine procedure by which this fact is conveyed to the servicemember's commander. Further, physicians at any federally-supported civilian alcohol or other drug treatment facility are prohibited by statute from releasing such information without the written consent of the patient. Hence, in cases where information of the emergency treatment does not otherwise come to the attention of the servicemember's unit commander, the following requirements must be met before the exemption policy becomes effective for the servicemember who receives emergency treatment for an actual or possible alcohol or other drug overdose from a civilian medical facility.

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

(2) The servicemember must give written consent to the treating civilian physician or facility for release of information verifying that emergency treatment was rendered for an actual or possible alcohol or other drug overdose.

(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 servicemember's giving written consent, the commander will interpret the member's actions described in (1) above as an act of volunteering for treatment in the ADAPCP, and the exemption policy is effective as of the time the treatment was rendered.

c. A military associate 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 he himself is an alcohol or other drug abuser and fears possible adverse consequences of becoming involved. Although exemption is not automatically extended to such an in-

dividual, the availability of the following options to that servicemember and his/her commander should reduce reluctance to assist the victim:

(1) The servicemember may seek help for his/her own alcohol or other drug problem from his/her commander, from the physician at the military medical treatment facility, or from any other agency or individual described in paragraph 3-3.

(2) If the commander, because of a servicemember'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 inform the member of these suspicions, insure that the member is aware of the treatment and rehabilitation services available, and give the member an opportunity to volunteer for help. 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. The servicemember protected by the exemption policy who is recommended for administrative discharge based on nonexempt grounds (paragraphs 3-17b and c) supported solely by evidence other than evidence obtained directly or indirectly from the member's having been involved in the ADAPCP, and as to whom the decision to initiate discharge action is not motivated by the

member's having been identified as an alcohol abuser, by the member's exempt use or incidental possession of drugs, or by the member having been involved in the ADAPCP, may receive an honorable, general, or undesirable discharge, as provided in AR 635-100, AR 635-200, or other regulations authorizing discharge with less than an honorable discharge certificate. However, if either the commander (in his/her recommendation for discharge or in documents forwarded with his/her recommendation), or any member of the board of officers adjudicating the servicemember's case, or the investigating officer/recorder presenting the case before the board, initially introduces evidence prohibited above, the member will receive an honorable discharge certificate, regardless of his overall performance of duty. On the other hand, if the servicemember (respondent) or his counsel initially introduces such evidence, the type of discharge certificate issued is not restricted to an honorable discharge certificate merely because of the presence of that evidence (or rebuttal thereto) in the discharge action record.

e. 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.

Section VI. BIOCHEMICAL TESTING

3-19. Objectives. The objectives of biochemical testing are early identification of drug abusers, deterrence of experimental and casual drug use, monitoring rehabilitation progress, and development of data on the prevalence of drug abuse within the Army.

3-20. Policies. a. *Concept.* Biochemical testing of urine can detect various drugs, including amphetamines, barbiturates, opiates, methaqualone 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. Current laboratory methodology is such that virtually no false positives are reported.

b. *Personnel to be tested.*

(1) Military personnel 25 years of age and below on active duty or active duty for training for more than 30 days will be subject to random

testing at or above the frequencies given in appendix F. Military personnel 26 years of age and older are not liable for selection for random testing but are subject to all other categories of testing.

(2) In addition, mandatory event testing of all personnel is required at the following events:

(a) Initial entry on active duty and active duty for training.

(b) Reentry of prior service personnel.

(3) Clinically confirmed military alcohol abusers will be tested as follows:

(a) While in detoxification—three times per week, regardless of age.

(b) If detoxification is not required—during the physical examination when entering into the rehabilitation program, regardless of age.

(c) During rehabilitation for personnel 25 years of age and younger—a sufficient number of tests must be conducted to confirm either multiple

Table 3-1. HQDA Exemption Policy
(Subject to Exceptions Outlined in Paragraphs 3-17b and 3-17c)

LINE	A	B	C	D
	If a member is identified as an abuser of alcohol or other drugs by the method indicated below—	—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 alcohol abuse, or drug use or drug possession incidental to personal use, which occurred prior to the effective time of exemption as indicated below:	Additionally, 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 alcohol abuse, or drug use or drug possession incidental to personal use, which is revealed to a physician or ADAPCP counselor at a scheduled interview or evaluation, or by a positive urinalysis administered during active or follow-up rehabilitation. This exemption is effective at the time such occurrences are revealed, or the urine test is laboratory confirmed as positive.	Further, 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 or evaluation, or by a positive urinalysis administered either to identify drug abusers for entry into the ADAPCP or to monitor progress during the active or follow-up rehabilitation phases of the ADAPCP, will not be used in any disciplinary action under the UCMJ, or in any administrative separation proceeding in which the servicemember is subject to less than an honorable discharge. (See paragraph 3-18d.)
1	Member voluntarily seeks help for an alcohol or other drug problem. (See para 3-3.)	At the time of volunteering.		
✓ 2	Member receiving emergency medical treatment for an actual or possible alcohol or other drug overdose.	At the time the member receives the emergency treatment. See paragraph 3-18b for special procedures to be followed when treatment is obtained from a civilian medical facility.		
3	Urine test administered to identify drug abusers for entry into the ADAPCP.	At the time the urine test is laboratory confirmed as positive.		
4	Medical referral to the ADAPCP by a physician who has diagnosed alcohol or other drug abuse incident to a sick call or other routine medical examination.	At the time of the diagnosis.		
5	Commander referral to the ADAPCP based on deteriorating job performance, conduct, or other behavior in a manner frequently associated with alcohol or other drug abuse; or based on apprehension by other than civilian or military law enforcement officials; or based on discovery of use or possession of drugs or drug paraphernalia during a routine inspection.	At the time of the initial interview by ADAPCP counselor. (See paragraph 3-11a.)		

**Table 3-1. HQDA Exemption Policy
(Subject to Exceptions Outlined in Paragraphs 3-17b and 3-17c)—Continued**

LINE	A	B	C	D
6	Apprehension/investigation referrals (through the member's unit commander) by civilian or military law enforcement officials.	At the time of the initial interview by ADAPCP counselor. (See paragraph 3-11a.)		

drug abuse or alcohol abuse only. The number is determined by the unit commander in consultation with the rehabilitation and medical staff.

(d) During rehabilitation for personnel 26 years of age and older—as determined by the unit commander in consultation with the rehabilitation and medical staff, with follow-up testing as appropriate.

(e) If determined to be a multiple drug abuser at any time, regardless of age—four times per month, on days selected at random, for 2 months, then two times per month on days selected at random for 10 months.

(4) Clinically confirmed military drug abusers, regardless of age, will be tested as follows:

(a) While in detoxification—three times per week.

(b) While in rehabilitation—minimum of four times per month, on days selected at random, for 2 months; two times per month, on days selected at random, for remaining 10 months.

(5) Military personnel participating in a mandatory urine surveillance program will be tested a minimum of eight times during a 1-month period, on days selected at random.

(6) Military and civilian alcohol and other drug treatment and rehabilitation staff personnel (to include but not limited to typists, record clerks, receptionists, detoxification and laboratory personnel, CPC, counselor, ADAPCP physician, personnel collecting urine specimens, etc.) 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 may require urinalysis as a precondition and 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 (app C). The ADAPCP is a combined program for the rehabilitation of abusers of alcohol and other drugs. In the few programs that have not been implemented as combined programs, the following procedures regard-

ing urinalysis testing of civilian staff personnel will be followed:

(a) Personnel who may have been hired for, or are currently providing counseling services exclusively for clients whose only identified drug of abuse is alcohol will not be required to undergo periodic urine testing as a continuing condition of employment when the following conditions are met:

1. Clients' only identified drug of abuse continues to be alcohol.

2. Counselor and clients utilize a physical facility for treatment/rehabilitative purposes which is *separate and distinct* from one used by "other drug" clients and counselors.

(b) In those programs which currently utilize separate facilities for "alcohol only" abusers and "other drug only" abusers, any "alcohol only" client who is positively identified as an abuser of an "other drug" of abuse must be transferred to the facility designated for treatment/rehabilitation of "other drug" abusers. This will preclude establishing a requirement to conduct periodic urine testing of "alcohol counselors" on a temporary basis.

(7) Commanders may at any time direct that a servicemember be tested when the individual is suspected of having recently abused drugs.

(8) Commanders may establish local event testing beyond that required in this regulation when a need for such testing can be demonstrated (para 3-23).

(9) Physicians may at any time direct that a servicemember patient be tested when drug abuse is suspected.

(10) Military and civilian drug abuse testing laboratory personnel will be tested a minimum of two times per month, on days selected at random.

(11) Make-up tests are required for all categories of testing. See paragraph 3-22f(4) for make-up *random* testing time criteria.

3-21. Responsibilities. a. The Deputy Chief of Staff for Personnel, DA, will provide General Staff supervision of biochemical testing.

b. The Surgeon General 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. Major Army commanders will coordinate and monitor biochemical testing within their commands.

d. Commanding Generals of FORSCOM, TRADOC, DARCOM, USASA, USAHSC, USACC, MDW; and MTMC; and commanders of oversea commands will—

(1) Monitor the implementation of biochemical testing at installations and activities over which they exercise jurisdiction.

(2) Designate points at appropriate locations to collect and ship specimens to the responsible laboratory identified in appendix G.

(3) Establish and monitor specimen submission quotas for specimen collection points.

(4) Establish contact and coordination with servicing laboratories as appropriate.

e. 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 guidelines in paragraphs 3-12, 3-13, 3-22, and 3-23.

(4) Establish procedures whereby unit commanders are informed of all laboratory positive results concerning personnel in their units.

f. 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 G. (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 3-2.

(3) Evaluate all urine specimens for test 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) Within 2 duty days after receipt of specimens, report to the originating agency, electrically or telephonically, 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 (para 3-24b(5)). 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 for purposes of standardization of methodology and the exchange of technical information which may be of mutual benefit.

g. 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 OASD (HA) in determining laboratory proficiency.

3-22. Random testing. Biochemical testing of randomly selected personnel is the major component of the DOD Drug Abuse Testing Program. Installation random testing procedures will be designed and implemented to—

a. Insure a relatively constant workload on the drug testing laboratories.

b. Provide a completely random system of selecting those to be tested so that a unit's or an individual's chances for testing will remain relatively constant throughout the year.

c. Be completely unannounced to the units or individuals to be tested.

d. Be invulnerable to prediction based on historical analysis.

e. Be capable of adjusting to changing requirements.

f. Insure that selected personnel are tested promptly, in accordance with the following guidelines:

(1) Notification of selection should be made at the first formation of the day (e.g., work call or start of office hours).

(2) To the maximum extent possible, selected personnel should be tested during the duty day of notification.

(3) Selected personnel who are away from the unit area or workplace for authorized purposes on the day of notification will be tested if they return prior to the end of the second day after notification.

(4) Selected personnel whose authorized absence (leave, TDY, hospital, confinement) extends beyond 2 days after notification need not be tested upon their return.

(5) Selected personnel who are not tested during the 2 days after notification and whose absence was not authorized will be tested upon their return.

(6) Rosters of personnel selected for testing will be maintained and annotated with a brief explanation of the reason for any selected individual's failing to be tested. Rosters will be retained for 1 year.

g. Use one of the selection schemes described in DA Pam 600-18. Requests to use alternate selection schemes will be forwarded through command channels to HQDA (DAPE-HRL-A) WASH DC 20310.

3-23. Additional commander-directed testing.

Commanders desiring to conduct additional testing (para 3-20b(8)) will follow the procedures in *a* and *b* below.

a. Requests to implement recurring event testing beyond that required in paragraph 3-20b(1) will be forwarded, through command channels, to HQDA (DAPE-HRL-A) WASH DC 20310.

b. Requests for large volume testing on a one-time basis will be forwarded to the major command coordination officer for determination of laboratory capability.

3-24. Collection and transportation of urine specimens.

a. The installation commander has the overall responsibility for the collection of urine samples. At many installations medical resources have been provided to support this function. Where such hospital support resources exist, the MEDCEN/MEDDAC will provide personnel to the ADCO to assist in urine collection procedures.

b. 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 6640-00-165-5778, 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 and Services) will be included with specimens forwarded to a civilian contract laboratory.

c. Urine specimens will be shipped without preservative or refrigeration to the appropriate test laboratory by the method of expedited transportation which will insure delivery at the earliest practicable date but 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 expedited surface transportation; US Postal Service; the Military Airlift Command transportation system; non-industrially funded military organic aircraft; US flag commercial air freight; air express; air freight forwarder; or, when none of these can satisfy the movement requirement, by foreign flag air carriers.

d. Specimens which have been collected from individuals participating in rehabilitation programs will be clearly identified by the collecting agency with the word "REHAB" at the top of each DD Form 1892 and on each specimen bottle. "REHAB" 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" specimens priority testing by inserting them in production lines ahead of all routine drug urine specimens awaiting testing.

Table 3-2. Minimum Drug Detection Sensitivity Levels

<i>Drug Class</i>	<i>RIA/GLC</i>
Opiates	
Total Morphine	400 ng/ml
Methadone/Codeine	400 ng/ml
Amphetamines	400 ng/ml
Barbiturates	200 ng/ml
Methaqualone	1000 ng/ml
Cocaine	1000 ng/ml

CHAPTER 4

DETOXIFICATION

4-1. General. Detoxification involves withdrawing an individual from drugs of abuse (including alcohol), treating the physical symptoms of that withdrawal, and initiating rehabilitation. Not every alcohol or other drug abuser (even those who are truly dependent) need be hospitalized. The decision as to whether hospitalization is required is medical and will be made only by a physician. Requirements to submit to medical care will be in accordance with the provisions of section IV, AR 600-20, and paragraph 2-8, AR 40-3.

4-2. Methods of referral. An individual will normally be admitted for detoxification to a medical treatment facility (MTF) by one of the following methods:

a. Referral by the ADAPCP staff to a physician for evaluation for admission for detoxification.

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 ADAPCP staff.

4-3. Responsibilities. *a.* The MEDCEN/MEDDAC commander will—

(1) Provide adequate personnel and facilities to evaluate and detoxify alcohol and other drug patients in an alcohol and drug free environment.

(2) Notify the ADCO and the individual's unit commander of all alcohol and other drug abusers who come to the attention of MEDCEN/MEDDAC personnel (e.g., alcohol or other drug-related diseases or injuries, or emergency treatment of overdose cases).

(3) Implement, in coordination with the ADCO (who has overall responsibility for the total rehabilitation program), a structured rehabilitation regimen for individuals undergoing detoxification.

(4) Insure that biochemical testing is performed on patients undergoing detoxification and on military and civilian treatment staff (para 3-20).

b. The ADCO will—

(1) Coordinate with the clinical consultant to insure that the ADAPCP rehabilitation staff participates in the initiation of rehabilitation for individuals undergoing detoxification.

(2) Insure a smooth transition of individuals from detoxification to the ADAPCP.

(3) Insure that DA Form 4465 is prepared (para 6-5).

c. The unit commander will maintain contact with the individual undergoing detoxification and will participate in the rehabilitation effort.

4-4. Medical processing. *a.* As early in detoxification as possible, the individual will receive a complete medical examination, to include a psychiatric evaluation if indicated. Individuals with a medical condition which renders them unfit for retention (e.g., schizophrenia, chronic brain syndrome, chronic cirrhosis) will be processed in accordance with the provisions of AR 40-3, AR 635-100, or AR 635-200.

b. The attending physician will determine the time necessary for detoxification. Usually 3 to 7 days of inpatient care will be sufficient for most drug dependent individuals; however, longer periods may be necessary for some, especially in cases of alcohol dependence. TB MED 290 provides specific clinical details regarding detoxification.

c. No patient will be medically evacuated from overseas who has not been completely detoxified, except under very unusual circumstances.

4-5. Use of methadone. Methadone may be used only to ease extreme and otherwise uncontrollable discomfort of rapid withdrawal from opiate dependency (para 5-12a). Methadone will not be used for maintenance therapy.

4-6. Line of duty determination. During detoxification a line of duty determination is not required, unless an individual is determined by a physician to be totally 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 total incapacitation (para 6-16 and AR 600-33).

4-7. Action after detoxification. After detoxification for alcohol and other drug abuse has been completed, the individual will continue in the active phase of rehabilitation in the ADAPCP.

CHAPTER 5

REHABILITATION

Section I. INTRODUCTION

5-1. General. 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 and will insure that all community resources are used in assisting individuals during rehabilitation. Commanders must insure that individuals are assisted in coping with the environment in which they are expected to function. The commander's attitude toward the rehabilitation process will influence the entire effort; therefore, his support and the support of the first-line supervisor must be positive and clearly visible.

5-2. Objectives. The objectives of the rehabilitation program are to—

a. Return individuals clinically confirmed as alcohol or other drug abusers to effective duty through short-term rehabilitative efforts.

b. Identify individuals requiring long-term care and provide for continuity of treatment until they are discharged or terminated from Government service.

5-3. Coordination. Alcohol and other drug abuse rehabilitation, as in other human resource programs, 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.

In the interest of maintaining client confidence in the ADAPCP, the responsible staff member will, whenever feasible, employ command consultation techniques. This involves joint discussions with the unit commander; NCO supervisor, if applicable; and the client. The commander and the ADAPCP staff member should exchange information concerning the nature of the servicemember's alcohol or other drug problem, his duty performance and adjustment, and other collateral matters pertaining to alcohol and other drugs which affect the unit and/or the member's rehabilitation outcome. A record of this consultation will be maintained in the client's ADAPCP case file. No other records of this consultation will be maintained. In the case of civilian clients, these techniques may not be used unless program consent forms are on file.

5-4. Clinical confirmation. *a.* All eligible personnel (paras 1-1 and 1-5d) will be entered in the ADAPCP only after clinical confirmation of alcohol or other drug abuse has been established by a physician (paras 3-11 and 3-14). This policy is applicable in all instances, regardless of whether the source of referral is voluntary or involuntary.

b. Individuals referred for evaluation as a result of apprehension for driving under the influence of alcohol or other drugs (para 3-8b) will not be entered into the rehabilitation program unless clinical confirmation of alcohol or other drug abuse has been established by a physician.

Section II. REHABILITATION PROGRAM

5-5. General. *a.* After an individual has been clinically confirmed and entered into the rehabilitation program, the clinical director and his staff will make a determination of what rehabilitative approach will best meet the needs of

the individual and will achieve the earliest possible return to full duty. The individual's immediate unit commander will be consulted and will be made aware of the therapeutic plan. Frequency and length of counseling sessions will be coordinated

with the immediate unit commander to insure compatibility of therapeutic plan and mission requirements of the unit.

b. The rehabilitation program consists of two phases—active and follow-up.

(1) The active phase ordinarily should not exceed 60 days for servicemembers and 90 consecutive days for civilian employees and should consist of frequent and intensive treatment sessions (e.g., group and/or individual counseling) para 5-6).

(2) The follow-up phase ordinarily should not exceed 300 days for servicemembers and 270 consecutive days for civilian employees. The treatment sessions during this phase usually decrease in frequency and intensity (para 5-7).

c. No client will exceed a total of 360 days in the ADACP for reporting purposes. This includes the total time spent in detoxification, in the active phase, and in the follow-up phase.

d. Servicemembers will not be required to sign any agreements pertaining to the rehabilitation process.

5-6. Active rehabilitation phase. The two major rehabilitation alternatives of this phase are residential rehabilitation and nonresidential rehabilitation.

a. *Residential rehabilitation.* Initially, some individuals will require and respond better to rehabilitative efforts in the more structured and alcohol/drug-free environment of the halfway house (live in, work in). It is recognized that some installations will not generate a client caseload sufficient to justify the operation of such a facility. The decision to establish or maintain an installation halfway house is the responsibility of major commanders; however, discontinuance will be accomplished only after careful evaluation and coordination between major commands and HQDA(DAPE-HRL-A). Halfway houses will be operated in accordance with the following standards:

(1) *Structure.* Halfway houses will provide a balanced and carefully structured program consisting of regularly scheduled counseling sessions, military education and training, physical conditioning, and structured recreational activities. Operation of the halfway house will reflect a military environment. The halfway house program will provide structured activities under rehabilitation staff supervision after normal duty hours.

5-2

(2) *Physical plant.* The physical facility should reflect the same standards as local troop billets. Additionally, provisions should be made for one or two rooms for group therapy and several private offices in which individual counseling can be conducted with maximum privacy. Security procedures will be developed and implemented to insure that clients are provided an alcohol and drug-free environment.

(3) *Female clients.* Installations that have a female active duty military population will make provisions for billeting females in a halfway house as required. This will include provisions for separate sleeping and latrine facilities. When a female member is a halfway house resident, a female staff member will be on duty. If locked doors are provided for female residents, the female staff member on duty will have a master key in her possession at all times. If these conditions cannot be met within the installation ADAPCP, and if it has been determined that a female member requires a live-in period in a halfway house, the installation commander will take necessary action to assure that treatment is provided in an appropriate facility.

(4) *Duration of residency.* The full-time (24 hours) resident program will not exceed 15 days except under very unusual circumstances. Residents may, however, progress to a part-time residential phase (live in, work out). Under no circumstances will participation in any form of residential rehabilitation exceed 30 days.

b. *Nonresidential rehabilitation.* Individuals who do not need the more rigid structure and supportive environment of a live-in facility should be returned to their units and receive counseling during regularly scheduled appointments at the counseling center (live out, work out).

(1) *Scheduling appointments.* Appointments will be scheduled with the least possible interference with the individual's routine duties in the unit. Consideration will be given to scheduling sessions after normal duty hours and in the client's unit (even when in the field) when appropriate.

(2) *Type and frequency of counseling.* The type of counseling and frequency of counseling sessions for the individual in active or follow-up rehabilitation will vary, depending on the need of the individual; however, two sessions per week during the live-out, work-out portion of the 60-day period of active rehabilitation are recommended.

5-7. Follow-up rehabilitation phase. After the servicemember has satisfactorily completed the 60-day active rehabilitation phase and the immediate unit commander and the rehabilitation staff determine that the servicemember no longer requires structured rehabilitative counseling (para 5-8), the servicemember will be enrolled in the follow-up phase of the rehabilitation process.

a. Servicemembers in the follow-up phase will be seen at least twice monthly by the ADAPCP rehabilitation staff during the early portion of this phase. The frequency of subsequent visits will be determined by the ADAPCP staff on an individual client basis.

b. The ADAPCP rehabilitation staff will make periodic command consultation visits during the follow-up phase with the unit commander to monitor the servicemember's progress (para 5-3).

c. If recidivism occurs during the follow-up phase, the unit commander, in consultation with the ADAPCP rehabilitation staff, will determine, on a case-by-case basis, what course of action will be taken.

d. Follow-up reports will be prepared and submitted in accordance with the provisions of paragraph 6-6.

5-8. Determination of rehabilitation progress. On or about 60 days after entry into the ADAPCP, the servicemember's alcohol or other drug rehabilitation progress will be determined by the immediate unit commander, in consultation with the ADAPCP rehabilitation staff. If, at this time, the servicemember is declared a rehabilitation success, he/she will be moved into the follow-up phase of the rehabilitation program or will be processed in accordance with the provisions of a(4) below. If the servicemember is declared a rehabilitation failure, he/she will be processed for separation from the Service under the provisions of AR 635-100 or 635-200. The following criteria will be used to make this determination:

a. Rehabilitation is considered a success if—

(1) The servicemember is functioning effectively at full duty at the end of a 60-day period dating from the time of entry into the ADAPCP, and

(2) The servicemember is apparently free from the abuse of other drugs and of significant problems with alcohol, and

(3) The servicemember has received maximum benefit from active rehabilitation efforts

and can be moved into the follow-up phase of the rehabilitation program; or

(4) The servicemember clearly demonstrates motivation to remain free of alcohol or other drug abuse but still demonstrates a need for additional supportive counseling. These individuals will be evaluated on a case-by-case basis and will be transferred to the follow-up phase of rehabilitation and will be seen at a frequency rate determined by the ADAPCP staff.

b. Rehabilitation is considered a failure if—

(1) The servicemember has clearly demonstrated that he is unable or unwilling to be returned to effective duty after short-term rehabilitative efforts. This determination may be made at any time during the 60-day active rehabilitation phase or during the follow-up phase. Servicemembers who have been clinically confirmed as drug abusers and who have been declared a rehabilitation failure under the provisions of this chapter must be afforded a minimum of 30 days of rehabilitation or treatment, to include time spent in detoxification, in medical evacuation channels, and in the VA hospital, prior to separation from the Service; or

(2) The servicemember has clearly demonstrated inability or unwillingness to remain free from the abuse of alcohol or other drugs; or

(3) The immediate unit commander, in consultation with the ADAPCP rehabilitation staff, has determined that the servicemember has received maximum benefit from rehabilitation efforts and clearly demonstrates recalcitrance to the degree that further rehabilitative efforts in the military environment would not result in return to full effective duty.

Note. The ADAPCP will provide appropriate services to servicemembers determined to be rehabilitation failures until they are discharged from the Service.

c. Urine testing of clients in rehabilitation will be accomplished as follows:

(1) Urinalysis testing of clients during rehabilitation will be accomplished in accordance with the provisions of paragraph 3-20b for military personnel and paragraph 7-14b for civilian employees.

(2) Clinical evaluation by a physician of individuals with rehabilitation urine positives is not normally required. A previously clinically confirmed client on whom a laboratory positive urine test result has been received will be confronted

with that evidence by his/her counselor. If the client acknowledges that drug abuse was responsible for the laboratory positive test result (i.e., admits to continued drug abuse), an appropriate entry will be made to that effect of SF 600 contained in the individual client case file. If the client attributes the positive laboratory result to either administrative or laboratory error, or to legally prescribed medication (not substantiated by the existence of a valid prescription), then the individual will be referred to the physician designated to perform ADAPCP clinical evaluations for determination of possible continuing drug abuse. In this case, an appropriate entry will be made on SF 600 contained in the individual client case file concerning the physician's findings.

5-9. Reintegration to the unit. One of the most critical and difficult aspects of the rehabilitation process is the reintegration of the servicemember to his role and responsibilities in his 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 servicemember must be afforded a realistic opportunity to demonstrate that he/she is motivated to remain alcohol/drug free and can once more function effectively.

a. The immediate unit commander and other key unit personnel must insure that the servicemember is—

(1) Assigned duties commensurate with his abilities, experience, and military occupational specialty (MOS).

(2) Assigned the same standards for performance and behavior that are expected of other members of the unit of equal grade and length of service.

(3) 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.

b. Frequent consultation between the immediate unit commander and the ADAPCP staff is essential during this critical phase of the rehabilitation process (para 5-3).

5-10. Transfer to VA medical facilities. Alcohol and/or drug dependent servicemembers who are declared rehabilitation failures will be transferred to Veterans Administration medical facilities (para 6-15). Nondependent alcohol and other

drug abusers who are declared rehabilitation failures will not be transferred to the VA (para 6-15).

5-11. Acceptable 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 the needs of both the individual and the requirements for effective duty performance. Rehabilitation modalities used by the rehabilitation staff of the ADAPCP will be structured within the scope of the Army's rehabilitation objectives—short-term treatment and early return to duty. A number of recognized rehabilitation and treatment modalities may be modified or adapted to accomplish the Army's objectives. The ADCO, in coordination with the clinical director, will insure that—

a. Professional counselors are fully qualified and/or trained in all rehabilitation/treatment modalities which they employ.

b. Paraprofessional counselors are experienced and trained in the alcohol and drug abuse rehabilitation field, to include the modality of rehabilitation in which expertise is claimed or employed.

c. Adequate professional supervision/consultation is available for professional and paraprofessional counselors.

5-12. 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 (para 4-5). The policy is 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 this modality.

b. *Therapeutic communities.* The therapeutic community modality involves an extended period of time and removes the individuals from their living environment during rehabilitation and treatment. This modality is in conflict with the policy of short-term treatment and early return to duty, and will not be used. Certain techniques used by or

within a therapeutic community (e.g., encounter groups, token economy, resocialization) may be modified and adapted to Army rehabilitation programs.

c. Mandatory 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, nor will it 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, but to insure that rehabilitation program personnel consider its use on an individual basis rather than as a therapeutic requisite.

CHAPTER 6

ADAPCP CLIENT MANAGEMENT

Section I. INTRODUCTION

6-1. General. *a.* This chapter prescribes policies and procedures for the administrative and clinical processing of military and civilian personnel participating in the ADAPCP. Standard client records have been designed to yield information for use in client and program management. Precise preparation of all records will facilitate local, major command level, and Army-wide program management and evaluation, and will provide a sound basis for research.

b. Client categories and the responsibilities of the MEDCEN/MEDDAC commander, the ADCO, and the clinical director are described in this section. Records management is discussed in section II, and Active Army client personnel actions are discussed in section III. ADAPCP client record documentation is illustrated in figures 6-1 through 6-4. Tables 6-1 through 6-5 and tables 6-7 and 6-8 provide instructions and information required for completing ADAPCP client records. Overall personnel action policies applicable to the ADAPCP are listed in table 6-6.

c. Due to the varied categories of individuals eligible to participate in the ADAPCP and to the requirements of HQDA for diverse data for these categories, an understanding of the instructions, policies, and procedures which follow is critical to the efficient administrative and clinical processing of clients.

(1) Policies and procedures applicable only to Active Army servicemembers will use the identifying term "servicemember."

(2) Policies and procedures applicable only to civilian employees of the Army will use the identifying term "civilian employee."

(3) Policies and procedures applicable to both Active Army servicemembers and civilian employees will use the general identifying term "client."

(4) In addition to civilian employees, other civilians participating in the ADAPCP include a *residual* category comprised of retired military, dependents of active and retired military and, where military medical care is authorized them, dependents of civilian employees. The policies and procedures prescribed in this section and in section II, although not always directly applicable to this *residual* category, will be used as a guide in processing these individuals in the ADAPCP. The general identifying term "client should be interpreted in this light.

Note. Personnel of other Services will be considered as belonging to the *residual* category.

6-2. Responsibilities. *a.* The MEDCEN/MEDDAC commander will—

(1) Insure that the health records of newly assigned servicemembers are screened for evidence of alcohol or other drug abuse (or a diagnosis thereof) within the previous 360 days (AR 40-403). The immediate commander and ADCO will be informed promptly of individuals whose records contain such information.

(2) Insure that individual client case files are maintained and disposed of as medical records in accordance with the provisions of AR 340-18-9, AR 40-403, and AR 40-42.

(3) Be responsible for the release of information from individual client case files (sec V, chap. 1; and in accordance with the provisions of paragraph 1-5c, AR 40-400).

b. The ADCO will—

(1) Insure that ADAPCP initial interview record (fig. 6-1) is prepared for all personnel prior to their evaluation by a physician.

(2) Insure that appropriate individual client intake and follow-up records (para 6-3a) are prepared for all personnel who have been diag-

nosed by a physician as abusers of alcohol or other drugs.

(3) Authenticate and effect distribution of individual client intake and follow-up records for servicemembers and civilian employees (para 6-5, 6-6, and 7-17e). *Distribution of intake and follow-up records on the residual category of civilian clients (para 6-1c(4)) will be limited solely to the individual client's local case file.*

(4) Notify the gaining installation ADCO of a servicemember's projected reassignment to the new installation (para 6-14b(3)). Upon notification of servicemember's enrollment in the ADAPCP at the new duty station, forward in-

dividual client case file items to gaining installation ADCO (para 6-14b(6)(b)).

(5) Have administrative responsibility for maintenance of individual client case files.

(6) Be responsible for preserving confidentiality of client case files, to include physical security, in accordance with the provisions of AR 40-42 and insure that all client case files are returned to the central file area and stored in locked designated containers when not in actual use.

c. The clinical director is responsible for the completeness and technical accuracy of individual client case files.

Section II. RECORD MANAGEMENT

6-3. Local client files. a. Individual client case files are medical records and will be maintained by the ADAPCP rehabilitation staff in accordance with the provisions of AR 340-18-9, AR 40-42, and AR 40-403. A case file will be prepared and maintained for each individual entered in the ADAPCP. Files will be of sufficient quality and scope to insure continuity of client care throughout the rehabilitation process. The following forms and data will be maintained in the individual client case files:

(1) One copy of the ADAPCP Initial Interview record (para 6-4).

(2) One copy of section A, DA Form 4465 (ADAPCP Military Client Intake and Follow-Up Record), for servicemembers (para 6-5); or one copy of section A, DA Form 4466 (ADAPCP Civilian Client Intake and Follow-Up Record), for civilian employees and the *residual* category of civilian clients (para 6-5 and chap. 7).

(3) One copy of each submission of section B, DA Form 4465, for servicemembers (para 6-6); or one copy of each submission of section B, DA Form 4466, for civilian employees and the *residual* category of civilian clients (para 6-6 and chap. 7).

(4) Results of all medical/psychiatric consultations and laboratory findings, including results of biochemical testing.

(5) Psychosocial histories.

(6) Clinical notes (SF 600 (Health Record—Chronological Record of Medical Care)), which will include—

(a) Treatment plan and goals.

(b) Entries for each individual or group

counseling session, describing behavior and process in nondiagnostic terms and results of collateral contacts, such as command consultation.

b. ADCO will maintain individual client case files in two sections, current and inactive.

(1) *Current.* The current section will include case files for all clients participating in either the active or follow-up phases of rehabilitation.

(2) *Inactive.* The inactive section will include case files of clients terminated and/or transferred. One portion of this file must be established for records in a "comeback" status; i.e., awaiting acknowledgement by the gaining ADCO that a servicemember who has been reassigned has, in fact, been entered into the ADAPCP at the new location.

c. Access to individual client files will be restricted to rehabilitation staff members, medical department personnel concerned with treatment of individual cases, and evaluators (i.e., DA and MACOM ADAPCP staff personnel, detailed inspectors general, and qualified personnel participating as members of official inspection teams) determining the extent of compliance with this regulation. MEDCEN/MEDDAC commanders may authorize research personnel, on a project-by-project basis, to extract information from the files, provided that there is compliance with restrictions which are imposed by AR 40-42, AR 340-18-9, and paragraph 1-29f of this regulation.

d. Records in the inactive section will be disposed of in accordance with the provisions of AR 340-18-9 and AR 340-16.

6-4 Initial interview. *a.* An initial interview will be conducted with *all* individuals referred to the ADAPCP. This interview will be conducted by counselors and will be completed prior to the individual's referral to the physician for clinical evaluation.

b. An Initial Interview Record (and attached privacy act statement) will be prepared in duplicate for each client in the format shown in figure 6-1. The original will be forwarded to the physician performing the clinical evaluation, and the duplicate will be filed at the ADAPCP in a temporary file. *Further reproduction or distribution of this record is prohibited. Exception:* See paragraph 6-14b(6)(b).

c. Upon completion of the clinical evaluation, the physician will return the original to the ADCO. If the individual is clinically confirmed, the original form will become a permanent part of the individual client case file. The duplicate copy will be destroyed when the original is filed. *If the physician determines that there has been no alcohol or other drug abuse, both copies will be destroyed.* If the physician can neither confirm nor discount alcohol or other drug abuse (servicemember entered into social evaluation or USP), both copies will be retained by the ADAPCP until a final determination is made; upon final determination, disposition will be as described above.

6-5. Intake records. *a.* A military Client Intake Record (CIR) (sec A, DA Form 4465) (fig. 6-2) will be prepared for each Army servicemember who has been clinically confirmed by a physician as an alcohol or other drug abuser, *whether or not the member is expected to be separated from the Service in the immediate future.* Under the same conditions, CIR's are required for members on active duty for training periods in excess of 30 days. CIR's are not required for members identified as alcohol or other drug abusers at the time of death (e.g., fatal overdose cases). See paragraph 6-6a for information regarding the requirement for client follow-up records for a member whose death occurs while participating in the ADAPCP.

b. Immediately after clinical confirmation by a physician, the CIR will be completed by the ADAPCP counseling staff, and will be authenticated by the ADCO. Instructions for completing section A of DA Form 4465 are provided in table 6-1. DA Form 4465 may be requisitioned through normal AG publications supply channels.

c. Distribution of the completed CIR will be made as follows:

(1) The original will be forwarded to Chief, US Army Health Information Systems and Biostatistical Agency, ATTN: HSHI-QPI, Fort Sam Houston, TX 78234, in accordance with instructions for record transmission in paragraph 6-7. *Under no circumstances* will this copy contain client identifying data (name, full SSN, or duty unit). Such information is "For Local Use Only" and must appear only on the copies indicated in (2) and (3) below. Copies forwarded to HSHI-QPI with incomplete data items will be returned to the ADCO for completion.

(2) A *first* reproduction of the original CIR will be placed immediately in the servicemember's health record maintained by the MTF providing primary health care.

(3) A *second* reproduction will be retained in the ADAPCP individual client case file.

(4) *Additional reproduction or distribution of completed CIR's is prohibited. Exception:* See paragraph 6-14b(6)(b).

d. A similar intake record is required for civilian employees. The Civilian Client Intake Record (CCIR) (sec A, DA Form 4466) is discussed in paragraph 7-17e. Distribution of the completed CCIR will be as follows:

(1) The original will be forwarded to Chief, US Army Health Information Systems and Biostatistical Agency, ATTN: HSHI-QBC, Fort Sam Houston, TX 78234, in accordance with instructions for record transmission in paragraph 6-7.

(2) A *single* reproduction of the original CCIR will be retained in the ADAPCP individual client case file.

(3) *Additional reproduction and distribution of completed CCIR's are prohibited.*

e. Although CCIR's will be completed on the residual category of civilian clients, distribution will be limited solely to the individual client case file. *No distribution will be made to HSHI or to the health record for the residual category of civilian clients.*

6-6. Follow-up records. *a.* A military client Follow-up Record (FUR) (fig. 6-3) is required for Active Army servicemembers and will be prepared at each of the 60-, 120-, 180-, and 360-day anniversary dates of entry into the ADAPCP. A program termination FUR will be submitted promptly to

HSHI-QPI as a final report for clients who die, are discharged, or are dropped from the rolls.

b. The FUR will be prepared by the client's counselor with input from the unit commander, and from other ADAPCP staff members, military law enforcement personnel, medical personnel, and other appropriate Army personnel, (military or US citizen employee), as required. ADAPCP personnel are not authorized to request information from non-DOD personnel or agencies. The counselor will obtain all information through personal interviews, or by telephone when reasonable privacy is assured. Information will not be obtained through such methods as written "feeder reports." The ADCO will authenticate the FUR.

c. Instructions for completing section B of DA Form 4465 are provided in table 6-2.

d. Distribution of completed FUR's is identical to that for CIR's (para 6-5c). For exceptions to restrictions on reproduction and distribution, see paragraph 6-14b(6)(b).

e. A similar follow-up record is required for civilian employees. The Civilian Follow-up Record (CFUR) (sec B, DA Form 4466) is discussed in paragraph 7-17e. Distribution of completed CFUR's is identical to that for the CCIR's (para 6-5d).

f. CFUR's will be completed on the *residual* category of civilian clients. Distribution of completed CFUR's for these clients will be limited solely to the individual client case file (para 6-5e).

6-7. Record transmission. a. The installation ADCO is responsible for the scheduled transmission of authenticated intake and follow-up records to the US Army Health Information Systems and Biostatistical Agency. Original copies of the CIR's, FUR's, CCIR's, and CFUR's will be compiled and forwarded weekly, covering the period from 0001 hours Tuesday through 2400 hours the following Monday. Each package forwarded will consist of four sections:

- (1) Optional Form 41 (Routing and Transmittal Slip) plus CIR's.
- (2) Optional Form 41 plus FUR's.
- (3) Optional Form 41 plus CCIR's.
- (4) Optional Form 41 plus CFUR's.

b. Each Optional Form 41 (fig. 6-4) will contain the following information:

- (1) Transmittal code (c below).
- (2) Total number of forms being transmitted.
- (3) A list of transferred (PCS) clients dropped

from local ADAPCP during the reporting period based on confirmed enrollment in the ADAPCP at new duty station. List by client program number, service area code and name of gaining ADAPCP.

(4) A list of clients enrolled in the local ADAPCP as the result of a PCS transfer from another ADAPCP. List by client program number, service area code and name of losing ADAPCP.

c. A transmittal code, used to identify the report period, will be placed in the first paragraph of the accompanying Optional Form 41. This transmittal code consists of four elements, reflecting the number of the week in the calendar year and the type of forms transmitted (e.g., 026A). The first two digits show the number of the reporting week within the calendar year, (01 through 52). The third digit corresponds to the last digit of the year which the report period covers (e.g., 1976 would be coded "6"). The suffix letters "A", "B", "C", or "D" complete the transmittal code. "A" indicates that the Optional Form 41 transmits DA Form 4465 (sec A, CIR's), "B" indicates that the Optional Form 41 transmits DA Form 4465 (sec B, FUR's), "C" indicates that the Optional Form 41 transmits DA Form 4466 (sec A, CCIR's); and "D" indicates that the Optional Form 41 transmits DA Form 4466 (sec B, CFUR's). (The example used above (026A) would show that the forms transmitted were the military CIR for the second reporting week of CY 1976.)

d. Within 2 working days following the end of the report period, forms will be dispatched by the most expeditious means *directly* to the Chief, US Army Health Information Systems and Biostatistical Agency, Fort Sam Houston, TX 78234, ATTN: HSHI-QPI (Active Army records), or ATTN: HSHI-QBC (civilian employee records). Forms used for the *residual* category of civilian clients will *not* be sent to HSHI.

e. *Negative reports are required.*

6-8. Deletion of erroneously identified clients from the ADAPCP. If a client's entry into the ADAPCP is discovered to be in error, the ADCO will cease submission of follow-up reports and terminate the case by forwarding a letter to Chief, US Army Health Information Systems and Biostatistical Agency (ATTN: HSHI-QPI or HSHI-QBC, as appropriate), requesting that the record in question be expunged from the data files. Requests should contain only the client program number and the reason for termination. Deletion letters will be signed by the requesting ADCO and

forwarded to HSHI with the weekly transmittal of records.

6-9. Management feedback reports. *a.* Based on the weekly submission of client intake and follow-up records to the US Army Health Information Systems and Biostatistical Agency, a file of aggregate ADAPCP data is maintained as a source of vital program evaluation and management information. A privacy safeguard in the design of the data base, Client-Oriented Drug Abuse Reporting System (CODARS (RCS CSGPA-1400)), is that no information which could identify any client as an individual can be entered into the system or retrieved from it by the US Army Health Information Systems and Biostatistical Agency, by HQDA, or by any other Federal or civilian agency.

b. The Surgeon General is responsible for monitoring and assessing the data and will provide

monthly and quarterly ADAPCP management reports to HQDA (DAPE-HRL-A) for release to MACOM and installation ADCO's.

c. In addition to receiving monthly and quarterly management reports, each ADCO will receive periodic feedback reports directly from HSHI for the purpose of maintaining his portion of the data base. Included will be a listing of client categories contained on the data files, data errors requiring correction by the ADCO, and overdue follow-up records. Corrections and comments will be entered directly on the report and returned to HSHI-QPI (servicemembers) or to HSHI-QBC (civilian employees) within 30 days of receipt.

d. Direct communication between the Office of the Chief, Health Information Systems and Biostatistical Agency and local ADCO is authorized.

Section III. ACTIVE ARMY CLIENT PERSONNEL ACTIONS

6-10. General. The purpose of this section is to provide guidance on personnel actions affecting Active Army ADAPCP clients. Policies pertaining to these various personnel actions are contained in regulations and directives not directly related to the ADAPCP; however, these policies must be interpreted in light of the overall goals of the ADAPCP. It is essential that the commander balance the needs of the individual, the unit, and the Army in handling each action. Table 6-6 provides guidance for frequently encountered personnel actions.

6-11. Suspension of access to classified information and relief from sensitive or hazardous duties. *a.* A servicemember who has been referred to the ADAPCP for evaluation or who has been identified as an abuser of alcohol or other drugs may be subject to certain administrative actions necessary for reasons of national security, or for his or his unit's safety.

b. The commander may temporarily suspend the member's access to classified information. If access is suspended, paragraph 3-1b, AR 604-5 requires the commander to initiate or request an investigation in order to permit expeditious restoration of access or to provide a sound basis for revocation of the individual's security clearance. The approximate 60-day period normally required

to determine ADAPCP rehabilitation success or failure (para 5-8), is compatible with the time criterion described in paragraph 3-1b, AR 604-5. Access should be restored as soon as possible so as not to unnecessarily impede or interrupt normal training cycles or duties. In any event, revocation of clearance with consequent loss of occupational specialty should not occur until, in the judgment of the clearance authority, every reasonable effort toward rehabilitation has been afforded and the individual has failed to respond satisfactorily to such efforts.

c. The commander may temporarily relieve the servicemember from performing duties which are sensitive or hazardous or which require special mental or physical alertness. Such relief from duty may remain in effect during the assessment of the servicemember's alcohol or other drug involvement and through the active phase of rehabilitation.

6-12. Disposition of personnel identified while in leave, TDY, or in-transit (PCS) status. *a.* Individuals who are diagnosed as alcohol or other drug dependent, and require detoxification, will be admitted to the nearest military medical treatment facility with capabilities for detoxification.

b. Personnel upon completion of detoxification (*a* above); individuals diagnosed as dependent, but not requiring detoxification; and individuals in-

initially diagnosed as abusers, but not dependent, will be processed as follows:

(1) Personnel in a leave or TDY status not associated with PCS will be directed to return directly to their unit of assignment for rehabilitation.

(2) Personnel in a transit (PCS) status from overseas to CONUS will be directed to proceed directly to their CONUS installation for rehabilitation.

(3) Personnel in an intertheater transit status (PCS) and who are clinically confirmed outside CONUS, will be directed to return to the losing installation for rehabilitation. If identified in CONUS, assignment instructions will be requested from MILPERCEN (DAPC-EPC (Appropriate Career Division)). Based on these instructions, the individual will be ordered to proceed directly to the new installation for rehabilitation.

(4) Personnel in a transit (PCS) status from one CONUS installation to another CONUS installation will be ordered to return directly to the losing CONUS installation for rehabilitation. If the member successfully completes rehabilitation, he may, with approval of the appropriate career management division in MILPERCEN, be reassigned to the new installation.

(5) Personnel in a transit (PCS) status from CONUS to an overseas assignment will be ordered to return to the losing CONUS installation for rehabilitation. If the servicemember successfully completes rehabilitation, he may, with approval of the appropriate career management division in MILPERCEN, continue to the overseas assignment.

c. In all cases described in *b* above, the commander of the installation at which rehabilitation is to take place will be notified of the circumstances that led to the curtailment of the individual's intransit, leave, or TDY status. Notification will be by electrically transmitted FOUO message and will cite this paragraph as authority.

6-13. Minimum time in program. Servicemembers who are clinically confirmed as abusers of, or dependent on, alcohol or other drugs will receive a *minimum* of 30 days of treatment/rehabilitation. This period will begin when the individual is clinically confirmed. Time spent in detoxification and medical evacuation channels will be counted as part of the 30-day period. *Exceptions are:* Retention beyond ETS (rule 2, table 6-6); servicemembers with less than 120 days' 6-6

service who have been diagnosed as having an alcohol or other drug problem that existed prior to entry will be separated within 72 hours following approval by the discharge authority (para 5-9, AR 635-200).

6-14. Reassignment while in ADAPCP. *a.* Eligibility is stated in rule 6, table 6-6.

b. ADAPCP client transfer procedures are—

(1) Through close liaison with the client and the unit commander, the ADAPCP staff should be aware of the client's impending reassignment.

(2) ADCO will be responsible for monitoring clients who are departing from a local program until they are enrolled in the ADAPCP at the gaining installation. *Until acknowledgement of enrollment is received from the gaining ADAPCP, the losing ADAPCP will retain reporting accountability for each client and will submit any FUR which becomes due (para 6-6a).* The losing ADCO cannot drop the client from the local ADAPCP until transfer to the gaining program has been accomplished. Therefore, if confirmation of the member's enrollment at the new location is not received within 30 days of the previously established reporting date ((3)/*d*) below), the losing ADCO will take action to trace the member.

(3) Upon client's departure for the new assignment, the ADCO of the losing installation will furnish the following information, by first class mail, to the ADCO of the gaining installation (for mailing addresses see table 6-4). (See *c* below for reassignments to overseas locations.)

(*a*) Client's name, grade, and SSN.

(*b*) Client program number.

(*c*) Client's status in the ADAPCP.

1. Entry date.

2. Date of last periodic report to HSHI.

3. Rehabilitation progress (satisfactory, unsatisfactory, undetermined).

(*d*) Client's assignment instructions and reporting date.

(*e*) Telephone number of losing ADAPCP.

(4) Gaining installation ADCO will contact local in-processing facility or commander of client's new unit of assignment to insure client's enrollment in the ADAPCP upon arrival.

(5) Upon client's enrollment in the gaining ADCO's program, the gaining ADCO will—

(*a*) Notify the losing ADCO of the client's enrollment in the ADAPCP at the new location, referencing the client's name, grade, SSN, client

program number, and provide the name and service area code of the gaining ADCO/ADAPCP (table 6-4).

(b) Notify HSHI of the client's enrollment as a PCS transfer gain, referencing the client program number, and provide the name and service area code of the losing ADAPCP (table 6-4). Notification of HSHI will be done as part of the weekly record transmission (para 6-7b(4)).

(6) Upon notification of client's enrollment at the new installation, the losing ADCO will—

(a) Notify HSHI that the client has been dropped from the local program, referencing the client program number, and provide the name and service area code of the gaining ADAPCP (table 6-4). Notification of HSHI will be done as part of the weekly record transmission (para 6-7b(3)).

(b) Forward to the gaining installation ADCO by first class mail the following: copies of the Initial Intake Record; CIR; FUR's completed to present; together with unused FUR's. Additional information from the individual client case file may be furnished upon request by the gaining ADCO.

c. When the losing installation ADCO cannot determine from a client's assignment instructions the specific *oversea* ADAPCP in which a PCS client will be enrolled, the following procedures will apply:

(1) For personnel whose *oversea* assignment instructions include a specific duty unit mail address, the losing installation ADCO will forward the information described in b(3) above to the client's commander. For example:

Commander of:
PFC Joh Doe, SSN 110-26-7093
Company C, 793 Medical Company
APO San Francisco 96334

(2) For personnel whose *oversea* assignment instructions fail to list a specific duty unit or show only assignment to a replacement organization, the losing installation ADCO will forward the information described in b(3) above to the client's commander in care of the appropriate MACOM casual mail delivery address listed in table 6-8. For example:

Commander of:
PFC John Doe, SSN 110-26-7093
c/o Casual Mail Section
APO San Francisco 96335

(3) *No information that would identify the servicemember as an ADAPCP client will appear*

on the mailing envelope. Correspondence to the client's new commander will include a request that the enclosed information pertaining to the client be forwarded to the supporting ADAPCP, to expedite the transfer of the client to that ADAPCP.

Note: ADAPCP client records will not be forwarded to or in care of the client's commander. Transfer of individual client case files is from ADAPCP to ADAPCP and will be accomplished in such a manner as to insure the confidentiality of the individual client data.

(4) Upon receipt of the information forwarded by the servicemember's new commander, the gaining *oversea* ADCO will follow the procedures prescribed in b(5) above.

d. Procedures for special situations are—

(1) TDY clients who are absent from their permanent duty station in excess of 90 days will be handled according to transfer procedures prescribed in b above.

(2) Clients admitted to installation MTF or to a local (short-term) military or civilian confinement facility will be continued in local ADAPCP, with FUR submitted according to schedule.

(3) For clients transferred from the local ADAPCP to a correctional facility, transfer procedures (b above) apply, except for individuals who are being separated/discharged and require a program termination FUR to HSHI-QPI.

(4) Former clients returned to military control from DFR status will be treated as new clients requiring clinical confirmation. Item 14, CIR will be checked "yes". Such clients will be required to restart and complete the entire 360 days of rehabilitation.

(5) Submission of termination FUR to HSHI-QPI by *oversea* ADCO is required for clients returned to CONUS for separation.

6-15. Discharge from the Service and/or transfer to Veterans Administration (VA) medical facilities. a. Unless facing criminal prosecution, servicemembers who are *not* alcohol or drug *dependent* and who, as a result of failing to respond satisfactorily to treatment/rehabilitation are to be discharged from the Service prior to normal ETS, will be discharged according to applicable procedures for administrative separations. These individuals will *not* be transferred to a MEDCEN/MEDDAC or to a VA medical facility prior to discharge, and will *not* be entered into medical evacuation channels for an alcohol or other drug abuse problem. Such members will be

advised of their eligibility for VA services and will be encouraged to seek assistance from the VA or a civilian alcohol/drug rehabilitation program following discharge.

b. Unless facing criminal prosecution, servicemembers in *c* below will be transferred to the VA for fifteen days treatment/rehabilitation prior to being discharged. Transfer will be to the VA medical facility that is closest to the member's home and that has the capability of providing long term rehabilitation. Members to be transferred to the VA will undergo transfer processing in accordance with the procedures specified in appendix J. Transfer processing will be accomplished prior to member's departure for the VA. Members transferred to the VA from OCONUS will be medically evacuated direct from the OCONUS MEDCEN/MEDDAC to the VA medical facility. Members approaching ETS separation date will be transferred to the VA only if it can be definitively determined in advance that, after computation of the number of days required for transfer processing and travel, a member will arrive at the VA hospital/facility with not less than fifteen days remaining to a normal ETS separation date. In no case will a normal unadjusted ETS date be extended, to permit transfer to the VA, without prior consent of the individual concerned.

c. Subject to the provisions and limitations of paragraph *b* above, servicemembers in the following categories will be transferred to a VA medical facility prior to separation:

(1) CONUS or OCONUS rehabilitation failures (para 5-8b) who are clinically confirmed as dependent on alcohol or other drugs.

(2) Members who are clinically confirmed as dependent on alcohol or other drugs, whose normal ETS separation date will not permit sufficient time in the local program to determine rehabilitation success/failure status (para 5-8b(1)).

6-16. Line of duty determination. a. References are—

(1) 37 United States Code 802.

(2) 10 United States Code 972.

(3) AR 600-33.

(4) Rule 3, table 1-3-2, DOD Military Pay and Allowances Entitlements Manual.

b. References in *a* above apply to clients who are in an inpatient status with a diagnosis of one or more of the following: improper use of drugs, non-

dependent abuse of alcohol, drug dependence, alcoholism.

c. Members in an inpatient status who are determined by a physician to be totally physically incapacitated from performing their regular duty for a period of more than 24 consecutive hours solely on the basis of alcohol or other drug abuse will be administratively determined to be "Not in Line of Duty: Due to Own Misconduct" only for such period of actual total incapacitation (para 4-6).

d. Unless a member is incapacitated as described in *c* above, a line of duty determination is not required and will not be made.

e. Any member (other than one identified in *c* above) who is undergoing ADAPCP detoxification, treatment, or rehabilitation will be considered absent from previous duties because of administrative policies; the line of duty provisions of references in *a* above do not apply.

f. The policies described above in no way offer bases for favorable consideration by the physical disability processing system for a disability directly related to the abuse of alcohol or other drugs.

g. The requirement still exists for formal line of duty investigations for—

(1) Injuries or other diseases incurred while under the influence of alcohol or other drugs, but not directly related to the use of drugs per se.

(2) Servicemembers who wish to appeal initial line of duty findings.

6-17. Pay and entitlements. Time computed as "Not in Line of Duty; Due to Own Misconduct" (para 6-16) will be documented as lost time. Under the provisions of DOD Military Pay and Allowances Entitlements Manual, lost time causes the individual to lose all pay (basic, special, and incentive); however, he is entitled to allowances.

6-18. Introduction of individual's alcohol and other drug involvement in administrative discharge proceedings when individual is covered by the exemption policy. See section V, chapter 3.

6-19. Medical profiles. The servicemember who is clinically confirmed as an alcohol or other drug abuser may be assigned a temporary S-2 physical profile (DA Form 3349, Medical Condition—Physical Profile Record). This indicates that the servicemember has identifiable behavioral/attitudinal problems which may impair judgment and/or reliability. When used, DA

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Form 3349 will be prepared by the MEDDAC/MEDCEN responsible for medical support and will be signed by a physician. DA Form 3349 will not contain specific reference to alcohol or other drug diagnoses, but rather a brief non-technical description and assignment limitations,

if any (e.g., situational maladjustment, may not be reassigned for approximately 60 days). Temporary S-2 profiles may be revised to S-1 when deemed appropriate by medical authorities. Reclassification to S-1 does not imply that treatment and rehabilitation should terminate.

ADAPCP INITIAL INTERVIEW RECORD
AND
PRIVACY ACT STATEMENT (Fig. 6-1)

I. IDENTIFYING DATA:
NAME AGE RACE
RANK OR GRADE ... PRESENT UNIT/JOB
LENGTH OF GOVERNMENT SERVICE
ETS (MILITARY PERSONNEL ONLY)

II. NATURE OF REFERRAL: (Record referral source and circumstances of referral.)

III. ALCOHOL/DRUG HISTORY: (Record all alcohol/drug history obtained from the individual, including data such as drug(s) used, frequency, and how taken.)

IV. COLLATERAL DATA FOR *MILITARY PERSONNEL ONLY*: (Record any additional data obtained from servicemember's unit commander or intermediate supervisors, military or civilian law enforcement authorities, or the servicemember's medical or personnel records.)

V. IMPRESSIONS AND OBSERVATIONS: (Record interviewer's impressions and pertinent behavioral observations. Avoid diagnostic terminology; use behavioral descriptions.)

INTERVIEW CONDUCTED BY

* * * * *

VI. DISPOSITION: (Complete only after clinical evaluation by a physician. Record appropriate disposition.)

Figure 6-1.

DATA REQUIRED BY THE PRIVACY ACT OF 1974
ADAPCP INITIAL INTERVIEW RECORD

1. AUTHORITY.

Military Personnel: Title V, Public Law 92-129; Civilian Personnel: Section 413, Public Law 92-255.

2. PRINCIPAL PURPOSE.

To provide necessary information to the physician evaluating the individual for possible alcohol or other drug abuse. Two copies of this record are prepared; original goes to physician for use in evaluating the individual, duplicate placed in temporary file in ADAPCP facility. If physician determines abuse, individual is enrolled in ADAPCP, original copy included in client's case file and duplicate destroyed. If physician determines no abuse (or for inconclusive determination for civilian personnel) both copies will be destroyed. If physician can neither confirm nor discount abuse by military personnel and the individual enters Urinary Surveillance Program or Social Evaluation, both copies will be retained by the ADAPCP until a final determination is made; upon final determination, disposition will be as described above.

3. ROUTINE USES.

Release of any information from this form 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 of information that would identify the individual as an abuser of alcohol or other drugs is authorized, if the individual is a servicemember, 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 servicemember's unit commander). All other disclosures concerning servicemembers and all disclosures concerning civilian personnel 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.

4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION.

a. Military Personnel: Disclosure is mandatory. Failure to obey an order from competent authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.

b. Civilian Personnel: Disclosure is voluntary. Failure to disclose the information will result in a reduced capability of the physician to make a proper evaluation of the individual.

Table 6-1. Instructions For Completing ADAPCP Client Intake Record
(Sec A, DA Form 4465, fig. 6-2)

Item	Title	Completed By	Remarks
	Name SSN Duty unit	ADAPCP staff	For local use only. Include only on health record and ADAPCP client record copies. Information <i>not</i> to be forwarded HSHI-QPI.
1	Physician's diagnosis	Physician	See table 6-3. ADCO will insure that physicians performing clinical evaluations have access to information in table 6-3.
2	Client program number*	ADAPCP staff	
2a	YOB	.....	Enter final two digits of client's year of birth.
2b	Last five digits of SSN	.....	Enter last five digits of servicemember's social security number.
3	Grade	ADAPCP staff	
3a	.....	.....	Enter three-letter grade designation (e.g., SGT, CPT).
3b	Grade code	.....	Enter pay grade designation (e.g., E6, O3). Exceptions: for general officers, insert: GF.
4	Svc area code	ADAPCP staff	
4a	Initial MTF*	.....	See table 6-4.
4b	Current area	.....	See table 6-4.
5	Diagnostic codes	Physician	Table 6-3; item 5 must coincide with item 1. List primary diagnosis first.
6	Name, grade, MTF of physician	Physician	Enter name, grade, and MTF of physician performing clinical confirmation. Signed by physician.
7	Date		
7a	Year, month, day	Physician	Enter calendar date clinical confirmation performed.
7b	Julian date	ADAPCP staff	Enter last two digits of calendar year plus Julian date of clinical confirmation; e.g., 11 Jan 77 would be entered as <u>77/01/11</u> .
8-8a	Length of service	ADAPCP staff	See paragraph 1, table 6-5.
8b	LOS date code	.....	See paragraph 2, table 6-5.
9	Race	ADAPCP staff	Check appropriate box.
10	Sex	ADAPCP staff	Check appropriate box.
11	PMOS	ADAPCP staff	
11a	Code	.....	Enter PMOS code. For four-digit codes, leave first block blank.
11b	Performing Duty in MOS	.....	Check appropriate box.

*To assist in compilation of accurate data and to insure the matching of intake records with follow-up records, it is imperative that entries in items 2 and 4a be identical on all forms submitted on the same client. Once a CIR has been submitted to HSHI-QPI, items 2 and 4a must not be changed on any subsequent FUR submission unless specifically requested by HSHI-QPI.

**Table 6-1. Instructions for Completing ADAPCP Client Intake Record
(Sec A, DA Form 4465, fig. 6-2)—Continued**

<i>Item</i>	<i>Title</i>	<i>Completed By</i>	<i>Remarks</i>
12	Level of education	ADAPCP staff	Check appropriate box. "HS Grad" includes GED equivalent.
13	Marital status	ADAPCP staff	Check current marital status.
14	Previous Army program member	ADAPCP staff	Check "yes" to indicate previous terminations from an ADAPCP. Supporting documentation should be in health records.
15	Disciplinary record	ADAPCP staff	Indicate numbers appropriate to specific disciplinary record items. For any entry which exceeds value of "9", enter "9". <i>Note:</i> The number of "civ jail terms" (item 15b) must not exceed the number of "civ convictions" (item 15a)
15a	Number of civ convictions		
15b	Number of civ jail terms		
15c	Number of Article 15's		
15d	Number of courts-martial		
15e	Number of AWOL episodes		
16	Case finding: Biochemical testing a. Initial entry on active duty b. Re-entry with prior service c. Commander directed test d. Random testing program e. Rehabilitation staff f. Other local testing Nonbiochemical g. Self/voluntary referral h. Medical discovery i. Investigation/apprehension j. Command referral	ADAPCP staff	Check the box which best describes how the client's problem was initially discovered or "surfaced". <i>Notes:</i> 1. See paragraphs 3-3 through 3-7 for clarification of case finding methods. 2. Do not check item "h" if client was referred by his commander to AMEDD for evaluation. 3. Item "j" implies that client was referred for <i>interview</i> or <i>consultation</i> with ADAPCP staff.
17	Immediate disposition a. To resident rehab b. To non-resident rehab c. To detoxification d. Expiration term of service e. Failure to meet medical standards, etc. f. Other honorable discharge g. General discharge h. Undesirable discharge i. BCD or DD	ADAPCP staff	Check appropriate box for disposition of client at time of program entry. <i>Note:</i> A check in blocks "d" through "i" indicates that this CIR is both an initial and final record; therefore, submission of FUR's is not required.
18	Transferred to VA	ADAPCP staff	Check appropriate box. If "yes" is checked (implying alcohol or other drug dependency), then item 17 should have a check in one of the entries "d" through "i".
19	Drug usage profile a. Last time used b. How often used c. How taken d. Use EPTS	ADAPCP staff	Shows history of client's drug usage. A response is required for each drug listed. Except where a drug is marked "Never Used", an appropriate entry must be made for each frequency-of-use category.

Table 6-1. Instructions for Completing ADAPCP Client Intake Record **
 (Sec A, DA Form 4465, fig. 6-2)—Continued

<i>Item</i>	<i>Title</i>	<i>Completed By</i>	<i>Remarks</i>
e. Current problem			<i>Notes:</i> 1. "Use EPTS" means: Did the service-member use this drug prior to enlistment? 2. "Current problem" must show a "yes" answer if diagnosis is recorded in item 1.
20	Installation/ mailing address of ADCO	ADAPCP staff	Enter complete mailing address of ADCO and organization to which assigned.
21-22	Name/grade, signature of ADCO	ADCO	Must be authenticated by ADCO. Unsigned forms will be returned.

** Incomplete records will be returned to submitting ADAPCP for completion.

FOR LOCAL USE ONLY

NAME (Member) **DOE, JOHN** SSN **110-26-7093** DUTY UNIT **121 ENGR CO**

ADAPCP MILITARY CLIENT INTAKE AND FOLLOW-UP RECORD
 For use of this form, see AR 600-85; the proponent agency is the Office of the Deputy Chief of Staff for Personnel.
 PRIVACY ACT STATEMENT - SEE REVERSE SIDE

SECTION A - MILITARY CLIENT INTAKE RECORD

1. PHYSICIAN'S DIAGNOSES
ALCOHOLISM - HABITUAL EXCESSIVE DRINKING

2. CLIENT PROGRAM NO.
 a. YOB **50** b. LAST 5 DIGITS OF SSN **67093** c. INITIAL MTF **402**

3. GRADE **SP 4** d. GRADE CODE **E 4** e. CURRENT AREA **F 1 2 1**

4. SVC AREA CODE

5. DIAGNOSTIC CODES

3	0	3	1

6. NAME AND GRADE OF PHYSICIAN, NAME OF MTF
CHAS P. BOWDEN, MAJ MC
BROOKE ARMY MEDICAL CENTER

7. DATE
76 JUN 18
(Year, Month, Day)

8. LENGTH OF SERVICE
4 YRS

9. RACE
 CAUCASIAN
 NEGRO
 OTHER

10. SEX
 MALE
 FEMALE

11. PMOS
12E20

12. LEVEL OF EDUCATION
 COLLEGE GRADUATE
 SOME COLLEGE
 HIGH SCHOOL GRAD
 SOME HIGH SCHOOL
 GRADE SCHOOL

13. MARITAL STATUS
 NEVER MARRIED
 NOW MARRIED
 DIVORCED/ANNULLED
 SEPARATED
 WIDOWED

14. PREVIOUS ARMY PROGRAM MEMBER
 YES
 NO

15. DISCIPLINARY RECORD
 PRIOR TO ENTRY ON AD
 a. NUMBER OF CIV CONVICTIONS **0**
 b. NUMBER OF CIV JAIL TERMS **0**
 MILITARY
 c. NUMBER OF ARTICLE 15'S **1**
 d. NUMBER OF COURTS MARTIAL **0**
 e. NUMBER OF AWOL EPISODES **0**

16. CASE FINDING (Check one box only)
 BIOCHEMICAL TESTING
 a. INITIAL ENTRY ON ACTIVE DUTY
 b. REENTRY WITH PRIOR SERVICE
 c. COMMANDER-DIRECTED
 d. RANDOM TESTING PROGRAM
 e. REHABILITATION STAFF
 f. OTHER LOCAL TESTING
 NON BIOCHEMICAL TESTING
 g. SELF/VOLUNTARY REFERRAL
 h. MEDICAL DISCOVERY
 i. INVESTIGATION APPREHENSION
 COMMAND REFERRAL

17. IMMEDIATE DISPOSITION (Check one box only)
 TO RESIDENT REHABILITATION
 TO NON-RESIDENT REHABILITATION
 TO DETOXIFICATION
 SEPARATED FROM SERVICE
 EXPIRATION TERM OF SERVICE
 FAILURE TO MEET MED STANDARDS DUE TO HISTORY OF ALCOHOL/DRUG ABUSE
 OTHER HONORABLE DISCHARGE
 GENERAL DISCHARGE
 UNDESIRABLE DISCHARGE
 BAD CONDUCT OR DISHONORABLE DISCHARGE

18. TRANSFERRED TO VA
 YES
 NO

19. DRUG USAGE PROFILE (All drugs below (a) through (k) must be accounted for by checking appropriate block(s))

DRUG	LAST TIME USED						HOW OFTEN USED						HOW TAKEN	USE EPTS	CURRENT PROBLEM			
	NEVER USED	WITHIN 48 HRS	2-7 DAYS AGO	1-4 WEEKS AGO	1-6 MONTHS AGO	OVER 6 MONTHS AGO	DA - Y	2-6 TIMES PER WEEK	ONCE A WEEK	2-3 TIMES MONTH	ONCE A MONTH	LESS THAN ONCE A MONTH			BY NEEDLE	NOT BY NEEDLE	YES	NO	YES	NO
a. AMPHETAMINES	X						1	2	3	4	5	6	1	2	Y	N	Y	N
b. OPIATES	X						1	2	3	4	5	6	1	2	Y	N	Y	N
c. COCAINE	X						1	2	3	4	5	6	1	2	Y	N	Y	N
d. BARBITURATES	X						1	2	3	4	5	6	1	2	Y	N	Y	N
e. METHAQUALONE	X						1	2	3	4	5	6	1	2	Y	N	Y	N
f. OTHER TRANQUILIZERS	X						1	2	3	4	5	6	1	2	Y	N	Y	N
g. MARIJUANA	X						1	2	3	4	5	6	1	2	Y	N	Y	N
h. OTHER CANNABIS SATIVA	X						1	2	3	4	5	6	1	2	Y	N	Y	N
i. ALCOHOL	X						1	2	3	4	5	6	1	2	Y	N	Y	N
j. HALLUCINOGENS	X						1	2	3	4	5	6	1	2	Y	N	Y	N
k. OTHER (Specify)	X						1	2	3	4	5	6	1	2	Y	N	Y	N

20. INSTALLATION/MAILING ADDRESS OF ADCCO
ADAPCP, FT SAM HOUSTON, TX 78234

21. TYPED NAME/GRADE OF ADCCO
JOHN A. BARTON, CPT

22. SIGNATURE OF ADCCO
John A. Barton

DA FORM 4465 NOV 75

REPLACES DA FORMS 2985-1R, 2985-2R AND 2985-3R, 1 MAY 72 WHICH ARE OBSOLETE.

Figure 6-2.

DATA REQUIRED BY THE PRIVACY ACT OF 1974	
1. AUTHORITY	Title V, Public Law 92-129
2. PRINCIPAL PURPOSE(S)	<p>a. To provide necessary information to evaluate the nature and extent of the client's alcohol and other drug problem.</p> <p>b. To provide baseline information for monitoring the client's progress during the rehabilitation and followup phases of the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).</p> <p>c. To assist in insuring continuity of care of client enrolled in the ADAPCP.</p> <p>d. As part of the client's medical records, to provide information to military physicians in diagnosing other medical problems and in prescribing medication.</p>
3. ROUTINE USES	<p>a. Release of any information from this form is subject to the restrictions of 21 U.S.C. 1175 as amended by 88 Stat 137; 42 U.S.C. 4582 as amended by 88 Stat 131; and Chapter I, Title 42, Code of Federal Regulations. Under these statutes and regulations, disclosure of information that would identify the client as an abuser of alcohol or other drugs 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, the client's unit commander, etc.). 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.</p> <p>b. Information from this form, <u>less entries that identify the individual client</u>, is forwarded to US Army Health Information Systems and Biostatistical Agency for statistical analysis, Armywide program evaluation, trend data, and gross data for research purposes.</p>
4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION	<p>Disclosure is mandatory. Failure to obey an order from competent authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.</p>

Figure 6-2 — Continued

**Table 6-2. Instructions For Completing ADAPCP Client Follow-Up Record
(Sec B, DA Form 4465, fig. 6-3)**

<i>Item</i>	<i>Title</i>	<i>Completed By</i>	<i>Remarks</i>
	Name SSN Duty unit	ADAPCP staff	For local use only. Include only on health record and ADAPCP client record copies. Information <i>not</i> to be forwarded to HSHI-QPI.
2 2a 2b	Client program number* YOB Last five digits of SSN	ADAPCP staff	See same items in table 6-1.
3 3a 3b	Grade Grade code	ADAPCP staff	See same items in table 6-1.
4 4a 4b	Svc area code Initial MTF* Current area	ADAPCP staff	As previously reported (table 6-4). Indicate current area assigned from appropriate "area code" in table 6-4.
5	Additional diagnostic codes	ADAPCP staff	Record any diagnosis determined by a physician since last report. Use codes from table 6-3. Additional diagnosis and signature of physician will be entered in Remarks section of FUR.
6 6a 6b	Date due Year, month, day Julian date	ADAPCP staff 	Enter calendar date on which record is <i>due</i> . Enter must reflect passage of 60, 120, 180, or 360 days from calendar date of clinical confirmation (item 7, CIR). <i>Do not report date on which FUR is prepared.</i> Enter last two digits of calendar year for which record is due, plus Julian date equivalent of calendar date entry for item 6a.
7	Reason for record	ADAPCP staff	Check entry which best reflects reason for FUR.
8	Rehabilitation methods used since last report	ADAPCP staff	<i>Initial FUR:</i> Check all entries applicable to client since entry into ADAPCP. <i>Subsequent FUR:</i> Check <i>only</i> those rehab methods used since <i>last</i> FUR.
9	Program status as of report date	ADAPCP staff	Check client's status in program as of due date of FUR.

*To assist in compilation of accurate data and to insure the matching of intake records with follow-up records, it is imperative that entries in items 2 and 4a be identical on all forms submitted on the same client. Once a CIR has been submitted to HSHI-QPI, items 2 and 4a must not be changed on any subsequent FUR submission unless specifically requested by HSHI-QPI.

Table 6-2. Instructions for Completing ADAPCP Client Follow-Up Record **
(Sec B, DA Form 4465, fig. 6-3)—Continued

<i>Item</i>	<i>Title</i>	<i>Completed By</i>	<i>Remarks</i>
10	Transferred to VA	ADAPCP staff	Check appropriate box. If "yes" is checked (implying alcohol or other drug dependency), item 7 must also have a check in one of the entries "f" through "k". Also, item 9, entry "i" must be checked.
11	Progress and military effectiveness		
11a	CO's appraisal of efficiency	Commander through	Check entry that best reflects member's efficiency within unit.
11b	CO's appraisal of conduct	ADAPCP staff	Check entry that best reflects member's conduct within unit.
11c	Counselor's opinion of progress	ADAPCP staff	Check entry that best reflects client's progress.
	Remarks:	ADAPCP staff	As appropriate. Do not reference client's name, SSN, or duty unit.
12	Installation/ mailing address of ADCO	ADAPCP staff	Enter complete mailing address of ADCO and organization to which assigned.
13-14	Name/grade and signature of ADCO	ADCO	Must be authenticated by ADCO. Unsigned forms will be returned.

** Incomplete records will be returned to submitting ADAPCP for completion.

FOR LOCAL USE ONLY																									
NAME (Number) DOE, JOHN	SSN 110-26-7093																								
DUTY UNIT 121 ENGR CO																									
ADAPCP MILITARY CLIENT INTAKE AND FOLLOW-UP RECORD <small>For use of this form, see AR 600-85; the proponent agency is the Office of the Deputy Chief of Staff for Personnel. PRIVACY ACT STATEMENT - SEE REVERSE SIDE</small>																									
SECTION B - MILITARY CLIENT FOLLOW-UP RECORD																									
<p>1. DO NOT WRITE IN THIS BOX</p> <div style="background-color: #cccccc; height: 150px; width: 100%;"></div> <p>7. REASON FOR RECORD (Check one box only)</p> <p style="text-align: center;"><u>IN PROGRAM REPORTS</u></p> <p>a. <input checked="" type="checkbox"/> 60 DAY FOLLOW-UP REPORT</p> <p>b. <input type="checkbox"/> 120 DAY FOLLOW-UP REPORT</p> <p>c. <input type="checkbox"/> 180 DAY FOLLOW-UP REPORT</p> <p style="text-align: center;"><u>PROGRAM TERMINATION REPORT</u></p> <p>4. <input type="checkbox"/> 360 DAY FOLLOW-UP REPORT-COMPLETED PROGRAM</p> <p>5. <input type="checkbox"/> 360 DAY FOLLOW-UP REPORT-CONTINUING IN PROGRAM - REPORTING REQUIREMENT COMPLETED</p> <p>6. <input type="checkbox"/> EXPIRATION TERM OF SERVICE</p> <p>7. <input type="checkbox"/> FAILURE TO MEET MED STANDARDS DUE TO HISTORY OF ALCOHOL/DRUG ABUSE</p> <p>8. <input type="checkbox"/> OTHER HONORABLE DISCHARGE</p> <p>9. <input type="checkbox"/> GENERAL DISCHARGE</p> <p>10. <input type="checkbox"/> UNDESIRABLE DISCHARGE</p> <p>11. <input type="checkbox"/> BAD CONDUCT OR DISHONORABLE DISCHARGE</p> <p>12. <input type="checkbox"/> DFR FOR AWOL OVER 30 DAYS</p> <p>13. <input type="checkbox"/> DEATH</p>	<p>2. CLIENT PROGRAM NO.</p> <p>a. YOB 50 b. LAST 5 DIGITS OF SSN 67093</p> <p>3. GRADE SP4 c. GRADE CODE E4 d. CURRENT AREA F12</p> <p>4. SVC AREA CODE INITIAL MTF 402</p> <p>5. ADDITIONAL DIAGNOSTIC CODES SEE REMARKS BELOW</p> <p>6. DATE DUE 76 AUG 17 <small>(Year, Month, Day)</small></p> <p>7. JULIAN DATE 76230</p> <p>8. REHABILITATION METHODS USED SINCE LAST REPORT (Check as many boxes as appropriate)</p> <p>a. <input checked="" type="checkbox"/> HALFWAY HOUSE RESIDENT - FULL TIME</p> <p>b. <input type="checkbox"/> HALFWAY HOUSE RESIDENT - PART TIME</p> <p>c. <input checked="" type="checkbox"/> SCHEDULED NON-RESIDENT COUNSELING</p> <p>d. <input type="checkbox"/> COMMAND CONSULTATION</p> <p>e. <input type="checkbox"/> GROUP COUNSELING/THERAPY</p> <p>f. <input type="checkbox"/> INDIVIDUAL COUNSELING/THERAPY</p> <p>g. <input type="checkbox"/> ANTABUSE</p> <p>h. <input type="checkbox"/> OTHER CHEMOTHERAPY</p> <p>i. <input type="checkbox"/> SPECIALIZED RETRAINING</p> <p>j. <input checked="" type="checkbox"/> ALCOHOLICS ANONYMOUS</p> <p>k. <input type="checkbox"/> OTHER (Specify) _____</p> <p>9. PROGRAM STATUS AS OF REPORT DATE (Check one box only)</p> <p>a. <input type="checkbox"/> HALFWAY HOUSE RESIDENT - FULL TIME</p> <p>b. <input type="checkbox"/> HALFWAY HOUSE RESIDENT - PART TIME</p> <p>c. <input type="checkbox"/> HOSPITALIZED - DRUG RELATED</p> <p>d. <input type="checkbox"/> HOSPITALIZED - NOT DRUG RELATED</p> <p>e. <input checked="" type="checkbox"/> ACTIVE REHAB - SCHEDULED NON-RESIDENT COUNSELING</p> <p>f. <input type="checkbox"/> IN FOLLOW-UP PROGRAM - ON DUTY</p> <p>g. <input type="checkbox"/> IN CONFINEMENT (Military or civilian facility)</p> <p>h. <input type="checkbox"/> AWOL - LESS THAN 30 DAYS</p> <p>i. <input type="checkbox"/> REPORTING REQUIREMENT COMPLETED</p> <p>10. TRANSFERRED TO VA YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 25%;">11. PROGRESS AND MILITARY EFFECTIVENESS</td> <td style="width: 10%;">EXC 1</td> <td style="width: 10%;">GOOD 2</td> <td style="width: 10%;">FAIR 3</td> <td style="width: 10%;">UNSAT 4</td> <td style="width: 10%;"></td> </tr> <tr> <td>a. COMMANDING OFFICER'S APPRAISAL OF EFFICIENCY</td> <td></td> <td>X</td> <td></td> <td></td> <td></td> </tr> <tr> <td>b. COMMANDING OFFICER'S APPRAISAL OF CONDUCT</td> <td></td> <td>X</td> <td></td> <td></td> <td></td> </tr> <tr> <td>c. COUNSELOR'S OPINION OF PROGRESS</td> <td></td> <td>X</td> <td></td> <td></td> <td></td> </tr> </table> <p>REMARKS ENTER ADDITIONAL DIAGNOSIS AND SIGNATURE OF PHYSICIAN.</p>	11. PROGRESS AND MILITARY EFFECTIVENESS	EXC 1	GOOD 2	FAIR 3	UNSAT 4		a. COMMANDING OFFICER'S APPRAISAL OF EFFICIENCY		X				b. COMMANDING OFFICER'S APPRAISAL OF CONDUCT		X				c. COUNSELOR'S OPINION OF PROGRESS		X			
11. PROGRESS AND MILITARY EFFECTIVENESS	EXC 1	GOOD 2	FAIR 3	UNSAT 4																					
a. COMMANDING OFFICER'S APPRAISAL OF EFFICIENCY		X																							
b. COMMANDING OFFICER'S APPRAISAL OF CONDUCT		X																							
c. COUNSELOR'S OPINION OF PROGRESS		X																							
12. INSTALLATION/MAILING ADDRESS OF ADCO ADAPCP FT SAN HOUSTON TX 78234	13. TYPED NAME AND GRADE OF ADCO JOHN A. BARTON, CPT	14. SIGNATURE OF ADCO <i>John A. Barton</i>																							

DATA REQUIRED BY THE PRIVACY ACT OF 1974	
1. AUTHORITY	Title V, Public Law 92-129
2. PRINCIPAL PURPOSE(S)	<p>a. To monitor the client's progress during the rehabilitation and follow-up phases of the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).</p> <p>b. To assist in insuring continuity of care of the client enrolled in the ADAPCP.</p> <p>c. As part of the client's medical records, to provide information to military physicians in diagnosing other medical problems and in prescribing medication.</p>
3. ROUTINE USES	<p>a. Release of any information from this form is subject to the restrictions of 21 U.S.C. 1175 as amended by 88 Stat 137, 42 U.S.C. 4582 as amended by 88 Stat 131, and Chapter I, Title 42, Code of Federal Regulations. Under these statutes and regulations, disclosure of information that would identify the client as an abuser of alcohol or other drugs is authorized within the Armed Forces or to those components of the VA 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, the client's unit commander, etc.). 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.</p> <p>b. Information from this form, less entries that identify the individual client, is forwarded to US Army Health Information Systems and Biostatistical Agency for statistical analysis, Armywide program evaluation, trend data, and gross data for research purposes.</p>
4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION	<p>Disclosure is mandatory. Failure to obey an order from component authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.</p>

Figure 6-3 - Continued

Table 6-3. Diagnostic Codes

In recording diagnoses, the term "alcoholism" should be applied only to individuals whose alcohol intake is great enough to damage their physical health or their personal or social functioning, or when it involves psychological or physiological dependency. For other individuals whose use of alcohol has brought them to medical attention, the appropriate term is "nondependent abuse of alcohol." This term is applicable to individuals formerly diagnosed as "Simple Drunkenness" cases. It also applies to individuals not suffering from Alcoholism, whether or not intoxicated when seen by the physician, who are referred to him in connection with driving while intoxicated charges, altercations involving alcohol, AWOL's or absences from work due to overuse of alcohol, or for similar reasons, when these individuals may benefit from available rehabilitative services.

<i>Diagnostic Code</i>	<i>Description</i>
3030	<i>Alcoholism—episodic excessive drinking.</i> The American Psychiatric Association defines this term as follows: If alcoholism is present and the individual becomes intoxicated as frequently as four times a year, the condition should be classified here. Intoxication is defined as a state in which the individual's coordination or speech is definitely impaired or his behavior is clearly altered.
3031	<i>Alcoholism—habitual excessive drinking.</i> The American Psychiatric Association defines this term as follows: This diagnosis is given to persons who are alcoholic and who either become intoxicated more than 12 times a year or are recognizable under the influence of alcohol more than once a week, even though not intoxicated.
3032	<i>Alcoholism—alcoholic addiction.</i> The American Psychiatric Association defines this term as follows: This condition should be diagnosed when there is direct or strong presumptive evidence that the patient is dependent on alcohol. If available, the best direct evidence of such dependence is appearance of withdrawal symptoms. The inability of the patient to go one day without drinking is presumptive evidence. When heavy drinking continues for 3 months or more it is reasonable to presume addiction to alcohol has been established.
3039	<i>Alcoholism—other and unspecified.</i>
7932	Nondependent abuse of alcohol.
3040	Dependence on opium, opium alkaloids, and their derivatives (e.g., heroin, codeine, morphine, paregoric).
3041	Dependence on synthetic analgesics with morphine-like effects (e.g., methadone).
3042	Dependence on barbiturates.
3043	Dependence on other hypnotics and sedatives or tranquilizers (e.g., chloral hydrate, Librium, Valium). <i>Note.</i> methaqualone no longer included under 3043. See 793M and 304M below.
3044	Dependence on cocaine.
3045	Dependence on cannabis sativa (e.g., marijuana, hashish).
3046	Dependence on other psychostimulants (e.g., Benzedrine, Dexedrine, other amphetamines).
3047	Dependence on hallucinogenics (e.g. LSD, mescaline).
3048	Dependence on other specified drugs (e.g., "airplane glue," chloroform).
3049	Dependence on unspecified drugs (e.g., "sleeping pills," "cough syrup").
793A	Improper use of opium, opium alkaloids, or their derivatives.
793B	Improper use of synthetic analgesics with morphine-like effects.
793C	Improper use of barbiturates.

Table 6-3. Diagnostic Codes — Continued

<i>Diagnostic Code</i>	<i>Description</i>
793D	Improper use of other hypnotics and sedatives or tranquilizers.
793E	Improper use of cocaine.
793F	Improper use of cannabis sativa.
793G	Improper use of other psychostimulants.
793H	Improper use of hallucinogenics.
793K	Improper use of other specified drugs.
793L	Improper use of unspecified drugs.
793M	Improper use of methaqualone.
304M	Dependence on methaqualone.

ROUTING AND TRANSMITTAL SLIP		ACTION
TO Chief, US Army Health Information Systems and Bio-Statistical Agency	INITIALS	CIRCULATE
	DATE	COORDINATION
(For Military Records) ATTN: HSHI-QPI Fort Sam Houston, TX 78234	INITIALS	FILE
	DATE	INFORMATION
(For Civilian Employee Records) ATTN: HSHI-QBC Fort Sam Houston, TX 78234	INITIALS	NOTE AND RETURN
	DATE	PER CON VERSATION
	INITIALS	SEE ME
	DATE	SIGNATURE
REMARKS		
1. Transmittal Code: _____		
2. Number of forms enclosed: _____		
3. PCS clients dropped based on verified enrollment in another ADAPCP:		
<u>Client Program Number</u> <u>Name/Area Code Gaining ADAPCP</u>		
4. PCS transfer gains of clients from another ADAPCP:		
<u>Client Program Number</u> <u>Name/Area Code Losing ADAPCP</u>		
Do NOT use this form as a RECORD of approvals, concurrences, disapprovals, clearances, and similar actions.		
FROM (NAME, GRADE, SIGNATURE OF ADCO, MAILING ADDRESS).	DATE	
	PHONE	

OPTIONAL FORM 41
AUGUST 1967
GSA FPMR (41CFR) 101-11.206

GPO 1973 OF - 676-326 6041-101

Figure 6-4.

Table 6-4. Service Area Codes*

PART I — OVERSEA AREAS

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
A. ALASKA		
1. HQ 172d Infantry Brigade ADAPCP Fort Richardson, Alaska APO Seattle 98749	ACB	A02
B. CANAL ZONE		
1. HQ 193d Infantry Brigade ADAPCP (AFZUPA-DA) Fort Amador Canal Zone APO NY 09834	SDB	C01
C. EUROPE		
1. Amberg CDAAC 3rd Sqdn 2d ACR (Pond Bks) APO New York 09452	EAK	E01
2. Ansbach CDAAC Hindenberg Kas APO New York 09326	EAK	E02
3. Aschaffenburg CDAAC 3rd Bde, 3rd ID (Ready Bks) APO New York 09162	EAF	E03
4. Augsburg CDAAC APO New York 09178	EAA	E04
5. Bad Hersfeld CDAAC 3rd Sqdn, 11th ACR (McPhetter Bks) APO New York 09141	EAF	E05
6. Bad Kissingen CDAAC Bad Kissingen Community APO New York 09330	EAM	E06
7. Bad Kreuznach CDAAC c/o HHC, 8th ID (Rose Bks) APO New York 09111	EAH	E07
8. Babenhausen CDAAC c/o Hq, 41st FA Gp APO New York 09175	EAF	E08
9. Bamberg CDAAC 188th Gen Disp (Warner Bks) APO New York 09139	EAK	E09
10. Baumholder CDAAC Div Arty APO New York 09034	EAH	E10
11. Berlin CDAAC Berlin Bde (McNair Bks) APO New York 09742	EAD	E11

*This table lists Medical Treatment Facility Codes and Service Area Codes required for completion of Items 4a and 4b of DA Form 4465 and DA Form 4466. Mailing address corrections for ADAPCP listed should be sent directly to USA Health Information Systems and Biostatistical Agency (HSIH-QPI) Fort Sam Houston, TX 78234.

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
12. Bindlach CDAAC 188th Gen Disp Bindlach Health Clinic (Christensen Bks) APO New York 09411	EAK	E12
13. Boeblingen CDAAC Panzer Kas APO New York 09046	EAL	E13
14. Bremerhaven CDAAC 2d Fld Hosp APO New York 09069	EAE	E14
15. Buedingen CDAAC c/o Coleman Kaserne CDAAC, Gelnhausen 2d Bde, 3rd AD APO New York 09091	EAJ	E15
16. Butzbach CDAAC c/o Ayers Kas CDAAC, Kirchgoens HHC, 1st Bde, 3rd AD APO New York 09045	EAJ	E16
17. Crailsheim CDAAC 1st AD (McKee Bks) APO New York 09751	EAL	E17
18. Darmstadt CDAAC Cambrai Fritch Kas APO New York 09175	EAJ	E18
19. Dexheim CDAAC 12th Engr Bn (Anderson Bks) APO New York 09111	EAJ	E19
20. Erlangen CDAAC Ferris Bks APO New York 09066	EAK	E20
21. Finthen CDAAC Finthen Army Airfield APO New York 09185	EAJ	E21
22. Fliegerhorst CDAAC c/o HQ, 11th Avn Bn APO New York 09165	EAJ	E22
23. Betts Kas CDAAC, Frankfurt c/o HQ, V COSCOM Drug Control Office APO New York 09757	EAJ	E23
24. Camp Eschborn CDAAC, Frankfurt c/o HQ, 317th Cbt Engr Bn APO New York 09757	EAJ	E24
25. Edwards Disp CDAAC, Frankfurt c/o HHC, DISCOM, 3rd AD APO New York 09039	EAJ	E25

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
26. Friedberg CDAAC c/o HHC, 3rd Bde (Ray Bks) APO New York 09074	EAF	E26
27. Fuerth CDAAC c/o HHC, 1st AD SUPCOM (Montieth Bks) APO New York 09068	EAK	E27
28. Fulda CDAAC c/o HHT Regt, 11th ACR (Downs Bks) APO New York 09146	EAF	E28
29. Gelnhausen CDAAC 2d Bde, 3rd AD (Coleman Kaserne) APO New York 09091	EAF	E29
30. Germersheim CDAAC Germersheim Army Depot APO New York 09095	EAG	E30
31. Giessen CDAAC 42d Fld Arty Gp ATTN: CASCC (Bldg 57) APO New York 09169	EAF	E31
32. Gibelstadt CDAAC CDR, US Military Sub-Community Activity Gibelstadt ATTN: CDAAC APO New York 09036	EAM	E32
33. Goepingen CDAAC c/o HHC, 1st ID (Fwd)(Cook Bks) APO New York 09137	EAL	E33
34. Grafenwoehr CDAAC 7th ATC APO New York 09114	EAK	E34
35. Hanau North CDAAC c/o HHB, 3rd AD (Francois Kas) APO New York 09165	EAF	E35
36. Hanau South CDAAC 130th Engr Bde (Pioneer Kas) APO New York 09165	EAF	E36
37. Patton Bks CDAAC, Heidelberg APO New York 09102	EAG	E37
38. Tompkins Bks CDAAC, Heidelberg APO New York 09102	EAG	E38
39. Heilbronn CDAAC c/o Office of the Community Commander (Wharton Bks) APO New York 09176	EAL	E39
40. Herzo Base CDAAC APO New York 09352	EAK	E40

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
41. Hoechst CDAAC McNair Kas APO New York 09403	EAF	E41
42. Hohenfels CDAAC c/o HQ Det, HTC, 7th ATC APO New York 09173	EAK	E42
43. Idar-Oberstein CDAAC c/o Baumholder CDAAC Div Arty APO New York 09034	EAH	E43
44. Illesheim CDAAC 1st Bde, 1st AD (Stork Bks) APO New York 09140	EAK	E44
45. Daenner Kas CDAAC, Kaiserslautern APO New York 09227	EAH	E45
46. Rhine Ordnance Bks CDAAC, Kaiserslautern APO New York 09227	EAH	E46
47. Gerzewski Bks CDAAC, Karlsruhe c/o Gerzewski Counseling Center APO New York 09360	EAG	E47
48. Neureat Kas CDAAC, Karlsruhe c/o Harmonh Hall APO New York 09164	EAG	E48
49. Kirchgoens CDAAC c/o HHC, 1st Bde, 3rd AD (Ayers Kas) APO New York 09045	EAF	E49
50. Harvey Bks CDAAC, Kitzingen APO New York 09031	EAM	E50
51. Larson Bks CDAAC, Kitzingen APO New York 09701	EAM	E51
52. Landstuhl CDAAC c/o Daenner Kas CDAAC, Kaiserslautern APO New York 09227	EAH	E52
53. Ludwigsburg CDAAC Ludwigsburg/Kornwestheim (Ludendorf Kas) APO New York 09154	EAL	E53
54. Mainz CDAAC 1st Bde, 8th ID (Lee Bks) APO New York 09185	EAF	E54
55. Coleman Bks CDAAC, Mannheim c/o Sullivan Bks CDAAC, Mannheim HHC, 1st Spt Bde APO New York 09086	EAG	E55

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
56. Sullivan Bks CDAAC, Mannheim c/o HHC, 1st Spt Bde APO New York 09325	EAG	E56
57. Turley Bks CDAAC, Mannheim c/o Sullivan Bks CDAAC, Mannheim HHC, 1st Spt Bde APO New York 09325	EAG	E57
58. Miesau CDAAC c/o USMCA Zweibreucken, ATTN: CDAAC APO New York 09052	EAH	E58
59. Munich CDAAC c/o Office of the Community Commander (McGraw Kas) APO New York 09407	EAA	E59
60. Neu Ulm CDAAC c/o US Mil Com Det, New Ulm (Nelson Bks) APO New York 09035	EAA	E60
61. Nellingen CDAAC c/o HHC, 2d SUPCOM APO New York 09160	EAL	E61
62. North Point CDAAC c/o USMCA ATTN: WORMS CDAAC APO New York 09058	EAH	E62
63. Merrel Bks CDAAC, Nuernberg 2d ACR APO New York 09093	EAK	E63
64. Wm O'Darby Kas CDAAC, c/o USMCA, Nuernberg APO New York 09696	EAK	E64
65. Oberursel CDAAC c/o HQ, TRANSCOMEUR (Camp King) APO New York 09451	EAF	E65
66. Pirmasens CDAAC Huesterhoeh Kas APO New York 09189	EAH	E66
67. Regensburg CDAAC (Satellite) c/o Hohenfels CDAAC HQ Det, HTC, 7th ATC APO New York 09173	EAK	E67
68. Schwabach CDAAC c/o HHR, 2d Bn, 59th ADA (O'Brien Bks) APO New York 09142	EAK	E68

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
69. Schwaebisch Gmuend CDAAC Bismarch Kas APO New York 09281	EAL	E69
70. Schwaebisch Hall CDAAC c/o Office of the Community Commander (Dolan Bks) APO New York 09025	EAL	E70
71. Conn Bks CDAAC, Schweinfurt c/o Ledward Bks CDAAC, Schweinfurt Office of the Community Commander ATTN: Human Resources Center APO New York 09033	EAM	E71
72. Ledward Bks CDAAC, Schweinfurt ATTN: Human Resources Center APO New York 09033	EAM	E72
73. Camp Darby CDAAC, SETAF, Livorno, Italy HQ, 8th Log Cmd ATTN: CAC APO New York 09019	EAN	E73
74. Caserna Ederle CDAAC, SETAF, Vincenza Italy HQ, Spt Gp NI ATTN: CAC APO New York 09221	EAO	E74
75. CDAAC, SHAPE, Belgium NATO/SHAPE Spt Gp ATTN: CAC APO New York 09088	EAC	E75
76. Spangdahlem CDAAC 6th Bn, 56th AD Arty APO New York 09123	EAH	E76
77. Kelly Bks CDAAC, Stuttgart c/o HQ, VII Corps APO New York 09107	EAL	E77
78. Patch Bks CDAAC, Stuttgart (Satellite) c/o Kelly Bks CDAAC, Stuttgart HQ, VII Corps APO New York 09107	EAL	E78
79. Vilseck CDAAC (Satellite) c/o Grafenwoehr CDAAC 7th ATC APO New York 09114	EAK	E79

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
80. Wackernheim CDAAC c/o HHB, 1st Bn, 59th Arty ATTN: The Cabin APO New York 09185	EAF	E80
81. Wertheim CDAAC c/o HQ, 72d Arty Gp APO New York 09047	EAM	E81
82. Camp Pieri CDAAC (Satellite) 1st Bn, 333rd FA APO New York 09353	EAF	E82
83. Wildflecken CDAAC Wildflecken Training Area APO New York 09026	EAM	E83
84. Worms CDAAC SUPACT Worms APO New York 09058	EAG	E84
85. Wuerzburg CDAAC Leighton Bks ATTN: ADCO APO New York 09801	EAM	E85
86. Wiesbaden CDAAC c/o Cdr USMCA Wiesbaden APO New York 09457	EAF	E86
87. Zweibruecken CDAAC c/o HQ, USAMMAE (Grenadier Kas) APO New York 09052	EAH	E87
D. HAWAII		
1. ADAPCP HQUSASCH ATTN: DPCA APO SF 96557	HEA	W01
E. JAPAN		
1. Cdr HQ USAG HONSKY ADAPT Center APO SF 96343	JHA	J01
F. OKINAWA		
1. HQ USARBCO ATTN: BCOA "IMPACT CENTER" APO SF 96331	RFA	R01
G. KOREA		
1. Camp Humphrey ADAPCP 19th Spt Bde APO SF 96271	KKC	K01
2. Casey House 2d Inf Div APO SF 96224	KKC	K02

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>-MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
3. Camp Page ADAPCP 4th MSL CMD APO SF 96208	KKC	K03
4. Camp Pelham ADAPCP Co C. 2nd MED BTN APO SF 96224	KKC	K04
5. Camp Red Cloud ADAPCP I Corps APO SF 96358	KKC	K05
6. Camp Stanley ADAPCP 2d Inf Div APO SF 96224	KKC	K06
7. Freedom House ADAPCP USAGY APO SF 96301	KKC	K07
8. PUSAN ADAPCP 2d Trans Gp APO SF 96259	KKC	K08
9. Taegu ADAPCP 19th Spt Gp APO SF 96212	KKC	K09
H. THAILAND		
1. HHD Bangkok Det ADAPCP APO SF 96346	TGA	T01
2. HHC, USAMEDDAC-T ATTN: THMC-HHC APO SF 96346	TGA	T02
3. Troop Cmd Drug Control Ofc. 7th RRFS RAMASUN Station APO SF 96386	TGA	T03
4. USA AMO ACT ATTN: THAM APO SF 96233	TGA	T04
5. USACC-T ATTN: CCPH-D APO SF 96346	TGA	T05
6. USA STATAHIP DET ATTN: THSD-I APO SF 96232	TGA	T06
7. USA UDORN DET ATTN: THUD-SUP APO SF 96237	TGA	T07
8. 13th MP Co ATTN: THBD-MP APO SF 96346	TGA	T08
9. 70th AVN Det ATTN: THAV APO SF 96303	TGA	T09

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
10. USACC-TAIWAN ATTN: CCPT-ADCO APO SF 96263	TGA	T10
I. PUERTO RICO		
1. Fort Buchanan ADAPCP ATTN: AFZL-PAJ APO New York 00934	334	F10
PART II — CONUS		
A. DARCOM		
1. Aberdeen Proving Ground ADAPCP Aberdeen Proving Ground, MD 21005	110	G02
2. Anniston Army Depot ADAPCP Anniston, AL 36201	342	G03
3. Army Materials & Mechanics Research Center ADAPCP Watertown, MA 02172	117	G04
4. Harry Diamond Laboratories ADAPCP Washington, DC 20438	108	G12
5. Dugway Proving Ground ADAPCP Dugway, Utah 84022	203	G13
6. Frankford Arsenal ADAPCP Bridge & Tacony Sts. Philadelphia, PA 19137	115	G15
7. Jefferson Proving Ground ADAPCP Madison, IN 47250	122	G19
8. Letterkenny Army Depot ADAPCP Chambersburg, PA 17201	115	G23
9. Lexington-Blue Grass Army Depot Lexington, KY 40507	128	G24
10. Fort Monmouth ADAPCP Fort Monmouth, NJ 07703	136	G30
11. Natick Research and Development Command ADAPCP Kansas St Natick, MA 01760	117	G31
12. New Cumberland Army Depot ADAPCP New Cumberland, PA 17070	115	G33
13. Picatinny Arsenal ADAPCP Dover, NJ 07801	136	G35
14. Pine Bluff Arsenal ADAPCP Pine Bluff, AR 71601	445	G36
15. Pueblo Army Depot ADAPCP Pueblo, CO 81001	216	G37

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
16. Red River Army Depot ADAPCP Texarkana, TX 75501	423	G39
17. Redstone Arsenal ADAPCP Redstone Arsenal, AL 35809	340	G40
18. Rock Island Arsenal ADAPCP Rock Island, IL 61201	243	G43
19. Rocky Mountain Arsenal ADAPCP Denver, CO 80240	203	G44
20. Sacramento Army Depot ADAPCP Sacramento, CA 95813	604	G45
21. Savanna Army Depot ADAPCP Savanna, IL 61074	243	G48
22. Seneca Army Depot ADAPCP Romulus, NY 14541	117	G50
23. Sharpe Army Depot ADAPCP Lathrop, CA 95330	604	G51
24. Sierra Army Depot ADAPCP Herlong, CA 96113	604	G52
25. Tobyhanna Army Depot ADAPCP Tobyhanna, PA 18466	115	G55
26. Tooele Army Depot ADAPCP Tooele, UT 84074	203	G56
27. Umatilla Army Depot ADAPCP Hermiston, OR 97838	705	G58
28. Watervliet Arsenal ADAPCP Watervliet, NY 12189	117	G60
29. White Sands Missile Range ADAPCP White Sands Missile Range, NM 88002	501	G61
30. Yuma Proving Ground ADAPCP Yuma, AZ 85364	524	G63
31. HQ US Army Development and Readiness Command ADAPCP Alexandria, VA 22333	108	G65
32. US Army Aviation Systems Command ADAPCP St Louis, MO 63166	231	G66
33. US Army Troop Support Command ADAPCP St Louis, MO 63120	231	G67
34. Corpus Christi Army Depot ADAPCP Corpus Christi, TX 78419	402	G68
B. DCSPER		
1. United States Military Academy ATTN: Chief PSD (MAPS-G) West Point, NY 10996	147	D01

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
C. DMA		
1. Army Topographic Station ADAPCP 6500 Brooks Lane N.W. Washington, DC 20315	108	P01
D. DSA		
1. Defense Construction Supply Center ADAPCP Columbus, OH 43215	128	L01
2. Defense General Supply Center ADAPCP Richmond, VA 23219	130	L02
3. Defense Personnel Support Center ADAPCP 2800 S. 20th Street Philadelphia, PA 19101	118	L03
4. Memphis Defense Depot ADAPCP Airways Blvd. Memphis, TN 38115	314	L04
5. Ogden Defense Depot ADAPCP Ogden, UT 84402	203	L05
E. FORSCOM		
1. Fort Bragg ADAPCP Fort Bragg, NC 28307	113	F03
2. Fort Campbell ADAPCP Fort Campbell, KY 42223	314	F04
3. Fort Carson ADAPCP Fort Carson, CO 80913	216	F05
4. Fort Devens ADAPCP Fort Devens, MA 01433	117	F07
5. Fort Drum ADAPCP Watertown, NY 13601	117	F08
6. Fort Hood ADAPCP Fort Hood, TX 76544	423	F11
7. Fort Sam Houston ADAPCP Fort Sam Houston, TX 78234	402	F12
8. Fort Indiantown Gap ADAPCP Annville, PA 17003	115	F13
9. Fort Lewis ADAPCP Fort Lewis, WA 98433	705	F14
10. Fort MacArthur ADAPCP Fort MacArthur, CA 90731	604	F15
11. Fort McCoy Sparta, WI 54656	243	F16
12. Fort McPherson ADAPCP Fort McPherson, GA 30330	334	F17
13. Fort George G. Meade ADAPCP Fort George G. Meade, MD 20755	135	F18

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
14. Fort Riley ADAPCP Fort Riley, KS 66442	241	F19
15. Presidio of San Francisco ADAPCP Presidio of San Francisco, CA 94129	604	F20
16. Fort Sheridan ADAPCP Fort Sheridan, IL 60037	243	F21
17. Fort Stewart ADAPCP Fort Stewart, GA 31313	346	F22
18. 31st ADA ATTN: AFV H-SA Homestead AFB, FL 33030	334	F09
19. Fort Ord ADAPCP Fort Ord, CA 93941	638	F26
20. Fort Polk ADAPCP Fort Polk, LA 71459	439	F27
F. HSC		
1. Fort Detrick ADAPCP Frederick, MD 21701	108	H01
2. Fitzsimons Army Medical Center ADAPCP Denver, CO 80240	203	H02
3. Walter Reed Army Medical Center ADAPCP 6925 16th St. NW Washington, DC 20012	108	H03
G. MDW		
1. Cameron Station ADAPCP Alexandria, VA 22314	108	M01
2. Fort Lesley J. McNair ADAPCP 4th & P Streets SW Washington, DC 20315	108	M02
3. Fort Myer ADAPCP Fort Myer, VA 22211	108	M03
H. MTMC		
1. Bayonne Military Ocean Terminal ADAPCP Bayonne, NJ 07002	136	X01
2. Oakland Army Base ADAPCP Oakland, CA 94626	604	X02
3. Sunny Point Military Ocean Terminal ADAPCP Southport, NC 28461	113	X03
4. HQ MTMC ADAPCP Washington, DC 20315	108	X04
I. USACC		
1. Fort Huachuca ADAPCP Fort Huachuca, AZ 85613	524	Z01

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
2. Fort Ritchie ADAPCP Fort Ritchie, MD 21719	135	Z02
J. TRADOC		
1. Fort Belvoir ADAPCP Fort Belvoir, VA 22060	111	B01
2. Fort Benning ADAPCP Fort Benning, GA 31905	312	B02
3. Fort Bliss ADAPCP Fort Bliss, TX 79916	501	B03
4. Carlisle Barracks ADAPCP Carlisle Barracks, PA 17013	115	B04
5. Fort Dix ADAPCP Fort Dix, NJ 08640	118	B05
6. Fort Eustis ADAPCP Fort Eustis, VA 23604	120	B06
7. Fort Gordon ADAPCP Fort Gordon, GA 30905	309	B07
8. Fort Benjamin Harrison ADAPCP Fort Benjamin Harrison, IN 46216	122	B08
9. Fort Jackson ADAPCP Fort Jackson, SC 29207	327	B11
10. Fort Knox ADAPCP Fort Knox, KY 40121	128	B12
11. Fort Leavenworth ADAPCP Fort Leavenworth, KS 66027	229	B13
12. Fort Lee ADAPCP Fort Lee, VA 23801	130	B14
13. Fort McClellan ADAPCP Fort McClellan, AL 36201	333	B15
14. Fort Monroe ADAPCP Fort Monroe, VA 23651	130	B16
15. Presidio of Monterey ADAPCP Presidio of Monterey, CA 93940	638	B17
16. Fort Rucker ADAPCP Fort Rucker, AL 36360	342	B21
17. Fort Sill ADAPCP Fort Sill, OK 73503	445	B22
18. Fort Leonard Wood ADAPCP Fort Leonard Wood, MO 65473	231	B24
19. Fort Hamilton ADAPCP Fort Hamilton, NY 11252	136	B25

Table 6-4. Service Area Codes — Continued

<i>ADAPCP/Organization/Location</i>	<i>MTF Code (Item 4a)</i>	<i>Area Code (Item 4b)</i>
K. USASA		
1. Arlington Hall Station ADAPCP 4000 Arlington Blvd Arlington, VA 22212	108	U01
2. Vint Hill Farms Station ADAPCP Warrenton, VA 22186	111	U02

Table 6-5. Length of Service Codes

1. For item 8a of DA Forms 4465 and 4466, Length of Service will be indicated as follows:
 - a. For less than 1 month, list service in *days*.
 - b. For less than 2 years, list service in *months* (round down).
 - c. More than 2 years, list service in *years* (round down).
2. For item 8b, length of service data code, one of the following will be used:

<i>Length of Service</i>	<i>Data Codes</i>
One week or less	A1
Over 1 week to 1 month	A2
One month, less than 2	A3
Two months, less than 3	A4
Three months, less than 4	B1
Four months, less than 5	B2
Five months, less than 6	B3
Six months, less than 7	C1
Seven months, less than 8	C2
Eight months, less than 9	C3
Nine months, less than 10	D1
Ten months, less than 11	D2
Eleven months, less than 12	D3
Twelve months, less than 16	E1
Sixteen months, less than 19	F1
Nineteen months, less than 22	G1
Twenty-two months, less than 24	H1
Two years, 3 years, etc.	02, 03, etc.

Table 6-6. Personnel Action Policies

R U L E	1	2	3	4		5
	Personnel Action Policy	Intake, Social Evaluation, or USP	Detoxification	Rehabilitation		Follow-up (Approx. 10 months)
				Active (Approx. 60 days)		
1	Leave a. Ordinary b. Emergency	Not authorized Authorized. On return, individual will, as a minimum, complete the remainder of social evaluation or USP. Commander may require individual to complete a full, uninterrupted cycle of social evaluation or USP.	Not authorized Authorized. May be granted when physician determines clinical condition permits.	Not authorized Authorized. On return, individual will participate in the uncompleted portion of the program.		Authorized Authorized
2	Retention beyond expiration of term of service (ETS). a. Unadjusted ETS. b. Adjusted ETS. (See note 1.)	Not authorized Authorized at the discretion of the commander.	See paragraph 2-22e, AR 601-280. Mandatory. If individual is dependent on alcohol or other drugs, he will be detoxified and entered into rehabilitation.	See paragraph 2-22e, AR 601-280. If individual was dependent on alcohol or other drugs, rehabilitation is mandatory until individual has been in the program at least 30 days. At the discretion of the commander, individual may be required to remain in the program until statutory ETS.		See paragraph 2-22e, AR 601-280. Authorized at the discretion of the commander.
3	Reenlistment	Not authorized	Not authorized	Not authorized		To be determined in accordance with the provisions of AR 601-280.
4	Temporary duty to another installation. a. Individual TDY.	Not authorized	Not authorized	Not authorized. Exception: If commander and ADAPCP staff determine that brief absence will not interfere with rehabilitation process,		Authorized if TDY and continuity of treatment can be provided at place of TDY.

See notes at end of table.

Table 6-6. Personnel Action Policies -- Continued

R U L E	1	2	3	4		5
	Personnel Action Policy	Intake, Social Evaluation, or USP	Detoxification	Rehabilitation		Follow-up (Approx. 10 months)
				Active (Approx. 60 days)		
	b. As part of parent unit. (See note 2)	Authorized if TDY location is equipped to conduct intake, social evaluation, or USP.	Not authorized	or if TDY is required for rehabilitation. Authorized if adequate rehabilitation program is available.		Authorized
5	Suspension of favorable personnel action.	Not applicable	See note 3	See note 3		See note 3
6	Eligibility for reassignment. (See note 4.)	Eligible for reassignment. Soldier should comply with orders unless results of intake, social evaluation, or USP sooner indicate individual is an abuser and physician diagnoses alcohol or other drug abuse.	Not eligible for reassignment. Upon completion of detoxification, member will be entered into rehabilitation at the same installation at which detoxification was accomplished. If reassignment reporting date would otherwise occur during detoxification period or during rehabilitation, transfer will be deferred until successful completion of active phase. (See note 5.)	Not eligible for reassignment until successful completion of rehabilitation. If reassignment reporting date would otherwise occur during active phase, transfer will be deferred until successful completion of active phase. (See note 5.) If individual is determined to be a rehabilitation failure, he will be processed for separation from the service in accordance with appropriate paragraphs of AR 635-200 or AR 635-100.		Eligible for reassignment.

See notes at end of table.

Table 6-6. Personnel Action Policies — Continued**NOTES**

1. This category applies to the soldier who has been assigned, or who has applied for and been granted, a release date prior to his statutory ETS.
2. Reports are required for this situation. See chapter 6.
3. It is neither required nor recommended that the commander suspend favorable personnel actions under the provisions of AR 600-31 simply because an individual has been clinically confirmed as dependent on, or an abuser of, alcohol or other drugs. Since the commander may *selectively disapprove (or recommend disapproval of)* personnel actions without the formal act of suspension, little is to be gained by the act and the commander runs the risk that rehabilitation will be hindered. If the commander elects to take action under the provisions of AR 600-31, such an action will not be initiated until the individual has been clinically confirmed as dependent on, or an abuser of, alcohol or other drugs.
4. Rules in columns 2 through 5 apply to assignments to, from, and within CONUS and oversea commands. See chapter 8, AR 614-30 for additional restrictions pertaining to oversea assignments. Criteria for "appropriate rehabilitative action," as discussed in AR 614-30, are those described in columns 4 of this table.
5. Deferral of reporting date —
For officers: Request new assignment instruction from appropriate career branch of HQDA (DAPC-OPD).
For enlisted personnel: Requests for deferments (or deletion, if applicable), of enlisted personnel on assignment instructions should be submitted to HQDA (DAPC-FPC-A) in accordance with the provisions of chapter 7, AR 614-200.

Table 6-7. Losing and Gaining ADCO Reporting Responsibilities*

	<i>Losing ADCO Will:</i>						<i>Gaining ADCO Will:</i>				
	Submit 60-day FUR	Submit 120-day FUR	Submit 180-day FUR	Submit 360-day FUR	Notify HSHI-QPI of PCS loss upon confirmation of enrollment at new duty station	Notify gaining ADCO or CMD. Forward client records upon enrollment in gaining ADAPCP	Notify losing ADCO & HSHI-QPI of transfer gains upon enrollment	Submit 120-day FUR on due date	Submit 180-day FUR on due date	Submit 360-day FUR	
<i>If Client Departs PCS Between:</i>											
1. 1st through 60th day of program		Not eligible for PCS. See rule 6, table 6-6.									
2. 61st through 90th day of program	X				X	X		X	X	X	X
3. 91st through 120th day of program		X			X	X		X		X	X
4. 121st through 150th day of program					X	X		X		X	X
5. 151st through 180th day of program			X		X	X		X			X
6. 181st through 360th day of program				X*	X	X		X			X*

*General rule—Losing ADCO responsible for submission of all FUR until gaining ADCO confirms enrollment of transfer cases.

Table 6-8. Oversea Casual Mail Directory*

<i>Destination of personnel</i>	<i>Address</i>
Alaska	Casual Mail Delivery APO Seattle 98732
Caribbean Area (Puerto Rico)	Casual Mail Directory APO New York 09851
Caribbean Area (Panama CZ)	Casual Mail Directory APO New York 09834
Europe	Casual Mail Directory APO New York 09743
Hawaii	Casual Mail Directory APO San Francisco 96558
Japan	Casual Mail Directory APO San Francisco 96503
Korea	Casual Mail Section APO San Francisco 96335
Marianas, Bonins Area (Guam)	Casual Mail Directory APO San Francisco 96334
Okinawa	Area Postal Directory (APD) APO San Francisco 96331

*Source: AR 612-2.

CHAPTER 7

DA CIVILIAN EMPLOYEE PARTICIPATION IN THE ADAPCP

Section I. INTRODUCTION

7-1. General. This chapter details the aspects of ADAPCP policies and program functions particularly applicable to eligible civilian employees. It also provides general guidance on the identification, referral, and rehabilitation of civilian employees whose job performance has been adversely affected by the abuse of alcohol or other drugs.

7-2. Objectives. The objectives of civilian employee support are consistent with and are an integral part of the ADAPCP. These objectives are to-

a. Increase efficiency, productivity, and effectiveness and ultimately reduce the use of sick leave by the civilian work force through the prevention of alcohol and other drug abuse.

b. Provide assistance, rehabilitation, or referral services to identified alcohol and other drug abusers among the civilian work force.

7-3. Policy. *a.* The civilian program coordinator (CPC) will be under the operational control of the ADCO. When the CPC position is an additional duty, the individual will be responsible to the ADCO for duties directly related to ADAPCP functions.

b. Participation by civilian employees in all aspects of the ADAPCP is *voluntary*. Civilian employees who choose to accept ADAPCP services will be enrolled in the installation ADAPCP and may participate in either the installation rehabilitation program or an *approved* rehabilitation program in the civilian community (para 7-15*b*).

c. The CPC will provide referral and follow-up services for civilian employees who elect to participate in *approved* community rehabilitation programs.

d. Civilian employees will be requested to sign the locally reproduced DA Civilian Employee Con-

sent Statement (fig. 7-1) upon entry into the ADAPCP. Civilian employees cannot be denied rehabilitation services based on refusal to sign the consent statement.

e. The diagnosis of alcohol and other drug abuse can be made only by a physician. Until a physician has made such a diagnosis, no diagnostic term will be used with reference to the individual.

f. No employee will enter the ADAPCP or be referred by the CPC staff to an approved civilian rehabilitation program without an ADAPCP initial interview (para 6-4) and clinical confirmation by a physician (para 3-14).

g. Civilian employees enrolled in the ADAPCP will be limited to 90 consecutive days of active rehabilitation, and 9 consecutive months' participation in follow-up rehabilitation. This policy will apply equally to clients participating in either the installation rehabilitation program or in an *approved* civilian program (para 7-18).

h. No employee will have job security or promotion action jeopardized by a request for counseling or referral assistance, except as limited by a "sensitive position" assignment. (For the purpose of this regulation, "sensitive positions" are those defined in para 6*c*(2), AR 690-1.) Should an activity commander determine that the sensitivity of a position is so great that an incumbent problem drinker, alcoholic, or other drug abuser could have a materially adverse effect on national security, the individual must be temporarily reassigned or placed on appropriate leave while undergoing rehabilitation under the ADAPCP. If the employee refuses assistance under the ADAPCP or is determined to be a rehabilitation failure, normal procedures will apply (para 7-18).

i. Management has the authority to direct employees to undergo fitness-for-duty medical examinations. When, as a result of physical or men-

tal impairment, an employee can no longer efficiently or safely perform the duties of his position, management may separate the employee. Before taking such an action, every reasonable effort should be made to assist the individual by reassignment to a position with more flexible physical and/or mental requirements, by granting liberal leave (including LWOP) for rehabilitation purposes, or in the case of employees who clearly cannot be restored to productive work, by encouraging eligible individuals to file for disability retirement. (See subchap. 4, FPM chapter 339.)

j. Tenant or other activities are responsible for developing procedures by which their civilian employees may utilize the facilities and services of the host/servicing installation.

7-4. Program support and endorsement. Successful achievement of the objectives of ADAPCP support for civilian employees is vested in commanders and supervisors (para 7-2). Major installation, activity or organizational commanders will issue a policy statement endorsing

and supporting civilian employee participation in the ADAPCP. The civilian personnel officer and staff will work closely with supervisors, staff of civilian employee health service, ADCO, CPC, and ADAPCP staff to insure their mutual support.

7-5. Eligibility. All US citizen employees of the Army who are provided medical service under the Army Federal Civilian Employee's Health Service Program are eligible to participate in the ADAPCP. Other DOD employees entitled to care in an Army medical treatment facility may participate in the ADAPCP. In rare instances, foreign national employees are provided medical services by DA through special treaty arrangements. In such cases, these individuals can be entered into the program if space and resources are available.

7-6. Facilities. ADAPCP facilities and services skills will be extended to eligible civilian employees to the maximum extent of available resources and space.

Section II. RESPONSIBILITIES

7-7. Commanders. Major Army commanders, their subordinate commanders, and commanders of military installations/areas, activities, and organizations will make the ADAPCP available to eligible civilian employees.

7-8. CPA and CPC. a. The CPA will-

(1) Advise the commander on all matters pertaining to the civilian aspects of the ADAPCP.

(2) Develop MACOM guidelines for provision of ADAPCP services for civilian employees.

(3) Provide staff guidance for the CPC.

(4) Serve as staff liaison between the CPC and HQDA.

(5) Provide technical assistance to CPC at installations and activities.

(6) Collect and maintain data pertaining to the status of civilian employee participation in the ADAPCP and progress made within the command, activity, or organization and provide reports, as required to HQDA (DAPE-HRL-A).

b. The CPC will-

(1) Function under the operational control of the ADCO.

(2) Assist in developing installation, activity, or organizational operating procedures to provide

ADAPCP services to all civilian employees.

(3) Establish and maintain liaison with CPO, MEDCEN/MEDDAC, and staff of civilian employee health service or occupational health program.

(4) Periodically evaluate local (community) rehabilitation resources used for referral, in consultation with the clinical director or MEDCEN/MEDDAC personnel.

(5) Develop and provide alcohol and drug education and training programs, in coordination with the EDCO, for supervisors and other civilian employees.

(6) Arrange, as requested, medical diagnostic consultation with a physician for civilian employees.

(7) Refrain from involvement in personnel actions; e.g., disciplinary or administrative actions, except when permitted under CSC and DA regulations relating to confidentiality of information.

(8) Provide current information to the ADCO concerning civilian employee aspects of the ADAPCP.

(9) Advise civilian employees who have been

confirmed as alcohol or other drug abusers that cancellation of adverse actions (para 7-18) does not apply to individuals who either refuse to consent to the CPC's providing rehabilitation progress reports to the supervisor of the individual concerned (fig. 7-1), or do not accept ADAPCP rehabilitation services from the installment program or an *approved* community program.

7-9. Civilian personnel officer. The CPO will—

a. Advise and assist the ADCO and CPC or CPA in development and implementation measures.

b. Insure that procedures are established which will enable civilian employees to use appropriate leave to attend ADAPCP counseling sessions during working hours.

c. Assist the CPC and ADCO in developing and implementing a comprehensive alcohol and drug abuse training and education program for civilian employees and supervisors.

d. Insure that employees and supervisors are scheduled to attend ADAPCP education and training sessions.

e. Maintain liaison with appropriate labor organization representatives.

7-10. Supervisors of civilian employees. When alcohol or other drug problems are underlying factors in deteriorating job performance, prompt assistance may lead to early, even life-saving identification and rehabilitation. Recognition of deteriorating job performance is a basic supervisory responsibility; early intervention will be most helpful in returning employees to full productivity.

a. The supervisor will

(1) Be alert, through continuing observation, to changes in the work and/or behavior of assigned employees.

(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, CPO, or physician regarding questionable employee 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) If necessary, request a fitness-for-duty examination in accordance with the provisions of FPM chapter 752, FPM Supplement 752-1; and subchapters 3 and 4, FPM 339 (para 7-3i).

(7) Conduct a subsequent interview, in follow-up to (4) above, to 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.

(8) Direct personnel actions to be taken (e.g., disciplinary or separation actions) in accordance with current civilian personnel regulations, when counseling and rehabilitation efforts have not been successful and the overall job performance of the employee warrants such actions.

b. Civilian employee supervisors will not confront an employee with the possibility of alcohol or other drug involvement unless—

(1) The employee appears to be under the influence of alcohol or other drugs. In such an instance, the supervisor should immediately order a fitness for duty examination. In ordering such examinations, supervisors should be aware that other health problems may create the impression that a person is under the influence of alcohol or other drugs. If such cases ultimately are determined to have resulted from abuse of alcohol or other drugs, supervisors will discuss the facts of the situation with the employee and refer him to the CPC.

(2) The employee is involved in illegal activities related to alcohol or other drugs. In this instance, the following measures are appropriate and consistent with DA and Civil Service Commission (CSC) 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 super-

visor 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.

7-11. Civilian employees. The employee whose job performance has been adversely affected by problems with alcohol or other drugs is the focal point of the civilian aspect of the ADAPCP. Success will be measured by the return of the employee's job performance to an acceptable level.

a. The employee is responsible for—

(1) Recognizing the adverse effect that alcohol or other drug abuse is having on job performance.

(2) Seeking appropriate assistance in problem resolution.

(3) Bringing job performance to an acceptable level through control of the problem.

b. Progress in rehabilitation will depend in great part on the employee's motivation and determination to control the alcohol or other drug

problem and the employee's ability to improve job performance.

c. Civilian employees at all levels must recognize a responsibility to the employer, supervisor, and co-workers when safety or the national interest is involved. Abuse of alcohol and other drugs has a marked effect on individual job performance, employee safety (both the abuser's and other workers'), overall productivity of the work unit, and cost/benefit accounting.

7-12. Physician. Physician responsibilities in support of civilian employee aspects of the ADAPCP include—

a. Performance of fitness for duty examinations as required.

b. Performance of clinical evaluation and confirmation procedures.

c. Completion of diagnosis and signature blocks on DA Form 4466 (ADAPCP Civilian Client Intake and Follow-up Record) for individual clinically confirmed as alcohol and other drug abusers.

Section III. CIVILIAN EMPLOYEE PROCEDURES

7-13. Prevention. a. *Education and training.* Alcohol and drug abuse training and education courses will be provided for all supervisors and members of the civilian work force. These courses will be developed within the ADAPCP and implemented with the assistance of the CPO (para 7-9).

(1) Course content will comply with appropriate DA policy for training and education prescribed in this regulation (sec III, chap. 1 and sec II, chap. 2).

(2) Training for civilian program administrators and for full-time and part-time civilian program coordinators is mandatory and is available through DA-sponsored courses. This and other training should have prior approval of the major command.

(3) During ADAPCP orientations, supervisors will be made aware that Public Laws 91-616, 92-255, and 93-282 require agencies to maintain treatment and rehabilitation programs. These laws do not assign DA agencies or their personnel with any responsibility for seeking out information on illegal employee activities for the purpose of reporting the activities to law enforcement authorities. The statutes do not, however, justify the failure of a supervisor or of any Federal

employee to report the illegal activities to responsible authorities when they are directed against, or are potentially harmful to others.

b. *Law enforcement.* As an employer, DA is concerned with the accomplishment of its missions and the requisite need to maintain employee productivity. When an employee's use of alcohol or other drugs interferes with the efficient and safe performance of assigned duties, reduces dependability, or reflects discredit on the Army, military and/or civilian supervisors may take necessary actions prescribed in appropriate Army and civilian personnel regulations.

7-14. Biochemical testing. Civilian employees are *not* subject to mandatory random or commander-directed urinalysis for purposes of initial identification. *Exemptions* are

a. Designated civilian alcohol and other drug treatment and rehabilitation personnel (para 3-20b(6)).

b. Civilian employees enrolled in the ADAPCP who may volunteer to submit specimens for the purpose of monitoring their progress in rehabilitation. Frequency of testing will be the same as that for military clients (para 3-20b).

7-15. Program entry and referral. a. When an

employee has an alcohol or other drug abuse problem, he may obtain assistance by—

(1) Volunteering for referral to the ADAPCP directly or through his supervisor, civilian program coordinator, chaplain, Army Community Services, occupational health services, private physician, labor organization representatives, or any other appropriate source of referral.

(2) Referral to the ADAPCP by a physician as the result of a fitness-for-duty examination.

b. All civilian employees will be requested to sign the DA Civilian Employee Consent Statement (fig. 7-1) prior to entering the ADAPCP. If the employee refuses to sign the consent form, the ADAPCP record will be so annotated and appropriate precautions will be taken regarding release of information (sec. V, chap. 1). Signing of the consent form or revoking prior consent is strictly voluntary. The consent enables the CPC, acting for the ADCO, to report specific information to the supervisor named on the consent form, once every 2 weeks, regarding clinical progress of the civilian client during rehabilitation. This disclosure enables the supervisor to assist the employee during the rehabilitation period and/or to take the necessary personnel action. The consent form provides for voluntary participation in urinalysis used to monitor progress during rehabilitation. The client may sign each section of the form separately and will not be denied entry into the program if he elects not to sign the consent form. The client may revoke consent on either section or on the entire form at any time. If, during the initial 90 day period of rehabilitation, an employee withdraws consent for the CPC to provide progress reports to the supervisor, the CPC will notify the supervisor of the withdrawal and no additional information or progress reports will be provided.

c. Referral will not be made to a civilian community rehabilitation program until the program has been approved by the clinical director and CPC and until a satisfactory agreement of client confidentiality and exchange of specific information for progress reporting purposes has been achieved.

d. Throughout rehabilitation the CPC will remain in contact with all civilian employee clients in the ADAPCP including those participating in approved civilian community programs. Clients participating in approved community rehabilitation programs will be included in the ADAPCP

reporting system. If the client is determined to be a rehabilitation failure and if his job performance is not satisfactory, the supervisor (with CPO consultation) will determine the administrative action to be initiated.

7-16. Clinical confirmation. The medical evaluation and clinical confirmation for civilian employees will be provided by an occupational health services physician, other appropriate medical officer, or private physician (para 3-14).

7-17. Client management. a. Civilian employees will comply with usual ADAPCP policy and procedures as prescribed by this regulation within the constraints of CSC, DOD, and DA regulations and special provisions of section V, chapter 1.

b. Civilian employees will be granted sick leave or other authorized leave, in accordance with existing rules and regulations, to obtain treatment and rehabilitation.

c. Financial remuneration is required of civilian employees during certain phases of the ADAPCP. The discharge of these obligations is the responsibility of the client even though personal medical insurance may help defray certain costs during a particular phase of rehabilitation.

(1) Costs associated with the ADAPCP are as follows:

(a) Inpatient treatment in Army medical treatment facilities will be at the applicable inpatient rate stated in AR 40-330.

(b) Subsistence charges will be assessed for meals actually consumed while in a resident facility (e.g., halfway house or similar facility).

(2) There will no charges for—

(a) Army Federal Civilian Employees Health Services Program job-related (fitness for duty) medical examinations.

(b) All other ADAPCP services, including resident facilities, except those noted in (1)(a) and (b) above.

d. Client case management is illustrated in figure 7-2.

e. A Civilian Client Intake Record (sec A, DA Form 4466) (fig. 7-3) and a Civilian Follow-Up Record (sec B, DA Form 4466) (fig. 7-4) are required for civilian employees participating in the ADAPCP to include those participating in approved civilian community programs. Instructions for completing these forms are provided in tables

7-1 and 7-2. See paragraphs 6-5c and d for distribution instructions. DA Form 4466 may be requisitioned through normal publications supply channels.

7-18. Relationship to disciplinary 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 only 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 rehabilitation period (NTE 90 consecutive days), 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. Such action 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, the proposed adverse action need not be delayed as a result of the employee's subsequent request for rehabilitation.

b. The civilian aspects of the ADAPCP supplement but do not replace existing procedures for dealing with employees whose job performance is not satisfactory as cited in FPM Letter 792-4; FPM Letter 792-7; CPR 400, chapter 430, appen-

dix C; CPR 752-1 and CPR 751; FPM chapter 752; and FPM Supplement 752-1. Although the CPC should be familiar with types of disciplinary and adverse actions for DA employees, this is a function of the supervisor, and the CPC and the ADAPCP staff will not become involved.

c. If an employee decides to withdraw from the ADAPCP prior to completion of the prescribed rehabilitation, the CPC will refer the employee back to his/her supervisor for any disciplinary or adverse action that may be pending. A supervisor will be advised of withdrawal from the program only if the consent form has been executed and remains in effect.

d. There should 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 problem, and the supervisor and CPO who must deal with the employee's job performance and/or subsequent disciplinary or adverse actions. The CPC assists the ADCO by serving as the liaison between the supervisor/CPO and ADCO once the employee has been referred to the ADAPCP.

7-19. Civilian program records. Client records which deal with the identity, diagnosis, prognosis, treatment, or rehabilitation of any civilian employee enrolled in, any alcohol or drug abuse program will be disclosed only for the purposes and under the circumstances authorized by section V, chapter 1.

7-20. Eligibility for retirement. Eligibility requirements for disability retirement and procedures for applying for retirement are contained in FPM Letter 792-4 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 for disability retirement of the employee.

7-21. Relationship with labor organizations.

The support and active participation of labor organizations will contribute materially to the success of the ADAPCP. Union officers and stewards can be influential in developing and maintaining employee confidence in the activity program. It is important that labor organizations understand the efforts of management to assist the employee with a drinking or other drug-related problem. To insure the cooperation and support of labor organizations, management should consult

with and include labor organization representatives in briefing sessions or other discussions of

the activity program so that there will be mutual understanding of policy.

CIVILIAN EMPLOYEE CONSENT STATEMENT*

In Accordance With Section 408, Public Law 92-255, The Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175), as amended in 1974 by Section 303, Public Law 93-282

I. The assistance, understanding, and cooperation of my supervisor will affect my rehabilitation in the ADAPCP. Pursuant to S 1401.21 of the above law, I _____ to the CPC providing progress reports every 2 weeks to my supervisor during the time I am entered as a client in the ADAPCP. My supervisor is _____ (person who rates and/or initiates personnel action on the employee). The information to be disclosed is a clinical progress report which states that I am (or am not) progressing satisfactorily in the rehabilitation program. The purpose of this disclosure is to insure that my supervisor can assist in my rehabilitation and can take necessary actions in my case. I understand that I may withdraw this consent at any time.

(Date)

(Signed - Client's Name)

II. Urinalysis is a routine part of the rehabilitation process and serves to help indicate that I have remained test-detectable drug free during my rehabilitation. I hereby _____ to periodic urinalysis during the next 90 days. I understand that I may withdraw this consent at any time.

(Date)

(Signed - Client's Name)

(Witness)

(Date)

(Alcohol and Drug Control Officer)

(Date)

(Installation)

*This format will be prepared in the original only and remain on file in the ADAPCP. No copies will be made. If consent is withdrawn, the document will be so annotated.

Figure 7-1.

CLIENT FLOW CHART FOR THE ADAPCP (CIVILIAN EMPLOYEE)

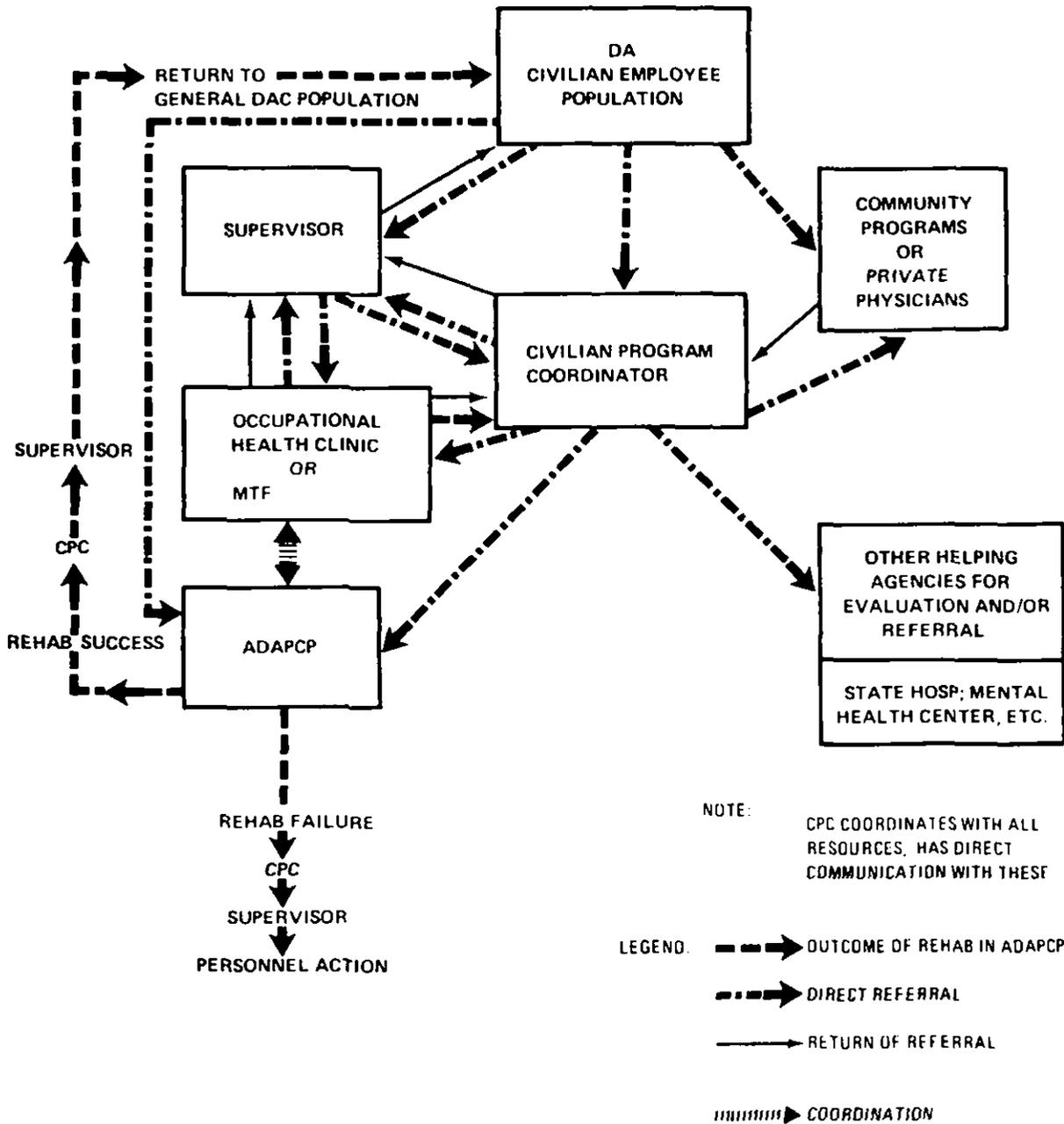


Figure 7-2.

Table 7-1. Instructions for Completing ADAPCP Civilian Client Intake Record

(Sec A, DA Form 4466, fig. 7-3)

<i>Item</i>	<i>Title</i>	<i>Completed By</i>	<i>Remarks</i>
1	Physician's diagnosis	Physician	See table 6-3. ADCO will insure that physicians performing clinical evaluations have access to information in table 6-3.
2	Client program number*	ADAPCP staff	
2a	YOB	.....	Last two digits of birth year.
2b	Last five digits of SSN	.....	Final five digits of social security number.
3	Grade and step	ADAPCP staff	For Fed svc employees: First two digits= alpha character indicating GS, WG, etc.; second two digits=pay grade level; last two digits=step number 01-10. For retired Fed employees, enter "RT0000"; for dependents of Fed employees, enter "DP0000". <i>Note.</i> Retired military currently working in Federal service will be listed under 3a Fed. Svc.
3a	Fed svc		
3b	Retiree (in-active)		
3c	Dependent		
4	Service area code	ADAPCP staff	
4a	Initial MTF*	.....	See table 6-4.
4b	Current area	.....	See table 6-4.
5	Diagnostic codes	Physician	See table 6-3. Must coincide with item 1. List primary diagnosis first.
6	Name, grade, MTF	Physician	Enter name, grade, and MTF of physician performing clinical confirmation signed by physician.
7	Date		
7a	_____ (Year, Month, Day)	Physician	Enter calendar date of clinical confirmation.
7b	Julian date	ADAPCP staff	Enter last two digits of calendar year plus Julian date of clinical confirmation; e.g., 11 Jan 77 would be entered as /7/7/0/1/1/
8-8a	Length of Gov svc	ADAPCP staff	Enter number of whole years client employed in Federal service.
8b	Date of onset of problem	ADAPCP staff	Enter month number and last digit of year (e.g., Feb 1975 = 025) that significance of problem was recognized by client, supervisor, etc.
9	Race	ADAPCP staff	Check appropriate box.
10	Sex	ADAPCP staff	Check appropriate box.

*To assist in compilation of accurate data and to insure matching of intake records with follow-up records, it is imperative that entries in items 2 and 4a be identical on all forms submitted on the same individual. Once CCIR has been submitted to HSHI-QBC, items 2 and 4a must not be changed on any subsequent CFUR submission unless specifically requested by HSHI-QBC.

Table 7-1. Instructions for Completing ADAPCP Civilian Client Intake Record**
(Sec A, DA Form 4466, fig. 7-3)—Continued

<i>Item</i>	<i>Title</i>	<i>Completed By</i>	<i>Remarks</i>
11	Level of education	ADAPCP staff	Check appropriate box. "HS grad" includes GED equivalent.
12	Marital status	ADAPCP staff	Check box reflecting current status.
13	Security clearance	ADAPCP staff	Check box reflecting current level of clearance.
14	Did client sign consent form?	ADAPCP staff	Check "yes" if client consented to release of rehab information to supervisor.
15	Case finding	ADAPCP staff	Check box which best describes how client's problem was discovered. <i>Note:</i> Final item implies that client was referred for interview or consultation with ADAPCP staff by his supervisor.
16	Case disposition	ADAPCP staff	Check box appropriate for client at time of program entry. If box <i>a</i> is checked, a second box <i>must</i> also be checked. Box <i>b</i> refers to installation rehabilitation programs; box <i>c</i> refers to a rehabilitation program in the civilian community. Boxes <i>d</i> thru <i>f</i> indicate that this CCIR is both an initial and final record; therefore, followup record is not required.
17	Drug usage Profile of current problem	ADAPCP staff	Must reflect a "yes" if diagnosis is recorded in item 1 (above).
18	Installation/mailling address of ADCO	ADAPCP staff	Enter complete mailing address of ADCO and organization to which assigned.
19-20	Name/grade, signature of	ADCO	Must be authenticated by ADCO. Unsigned forms will be returned.

** Incomplete records will be returned to submitting ADAPCP for completion.

DATA REQUIRED BY THE PRIVACY ACT OF 1974	
1. AUTHORITY	Section 413, Public Law 92-255
2. PRINCIPAL PURPOSE(S)	<p>a. To provide necessary information to evaluate the nature and extent of the client's alcohol and other drug problem.</p> <p>b. To provide baseline information for monitoring the client's progress during the rehabilitation and followup phases of the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).</p> <p>c. To assist in insuring continuity of care of client enrolled in the ADAPCP.</p>
3. ROUTINE USES	<p>a. Release of any information from this form is subject to the restrictions of 21 U.S.C. 1175 as amended by 88 Stat 137, 42 U.S.C. 4582 as amended by 88 Stat 131, and Chapter I, 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.</p> <p>b. Information from this form, <u>less entries that identify the individual client</u>, is forwarded to US Army Health Information Systems and Biostatistical Agency for statistical analysis, Armywide program evaluation, trend data, and gross data for research purposes.</p>
4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION	Disclosure is voluntary. Failure to disclose the information will result in a reduced capability of the program to provide proper treatment and services.

Figure 7-3--Continued

**Table 7-2. Instructions for Completing ADAPCP Civilian Client Follow-Up Record
(Sec B, DA Form 4466, fig. 7-4)**

<i>Item</i>	<i>Title</i>	<i>Completed By</i>	<i>Remarks</i>
2 2a 2b	Client program no.* YOB Last five digits of SSN	ADAPCP staff	See same items in table 7-1.
3 3a 3b 3c	Grade and step Fed svc Retiree (In-active) Dependent	ADAPCP staff	See item 3, table 7-1.
4 4a 4b	Svc area code Initial MTF* Current area	ADAPCP staff	See table 6-4. Program to which currently assigned. Use table 6-4.
5	Additional diagnostic codes	ADAPCP staff	Record any diagnosis determined by a physician since last report. Use code from table 6-3. Additional diagnosis and signature of physician will be entered in Remarks section of CFUR.
6 6a 6b	Date due Year, month, day Julian date	ADAPCP staff	Enter calendar date on which record is <i>due</i> . Entry must reflect passage of 90, 180, 270, 360 days from calendar date of clinical confirmation (item 7, CCIR). <i>Do not report date on which CFUR is prepared.</i> Enter last two digits of calendar year for which record is due, plus Julian date equivalent of calendar date entry for item 6a.
7	Reason for record	ADAPCP staff	Check box which best reflects reason for CFUR. For client who refuses further rehabilitation services (after prior acceptance), check box <i>j</i> (unknown) and make following note in Remarks section: "Refuses further rehabilitation services."
8	Rehabilitation methods used since last report	ADAPCP staff	<i>Initial CFUR:</i> Check entries applicable to client since entry into ADAPCP. <i>Subsequent CFUR:</i> Check entries only applicable since last CFUR. Column of boxes under "Civ prog" should be checked if rehab methods used were in an approved civilian program. <i>Note.</i> "In Patient" refers to Halfway House residence, not hospital admission.

*To assist in compilation of accurate data and to insure the matching of intake records with follow-up records, it is imperative that entries in items 2 and 4a be identical on all forms submitted on the same client. Once a CCIR has been submitted to HSHI-QBC, items 2 and 4a must not be changed on any subsequent CFUR submission unless specifically requested by HSHI-QBC.

Table 7-2. Instructions for Completing ADAPCP Civilian Client Follow-Up Record
(Sec B, DA Form 4466, fig. 7-4)—Continued**

<i>Item</i>	<i>Title</i>	<i>Completed By</i>	<i>Remarks</i>
9	Program status as of report date	ADAPCP staff	Check client's status in program as of CFUR due date. "Civilian program" refers to program in civilian community.
10	Average no. duty hours per week devoted to rehab.	ADAPCP staff	Enter only the no. of hours client is absent from duty for active or follow-up rehab.
11	Client progress and effectiveness	ADAPCP staff	Check entry that best reflects progress.
12	Installation/ mailing ADCO address	ADAPCP staff	Enter complete mailing address of ADCO and organization to which assigned.
13-14	Name/grade/signature of	ADAPCP staff	Must be authenticated by ADCO. Unsigned

** Incomplete records will be returned to submitting ADAPCP for completion.

FOR LOCAL USE ONLY																										
CLIENT PROGRAM NO.		b. LAST 5 DIGITS OF SSN																								
a. YOB 37	10738																									
ADAPCP CIVILIAN CLIENT INTAKE AND FOLLOW-UP RECORD																										
For use of this form, see AR 600-85; the proponent agency is the Office of the Deputy Chief of Staff for Personnel.																										
PRIVACY ACT STATEMENT - SEE REVERSE SIDE																										
SECTION B - CIVILIAN CLIENT FOLLOW-UP RECORD																										
1. DO NOT WRITE IN THIS BOX <div style="background-color: #cccccc; height: 100px;"></div>	2. CLIENT PROGRAM NO. a. YOB 37 b. LAST 5 DIGITS OF SSN 10738 3. GRADE/STEP a. FED SVC GS0307 b. RETIREE (IN-ACTIVE) <input type="checkbox"/> c. DEPENDENT <input type="checkbox"/> d. CURRENT AREA F12	4. SVC AREA CODE a. INITIAL MTF 402																								
5. ADDITIONAL DIAGNOSTIC CODES a. <table border="1" style="width: 100%; height: 20px;"><tr><td> </td><td> </td><td> </td></tr></table> b. SEE REMARKS BELOW c. <table border="1" style="width: 100%; height: 20px;"><tr><td> </td><td> </td><td> </td></tr></table> d. <table border="1" style="width: 100%; height: 20px;"><tr><td> </td><td> </td><td> </td></tr></table>										6. DATE DUE a. 75 SEP 18 (Year, Month, Day) b. JULIAN DATE 75261	7. REASON FOR RECORD (Check one box only) IN PROGRAM REPORTS (1) a. <input checked="" type="checkbox"/> 90 DAY FOLLOW-UP REPORT (1) b. <input type="checkbox"/> 180 DAY FOLLOW-UP (2) c. <input type="checkbox"/> 270 DAY FOLLOW-UP REPORT (3) ADAPCP TERMINATION REPORT (6) d. <input type="checkbox"/> 360 DAY FOLLOW-UP REPORT-COMPLETED PROGRAM (1) e. <input type="checkbox"/> 360 DAY FOLLOW-UP REPORT-CONTINUING IN PROGRAM-REPORTING REQUIREMENT COMPLETED (2) f. <input type="checkbox"/> LEAVING FEDERAL SERVICE (3) g. <input type="checkbox"/> SEPARATED FROM FEDERAL SERVICE (4) h. <input type="checkbox"/> TRANSFERRING TO ANOTHER FEDERAL AGENCY (5) i. <input type="checkbox"/> DEATH (6) j. <input type="checkbox"/> UNKNOWN (9)															
8. REHABILITATION METHODS USED SINCE LAST REPORT (Check as many boxes as appropriate) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>(1) ADAPCP</th> <th>(6) CIV PROG</th> </tr> </thead> <tbody> <tr> <td>a. IN PATIENT-FULL TIME (HALFWAY HOUSE) (1)</td> <td> </td> <td> </td> </tr> <tr> <td>b. IN PATIENT-PART TIME (HALFWAY HOUSE) (2)</td> <td> </td> <td style="text-align: center;">X</td> </tr> <tr> <td>c. ANTABUSE (3)</td> <td> </td> <td> </td> </tr> <tr> <td>d. ALCOHOLICS ANONYMOUS (4)</td> <td> </td> <td> </td> </tr> <tr> <td>e. NON-RESIDENT COUNSELING (OUT-PNT) (5)</td> <td> </td> <td> </td> </tr> <tr> <td>f. FOLLOW-UP (6)</td> <td> </td> <td> </td> </tr> <tr> <td>g. OTHER (Specify) (9)</td> <td> </td> <td> </td> </tr> </tbody> </table>			(1) ADAPCP	(6) CIV PROG	a. IN PATIENT-FULL TIME (HALFWAY HOUSE) (1)			b. IN PATIENT-PART TIME (HALFWAY HOUSE) (2)		X	c. ANTABUSE (3)			d. ALCOHOLICS ANONYMOUS (4)			e. NON-RESIDENT COUNSELING (OUT-PNT) (5)			f. FOLLOW-UP (6)			g. OTHER (Specify) (9)			10. AVERAGE NO. OF DUTY HOURS PER WEEK DEVOTED TO REHAB a. ACTIVE 10 (1) b. FOLLOW-UP <input type="checkbox"/> (6)
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f. FOLLOW-UP (6)																										
g. OTHER (Specify) (9)																										
9. PROGRAM STATUS AS OF REPORT DATE a. <input type="checkbox"/> ADAPCP - ACTIVE PHASE (1) b. <input type="checkbox"/> ADAPCP - FOLLOW-UP PHASE (2) c. <input checked="" type="checkbox"/> APPROVED CIVILIAN PROGRAM ACTIVE (3) d. <input type="checkbox"/> APPROVED CIVILIAN PROGRAM FOLLOW-UP (4)																										
11. COUNSELORS OPINION OF CLIENT PROGRESS AND EFFECTIVENESS AS OF REPORT DATE a. GOOD <input checked="" type="checkbox"/> (1) b. FAIR <input type="checkbox"/> (2) c. UNSAT <input type="checkbox"/> (3) d. N/A <input type="checkbox"/> (4)																										
REMARKS ENTER ADDITIONAL DIAGNOSIS (112) SIGNATURE OF PHYSICIAN.																										
12. INSTALLATION/MAILING ADDRESS OF ADCO ADAPCP, FT SAM HOUSTON, TX ; 34	13. TYPED NAME/GRADE OF ADCO JOHN A BARTON, CPT	14. SIGNATURE OF ADCO <i>A. Barton</i>																								

Figure 7-4.

DATA REQUIRED BY THE PRIVACY ACT OF 1974	
1. AUTHORITY	Section 413, Public Law 92-255
2. PRINCIPAL PURPOSE(S)	<p>a. To monitor the client's progress during the rehabilitation and follow-up phases of the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).</p> <p>b. To assist in insuring continuity of care of the client enrolled in the ADAPCP.</p>
3. ROUTINE USES	<p>a. Release of any information from this form is subject to the restrictions of 21 U.S.C. 1175 as amended by 88 Stat 137, 42 U.S.C. 4582 as amended by 88 Stat 131; and Chapter I, 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.</p> <p>b. Information from this form, <u>less entries that identify the individual client</u>, is forwarded to US Army Health Information Systems and Biostatistical Agency for statistical analysis, Armywide program evaluation, trend data, and gross data for research purposes.</p>
4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION	Disclosure is voluntary. Failure to disclose the information will result in a reduced capability of the program to provide proper treatment and services.

Figure 7-4—Continued

CHAPTER 8

PROGRAM REPORTS AND EVALUATION

Section I. REPORTS

8-1. General. A system of reports will be used to provide essential information to evaluate the ADAPCP at each level of command. More specifically, 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 education efforts.
- c. A measure of the progress made in the medical treatment and rehabilitative aspects of the ADAPCP.
- d. Information for replying to public, Congressional and other governmental agency inquiries and information to support budget requests for alcohol and other drug abuse program funds.
- e. Statistical trends to support requisite policy and procedural changes.

8-2. Alcohol and Drug Abuse Prevention and Control Program Summary (RCS CSGPA 1291-(R1)) (DA FORM 3711-R). a. This report (fig. 8-1) provides a basis for evaluating many aspects of the local program—compliance with policy, effectiveness of procedures, workload, and adequacy of resources. The report 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-14-inch paper.

DA Form 3711-R (fold-in) is located on pages 8-11 through 8-15.

b. Responsibilities regarding preparation, transmission, and review of the ADAPCP summary are as follows:

- (1) The Deputy Chief of Staff for Personnel, Department of the Army, 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) The Surgeon General, Department of the Army, will—

- (a) Review incoming reports for completeness and statistical accuracy.
- (b) Provide consolidated ADAPCP summary reports to HQDA (DAPE-HRL-A) for evaluation.
- (c) Prepare and forward to HQDA (DAPE-HRL-A) appropriate reports required by the Office of the Secretary of Defense.

(3) Major Army commanders will monitor the submission of ADAPCP summaries by subordinate elements and prepare consolidated reports for oversea areas indicated in appendix H.

(4) MEDCEN/MEDDAC commanders will provide the ADCO with information required to complete appropriate parts of the report.

(5) Installation and oversea area ADCO will—

- (a) Prepare the ADAPCP Summary each month for those installations and oversea areas listed in appendix H.

Note. Data concerning individuals from other military services participating in the ADAPCP will be recorded in the appropriate "Remarks" portions of the ADAPCP Summary, and will not be computed with data for AD and ADT Army personnel.

(b) Submit ADAPCP Summary by letter (para 8-3) through command channels to the major Army commander concerned.

8-3. Procedures for completing ADAPCP Summary. a. The ADAPCP Summary will be submitted by letter through command channels to the major commander concerned. To assist in meeting deadlines imposed on HQDA, a copy of both the report and the letter from each CONUS installation and oversea area will be mailed *directly* to Chief, US Army Health Information Systems and Biostatistical Agency (HISBA) ATTN: HSHI-QBC, Fort Sam Houston, TX 78234, for statistical

review and processing. Direct communication is authorized between Chief, HISBA and ADCO of CONUS installation and oversea areas. If, in this direct communication, a corrected report is required, copies of the revised report will be submitted directly to HISBA and through command channels to the major commander concerned.

b. A letter of transmittal signed by the appropriate commander will accompany the report and should include any information necessary to interpret data regarding program progress. Commanders providing support to off-installation military and civilian activities will list these activities and will indicate the nature and extent of the resources provided. If no medical treatment facility is located on the installation, the letter will indicate the facilities that provide clinical 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 reports will be dispatched as follows:

(1) *CONUS installations* will submit reports not later than the 5th duty day after the end of the report period.

(2) *Oversea areas* will submit consolidated report not later than the 10th duty day after the end of the report period.

d. Parts of the report require separate accounting for individuals with "alcohol" problems and for

those involved with "other drugs." *Individuals abusing both alcohol and other drugs will be accounted for under the heading applicable to the primary drug involved.* Throughout the report, negative entries will be indicated by leaving cells blank—zeros will not be entered. The report will be signed by the ADCO. DA Form 3711-R will be completed in accordance with instructions in table 8-1.

8-4. Federal Employees Occupational Health, Alcoholism and Drug Abuse Programs Annual Report (NARS 0058-CSC-AN). Civilian program coordinators will prepare Part 3 (Medical-Behavioral Counseling Programs) of Civil Service Commission Form 1210 as the annual report on the number of civilian employees counseled or helped by the ADAPCP. Installation reports will be submitted by letter through command channels to the major commander concerned not later than the 10th calendar day following the close of the fiscal year. Major Army commanders will submit a consolidated report, together with the individual activity reports, to HQDA (DAPE-HRL-A), Washington, D.C. 20310, not later than the 20th calendar day following the close of the fiscal year.

8-5. Other reports. Other reports may be required from time to time in order to meet ADAPCP objectives.

Section II. EVALUATION

8-6. General. The ADAPCP must include a comprehensive method of evaluation. The following guidelines address minimal evaluation standards. Evaluation should—

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 the prevention and rehabilitation of alcohol and other drug abusers.

d. Consider guidance contained in FPM Bulletin 792-15 concerning civilian aspects of the ADAPCP.

e. Ascertain the relative effectiveness of various approaches with different target groups.

8-7. Objectives. Program evaluation will—

a. Insure integration of all facets of the ADAPCP at every level of command.

b. Provide feedback as a basis for program im-

provement.

c. Identify areas for possible research by HQDA.

8-8. Concept. a. Evaluation is the assessment of program impact to determine if program objectives are being met and to identify factors that facilitate or hinder attaining program objectives. The Program Evaluation Worksheet (app I) is a tool designed to facilitate program evaluation by assisting commanders and staff members at all levels. Evaluation should—

(1) Determine if program objectives are being met.

(2) Determine program effectiveness and efficiency, including client perceptions.

(3) Obtain data for development of policies and procedures.

(4) Determine problem areas and need for technical assistance at specific installations or

commands.

(5) Determine compliance with pertinent directives.

b. Evaluation cannot be based solely on the compilation of statistical data, since records and reports are only one facet in the index of program progress. Such information, while essential, must be integrated and supplemented by subjective information. Program indicators are prevalent at all command levels for both subjective and analytical information.

8-9. Responsibilities. a. HQDA will maintain a continuous objective evaluation based on reports submitted. Staff assistance visits will be made by HQDA when subjective assessment is required.

b. Each major commander will maintain a continuous assessment of the ADAPCP through reports, staff visits, and drug and alcohol assistance teams. The ADAPCP Summary (RCS CSG PA-1291 (R1)) (DA Form 3711-R) and IG reports should be used to assist in programming and structuring staff and team visits.

c. Use of the Program Evaluation Worksheet is recommended 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 ADP is used in program evaluation, methods must be formulated to preclude identification of individuals, and to preserve confidentiality (chap. 1).

8-10. Assistance teams. a. *General.* Each major 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 subordinate installation/activity within the major command area of responsibility a minimum of once each fiscal year. Additional visits may be scheduled as required.

(2) The team visiting a particular installation will be tailored to meet the needs of that installation.

(3) Representatives of USAHSC will participate in all assistance team visits to installations having an HSC MEDCEN/MEDDAC and will observe program activities listed in (4)(d) below.

(4) Assistance team visits to installations will include, as a minimum, observations of the following:

(a) Total program effectiveness, including command support to all levels; ADDIC; and administration and organization management, personnel, and funding.

(b) Prevention, including law enforcement activities, community action, and preventive education and training efforts.

(c) Identification and referral procedures.

(d) Rehabilitation, medical support, records and reports, including intake and follow-up records.

(e) All aspects of service for civilian employees.

(5) Following visits, written reports of significant findings and observations, including recommendations for local program improvement, will be provided to subordinate elements through command channels.

Section III. RESEARCH

8-11. General. This section describes research and development efforts in support of the HQDA ADAPCP. Research and development in alcohol and drug abuse prevention, identification, treatment, and rehabilitation is designed to produce better ways of dealing with these problems.

8-12. Medical research. Medical research in support of the HQDA ADAPCP is designed to define and investigate the unique causes of alcohol and other drug abuse in the military and to develop

effective medical techniques for dealing with the problems.

a. *Implementation.* The proponent command is the Army Medical Research and Development Command.

b. *Major research efforts.*

(1) The prevalence and incidence of alcohol and other drug use in the Army. Research efforts will focus on identifying social-psychological factors and environmental conditions that appear

related to alcohol and drug abuse within the Army. Medical significance of alcohol and other drug abuse findings will be compared with statistical analyses of other requirements for medical attention.

(2) Development of improved laboratory and field screening techniques for the identification and diagnosis of drug abuse. The objective is a low-cost field screening test that requires minimum time, facilities, and training. Methods must be suitable for repeated screening of large numbers of soldiers. The research will consist of a survey of all existing biochemical and immunological techniques for detecting drugs and their metabolic products.

(3) Study of biochemical stress factors impacting on improved treatment and rehabilitation

programs. The objective is to study the fundamental mechanism of the action of drugs of abuse and alcohol to improve the understanding of the way alcohol and other drugs affect health and military performance. This program includes research in pharmacology, biochemistry, metabolism, and psychophysiology.

8-13. Behavioral research. The US Army Research Institute for the Behavioral and Social Sciences supports the ADAPCP with resources, reports, and technical assistance. Alcohol and other drug abuse is regarded as a human resource management problem within the Army Research Institute work program. Research focuses on tools and techniques for dealing with this set of problems in operational units.

Table 8-1. Instructions for Completing DA Form 3711-R
(DA Form 3711-R (fold-in) is located on pages 8-11 through 8-15.)

Part I. Biochemical Testing of Urine Specimens For Drug Abuse.

This part is for recording workload and results for various categories of urinalysis conducted for AD and ADT Army personnel and for certain civilian members of treatment/rehabilitation staffs. *Results of urinalysis conducted for personnel of other Services will be reported in the Remarks section only below Part II.*

Column	Line	Data
a	—	Enter data pertaining to AD and ADT Army personnel tested as a result of random selection.
b	—	Enter data pertaining to AD and ADT Army personnel tested at the direction of the commander when there is a reason to suspect drug abuse.
c	—	Enter data pertaining to testing of treatment/rehabilitation staff personnel, both military and civilian.
d	—	Enter data pertaining to AD and ADT Army personnel tested in connection with the urine surveillance program.
e	—	Enter data pertaining to testing of AD and ADT Army personnel in an active (inpatient, resident, or nonresident) rehabilitation status for both alcohol and other drug abuse (normally the first 60 days after identification).
f	—	Enter data pertaining to testing of AD and ADT Army personnel in a follow-up status for both alcohol and other drug abuse (i.e., beyond 60 days in the program).
g	—	TRADOC installations where reception stations are located will complete lines 1 through 16 for personnel tested upon entry into the Service. <i>Other reporting installations/commands will not use column g.</i>
h, i, j, k	—	Report event testing conducted at the local/command level beyond that required in paragraph 3-20. Report and label each type of event testing in a separate column.
	1	Enter the total number of tests administered during the report period for each category of testing, regardless of whether or not results have been received from the servicing drug testing laboratory.
	2	Give only the number of persons for whom the entire screening and evaluation process (i.e., laboratory testing results received, evaluations conducted) was completed during the report period for each category of testing. For columns c through k, these data will be purged of multiple urine specimens results received for the same individual during the reporting period so that individuals in each of these categories are accounted for only once during the report period; receipt of even a single laboratory positive test result will cause the individual to be reported as laboratory positive (line 4) for the entire reporting period. It is not necessary to purge the data of multiple specimens submitted by an individual under random or commander-directed testing (columns a and b). For each column a through k, line 2 is the sum of line 3 + 4. <i>Note.</i> Include on line 2 those individuals with laboratory positive test results for whom completion of confirmation procedures is no longer possible (line 16 below).
	3 and 4	For reporting test results for personnel on line 2. Enter on line 3 the number of individuals for whom laboratory test results were negative. Enter on line 4 the number of individuals for whom laboratory test results were positive, to include those individuals (line 16 below) for whom completion of confirmation procedures can never be accomplished because of the PCS, ETS, death, etc. of the individuals concerned.

Table 8-1. Instructions for Completing DA Form 3711-R-Continued

Column	Line	Data
	5-16	For reporting the outcomes of the confirmation procedure for personnel with positive laboratory test results. For personnel in active and follow-up rehabilitation (columns <i>e</i> and <i>f</i>) reconfirmation process by a physician of laboratory positive test results is not normally required (para 5-8c). However, laboratory positives not attributable to either authorized use (verified existence of a legal prescription) (line 13) or administrative error (line 14) will be itemized for lines 6 through 12.
	6-12	Give the breakdown, by drug class, of confirmed cases of drug abuse reported on line 5. <i>Note:</i> The opiate class (line 6) will include heroin, morphine, codeine, and morphine/codeine. In the "Remarks" section below Part II, specify the type of "other" drugs reported on line 11. "Polydrug" category (line 12) will include a single test result that indicates the presence of two or more drugs and multiple test results for the same individual if different drugs are detected in different samples. Specify polydrug combinations in the remarks section below Part II. The total of lines 6 through 12 will equal line 5 for each column.
	13	Indicate instances in which the medical officer conducting the clinical evaluation verifies the authorized use of the drug detected by urinalysis.
	14	Indicate cases for which the commander determines that an administrative error was made in the testing process.
	15	Give number of personnel determined by the commander to require urine surveillance. This category of personnel is different from confirmed abusers, who are formally enrolled in a rehabilitation program. Personnel in urine surveillance are not included in the caseload figures in Part III of the report.
	16	Of those reported as laboratory positive (line 4), specify the number of personnel for whom completion of confirmation procedures can never be accomplished because of the PCS, ETS, death, etc., of the individuals concerned. Entries on this line should be infrequent and are to be explained in the remarks section below Part II.

Part II. Rehabilitation Facilities and Staff

This part provides an inventory of resources available for the rehabilitation effort. Resident facilities are those in which individuals may live during a portion of their rehabilitation period, either full-time or part-time (live-in, work-out). A nonresident facility is one which operates strictly on a visit or drop-in basis. A resident facility may also perform nonresident functions.

Section	Data
A Resident	For each line (1 through 3) indicate by entering either a 1 ("yes") or a 0 ("no") the type resident facility operated by the local ADAPCP; i.e., either <i>combined</i> or <i>separate</i> resident facilities for alcohol and other drug abusers.
Nonresident	For each line (1 through 3) indicate by entering either a 1 ("yes") or a 0 ("no") the type of nonresident facility operated by the local ADAPCP; i.e., either <i>combined</i> or <i>separate</i> nonresident facilities for alcohol and other drug abusers. <i>Note.</i> The same facility may be reported only once under each column heading (resident, nonresident). Do not report the number of buildings or their client capacity.
B	Report number of personnel working in the ADAPCP. Give the number of spaces authorized by appropriate TDA's for each category of personnel (officer, enlisted, civilian). The number of personnel assigned will include those assigned against these spaces, as well as those in a special duty or excess status. Report number of personnel on lines 1 through 3 by the activity in which they are primarily engaged. "Admin-

Table 8-1. Instructions for Completing DA Form 3711-R-Continued

Section

Data

istration" includes the ADCO, administrative officer, civilian program coordinator, chaplains' assistants, clerical staff, and personnel engaged in urine collection. "Counseling" includes clinical directors, counselors, and chaplains involved in the rehabilitation of alcohol and other drug abusers. "Education" includes the education coordinator and personnel whose primary activity is education. Twice yearly, in the reports for August and February, report in the "Remarks" section below Part II, the number of staff personnel authorized by and assigned against *medical* TDA's. The data will be presented in the following format:

MEDICAL TDA STAFF PERSONNEL

Officer	Enlisted	Civilian
Authorized/assigned	Authorized/assigned	Authorized/assigned

Part III. Caseload and Disposition of ADAPCP Cases

This part provides a summary of monthly activity of the ADAPCP caseload, both AD and ADT Army, and *Other* categories (military dependents, retired military, and eligible civilian employees). Data for AD and ADT personnel are listed and computed as an entity and recorded in the appropriate data cells. For *Other* categories (columns *e* through *h* and *m* through *p*), data for civilian employees are listed and computed as an entity, separate from data computed for military dependents and retirees. All civilian employee data are therefore to be enclosed in parenthesis (e.g., line 1, Part III) and placed alongside dependent/retiree data in the appropriate data cells. (Note: Do not compute civilian employee data as a subtotal of any other data). All individuals, whether in duty-unit rehabilitation, correctional custody programs, full-time or part-time residence in halfway houses or other live-in facilities, will be accounted for and included in installation totals. Accurate completion of Part III is extremely important for program evaluation. There is a close relationship between Part III of this report and individual client intake and follow-up records (sec A and B, DA Form 4465). For example, all entries on line 2, Part III require the completion of an identical number of section A's of either DA Form 4465 or 4466 (para 6-3a).

Line

Data

- 1 Enter the number of individuals participating in each phase of the rehabilitation program on the *first* day of the report period. These numbers should be identical to line 14, Part III of the previous month's report.
- 2 Indicate the number of new cases entered in the program during the report period by the status to which they were *initially* disposed, i.e., "alcohol" or "other drugs." Personnel reported on this line will be new accessions to the ADAPCP, and each entry should be substantiated by the concurrent completion of the appropriate client intake record. Note: Do not switch a client from "alcohol" to "other drugs" or vice versa.
- 3 Report gains to a local program of previously enrolled personnel transferring from another location (PCS).
- 4 and 5 For each column (*a* through *p*), indicate number of individuals whose status at the end of the report month is different from their status at the start of the month (line 1) or at entry into the local program (lines 2 and 3). On lines 4 and 5 for each column, indicate intraprogram changes of status for each program phase. Together, these two lines reflect the movement of ADAPCP cases between program phases. The sum across each section must balance for the two lines, according to the following:
- $$4a + 4b + 4c + 4d = 5a + 5b + 5c + 5d$$
- $$4e + 4f + 4g + 4h = 5e + 5f + 5g + 5h$$
- $$4i + 4j + 4k + 4l = 5i + 5j + 5k + 5l$$
- $$4m + 4n + 4o + 4p = 5m + 5n + 5o + 5p$$

Table 8-1. Instructions for Completing DA Form 3711-R--Continued

Line	Data
	Do not report program losses (personnel no longer accounted for in any phase of the local program) on line 4 or 5. (See line 6.)
6	Report all losses from the local program. Program losses are itemized on lines 7 through 13. For each column, line 6 will equal the sum of lines 7 through 13.
7	Enter number of AD and ADT Army personnel who have completed the full rehabilitation period and who remain on active duty (columns <i>d</i> and <i>l</i>) and Other personnel (columns <i>h</i> and <i>j</i>) who no longer require rehabilitation.
8	Enter number of AD and ADT Army personnel separated from the Service for abuse of or dependency on alcohol or other drugs. Include alcohol and other drug dependent rehabilitation failures transferred to the Veterans Administration.
9	Enter number of AD and ADT Army personnel separated from the Service for all other reasons (e.g., ETS and administrative separations for any reason <i>unrelated to alcohol or other drugs</i>).
10	Report losses through reassignment excluding medical evacuations. (See para 6-4 concerning reassignment procedures.)
11	Enter number of AD and ADT Army personnel absent without leave for over 30 days (dropped from the rolls). <i>Note:</i> Report individuals AWOL for <i>less than 30 days</i> (i.e., at the end of the report period) on line 14 in the column which indicates the individuals' status when absences began.
12	<i>Report all deaths of ADAPCP participants, regardless of cause. Give date, location, and probable cause of death in the "Remarks" section below Part IV for each case and specify whether death was related either to alcohol or other drug abuse.</i>
13	Indicate all other losses, including medical evacuation for any reason <i>unrelated to alcohol or other drugs</i> . For AD and ADT Army personnel, entries in this line should be infrequent. For Other personnel (cols <i>e</i> through <i>h</i> and <i>m</i> through <i>p</i>), include all other reasons for loss other than: "died" (line 12), and "completed follow-up" (line 7); this means that no further treatment is required for these personnel.
14	Indicate the caseload remaining in each phase of the program on the last day of the report period, according to the following specification: For each category of personnel by drug type (<i>Alcohol or Other Drugs</i>), the End of Month caseload for each phase of the program (inpatient, active residential rehabilitation, active nonresidential rehabilitation, and follow-up rehabilitation) will equal the caseload for that phase at the beginning of the report month (line 1), <i>plus</i> the cases entering that phase upon initial disposition (line 2), <i>plus</i> the cases transferring from other locations (line 3), <i>plus</i> the gains to that phase from other phases (line 4), <i>less</i> the changes of status to other phases (line 5), <i>less</i> the program losses from that phase (line 6).

Part IV. Rehabilitation Outcome For Separated AD And ADT Army Personnel

Indicate the outcome of the rehabilitation effort for those servicemembers in the ADAPCP who are separated from the Service (line 9, Part III) during the current reporting period.

Part V. Case Finding Method

This part of the report indicates the case finding method by which AD, ADT, and civilian employees were referred to the ADAPCP, evaluated, and clinically confirmed as abusing alcohol and other drugs. *Data for civilian employees are listed and computed separately from data for AD and ADT.* All civilian employee data are computed as an entity, enclosed in *parenthesis* (e.g., line 1, Part V) and *placed alongside* AD and ADT data.

(Note: Do not compute civilian employee data as a subtotal of any other data. Do not report data for military dependents or retirees in Part V.)

To avoid duplicative reporting, for lines 3 through 11, an individual is accounted for only *once* during the report period *according to primary category of drug involved*. For AD and ADT, the total of new confirmed Alcohol Abuse cases reported for column *f*, line 3, should equal the sum of "Alcohol" new program gains (cols a+b+c+d) line 2, Part III. Also, the total of new Confirmed Drug Abuse cases for column *f*, line 4, should equal the sum of *Other Drug* new program gains (cols i+j+k+l) line 2, Part III. In this regard, discrepancies between the totals in Part III and Part V should be explained in the "Remarks" section below Part VI. Since civilian employees cannot be compelled to participate in the ADAPCP, it is recognized that civilian employee confirmation data for Part V may exceed the number of civilian employee new program gains in Part III.

Table 8-1. Instructions for Completing DA Form 3711-R—Continued

Column	Line	Data
a	—	<i>Bio-chem.</i> It is recognized that biochemical testing of urine is employed in support of clinical confirmation of many individuals who are initially referred to the ADAPCP by other means (i.e., self/volunteer, commander/supervisor, investigation/apprehension, and medical referral). However, to insure that the actual <i>initial source of an individual's referral to and subsequent enrollment in the ADAPCP is correctly documented and reported in Part V, Bio-Chem as a category of case finding method is restricted to cases in which an individual's clinical confirmation may be traced directly to the production of a laboratory positive urine sample during random or commander-directed testing; on entrance to active duty, or as the result of other local event testing.</i>
b	—	<i>Self/Volunteer.</i> Includes all cases of individuals who, on their own initiative, request help for an alcohol or other drug problem from their unit commander, supervisor, unit ADAPCP or medical treatment facility, a chaplain, or other officer or noncommissioned officer in their chain of command. Also identifications resulting from a servicemember's seeking emergency medical treatment for an actual or possible alcohol or other drug overdose will be reported under the Self/Volunteer category. <i>Note:</i> Individuals who agree to treatment/rehabilitation as the result of their knowledge of impending detection by other means will <i>not</i> be reported under the Self/Volunteer category.
c	—	<i>Commander/Supervisor.</i> Includes those who are evaluated at the direction of a commander or recommendation of a supervisor (civilian employees) for suspected alcohol or other drug abuse. An individual sent to the ADAPCP by a commander or supervisor <i>subsequent</i> to investigation or apprehension by law enforcement authorities will be reported in column <i>d</i> , Investigation/Apprehension referral.
d	—	<i>Investigation/Apprehension.</i> Includes those evaluated as the result of law enforcement activities e.g., individuals referred to the ADAPCP under provisions of AR 190-5, or members apprehended by civilian or military law enforcement officials for a drug offense.
e	—	<i>Medical.</i> Includes those evaluated during an annual or other routine medical examination, or during observation or treatment for a condition which was not recognized as related to alcohol or other drug abuse at the time that the observation or treatment was begun. Those who voluntarily seek help from medical activities for alcohol or other drug problems are reported in column <i>b</i> , Self/Volunteer.
f	—	For each line (1 through 11), column <i>f</i> is the sum of columns a+b+c+d+e.
	1	Specify, by case finding method, the number of AD/ADT personnel and civilian employees seen for initial ADAPCP interview during the reporting period regardless of disposition.
	2	Specify, by case finding method, the number of AD/ADT personnel and civilian employees referred to the physician for clinical evaluation during the reporting period.

Table 8-1. Instructions for Completing DA Form 3711-R--Continued

<i>Column</i>	<i>Line</i>	<i>Data</i>
	3 and 4	Specify, by case finding method, the number of confirmed Alcohol Abuse cases (line 3) and confirmed Drug Abuse cases (line 4) reported for the period.
	5 thru 11	Specify by case finding method, the distribution (according to drug class), of confirmed cases of drug abuse reported on line 4. The sum of lines 5 through 11 will equal line 4 for each column.
		<i>Note:</i> The opiate cases (line 5) will include heroin, morphine, codeine, and morphine/codeine.

Part VI. New Cases Counseled by Chaplains

This part is for recording the number of *new cases of AD and ADT personnel* who were counseled by all chaplains at an installation for problems associated with or related to alcohol or other drug abuse. Cases are to be reported without regard to disposition and are not limited to those referred to or enrolled in the ADAPCP. For columns *a* through *c*, report only the *number of new cases counseled, not the number of counseling sessions. Normally, individuals will be reported one time only and should not be accounted for in future reports unless the original counseling was terminated and was reinstated several months later.*

Locate figure 8-1, fold-in pages, at the end of the regular printed pages, and insert following this page.

CHAPTER 9

ARMY NATIONAL GUARD AND ARMY RESERVE

9-1. General. This chapter prescribes ADAPCP procedures for implementation and management for the Army Reserve and provides guidelines for the Army National Guard (not directive to the Army National Guard).

9-2. Applicability. The provisions of this chapter are applicable to—

a. Applicants for enlistment in and members of the Army National Guard and Army Reserve when not on active duty or any type of active duty for training.

b. Army National Guard and Army Reserve members upon mobilization.

9-3. Background. *a.* Although little information is available concerning incidence of alcohol or other drug abuse among members of the Army National Guard and Army Reserve, it can reasonably be assumed that alcohol and other drug abuse behavior exists to the same extent as that found in the surrounding community. The nature of alcohol and other drug abuse is such that it may influence the performance of the individual servicemember but may not be observed by the unit commander. This is particularly possible if the member is in an inactive duty status.

b. The effects that alcohol and other drugs would have on unit readiness at mobilization is a reason for the development of an effective ADAPCP by Army National Guard and Army Reserve commanders.

9-4. Responsibilities. In assuring unit readiness for active duty roles, the Commanding General, US Army Forces Command, and the adjutants general of the several States should prescribe procedures for alcohol and drug abuse identification and counseling within their components.

9-5. Implementation. Army National Guard should encourage both preventive education and limited procedures for the identification of alcohol

and other drug abuse. Army Reserve will ensure that preventive education and identification procedures are established. Law enforcement provisions of the ADAPCP do not apply to members of the Army National Guard and Army Reserve since these personnel are not normally subject to the provisions of the UCMJ unless they are on active duty or on active duty for training.

a. Prevention. Characteristics of a successful prevention program are—

(1) An awareness on the part of the commander and his staff of the contributory factors which create alcohol or other drug abuse. This awareness is not universally present among commanders and must be developed through preventive training and education.

(2) Credible communication. Personnel chosen to implement the program should have peer credibility with members of their units.

(3) Trust in the program and its objectives. Trust is best gained by encouraging openness and involving unit members in the development of the program. After programs are instituted, trust is enhanced by open reception of criticism and program modification when criticism is valid.

(4) Training of certain key Army National Guard personnel. This may be accomplished at existing or specially conducted active duty training courses. Training of USAR officers designated as ADCO's may be accomplished by attendance at courses conducted at Active Army installations or Army area schools.

(5) Development by commanders of imaginative approaches to alcohol and other drug abuse prevention. This is encouraged, with due consideration to resources available and the nature of the communities in which their commands are located. It is strongly recommended that each major commander appoint an ADCO to be operational program director. The ADCO should receive

special training and should be fully knowledgeable of the provisions of this regulation.

b. Identification. The purpose of this phase is to identify the servicemember who may have alcohol or other drug abuse problems. If a servicemember is identified as an alcohol or other drug abuser, the unit commander will use resources within the unit to assist this individual and guide him to appropriate civilian programs. All personnel involved in the identification process must be aware of policies concerning confidentiality (chap. 1).

(1) *Voluntary identification.* Commanders should maintain an atmosphere in which alcohol or drug abusers may identify themselves and ask for assistance.

(2) *Involuntary identification.* Commanders should be alert to deteriorating job performance; errors in judgment; periods of being unfit for duty; and increasing incidence of disciplinary, health, and personal problems. When it is believed that these circumstances are occasioned by alcohol or other drug abuse, actions prescribed in c(2) and (3) below apply.

c. Actions applicable to identified individuals. The following actions are applicable to persons identified as alcohol or other drug abusers:

(1) *Applicants for Army National Guard and*

Army Reserve. In accordance with the provisions of paragraph 2-34, AR 40-501 and NGR 40-501, chronic alcoholism, alcoholic addiction, and other drug addiction are causes for enlistment rejection.

(2) *Members of the ARNG and USAR units.* A commander who suspects that alcohol or other drug abuse is a factor in unsatisfactory performance of a unit member will take the following actions:

(a) Refer the unit member for medical evaluation.

(b) If the unit member is clinically confirmed as an alcohol or other drug abuser and subsequently determined to be unsuitable/unfit for continued service, initiate separation procedures under the provisions of the appropriate AR or ARNG regulation.

(3) *Nonunit servicemember of the Ready Reserve.* When a nonunit servicemember of the Ready Reserve is suspected of alcohol or other drug abuse, the Commanding General, US Army Reserve Components Personnel and Administration Center, may take actions prescribed in (2)(a) and (b) above.

(4) *Officers.* Officers will be considered for elimination under the provisions of AR 135-175 or NGR 635-101.

APPENDIX A

EXPLANATION OF TERMS

The following terms, not otherwise defined in a standard dictionary, AR 310-25, or this regulation, are intended solely for administration of the program described in this regulation and are not intended to modify or influence definitions applicable to statutory provisions; the administration of military justice under the Uniform Code of Military Justice; 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.

a. *Abuser*. One who is clinically confirmed by a physician as having illegally, wrongfully, or improperly used any controlled substance, alcohol, or other drug(s).

(1) *Nondependent abuser*. One who has been clinically confirmed as having illegally, wrongfully, or improperly used any controlled substance, alcohol, or other drug(s), but is not physically and/or psychologically dependent on the same. (See diagnostic codes 3030, 3031, 3039, 7932, 793A through 793H, and 793K through 793M in table 6-3 or in AR 40-400.)

(2) *Dependent abuser*. One who has been clinically confirmed as having a physical and/or psychological dependency upon any controlled substance, alcohol, or other drug(s). (See diagnostic codes 3032, 3040, 3042, 3043, 3044, 3045, 3046, 3047, 3048, 3049, and 304M in table 6-3 or in AR 40-400.)

b. *ADAPCP rehabilitation staff*. The professional and paraprofessional personnel assigned to perform rehabilitation and counseling functions of the ADAPCP. Typical military occupational specialties and civilian personnel job classifications include: psychiatrist (MOS 3129), clinical psychologist (MOS 3620), social worker (MOS 3606), behavioral sciences specialist (MOS 91G), neuropsychiatric specialist (MOS 91F), clinical psychologist (GS-180), social worker (GS-185), psychology technician (GS-181), and social

services assistant (GS-186).

c. *Administrative officer*. The officer who is responsible to the ADCO for supervision of the administrative staff of the ADAPCP.

d. *Alcohol and drug control officer (ADCO)*. The officer having staff responsibility for implementing, operating, and monitoring the ADAPCP at installation level.

e. *Civilian program coordinator (CPC)*. The individual who is responsible to the ADCO for the civilian employee aspects of the ADAPCP.

f. *Clinical confirmation*. The determination by a physician that an individual is an alcohol or other drug abuser.

g. *Clinical consultant*. The military officer (i.e., physician, psychologist, or social worker) who is responsible for technical supervision of the medical aspects of the ADAPCP for the MEDCEN/MEDDAC commander and serves as the principal coordinator between the MEDCEN/MEDDAC commander and the ADCO.

h. *Clinical director*. The behavioral science professional who is responsible to the ADCO for implementing and monitoring the medical rehabilitation aspects of the ADAPCP, including supervision and training of the counselors and, if applicable, clinical aspects of the halfway house operation.

i. *Clinical evaluation*. The process whereby a physician determines whether an individual is or is not an alcohol or other drug abuser.

j. *Command consultation*. A concept through which members of the ADAPCP staff and/or MEDCEN/MEDDAC meet with an immediate commander to discuss or recommend a course of action concerning a servicemember.

k. *Controlled substances*. Those substances or immediate precursors listed in the current schedules of title 21, US Code, section 812. General categories in this section include but are not

limited to: narcotics, derivatives of the cannabis sativa plant, amphetamines, barbiturates, hallucinogens, and methaqualone.

l. Drug. Any substance which by its chemical nature alters structure or function in the living organism. Note that alcohol, glue, and aerosols are included under this definition.

m. Education coordinator. The individual who is responsible to the ADCO for administering alcohol and other drug preventive education and training programs.

n. Initial interview. The process whereby the ADAPCP staff obtains information about suspected abuse from the individual; and for service-members, his/her immediate commander/supervisor or; his/her medical and personnel records, to assist the physician during clinical evaluation.

o. Rehabilitation. (1) Active rehabilitation. The 60-days (90 consecutive days for civilian employees) period of intensive rehabilitative counseling dating from time of initial entry into the ADAPCP.

(2) *Follow-up rehabilitation.* The 300-days (270 consecutive days for civilian employees) period of less intensive rehabilitative counseling following completion of the active phase.

p. Social evaluation. A detailed ADAPCP staff investigation into the circumstances, current history, and background data concerning a suspected abuser to assist in determining the status of abuse when a physician, during clinical evaluation, was unable to make a diagnosis. This will be performed by an experienced member of the ADAPCP counseling staff.

APPENDIX B

REFERENCES

B-1. Public laws and statutes:

- a. 91-616 (42 USC 4561, et seq) (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970).
- b. 92-129 (Title V—Identification and Treatment of Drug and Alcohol Dependent Persons in the Armed Forces).
- c. 92-255 (21 USC 1101, et seq) (Drug Abuse Office and Treatment Act of 1972 as amended by Public Law 93-282).
- d. 93-282 (42 USC 4541, et seq) (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Amendments of 1974).
- e. 37 USC 802 (Forfeiture of Pay During Absence from Duty Due to Disease from Intemperate Use of Alcohol or Drugs).
- f. 10 USC 972 (Enlisted Members: Required to Make Up Time Lost).
- g. 91-513 (21 USC 801, et seq) Comprehensive Drug Abuse Prevention and Control Act of 1970).
- h. 5 USC 552 (Freedom of Information Act).
- i. 5 USC 552a (Privacy Act).

B-2. DOD publications:

- a. DOD Manual: 5030-49-R, Customs Inspection.
- b. DOD Directives: 1010.2, Alcohol Abuse by Personnel of the DOD.
1300.11, Illegal or Improper Use of Drugs by Members of the DOD.
- c. DOD Instructions: 1010.1, DOD Drug Abuse Testing Program.
1010.3, Drug and Alcohol Abuse Reports.
- d. DOD Military Pay and Allowances Entitlements Manual.

B-3. Army regulations:

- a. *Alcohol*: AR 210-65, Alcoholic Beverages.
- b. *Medical*:
 - (1) AR 40-2, Army Medical Treatment Facilities, General Administration.
 - (2) AR 40-3, Medical, Dental, and Veterinary Care.
 - (3) AR 40-5, Health and Environment.
 - (4) AR 40-8, Temporary Flying Restrictions Due to Exogenous Factors.
 - (5) AR 40-42, Policy on Confidentiality of Medical Information.
 - (6) AR 40-330, Rates for Army Medical Department Activities.
 - (7) AR 40-350, Medical Regulating To and Within the CONUS.
 - (8) AR 40-400, Patient Administration.
 - (9) AR 40-403, Health Records.
 - (10) AR 40-501, Standards of Medical Fitness.
 - (11) AR 40-535, Worldwide Aeromedical Evacuation.

c. Personnel:

- (1) AR 27-50, Status of Forces Policies, Procedures, and Information.
- (2) AR 28-1, Army Recreation Services.
- (3) AR 50-5, Nuclear Surety.
- (4) AR 135-175, Separation of Officers (Reserve Components).
- (5) AR 135-178, Separation of Enlisted Personnel (Reserve Components).
- (6) AR 165-20, Duties of Chaplains and Commanders' Responsibilities.
- (7) AR 310-10, Military Orders
- (8) AR 600-10, The Army Casualty System.
- (9) AR 600-20, Army Command Policy and Procedure.
- (10) AR 600-27, Department of the Army Military Personnel Management Teams.
- (11) AR 600-30, Human Self Development Program.
- (12) AR 600-33, Line of Duty Investigations.
- (13) AR 600-200, Enlisted Personnel Management System.
- (14) AR 601-270, Armed Forces Examining and Entrance Stations.
- (15) AR 601-280, Army Reenlistment Program.
- (16) AR 604-5, Clearance of Personnel for Access to Classified Defense Information and Material.
- (17) AR 608-1, Army Community Service Program.
- (18) AR 614-30, Oversea Service.
- (19) AR 614-200, Enlisted Personnel Selection, Training, and Assignment System, Grades E-1 through E-9.
- (20) AR 621-5, General Education Development.
- (21) AR 635-5, Separation Documents.
- (22) AR 635-10, Processing Personnel for Separation.
- (23) AR 635-40, Physical Evaluation for Retention, Retirement, or Separation.
- (24) AR 635-100, Personnel Separations: Officer Personnel.
- (25) AR 635-120, Personnel Separations: Officer Resignations and Discharges.
- (26) AR 635-200, Personnel Separations: Enlisted Personnel.
- (27) AR 635-206, Personnel Separations: Misconduct (Fraudulent Entry, Conviction by Civil Court, and Absence Without Leave or Desertion).
- (28) AR 640-10, Individual Military Personnel Records.
- (29) AR 680-1, Morning Report, RCS AG-140(R5).
- (30) AR 690-1, Civilian Applicant and Employee Security Program.
- (31) AR 690-3, Processing Procedures for Application for Employment as Social Workers and Clinical Psychologists.

d. Law enforcement:

- (1) AR 65-1, Army Postal Operating Instructions.
- (2) AR 190-5, Motor Vehicle Traffic Supervision.
- (3) AR 190-12, Military Police Working Dogs.
- (4) AR 190-13, The Army Physical Security Program.
- (5) AR 190-22, Search, Seizure, and Disposition of Property.
- (6) AR 190-24, Armed Forces Disciplinary Control Boards and Off-Installation Military Enforcement.
- (7) AR 190-30, Military Police Investigations.
- (8) AR 190-31, Department of the Army Crime Prevention Program.
- (9) AR 190-41, Customs Law Enforcement.
- (10) AR 190-46, Standardized Reporting of Crime and Security of Army Vehicles and Aircraft.

- (11) AR 190-47, The US Army Correctional System.
- (12) AR 195-1, Army Criminal Investigation Program.
- (13) AR 195-2, Criminal Investigation Activities.
- (14) AR 195-4, Use of CID Funds for Criminal Investigative Activities.
- (15) AR 195-5, Evidence Procedures.

e. Records:

- (1) AR 340-1, Records Management Program (Policies and Procedures).
- (2) AR 340-16 Safeguarding for "OFFICIAL USE ONLY" Information.
- (3) AR 340-17 Release of Information and Records from Army Files.
- (4) AR 340-18-9, Maintenance and Disposition of Medical Functional

Files.

f. Training: AR 350-1, Army Training.

g. Information: AR 360-61, Community Relations.

h. Miscellaneous:

- (1) AR 1-35, Basic Policies and Principles for Interservice, Interdepartmental, and Interagency Support.
- (2) AR 20-3, Department of the Army Special Subjects for Inspection.

B-4. DA pamphlets:

- a. DA Pamphlet 600-3, Officer Professional Development and Utilization.
- b. DA Pamphlet 600-17, A Commander's, Supervisor's, and Physician's Guide to Alcohol Abuse and Alcoholism.
- c. DA Pamphlet 600-18, Random Selection Schemes for the Drug Abuse Testing Program.
- d. DA Pamphlet 600-100 series, Alcohol and Drug Abuse Interchange.

B-5. Field manuals:

- a. FM 16-5, The Chaplain.
- b. FM 22-100, Military Leadership.
- c. FM 22-101, Leadership Counseling.
- d. FM 25-2 (Test), Unit Commander's Guide.

B-6. US Civil Service Commission guidelines:

- a. FPM Letter No. 792-4, dated 7 July 1971, subject: Federal Civilian Employee Alcoholism Programs.
- b. FPM Letter No. 792-7, dated 17 June 1974, subject: Federal Civilian Employee Alcoholism and Drug Abuse Program.

B-7. Technical bulletins:

- a. TB MED 290, Drug Abuse (Clinical Recognition and Treatment, including the Diseases Often Associated).
- b. TB MED 291, Guidance for Inventory, Control, and Accountability of Drugs and Injection Devices of Potential Abuse at Medical Treatment Facilities Worldwide.

APPENDIX C
CONDITION OF EMPLOYMENT
FOR CERTAIN CIVILIAN POSITIONS IN SUPPORT OF
THE ADAPCP

C-1. Civilian employees are not subject to random or 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. The format in figure C-1 will be used as the condition of employment and continuing employment agreement applicable to appropriate members of the ADAPCP staff (para 3-20b(6)). Since working arrangements within the program change from time to time, this requirement should be explained to *all* civilian employees within the ADAPCP (para 1-13d). For exceptions to staff testing requirement, see paragraph 3-20b(6).

CONDITION OF EMPLOYMENT
FOR CERTAIN CIVILIAN POSITIONS IN SUPPORT OF
ARMY ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL
PROGRAM

I. 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* for reassignment or separation of current employees, in accordance with applicable regulations. You are entitled to be provided any additional, reasonable information or clarification you desire prior to signing the agreement. Copies of the signed agreement will be given to you and your supervisor. The original will be placed in your official personnel folder.

II. 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 be a combined program in which both alcohol and other drug abuse clients are treated. 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 in direct contact with clients on at least a weekly basis must remain drug free to maintain credibility with drug abuse clients and commanders. The duties that you are to perform will require you to be in direct contact on a routine basis with clients who are alcohol and

Figure C-1.

drug abusers. To assure 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 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. If such drug use is detected, however, you will be provided with an opportunity for rehabilitation through referral to an approved rehabilitation program. It may be necessary to detail you to another position or place you on leave during the rehabilitation period. If rehabilitation efforts fail, you will be given appropriate consideration for a reassignment to a position for which you are qualified. If rehabilitation and/or reassignment efforts are not successful, action may be taken to separate you from employment. The results of urinalysis will be utilized for clinical and necessary administrative purposes only. Alcohol abuse will be determined by other methods.

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.

III. STATEMENT

This is to certify that I understand the contents of the policy described above and 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.

.....
 Date Signature

Figure C-1--Continued

APPENDIX D

THE ARMY ALCOHOL AND DRUG TRAINING AND EDUCATION MODEL

D-1. General. This model is designed to be used by the ADAPCP staff for planning effective training and education programs for carefully selected target populations. It explains the role of alcohol and other drug training and education in prevention; includes guidance for identifying target groups, developing objectives, determining message content, choosing types of presentation, designing curriculum techniques, and selecting media support materials; and addresses program evaluation.

D-2. Objectives. The Army Alcohol and Drug Training and Education Model incorporates the following objectives:

- a. That each member of the military community be provided maximum assistance in making responsible decisions concerning the use of alcohol and other drugs ("rational decision" concept).
- b. That an understanding of the ADAPCP be emphasized as the basis of effective management and use of the program.

D-3. Concept. The decision to use alcohol or other drugs is a personal decision; however, the decision is often not rational. The purpose of alcohol and other drug education is to intervene in the decisionmaking process by providing factual guidance or information at a point which will insure that rational decisions regarding alcohol or drug use are made in the future. This concept is illustrated in figure D-1.

D-4. Planning. The following planning steps, as a minimum, must be accomplished to insure the effectiveness of the ADAPCP training and education program (fig. D-2):

- (1) Identify characteristics of the target group.
- (2) Establish priorities.
- (3) Develop objectives.
- (4) Determine message content.
- (5) Select appropriate type of presentations.

(6) Select appropriate media support materials and resources.

(7) Select curriculum techniques.

D-5. Identification of target groups. Training and education will be more effective if target groups are identified and programs are tailored to meet the specific needs of each group. Central to this model is the accurate identification and assessment of specific target groups.

a. *Group characteristics.* Whether training and education is delivered to standard organizational groups or special groups, it is imperative that the characteristics of each group be analyzed prior to development of the presentations. Each ADAPCP will develop its own system for ascertaining characteristics that are essential for designing presentations that meet the needs of each target group. The following questions may lead to the identification of basic characteristics of each target group:

(1) Who are they? The answer should include background such as demographic, sociological, and psychological data.

(2) Is there evidence to suggest that alcohol and drug abuse is endemic among the group?

(3) What types of alcohol and other drugs does the evidence suggest this group may be using?

(4) Does there appear to be any obvious situational influence on the patterns of alcohol and other drug abuse?

(5) What is the attitude toward the ADAPCP?

(6) Are there strong motivational factors at work within this group such as peer persuasion, social pressure, and career demands?

b. *Target groups.* Each installation/command must identify target groups. This is a continuous process and must be kept current. Installation target groups should include—

(1) Commander and key staff.

(2) Senior officers, NCO's, and civilian supervisors.

- (3) Junior officers, NCO's, and civilian supervisors.
- (4) Other enlisted grades.
- (5) Receptees.
- (6) Basic trainees.
- (7) Advanced individual trainees.
- (8) ADAPCP professional staff.
- (9) ADAPCP paraprofessional staff.
- (10) ADAPCP clients.
- (11) Adult dependents.
- (12) Youth dependents (junior-senior high school).
- (13) Child dependents (elementary school).
- (14) Confinement facility population.
- (15) Confirmed alcohol/drug-related offenders.
- (16) Professional and special interest groups (e.g., physicians, lawyers, chaplains, ADDIC, civic organizations).
- (17) USMA and ROTC cadets and OCS students.
- (18) Staff, faculty, and students of Service schools and colleges.
- (19) Retired military personnel and their dependents.

D-6. Establishing priorities. Although the commander is responsible for providing appropriate training and education programs for each target group, availability of manpower and fiscal resources will impact on the frequency and level of effort. Consequently, target groups must be placed in priority to insure that resources are used in the most effective manner. Priorities will differ for similar commands in different environments and for the same command at different times. Under epidemic conditions, "risk" abuser groups must receive top priority in terms of available resources; however, under nonepidemic conditions, priority should be directed toward commanders, officers, NCO's, civilian supervisors, and enlistees. Other key target groups, in any instance, are those who manage, support, and operate the ADAPCP.

D-7. Develop objectives. Once target groups are identified, it is then necessary to establish the training and education objectives for them. Establishing objectives is answering the question, "What do we want to accomplish in this program with this group?" Each objective should contain two ingredients: group characteristics and program goals. In order to assist in the evaluation

of the training and education effort, objectives should be stated so that they are attainable and measurable. Guidelines for the development of objectives may be found in chapter 2, FM 25-2 (Test).

D-8. Determine message content. *a.* Content of presentation is important as it indicates the thrust established by the objectives. Content will be in accordance with guidelines contained in appendix E.

b. Objectivity in selecting message content is difficult because of the many attitudes surrounding substance abuse, including the attitude of the person making the content selection. To enhance objectivity in the development of subject content, a *balanced mix* of the following guidelines should be attained:

(1) The Army program is based on the assumptions that—

(*a*) Alcohol and other drug abuse reduces effective performance.

(*b*) Alcohol and other drug abuse is detrimental to the individual's social, psychological, physical, and spiritual development.

(*c*) Human resources education should facilitate the clarification of values and healthy alternatives which foster a well-adjusted life style and a meaningful and successful military career.

(2) Content must be relevant to the consequences of substance abuse in the Army environment.

(3) Content must be concerned with value clarification, decisionmaking, and alternatives. This requires professional expertise and skill to insure that it is accurate, relevant, and supportive of the ADAPCP effort.

c. The ADAPCP professional staff should validate each presentation produced for an intended target group. Additionally, they should formalize criteria for the selection and use of all instruction to facilitate the design of reliable programs for each specific target group.

D-9. Select appropriate types of presentations. *a.* The type of presentation appropriate for a particular target group must be selected by the instructor. Group characteristics should be the prime selection criterion; however, other factors such as available time and availability of instructor personnel will influence the selection.

b. Experience in alcohol and other drug training and education has produced several possible types of presentations. These are described in table D-1.

D-10. Media support materials. The guidelines in appendix E will govern the purchase, production, use, and distribution of all prevention materials used in support of the ADAPCP. The scope of these guidelines covers all printed, audio, and video materials for general, special, paraprofessional, and professional target groups.

D-11. Select curriculum technique. *a.* Curriculum should be designed to address each of the objectives related to a particular target group. A mix of the following techniques is recommended in the curriculum developed.

(1) *Fear of consequences.* This is generally a one-sided, antialcohol and drug "scare" tactic which stresses the harmful, legal, physiological, psychological, and/or moral consequences of alcohol and other drug abuse. Threats of legal sanctions; prospects of jeopardizing job, career, or promotion potential; and possible physical damage are typical of the bad consequences often stressed. This approach often makes use of authority figures such as policemen, doctors, and lawyers. Few current programs rely solely on this approach, and the use of this technique should be minimized.

(2) *Truth/facts.* This involves the presentation of "factual" information on alcohol and other drugs, their effects, possible reasons for taking them, and other related issues. The expectation is that the target group will make logical nonabuse decisions if given the benefit of accurate information about such behavior. The truth/fact approach should be integrated throughout an education curriculum instead of the 1-day "blitz" seminar.

(3) *Values/decisionmaking.* This approach emphasizes the development of self-awareness in value orientation, psychological makeup, decision-making abilities, interpersonal skills, etc. This technique deals explicitly with the value questions associated with abuse; questions which ordinarily receive only implicit attention.

(4) *Alternatives.* This technique offers "positive" alternatives such as religion, yoga, crafts, athletics, and social action. All alcohol and other drug education programs involve attempts to substitute other behavior for alcohol and other drug abuse; however, most of them merely imply or suggest specific substitutes.

b. The fear of consequences and truth/facts techniques are narrowly focused on alcohol and other drugs *per se*, while the latter two techniques often address alcohol and other drugs only as

symptoms of manifestations of personal or social needs and problems. Emphasis in alcohol and other drug education is shifting from a concern with *whether* people abuse alcohol and other drugs to *why* they abuse alcohol and other drugs; therefore, there is a growing emphasis on motivations and underlying personal wants and needs which may manifest themselves in substance abuse.

D-12. Monitoring and evaluating training and education. *a. Monitoring.* This is a key element that supports an effective evaluation procedure. It is imperative that an effective monitoring system be developed and used.

(1) A monitoring system should—

(a) Insure that instructions and orders are executed.

(b) Provide feedback on quality of program implementation.

(c) Assist in maintaining interface with other programs and related activities.

(d) Provide the data base for the training and preventive education portion of program evaluation.

(2) Once established, the monitoring system should, as a minimum, answer the following questions:

(a) Who is attending training and preventive education?

(b) Are they the desired target group?

(c) What is the quality of message content, delivery, and media materials?

(d) What resources are dedicated to training and preventive education (e.g., staff, facilities, equipment, fiscal)?

(e) What is the overall level of effort in terms of actual cost and manpower (man-hours/days)?

b. Evaluation.

(1) Program evaluation actually begins with the selection of the objectives. The important feature of evaluation is to determine whether or not objectives have been accomplished. If the objectives have been met, then new objectives can be established; if the objectives have not been met, then a reassessment should be accomplished. Evaluation is best employed as a continuous process rather than a "one-shot" effort.

(2) The evaluation process is dependent upon measurement and the most important characteristics of measurement are reliability and validity. Locally developed instruments may be

best for measuring objectives, but require time for development and refinement. Standard instruments may not be totally valid for the program objectives; yet they are readily available, complete with established norms. Measurement instruments should be designed and/or selected at

the time the objectives they are to measure are established.

(3) Further information concerning the total ADAPCP evaluation process is contained in chapter 8.

Table D-1. Available Strategies

Types of Presentations	Emphasis	Assumptions	Advantages/Disadvantages
Product	<ol style="list-style-type: none"> 1. Cognitive product 2. Presentation of information 	Individual requires additional information to make rational decisions.	<p><i>Advantages:</i></p> <ol style="list-style-type: none"> 1. Best for groups who are not abuse prone. 2. Best for groups well adjusted to their military situation. 3. Best for those not influenced by availability of substances. <p><i>Disadvantages:</i></p> <ol style="list-style-type: none"> 1. Temptation for instructor to talk about harmful consequences. 2. Counterproductive for groups other than listed above.
Process	Restructuring attitudes and values without reference to decisions.	Individual has inaccurate knowledge.	<p><i>Advantages:</i></p> <ol style="list-style-type: none"> 1. Best for groups that evidence abuse. <p><i>Disadvantages:</i></p> <ol style="list-style-type: none"> 1. Requires a great amount of time and skilled instructor. 2. Objections to instructor restructuring attitudes and clarifying values.
Mixed	Combination of above	Combination of above	<p><i>Advantages:</i></p> <ol style="list-style-type: none"> 1. Most effective for normal audience. 2. Better use of time. 3. Reduce number of instructors. <p><i>Disadvantages:</i></p> <ol style="list-style-type: none"> 1. May be too general and miss real need of target group. 2. Difficult to integrate a unified and effective presentation.

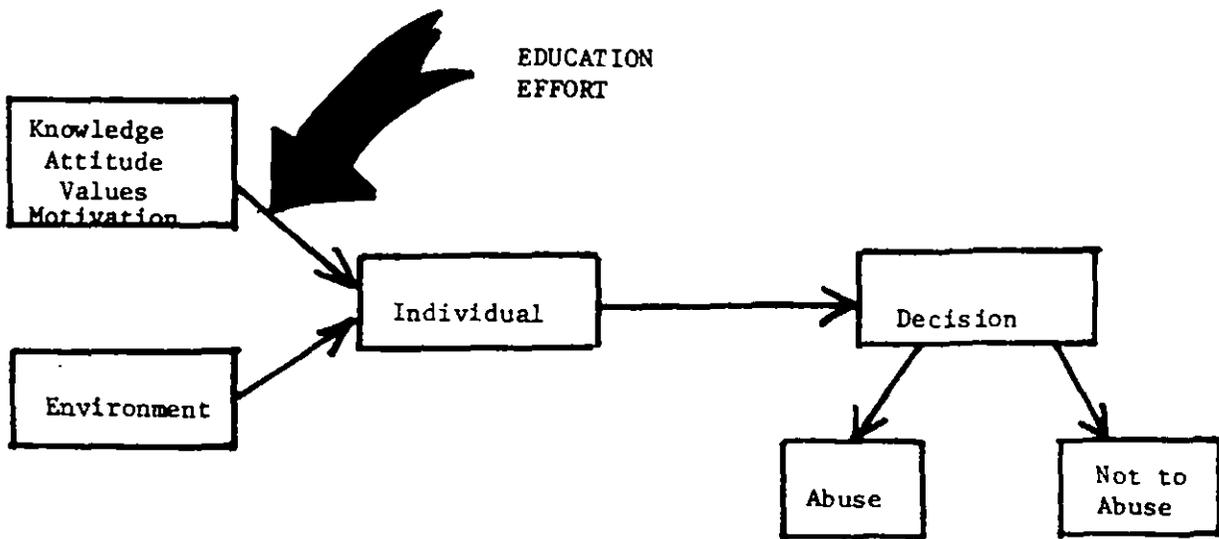


Figure D-1. Educational Intervention in Decisionmaking.

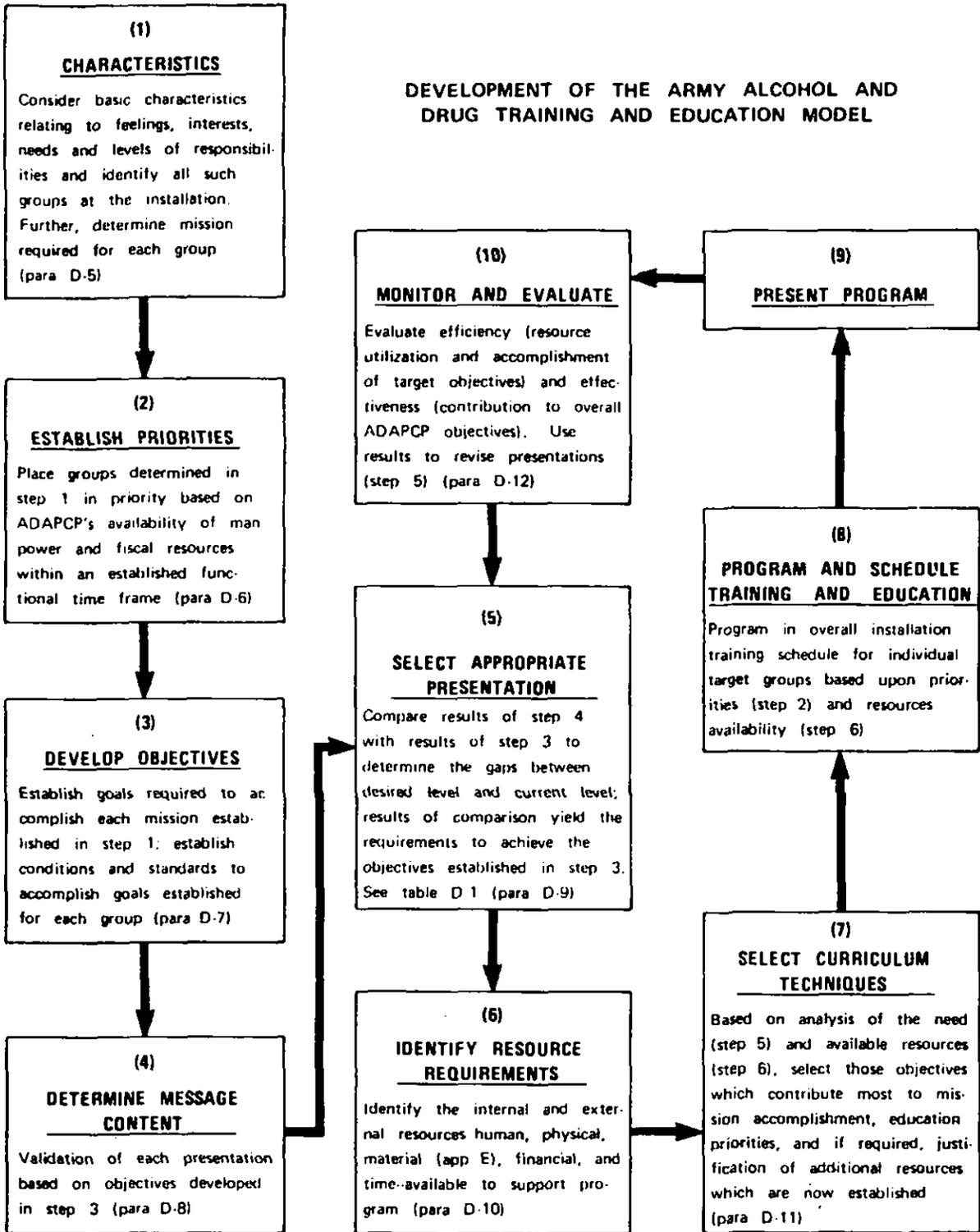


Figure D-2.

APPENDIX E

DEPARTMENT OF THE ARMY GUIDELINES FOR ALCOHOL AND DRUG TRAINING AND EDUCATION

E-1. General. These guidelines will govern the procurement, production, distribution, and use of all alcohol and other drug training and education materials. The scope of these guidelines covers printed material (other than correspondence, memoranda, and speeches), audio-visual materials, and training and education techniques used within the ADAPCP. These guidelines are designed to insure that all materials and techniques are generally consistent with the Federal standards and are in the best interest of the ADAPCP. The following general information is applicable.

a. All alcohol and other drug materials procured or produced will be for internal DOD audience use.

b. The major source of information about drugs and their effects is *A Federal Source Book: Answers to the Most Frequently Asked Questions About Drug Abuse* (Revised 1975). This publication is available through the Government Printing Office.

c. Audio-visual and printed materials produced by HQDA and all commercially adopted films and videotapes (off-the-shelf procurement) must be approved by the DOD Media Support Committee prior to use.

d. All alcohol and other drug materials which do not comply with these guidelines will be modified or removed from circulation as soon as possible.

E-2. Materials and techniques evaluation guidelines. a. Materials and techniques will be evaluated according to the following:

(1) Compliance with DA policy regarding alcohol and other drug abuse.

(2) Accuracy of information.

(3) Usefulness as an instructional aid.

(4) Appropriateness for use within the military environment.

(5) Compliance with the provisions of b through d below.

b. Materials will be identified to include:

(1) Designated target groups. (See para D-5 and D-6.)

(2) Type of message or intended use (e.g., information, training, discussion starter).

(3) Date of production.

c. The use of materials presenting the following kinds of messages is encouraged:

(1) The effect of substance abuse is a function of the dosage, the method of administration, the frequency of use, the individual, and the environment.

(2) The alcohol and other drug problem is complex. There are no easy answers and no two abusers are alike.

(3) Society has different attitudes regarding the use of substances to alter mood.

(4) Substance abuse is a social problem, as well as a medical problem. Therefore, we cannot reasonably expect to find *only* a medical solution to the problem.

(5) People need positive images rather than the reinforcement of existing stereotypes of dead-end addiction.

(6) People can help to solve the substance abuse problem by promoting the following conditions: better communication, people having a feeling of control over their own lives and a purpose in living, an acceptance of the validity of legitimate alternative life styles, and value structures which deemphasize immediate gratification.

(7) Special films for selected target groups, with emphasis on decisionmaking, attitudes, and values clarification.

d. The following kinds of messages have been generally ineffective, and thus materials employing such messages will *not* be used:

(1) The use of substance X always causes condition Y.

(2) The use of substance X never causes condition Y.

- (3) Substance abuse is the *only* problem.
- (4) Only illegal substances are abused.
- (5) Substance abuse is exclusively a youth problem.
- (6) Any message couched in terms which tend to overstate risks and make fear the main deterrent to future use.
- (7) Messages that rely on "moralizing" or "lecturing" to convince the audience not to abuse alcohol or other drugs.
- (8) Presenting only one treatment modality as "the answer."
- (9) Stereotypes for characters and settings, e.g., only minorities as abusers and pushers, drug abusers as hippies, the alcoholic as a skid row bum.
- (10) Demonstrating the use of illegal drugs, e.g., glue sniffing and mainlining.

E-3. Identification of materials. *a.* Materials produced by local installations will conform to paragraphs E-2*b* through *d* above.

b. Materials for professional and

paraprofessional audiences (e.g., physicians, chaplains, counselors, law enforcement personnel, ADAPCP staff) will be identified, to include—

- (1) The specific professional audience intended.
- (2) The date of production.

E-4. Narcotics educational training aids. Visual aid kits displaying *actual* samples of dangerous and illegal drugs will not be used. If displays are considered necessary to the education program, commercial display kits using facsimiles of drugs of abuse will be obtained.

E-5. Procedural guidelines. The process of revising and reprinting existing information and creating new information will follow a procedure that flows systematically from concept to production to dissemination to evaluation to reproduction. Figure E-1 shows criteria that should be used in making decisions during each procedural phase.

Procedural Considerations in the Production of Alcohol and Other Drug Abuse Information

CONCEPT	PRODUCTION	DISSEMINATION	EVALUATION	REPRODUCTION
Is there a need?	Which modality?	Who will distribute?	Is it accurate?	Is revision needed?
Does it duplicate?	Is modality cost-effective in terms of intended utilization and longevity?	How do you insure distribution will be restricted to intended target group?	Does message have desired effect according to its purpose?	Will material need updating?
Who is intended target?	Insure all material is labeled according to guidelines. (See paras E-2 <i>b</i> and E-3 <i>b</i> .)	Establish liaison with target group to restrict dissemination.	Is target group appropriate?	Is it cost-effective, considering the utility of materials?
What is purpose of message?	Have you consulted "message treatment guidelines?" (See paras E-2 <i>c</i> and <i>d</i> .)		Is it consonant with evaluation criteria? (See para E-2.)	
Is it consonant with message guidelines? (See paras E-2 <i>c</i> & <i>d</i> .)				

Figure E-1.

APPENDIX F
RANDOM TESTING FREQUENCIES

F-1. High risk areas. Frequency—3.0 tests per year per person.

- a. Thailand
- b. Philippines
- c. Okinawa
- d. Taiwan
- e. Guam

F-2. Moderate risk areas. Frequency—1.6 tests per year per person.

- a. Europe and the Middle East
- b. Korea
- c. Panama

F-3. Minimum risk areas. Frequency—1.2 tests per year per person. All geographical areas not listed above.

APPENDIX G
AREA RESPONSIBILITIES OF SUPPORTING
LABORATORIES

CONUS

<i>Laboratory</i>	<i>Area Supported</i>
Drug Abuse Testing Service Army Medical Laboratory Department of Pathology (WRAMC) Ft Meade, MD 20755 AUTOVON: 923-4076/6075	Connecticut, Delaware, Kentucky, Maine, Maryland, Massachusetts, MDW, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Vermont, West Virginia
Epidemiology Division Drug Detection Branch School of Aerospace Medicine Brooks AFB San Antonio, TX 78235 AUTOVON: 240-2604	Alabama, Arkansas, Colorado, Georgia, Kansas, Louisiana, Mississippi, Missouri, Oklahoma, Texas
Drug Screening Laboratory Naval Regional Medical Center Great Lakes, IL 60088 AUTOVON: 792-3407/6862	Arizona, Illinois, Idaho, Indiana, Iowa, Michigan, Montana, Minnesota, Wisconsin, Nebraska, New Mexico, North Dakota, South Dakota, Utah, Wyoming
Drug Screening Laboratory Naval Regional Medical Center Jacksonville, FL 32214 AUTOVON: 942-2497	Florida, South Carolina
<i>Mailing Address:</i> Toxicology Branch Bldg. S-33 Naval Air Station Norfolk, VA 23511 AUTOVON: 690-8120/8089	North Carolina, Virginia
or	
<i>Shipping Address (MAC or Common Carrier):</i> Toxicology Branch c/o Naval Air Station Receiving Office Supply Dept, Bldg. V-53, NAS Norfolk, VA 23511 AUTOVON: 690-8120/8089	

<i>Laboratory</i>	<i>Area Supported</i>
Naval Drug Screening Laboratory ... Naval Regional Medical Center Bldg 65B Oakland, CA 94627 AUTOVON: 855-2123/2244	California, Nevada, Oregon, Washington
Drug Screening Laboratory Naval Regional Medical Center Jacksonville, FL 32214 AUTOVON: 942-2497	Panama Canal Zone, Puerto Rico
USA Drug Screening Laboratory Wiesbaden, Germany APO NY 09633	European Command
USA Medical Laboratory Pacific Drug Screening Laboratory APO SF 96343 (Japan)	Korea, Japan, Okinawa, Taiwan, Philippines, Thailand, Guam
USA Tripler Medical Center, Hawaii Drug Screening Laboratory Schofield Barracks APO SF 96557	Hawaii
Drug Abuse Testing Service Army Medical Laboratory Depart- ment of Pathology (WRAMC) Ft Meade, MD 20755 AUTOVON: 923-4076/6075	Greenland
Naval Drug Screening Laboratory ... Naval Regional Medical Center Bldg 65B Oakland, CA 94627 AUTOVON: 855-2123/2244	Alaska

APPENDIX H

**CONUS INSTALLATIONS AND OVERSEA AREAS
FOR WHICH ADAPCP SUMMARY REPORTS ARE
REQUIRED****H-1. CONUS installations.***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 Lewis, WA
- (9) Ft McCoy, WI
- (10) Ft McPherson, GA
- (11) Ft Meade, MD
- (12) Ft Ord, CA
- (13) Ft Pok, LA
- (14) Presidio of San Francisco, CA
- (15) Ft Riley, KA
- (16) Ft Sam Houston, TX
- (17) Ft Sheridan, IL
- (18) Ft Stewart, GA
- (19) 31st ADA, Homestead AFB, FL

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 McClellan, AL
- (16) Ft Monroe, VA
- (17) Ft Rucker, AL
- (18) Ft Sill, OK

c. *DARCOM*. DARCOM installations/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 AVSCOM, 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) Pueblo Army Depot, Pueblo, CO
- (14) Red River Army Depot, Texarkana, TX
- (15) Sacramento Army Depot, Sacramento, CA
- (16) Savanna Army Depot, Savanna, IL
- (17) Seneca Army Depot, Romulus, NY
- (18) Sharpe Army Depot, Lathrop, CA
- (19) Sierra Army Depot, Herlong, CA
- (20) Tobyhanna Army Depot, Tobyhanna, PA
- (21) Tooele Army Depot, Tooele, UT

d. *Other*.

- | | |
|---|--------------|
| (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) West Point, NY | (DCSPER, DA) |
| (8) MTMC, Eastern Area, Bayonne, NJ | (MTMC) |
| (9) MTMC, Western Area, Oakland, CA | (MTMC) |

H-2. Oversea Areas.

<i>Area</i>	<i>Responsible Command</i>
a. Europe	USAREUR
b. Alaska	FORSCOM
c. Canal Zone	FORSCOM
d. Hawaii	FORSCOM
e. Korea	USAEIGHT
f. Japan	USARJ
g. Ryukyu Islands	USARJ
h. Thailand	USARSUPTHAI
i. Taiwan	USACC
j. Puerto Rico	FORSCOM

APPENDIX I
PROGRAM EVALUATION WORKSHEET

(To be published)

(As an interim evaluation measure, consult the Alcohol and Drug Abuse Prevention and Control Program checklist found in paragraph 2-2, AR 20-3, Department of the Army Special Subjects for Inspection, 4 August 1975.)

APPENDIX J

DISCHARGE PROCESSING FOR SERVICEMEMBERS
TRANSFERRED TO VETERANS ADMINISTRATION

J-1. Purpose. To provide guidance concerning transfer processing procedures to be accomplished in the case of those *alcohol or other drug dependent* servicemembers being transferred via medical evacuation to a Veterans Administration (VA) medical facility *prior* to being discharged from the Army (para 6-15).

J-2. Objectives. To insure completion of essential transfer processing procedures for those servicemembers being transferred to the VA.

J-3. Concept. For those servicemembers being transferred to the VA, discharge from the Army will occur *subsequent* to the members' arrival at the VA medical facility. Such cases, therefore, require the completion of some steps of transfer processing (for discharge) *before* the member departs for the VA, with the completion of additional steps occurring *after* the member's arrival at the VA. The expeditious processing of members being transferred to the VA will result in reduced opportunities for further alcohol or other drug involvement and will facilitate continuity of the rehabilitation effort for the members concerned.

J-4. Procedures. *a. Members assigned to CONUS units.*

(1) The commander of a servicemember designated for transfer to a VA medical facility *prior* to being discharged from the Army (para 6-15) will—

(a) Request that the supporting MEDCEN/MEDDAC obtain a VA bed designation from the Armed Services Medical Regulating Office (ASMRO).

(b) Request orders reassigning the member to the transfer activity listed in ASMRO message, (c) below. The request for orders will be deferred until notification of a VA bed designation has been received and administrative discharge proceedings have been completed.

(c) Furnish copies of ASMRO message to the Military Personnel Office (MILPO) and to the transfer activity listed in the ASMRO message.

(2) Upon notification by the member's commander, the losing MILPO will issue PCS orders (Format 430, app. A, AR 310-10) reassigning the individual to the transfer activity listed in the ASMRO message for separation processing. Additional instructions will specify that the member is to be admitted to the MEDCEN/MEDDAC (indicated) for medical evacuation to the (designated) VA medical facility as prescribed in this regulation. Since the identification cards of the member and his/her dependents will be surrendered at the transfer activity, additional instructions will authorize the member and dependents (by name and relationship) the same benefits and entitlements as authorized by their identification cards for a period of thirty days from the date the orders are issued.

(3) *Prior* to the member's being medically evacuated to the VA, the responsible transfer activity commander will—

(a) Accomplish transfer processing actions as outlined in paragraph 3-7, AR 635-10, except for final pay and discharge certificate which will be accomplished following evacuation of member to the VA.

(b) Collect identification cards of the member and of any dependents.

(c) Establish an effective date of discharge which will be at least fifteen days, but not more than twenty days from the date the member is expected to begin travel to the VA.

(d) Prepare DD Form 214 (Report of Separation from Active Duty) in accordance with AR 635-5.

(e) Obtain from the member the address to which final pay check and discharge certificate will be mailed ((6)(a) below).

(f) Request orders (Format 500, app. A, AR 310-10) discharging the member on the established effective date, (c) above.

(g) Mail copies of the discharge order to the VA medical facility to which the member will be evacuated, c/o Chief, Medical Administration Service #136 and to the CONUS MEDCEN/MEDDAC listed in ASMRO message.,

(h) Forego separation ceremony.

(4) The MEDCEN/MEDDAC which obtains the VA bed designation will insure that the clinical and health record accompanies the member to the VA.

(5) For strength accountability purposes at the transfer activity the member will be carried as PDY (AR 680-1) until the effective date of discharge.

(6) If, after evacuation to the VA, the member is not returned to military control and is not reported by the VA as either AWOL or deceased, the responsible transfer activity commander will—

(a) Mail final pay check, discharge certificate and other separation documents to the individual by registered mail on the next duty day following the effective date of discharge.

(b) Dispose of MPRJ and accompanying documents as prescribed in app. E, AR 635-10 and AR 640-10.

b. *Members assigned to OCONUS units.*

(1) The commander of a servicemember designated for transfer to a VA medical facility prior to being discharged from the Army (para 6-15) will—

(a) Request that supporting OCONUS MEDCEN/MEDDAC obtain a VA bed designation from ASMRO.

(b) Request that servicing MILPO initiate separation processing after notification of a VA bed designation has been received and administrative discharge proceedings have been completed.

(c) Furnish copy of ASMRO message to the MILPO.

(2) Upon notification by the member's commander, MILPO having custody of the member's records will—

(a) Accomplish transfer processing actions as outlined in paragraph 3-7, AR 635-10, except for final pay and for issuance of the discharge orders and discharge certificate which will be accomplished by the CONUS transfer activity ((4)

below). OCONUS MILPO will, however, obtain from the member the address to which the member desires that final paycheck, discharge certificate and other separation documents be mailed by the CONUS transfer activity. No separation ceremony will be conducted.

(b) Collect the identification cards of the member and of any dependents.

(c) Prepare DD Form 214 WS (Worksheet for Report of Separation from Active Duty), except for items 9d, 18 and 22 which will be completed by the CONUS transfer activity ((4) (e) below). Insert DD Form 214 WS in the member's MPRJ. A Request/Decline form for the DD Form 214 will be obtained and inserted in the MPRJ.

(d) Issue PCS orders (Format 430, app. A, AR 310-10) reassigning the member, for records processing only, to that CONUS transfer activity listed in the ASMRO message. Additional instructions will specify that the member is to be medically evacuated direct to the (designated) VA medical facility as prescribed in this regulation. Additional instructions will authorize the member and dependents (by name and relationship) the same benefits and entitlements as authorized by their identification cards for a period of 30 days from the date the orders are issued.

(e) Forward to the CONUS transfer activity named in the reassignment orders ((d) above), at the time of the member's medical evacuation, the following:

1. Member's MPRJ, to include sufficient copies of PCS orders.
2. Member's Personal Financial Record (PFR).
3. One copy of the ASMRO message.
4. Notification that the health record has accompanied the member to the VA.

(3) Upon transfer, the OCONUS MEDCEN/MEDDAC will insure that the clinical and health record accompanies the member to the VA.

(4) The CONUS transfer activity commander, upon receipt of the member's MPRJ, PFR and ASMRO message, will—

(a) Contact the VA medical facility listed in the reassignment orders (and also listed in the ASMRO message) to determine the date of the member's arrival at the VA.

Note. For strength accountability purposes at the transfer

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activity the member will be carried as PDY (AR 680-1) until the effective date of discharge.

(b) Establish an effective date of discharge which will be exactly fifteen days from the verified arrival date of the member at the VA.

(c) Issue the discharge order (Format 500, app. A, AR 310-10).

(d) Forward copies of the discharge order to the:

1. Army CONUS MEDCEN/MEDDAC designated in the ASMRO message,

2. Chief, Medical Administration Services (136), of the VA medical facility designated in the reassignment orders (and also listed in the ASMRO message).

(e) Prepare DD Form 214 (Report of Separation from Active Duty) in accordance with AR 635-5.

(f) Compute the member's final pay.

(g) Mail final pay check, discharge certificate and other separation documents to the individual by registered mail at the address furnished by the member ((2)(a) above) on the next day following the effective date of discharge; i.e., unless 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.

(h) Dispose of MPRJ and accompanying documents as specified in app. E, AR 635-10.

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-HRL-A) WASH DC 20310.

By Order of the Secretary of the Army:

FRED C. WEYAND
General, United States Army
Chief of Staff

Official:

PAUL T. SMITH
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 (Qty rqr block no. 382).

ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM SUMMARY <small>For use of this form, see AR 600-85; the proponent agency is the Office of the Deputy Chief of Staff for Personnel.</small>								REPORTS CONTROL SYMBOL CSGPA-1291 (R1)					
COMMAND/INSTALLATION MAILING ADDRESS								MONTH AND YEAR					
PART I - BIOCHEMICAL TESTING OF URINE SPECIMENS FOR DRUG ABUSE													
		RANDOM <small>a</small>	COMMANDER DIRECTED <small>b</small>	TREATMENT/ REHAB STAFF <small>c</small>	URINE SURV PROGRAM <small>d</small>	ACTIVE REHAB <small>e</small>	FOLLOW-UP REHAB <small>f</small>	EAD <small>g</small>	LOCAL EVENT				
									<small>h</small>	<small>i</small>	<small>j</small>	<small>k</small>	
1	TOTAL TESTS												
2	TOTAL PERSONS TESTED												
3	LAB NEGATIVE												
4	LAB POSITIVE (5+13+14+15+16)												
5	CONFIRMED ABUSE (6 thru 12)												
6	OPIATES												
7	AMPHETAMINES												
8	BARBITURATES												
9	COCAINE												
10	METHAQUALONE												
11	OTHER (Specify in remarks)												
12	POLYDRUG (Specify in remarks)												
13	AUTHORIZED USE												
14	ADMINISTRATIVE ERROR												
15	TO URINE SURV PROGRAM												
16	INCOMPLETE EVALUATION												
PART II - REHABILITATION FACILITIES AND STAFF													
Section A - FACILITIES						Section B - STAFF							
		RESIDENT		NONRESIDENT				OFFICER		ENLISTED		CIVILIAN	
								AUTH	ASGD	AUTH	ASGD	AUTH	ASGD
1	COMBINED					1	ADMINISTRATION						
2	ALCOHOL					2	COUNSELING						
3	OTHER DRUG					3	EDUCATION						
REMARKS													
TYPED NAME AND GRADE OF ADCO						SIGNATURE						DATE	

PART V - CASE FINDING METHOD AD/ADT AND DA/NAF EMPLOYEES						
List AD/ADT separately from civilian employees. Enter civilian employee data in parenthesis for each line of columns b thru f as shown below, line 1.						
	BIO-CHEM <i>a</i>	SELF/VOLUNTEER <i>b</i>	COMMANDER/SUPERVISOR <i>c</i>	INVESTIGATION/ APPREHENSION <i>d</i>	MEDICAL <i>e</i>	TOTAL <i>f</i>
INITIAL INTERVIEWS		()	()	()	()	()
REFERRALS FOR CLINICAL EVAL						
CONFIRMED ALCOHOL ABUSE						
CONFIRMED DRUG ABUSE (5 thru 11)						
OPIATES						
AMPHETAMINES						
BARBITURATES						
METHAQUALONE						
CANNABIS PRODUCT						
COCAINE						
OTHER						
PART VI - NEW AD/ADT CASES COUNSELED BY ALL INSTALLATION CHAPLAINS						
	ALCOHOL PROBLEMS ONLY <i>a</i>	OTHER DRUG PROBLEMS ONLY <i>b</i>	ALCOHOL AND OTHER DRUG PROBLEMS <i>c</i>			
12. NUMBER NEW CASES COUNSELED						
REMARKS (Explain discrepancies between column <i>f</i> , line 3 Part V and total of New Program Gains for Alcohol, line 2 Part III. Explain discrepancies between column <i>f</i> , line 4 Part V and total of New Program Gains for Other Drugs, line 2, Part III.)						
COMMAND/INSTALLATION MAILING ADDRESS						MONTH AND YEAR

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Figure 8-1. DA Form 3711-R-Continued

PART III - CASELOAD AND DISPOSITION OF ADAPCP CASES																
For "Other" cases (columns e thru h and n thru p), list and compute civilian employees separately from data on dependents and retired personnel. Enter civilian employee data in parenthesis as shown below, line 1.																
	ALCOHOL				OTHER				AD AND ADT ARMY				OTHER DRUGS			
	INPATIENT	ACTIVE RESIDENT REHAB	ACTIVE NON-RESIDENT REHAB	FOLLOW-UP REHAB	INPATIENT	ACTIVE RESIDENT REHAB	ACTIVE NON-RESIDENT REHAB	FOLLOW-UP REHAB	INPATIENT	ACTIVE RESIDENT REHAB	ACTIVE NON-RESIDENT REHAB	FOLLOW-UP REHAB	INPATIENT	ACTIVE RESIDENT REHAB	ACTIVE NON-RESIDENT REHAB	FOLLOW-UP REHAB
1	()				()				()				()			
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																
13																
14																
PART IV - REHABILITATION OUTCOME FOR SEPARATED AD AND ADT ARMY PERSONNEL																
Indicate below the rehabilitation outcome for those personnel reported as separated on line 9, Part III, above.																
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p
1	SUCCESS															
2	FAILURE															
REMARKS (Identify deaths from 12, Part III, by date, location and probable cause.)																
COMMAND/INSTALLATION MAILING ADDRESS														MONTH AND YEAR		

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Figure 8-1. DA Form 511-R-Continued.

PART III - CASELOAD AND DISPOSITION OF ADAPCP CASES

For "Other" cases (columns e thru h and m thru p), list and compute civilian employees separately from data for dependents and retired personnel. Enter civilian employee data in parenthesis as shown below, line 1.

	ALCOHOL								OTHER DRUGS							
	AD AND ADT ARMY				OTHER				AD AND ADT ARMY				OTHER			
	INPATIENT	ACTIVE RESIDENT REHAB	ACTIVE NON-RESIDENT REHAB	FOLLOW-UP REHAB	INPATIENT	ACTIVE RESIDENT REHAB	ACTIVE NON-RESIDENT REHAB	FOLLOW-UP REHAB	INPATIENT	ACTIVE RESIDENT REHAB	ACTIVE NON-RESIDENT REHAB	FOLLOW-UP REHAB	INPATIENT	ACTIVE RESIDENT REHAB	ACTIVE NON-RESIDENT REHAB	FOLLOW-UP REHAB
1	START OF MONTH CASELOAD () () () () () () () () () () () () () () () ()															
2	NEW PROGRAM GAINS															
3	TRANSFER GAINS															
4	INTRAPROGRAM CH OF STATUS-IN															
5	INTRAPROGRAM CH OF STATUS-OUT															
6	PROGRAM LOSSES (7 thru 13)															
7	COMPLETED FOLLOW-UP															
8	SEPARATED-ALCOHOL/DRUGS															
9	SEPARATED-ALL OTHER															
10	PCS															
11	AWOL															
12	DIED (see Remarks)															
13	OTHER (Specify in remarks)															
14	EOM CASELOAD (1+2+3+4-5-6)															

PART IV - REHABILITATION OUTCOME FOR SEPARATED AD AND ADT ARMY PERSONNEL

Indicate below the rehabilitation outcome for those personnel reported as separated on line 9, Part III, above.

	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p
1	SUCCESS															
2	FAILURE															

REMARKS (Identify deaths from 12, Part III, by date, location and probable cause.)

COMMAND/INSTALLATION MAILING ADDRESS

MONTH AND YEAR

ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM SUMMARY										REPORTS CONTROL SYMBOL CSGPA-1291 (R1)	
For use of this form, see AR 600-85; the proponent agency is the Office of the Deputy Chief of Staff for Personnel.											
COMMAND/INSTALLATION MAILING ADDRESS										MONTH AND YEAR	
PART I - BIOCHEMICAL TESTING OF URINE SPECIMENS FOR DRUG ABUSE											
								LOCAL EVENT			

APPENDIX J

DISCHARGE PROCESSING FOR SERVICEMEMBERS TRANSFERRED TO VETERANS ADMINISTRATION

J-1. Purpose. To provide guidance concerning transfer processing procedures to be accomplished in the case of those *alcohol or other drug dependent* servicemembers being transferred via medical evacuation to a Veterans Administration (VA) medical facility *prior* to being discharged from the Army (para 6-15).

J-2. Objectives. To insure completion of essential transfer processing procedures for those servicemembers being transferred to the VA.

J-3. Concept. For those servicemembers being transferred to the VA, discharge from the Army will occur *subsequent* to the members' arrival at the VA medical facility. Such cases, therefore, require the completion of some steps of transfer processing (for discharge) *before* the member departs for the VA, with the completion of additional steps occurring *after* the member's arrival at the VA. The expeditious processing of members being transferred to the VA will result in reduced opportunities for further alcohol or other drug involvement and will facilitate continuity of the rehabilitation effort for the members concerned.

J-4. Procedures. *a. Members assigned to CONUS units.*

(1) The commander of a servicemember designated for transfer to a VA medical facility *prior* to being discharged from the Army (para 6-15) will—

(a) Request that the supporting MEDCEN/MEDDAC obtain a VA bed designation from the Armed Services Medical Regulating Office (ASMRO).

(b) Request orders reassigning the member to the transfer activity listed in ASMRO message, (c) below. The request for orders will be deferred until notification of a VA bed designation has been received and administrative discharge proceedings have been completed.

(c) Furnish copies of ASMRO message to the Military Personnel Office (MILPO) and to the transfer activity listed in the ASMRO message.

(2) Upon notification by the member's commander, the losing MILPO will issue PCS orders (Format 430, app. A, AR 310-10) reassigning the individual to the transfer activity listed in the ASMRO message for separation processing. Additional instructions will specify that the member is to be admitted to the MEDCEN/MEDDAC (indicated) for medical evacuation to the (designated) VA medical facility as prescribed in this regulation. Since the identification cards of the member and his/her dependents will be surrendered at the transfer activity, additional instructions will authorize the member and dependents (by name and relationship) the same benefits and entitlements as authorized by their identification cards for a period of thirty days from the date the orders are issued.

(3) *Prior* to the member's being medically evacuated to the VA, the responsible transfer activity commander will—

(a) Accomplish transfer processing actions as outlined in paragraph 3-7, AR 635-10, except for final pay and discharge certificate which will be accomplished following evacuation of member to the VA.

(b) Collect identification cards of the member and of any dependents.

(c) Establish an effective date of discharge which will be at least fifteen days, but not more than twenty days from the date the member is expected to begin travel to the VA.

(d) Prepare DD Form 214 (Report of Separation from Active Duty) in accordance with AR 635-5.

(e) Obtain from the member the address to which final pay check and discharge certificate will be mailed ((6)(a) below).

(f) Request orders (Format 500, app. A, AR 310-10) discharging the member on the established effective date, (c) above.

(g) Mail copies of the discharge order to the VA medical facility to which the member will be evacuated, c/o Chief, Medical Administration Service #136 and to the CONUS MEDCEN/MEDDAC listed in ASMRO message.

(h) Forego separation ceremony.

(4) The MEDCEN/MEDDAC which obtains the VA bed designation will insure that the clinical and health record accompanies the member to the VA.

(5) For strength accountability purposes at the transfer activity the member will be carried as PDY (AR 680-1) until the effective date of discharge.

(6) If, after evacuation to the VA, the member is not returned to military control and is not reported by the VA as either AWOL or deceased, the responsible transfer activity commander will—

(a) Mail final pay check, discharge certificate and other separation documents to the individual by registered mail on the next duty day following the effective date of discharge.

(b) Dispose of MPRJ and accompanying documents as prescribed in app. E, AR 635-10 and AR 640-10.

b. Members assigned to OCONUS units.

(1) The commander of a servicemember designated for transfer to a VA medical facility prior to being discharged from the Army (para 6-15) will—

(a) Request that supporting OCONUS MEDCEN/MEDDAC obtain a VA bed designation from ASMRO.

(b) Request that servicing MILPO initiate separation processing after notification of a VA bed designation has been received and administrative discharge proceedings have been completed.

(c) Furnish copy of ASMRO message to the MILPO.

(2) Upon notification by the member's commander, MILPO having custody of the member's records will—

(a) Accomplish transfer processing actions as outlined in paragraph 3-7, AR 635-10, except for final pay and for issuance of the discharge orders and discharge certificate which will be accomplished by the CONUS transfer activity ((4)

below). OCONUS MILPO will, however, obtain from the member the address to which the member desires that final paycheck, discharge certificate and other separation documents be mailed by the CONUS transfer activity. No separation ceremony will be conducted.

(b) Collect the identification cards of the member and of any dependents.

(c) Prepare DD Form 214 WS (Worksheet for Report of Separation from Active Duty), except for items 9d, 18 and 22 which will be completed by the CONUS transfer activity ((4) (e) below). Insert DD Form 214 WS in the member's MPRJ. A Request/Decline form for the DD Form 214 will be obtained and inserted in the MPRJ.

(d) Issue PCS orders (Format 430, app. A, AR 310-10) reassigning the member, *for records processing only*, to that CONUS transfer activity listed in the ASMRO message. Additional instructions will specify that the member is to be medically evacuated direct to the (designated) VA medical facility as prescribed in this regulation. Additional instructions will authorize the member and dependents (by name and relationship) the same benefits and entitlements as authorized by their identification cards for a period of 30 days from the date the orders are issued.

(e) Forward to the CONUS transfer activity named in the reassignment orders ((d) above), at the time of the member's medical evacuation, the following:

1. Member's MPRJ, to include sufficient copies of PCS orders.
2. Member's Personal Financial Record (PFR).
3. One copy of the ASMRO message.
4. Notification that the health record has accompanied the member to the VA.

(3) Upon transfer, the OCONUS MEDCEN/MEDDAC will insure that the clinical and health record accompanies the member to the VA.

(4) The CONUS transfer activity commander, upon receipt of the member's MPRJ, PFR and ASMRO message, will—

(a) Contact the VA medical facility listed in the reassignment orders (and also listed in the ASMRO message) to determine the date of the member's arrival at the VA.

Note: For strength accountability purposes at the transfer

APPENDIX I
PROGRAM EVALUATION WORKSHEET

(To be published)

(As an interim evaluation measure, consult the Alcohol and Drug Abuse Prevention and Control Program checklist found in paragraph 2-2, AR 20-3, Department of the Army Special Subjects for Inspection, 4 August 1975.)

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